# CRISIS INTERVENTION IN RELIGIOUS COMMUNITY

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## Introduction

A religious community, like a family, is a complex interpersonal system–a dynamic web of personal relationships. Life cycle issues, such as ongoing growth, aging and death, as well as personal traumas, challenge the community in much the same ways that extended families are affected by the crises of change, death and loss. All crises demand a response on the part of the person and/or community for their successful resolution. As Martha Holden of the Family Life Development Center states: "Crisis is a normal, essential part of life. It's not a disorder but an opportunity for growth, no matter how severe the situation may appear." (Quoted in Henderson)

## Crisis

In a crisis, what has previously worked for the person or the community is no longer working and is precipitating some level of dysfunction (i.e., disruption of functional adaptation) in the individual or system. Dysfunction often goes unnoticed until the individual and/or community begins to suffer emotional distress, forcing the crisis into awareness. Crises can arouse feelings of anger, frustration, disorientation, powerlessness, apathy, guilt, depression, among others. Unresolved, severe crises can lead to prolonged unnecessary suffering, addiction, mental illness, loss of dignity and despair.

The word crisis means "a crucial situation." Crisis is from the Greek, *krinein*, meaning "to decide." Crisis is a turning point in life, demanding a decision for its resolution, and inevitably this requires a decision to change, to grow beyond what has become dysfunctional and maladaptive to a new level of adaptation and integration. One decides to change (for the better) or stagnate. In general, crisis has been divided into two categories: situational and developmental.[1] These may be experienced as either positive or negative events (e.g., loss or gain, birth or death, success or failure). What

[1]Situational crises are those psychological reactions to unpredictable and seriously frustrating, traumatic or even intensely fulfilling events, e.g., negative events such as loss of a loved one, loss of a job, catastrophe, addiction, sickness, or positive events such as a promotion, success of a major project, etc. Development crises are normal, predictable conflicts of the maturation and aging process through which each person passes. (See appendix on "Crisis.")

distinguishes a crisis is not the positive or negative value attributed to the situation, but the degree of stress and consequently the eventual success or failure at adaptation that occurs.

The basic principles of Crisis Theory in the human sciences were set out by Erich Lindemann and Gerald Caplan at the Harvard School of Medicine's Department of Psychiatry and at its School of Public Health in the 1970's. Lindemann defines crisis as a situation or event that disrupts the homeostasis or balance of a person or community. Caplan recognized that persons in crisis are very vulnerable, but that this brings with it an increased potential for growth. The fact that they are hurting increases the possibility of their being receptive to help from others. (Simington, Cargill, & Hill)

**Intervention Defined**

Intervention is broadly defined as "interference" in the affairs of one or more persons.[2] It evokes the synonyms of mediation, negotiation, arbitration, and intercession. Intervention, as we are examining it here, can be understood as an intentional process by which one or more persons attempt to introduce constructive change into the life of another person or social system. It becomes crisis intervention when these efforts address problems involving severe stress or breakdown in functioning. Interventions may be formal or informal. They may be single events or a series of actions in a developing process over a period of time in response to the changing nature of a crisis.

**Crisis Intervention**

Unacceptable levels of human suffering demand a response. The community has the moral responsibility and Christian duty to nurture and preserve the life and dignity of its members. In religious communities there has all too often been the risk in the past of members ignoring the inordinate suffering of a brother or sister as a given in an ascetical lifestyle. The Mother Superior of the Carmel at Lisieux initially rejected the doctor's diagnosis of St. Thérèse' tuberculosis in

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[2]The concept of "family intervention" was successfully developed and promoted by Vernon Johnson in the early 1960's whereby family members, and perhaps friends, come together to encourage a person to get help for his or her problem drinking. Over the years, this concept has expanded to include a wide range of issues and techniques for intervention. (See V. Johnson, *Intervention: how to help someone who doesn't want help*.)

disregard of her intense suffering, which she was, however, trying to make little of herself. We have to remain on guard against latent forms of Jansenism that value suffering for its own sake. It is helpful to remember the words of St. Irenaeus who tells us: "The glory of God is [the person] fully alive, and [the person] fully alive glorifies God." (*Against Heresies*, 4.20.7) Intervention should be motivated by authentic Christian charity in the attempt to reestablish homeostasis and preserve the life and dignity of the person.

**Criteria for Intervention**

Interventions become necessary because other attempts to rectify the situation by any other means have failed. Situations that might call for intervention include: failure at self-care, self-destructive behavior, behavior disrupting community life, addiction, and serious self-neglect as an indication of loss of mental competence that may signal emergent dementia or mental disorder (psychological or neurological). There are many types of addiction, and they usually present those in responsible positions with the moral dilemma of deciding at what point, if at all, to intervene.[3]

In religious communities, especially at this time in the life of the Church, the most common crises needing intervention are, perhaps, crises of aging–the gradual or sudden diminishment of physical and mental abilities and the profound consequences of these losses. Religious communities throughout the Church are experiencing a shortage of young people entering religious life and the movement of the average age of its members into the fifties, sixties and, for many, the seventies. Communities have traditionally responded well to the moral obligation of providing elder care for its members, but this task is turning some houses into nursing homes run by a handful of members in their forties, fifties and sixties. Some communities are facing the prospect of having no one younger to care for them when the caretakers have grown old. In such cases, the religious orders and the Church at large need to facilitate a resolution to the dilemma of who will care for our elderly religious when they can no longer care for themselves.

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[3]Besides addictions to alcohol, tobacco and drugs, there are major addictions to work, sex, food, gambling and video–including TV, computers, online chat rooms and video games, among others, and it is not impossible that any of these could occur in a religious community.

Preceding any intervention, a process of discernment is warranted and might include some form of medical or psychological assessment. This assessment might be performed by consultation within the community itself or by drawing on professional resources sensitive to community life and its particular issues.

Questions to ask in the process of discerning the need for intervention include: 1) Is the subject in a crisis situation that is causing undue suffering, loss of dignity, severe stress or emotional breakdown to self and/or others? 2) If left unaddressed, where might the crisis lead; what are the worst and best expectable outcomes if left unaddressed? 3) Is the situation, in any way, open to remedy? 4) What might a compassionate intervention look like for this situation? 5) What are the coping skills of the person(s) in crisis that might be harnessed by intervening the situation?

The alternative to intervention is letting the person be. The Anglican theologian, John Macquarrie, qualifies the meaning of "letting be" as it refers to God's love, and it is in this sense that I mean "let be": "In ordinary English usage, to 'let be' often means to leave alone, to refrain from interfering. This is not the sense that is intended here. By 'letting be' I mean something much more positive and active, as enabling to be, empowering to be, or bringing into being." (*Principles of Christian theology*, 113) It is in this supportive, nurturing and life-giving sense of "letting be" that I am speaking. Patient endurance motivated by genuine compassion may be an appropriate response. After careful discernment and assessment, this may be the preferred course to active intervention.

**Goals of Intervention**

The goal of intervention is positively to change the situation for the benefit of the person or persons negatively affected by the crisis at hand. This is done by evaluating alternatives and employing specific remedies in an effort to reestablish an optimal level of adaptation or homeostasis with a corresponding reduction in mood disturbance and the suffering of those affected. Other goals more specifically include: 1) understanding the problem, 2) emotionally supporting the person(s) involved, 3) assessing and evaluating the coping skills, competency, and resources of the subject(s) of the intervention, and 4) drawing on available resources in or out of the community to bring about a

satisfactory solution.

**The Intervention Process**

Usually, attempts at problem resolution have been tried and have failed before a judgment for intervention is made. It is common to see crises addressed by a series of failed solutions before the critical point for intervention is assessed. There are three basic movements to intervention after an assessment has been made: preparation, intervention, and follow up. There are a number of models for intervention, but most contain similar steps that elucidate these basic movements. A synthesis is presented here.[4]

Critical questions concerning intervention include: When does one intervene? Who should intervene? What approach does one take? What if the subject refuses or cannot cooperate? These and other salient questions are addressed in the following seven stage model of intervention. It is important to remember that interventions can often be highly emotional experiences for all involved and careful preparation provides a necessary safeguard in preventing things from getting out of hand and keeping the process focused and on track.

**Seven Stages of Intervention**

Stage 1: Pre-Planning

Stage 2: Recognition

Stage 3: Consultation

(Possible Intervention Stage: Informal Intervention)

Stage 4: Assessment and Evaluation

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[4] Roberts offers a Seven-Stage Crisis Intervention Model: 1) crisis assessment, 2) establishing rapport, 3) identifying the major problems, 4) dealing with feelings, 5) generating and exploring alternative ways of coping, 6) formulating a plan, and 7) establishing follow up. See A. R. Roberts, (Ed.), (2000), *Crisis intervention handbook: assessment, treatment and research,* New York: Oxford University Press. See also N. Golan, (1978), *Treatment in crisis situations,* New York: The Free Press; C. Nation,(1988), Managing Crises, *Streamlined Seminar*, 6; and R. L. Pavelsky, Crisis intervention theory, *Dictionary of Pastoral Care and Counseling,* ed. R. J. Hunter, Nashville: Abingdon Press.

Stage 5: Planning and Preparation

Stage 6: Formal Intervention

Stage 7: Post-Intervention Follow-Up

*Stage 1: Pre-Planning.* Planning in advance of any need for intervention can increase the likelihood a successful resolution. A community that is committed to the concept of intervention can prepare all members for the possibility that they may have to participate at some level, including being the subject of the intervention. Preplanning would include: 1) developing a crisis intervention team to co-ordinate any needed intervention; 2) maintaining a list of support services in and out of community that could facilitate an intervention, including medical doctors, psychiatrists, nurses, psychologists, counselors, and trauma responders; 3) designating an intervention space that is a neutral, safe place for members of the community and that preserves privacy and dignity; 4) maintaining a regular review of crisis intervention planning (every few months, but at least yearly); 5) training members of the crisis intervention team in the appropriate skills, including crisis management, empathic listening, and providing an emotionally "safe" environment for the subject(s); and 6) assigning a record keeper to document the process since such records might offer psychological, medical or legal assistance in an expanding intervention. In the case of alcoholism or drug abuse or other addiction, seeking help from a professional interventionist might increase the probability of a successful outcome since resistance and denial in the subject is usually high.[5]

*Stage 2: Recognition*. Recognition or identification of crises that might require intervention is the next stage. Some of the factors here include: 1) identifying the problem; 2) working through the possible denial in oneself and others; 3) effectively processing feelings of guilt one might have over the situation or the need to intervene; 4) initiating documentation; and 5) avoiding the role of "messiah" or co-dependency in which one or more persons decide to just suffer with the problem rather than effectively addressing it. Specific things to look for include: 1) changes in behavior that

[5]There are professionals who specialize in intervention, often with a background in addictions counseling, and referrals can be sought from psychiatrists, psychologists, family therapists or other mental health professionals.

seem out of character for the person and that are cause for alarm (e.g., a decrease in adequate hygiene, serious loss of memory, recurring injuries, emotional withdrawal from the community, significant uncharacteristic changes in temperament, or serious weight loss); 2) cries for help, (e.g., acting out behavior or the sudden making of unusual, distressing emotional demands on others); 3) development of an addiction as a symptom of some deeper crisis (e.g., use of alcohol or drugs as a form of self-medication or working long hours to compensate for some loss of mental ability); 4) serious decline in ability to care for self; and 5) threats or acts of self-destruction or self-injury, including serious addiction, parasuicidal behavior[6] or suicidal ideation or actual attempts to suicide.

*Stage 3: Consultation*. Consultation is a natural extension of the recognition or identification stage. Consultation normally begins within the community as the one who identifies the crisis seeks input from the subject of the crisis, the superior or others acting on her or his behalf, the infirmarian, and/or others who are directly or potentially involved. Depending on the severity and complexity of the crisis, the intervention team then might consult with professionals in the community who are experts in the particular needs of the subject(s). The steps here are: 1) listening to the subject(s) and understanding their take on the situation; 2) assessing their needs; 3) consulting within community; and 4)seeking professional advice, guidance and/or direct participation of outside experts.

*Possible Intervention Stage: Informal Intervention*. At this point, it could be decided that an informal intervention or series of interventions over time might be done by one or more interventionists. Informal interventions are often all that are necessary when the subject is mentally competent and potentially willing to involve her or himself in the process of healing. In fact, informal interventions might actually be the norm for intervention in the religious community as superiors, infirmarians, and friends intervene in the lives of religious who are in crisis. If the informal intervention fails or if it is not possible then the intervention team plans a formal intervention and moves through the next three stages. Intervention does not necessarily have to be carried out by a team, but might be done by one or two influential persons or a friend or friends of

[6]Parasuicidal behavior consists of violent acts against oneself that are destructive but usually do not result in death. These are often cries for help and not intended attempts to suicide.

the subject. Interventions may occur as a process, over time, as the situation demands.

*Stage 4: Assessment and Evaluation*. An assessment is made, most likely in the course of consultation, of the nature and cause of the crisis, including an evaluation of the severity of the crisis and the potential long term consequences if the situation goes unaddressed. One attempts to determine if the crisis is life threatening, urgent or slowly emergent. **If there is any indication of life threatening circumstances or serious self-harm to the subject, act immediately!** Consultation with professional medical and/or psychological resources may be warranted.

*Stage 5: Planning and Preparation*. In the planning stage, the intervention team, in possible consultation with psychological or medical personnel, do the following: 1) set priorities; 2) examine risks, benefits and alternatives; 3) identify the most appropriate action, treatment and environment; 4) identify the person or persons who will do the intervention; 5) possibly role play the intervention to perfect skills; 6) schedule time(s) and location(s), assuring all necessary support persons will be available; and 5) receive feedback from any parties involved.

*Stage 6: Formal Intervention*. If the subject of the intervention is mentally competent, he or she is informed at the time of the intervention about what is taking place. If they are mentally incompetent, then the intervention may simply be an acting on behalf of the subject. Intervention is, ideally, a compassionate act in the best interest of the person(s) in crisis in an attempt to introduce a constructive, healing remedy. It will be designed with the least amount of confrontation possible for effectiveness still to be maintained. The intervention team will seek to build the solution to the crisis situation around the subject's strengths and gifts, maintaining as much of his or her dignity in the face of a potentially painful, and possibly humiliating, experience. The persons intervening will practice active listening skills in order for the subject to feel understood and valued. Some important things to do: 1) be humble, gracious, respectful; 2) balance gentleness (not indulgence) with firmness and assertiveness (not aggression); 3) listen empathically; 4) provide a balanced, succinct explanation of what is happening; 5) be optimistic as can be about the future; and 6) seek to empower and strengthen the spirit of the subject. Some important things not to do: 1) do not become

a martyr or messiah (you are not their savior); 2) do not become over-emotional, but remain calm and reassuring; 3) do not take yourself too seriously, but be warm and easy to be with; and 4) avoid being judgmental, but exercise understanding and patience.

*Stage 7: Post-Intervention Follow-Up*. Follow up is essential to both formal and informal interventions in order to assess their effectiveness. The intervention person or team may perform a follow-up assessment and consultations with those who have been involved. Record-keeping may continue until a final determination of the success of the intervention has been made by the team.

**Conclusion (Ending on the Most Important Point of All)**

Most importantly of all, prepare and conduct interventions in a prayerful way. To be a contemplative presence to the person can be healing and consoling for all involved. Remember, contemplation means "to gaze upon attentively." One attends, with an open awareness, to the whole field of interpersonal relationship unfolding in the crisis intervention. This contemplative presence is a nonmanipulative presence to God and the person. It is a "letting be" of the other who is encouraged and challenged in the natural and graced unfolding of their life. Contemplative presence is loving and gentle, yet disciplined and firm if need be. ["Attention" comes from the Latin root *tendere* which means "to stretch" and *attendere* = "to stretch toward, give heed to."] Contemplative presence is a stretching out of and extending of oneself in love for the other. As W. B. Yeats has written: “We can make our minds so like still water that beings gather about us that they might see, it may be, their own images, and so live for a moment with a clearer, perhaps even with a fiercer life because of our quiet.” (W. B. Yeats, *The Celtic Twilight*)

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# Appendix

## Some Thoughts on Crisis

Crises inevitably challenge one's sense of self-assurance and autonomy. A passage through crisis is a passage through the darkness and loneliness of self-sufficiency. Crisis forces a radical confrontation with one's secure ways of being in the world, demanding the surrender of part of one's very self. Unless one is willing to die to one's maladaptive and egocentric ways of living and being, one does not mature in understanding and love; one refuses to grow. The act of surrender opens one to transformation, to the possibilities of being remade and reborn anew by powers and persons beyond one's control. Crisis' successful resolution is contingent upon this surrender, in love, of part or all of oneself. "If a person wishes to come after me, he must deny his very self, take up his cross, and begin to follow in my footsteps. Whoever would save his life will lose it, but whoever loses his life for my sake will find it." (Mt 16:24-25)

For the Christian, the paradigmatic symbol of the passage through crisis is the Paschal Mystery: the life, death, and resurrection of Jesus Christ. Mark Searle observes that, "The pilgrimage of faith is not a journey in a straight line, with death waiting at the end, but a kind of spiral through which progress is made only in successively deeper experiences of death and rebirth" (Searle, pp. 44-45). Entry into crisis is dark and painful; it is an experience of crucifixion that demands the sacrifice of self-centered ways of living and being. In crisis the individual is hung up and stretched out between old ego-centric patterns of behaving and relating, and the demand to open to the new, to the life-giving, to love and a life of greater selflessness. The resolution of crisis depends not so much on any changes in the external world--often these never occur, but on the graced transformation of the subject. Transformation ultimately comes as gift. One is powerless to effect it on one's own, although one must open to it. The decision to be transformed by the grace offered in this encounter is the moment of both self-transcendence and conversion; it is the experience of cross and resurrection. Understood in this way, Jesus' death and resurrection forms the paradigmatic symbol for all human life and growth. Truly, whoever loses his or her self in God as Christ has done will find it transformed anew in resurrection.

# SEVEN STAGES OF INTERVENTION

## STAGE 1: PRE-PLANNING

1) develop crisis intervention team
2) maintain list of support services in & out of community
3) designate neutral intervention space
4) maintain regular review of crisis intervention planning
5) train members of crisis intervention team
6) assign a record keeper

## STAGE 2: RECOGNITION

1) identify problem
2) work through denial in oneself & others
3) process feelings of guilt one might have
4) initiate documentation
5) avoid role of "messiah" or co-dependent

**Specific things to look for include:**

1) changes in behavior that seem out of character for the person & that are cause for alarm
2) cries for help
3) development of an addiction as symptom of some deeper crisis
5) threats or acts of self-destruction, self-injury or violence toward others

## STAGE 3: CONSULTATION

1) listen to the subject(s) & understand their take on situation
2) assess their needs
3) consult within community
4) seek professional advice, guidance and/or direct participation of outside experts

## POSSIBLE INTERVENTION STAGE: INFORMAL INTERVENTION

1) might be sufficient if subject is mentally competent & willing to involve self in process
2) might be done by one or two influential persons or a friend or friends
3) may occur as a process, over time, as the situation demands

## STAGE 4: ASSESSMENT AND EVALUATION

1) assess nature & cause of the crisis
2) determine if crisis is life threatening, urgent or slowly emergent.

**Any indication of life threatening circumstances or serious self-harm to the subject act immediately!**

3) professional medical and/or psychological resources may be warranted

## STAGE 5: PLANNING AND PREPARATION

1) set priorities
2) examine risks, benefits & alternatives
3) identify the most appropriate action, treatment & environment
4) identify the person or persons who will do the intervention
5) possibly role play the intervention to perfect skills
6) schedule time(s) & location(s), assuring all necessary support persons will be available
5) receive feedback from parties involved

## STAGE 6: FORMAL INTERVENTION

1) be humble, gracious, & respectful of subject's dignity
2) balance gentleness (not indulgence) with firmness & assertiveness (not aggression)
3) listen empathically & compassionately
4) provide a balanced, succinct explanation to subject of what is happening
5) be optimistic as can be about the future, but be honest
6) seek to empower & strengthen the spirit of the subject, building on his/her strengths

**Some important things not to do:**

1) do not become a martyr or messiah (you are not their savior)
2) do not become over-emotional, but remain calm & reassuring
3) do not take yourself too seriously, but be warm & easy to be with
4) avoid being judgmental, but exercise understanding & patience

## STAGE 7: POST-INTERVENTION FOLLOW-UP

1) assess effectiveness in follow-up
2) consultation with those who have been involved
3) record-keeping reviewed

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