

I. THE EXPERIENCE OF CRISIS

Crisis crushes. And in crushing, it often refines and purifies. You may be discouraged today because the crushing has not yet led to a surrender. I've stood beside too many of the dying, ministered to too many of the broken and bruised to believe that a crushing is an end to itself. Unfortunately, however, it usually takes the brutal blows of affliction to soften and penetrate hard hearts. Even though such blows often seem unfair.... After crises crush sufficiently, God steps in to comfort and teach.

--Charles Swindoll, *Growing Strong in the Seasons of Life* ¹

When people ask about the reasons for their crises, it is difficult and often impossible to give definitive answers.... We may agree that every event has a divine purpose and ultimately is under God's control. We know that crises can be learning experiences that mold character, teach us about God and His resources, and stimulate growth. But the ultimate reasons for specific life crises may never be known while we are on this earth.

--Gary R. Collins, *Christian Counseling: A Comprehensive Guide* ²

Blessed be God, even the Father of our Lord Jesus Christ, the Father of mercies, and the God of all comfort; Who comforteth us in all our tribulation, that we may be able to comfort them which are in any trouble, by the comfort wherewith we ourselves are comforted of God. For as the sufferings of Christ abound in us, so our consolation also aboundeth by Christ.

--2 Corinthians 1:3-5

II. CHARACTERISTICS OF PERSONS WHO EXPERIENCE CRISIS

Mental health professionals use the *Diagnostic and Treatment Manual of Mental Disorders*³ (DSM-IV) as their official guideline for defining and diagnosing patients' symptoms. The category for severe trauma or distress from a traumatic event is called "Post Traumatic Stress Disorder," or P.T.S.D., which is what used to be known as "shell shock" or "combat fatigue" suffered by many war veterans, but which now includes anyone who is overwhelmed by traumatic life circumstances.

The National Center for P.T.S.D. suggests that most people who experience an extremely stressful life event will have symptoms of P.T.S.D. for some days or weeks afterward, but the symptoms generally decrease and disappear over time. But 8 percent of males and 20 percent of females who endure such an experience will develop P.T.S.D., and approximately 30 percent of these individuals will have a chronic or life-long version of the disorder. ⁴

P.T.S.D. has three “clusters” of symptoms:⁵

1

Re-experiencing the traumatic event:

- Recurring nightmares
- Intrusive daydreams or flashbacks
- Dissociative experiences [experiencing one’s self in another place or time—reliving the trauma]
- Intensification of symptoms on exposure to reminders of the event

2

Avoidance or numbing:

- Efforts to avoid thoughts, feelings, activities or situations associated with the trauma
- Feelings of detachment or alienation
- Inability to have loving feelings

3

Hyper-arousal:

- Exaggerated startle response
- Insomnia and other sleep disturbances
- Irritability or outbursts of anger
- Physiological reactions to exposure to reminders of the event

The diagnostic criteria for P.T.S.D. include:

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror. Note In children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
 - (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of (detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - (1) difficulty falling or staying asleep
 - (2) irritability or outbursts of anger
 - (3) difficulty concentrating
 - (4) hypervigilance
 - (5) exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor. ⁶

[P.T.S.D.] can affect anyone who has experienced a traumatic event, such as rape, robbery, a natural disaster, or a serious accident. A diagnosis of a serious disease can trigger P.T.S.D. in some people. Considered to be a group of conditions known as “anxiety disorders,” it can affect people of all ages who have experienced severe trauma. Children who have experienced severe trauma, such as war, a natural disaster, sexual or physical abuse, or the death of a parent, are also prone to P.T.S.D.⁷

People helpers and family members need to understand that when a person survives trauma, his or her ability to relate to others is drastically affected:

Survivors of childhood sexual and physical abuse, rape, domestic violence, combat, or terrorism, genocide, torture, kidnapping or being a prisoner of war, often report feeling a lasting sense of terror, horror, vulnerability and betrayal that interferes with relationships. Feeling close, trusting and emotionally or sexually intimate may seem a dangerous “letting down of my guard” because of past traumas.... Having been victimized and exposed to rage and violence, survivors often struggle with intense anger and impulses that usually are suppressed by avoiding closeness or adopting an attitude of criticism or dissatisfaction with loved ones and friends.... Survivors may be overly dependent upon or overprotective of partners, family members, friends or support persons (such as healthcare providers or therapists). Alcohol abuse and substance addiction—as an attempt to cope with P.T.S.D.—can destroy intimacy or friendships.⁸

Parents, counselors, teachers and others who love and work with children should be aware of the devastating effects of violence on young lives. Children who are exposed to violence, whether as victims or as witnesses, experience numerous destructive consequences, according to a review of psychological research by the Department of Psychology at the University of Southern California. The reviewers looked at 206 recent studies and found the following:

- Children’s aggressive behaviors, and acceptance of aggression as a norm in close relationships, are consequences of physical abuse.
- Children who experienced physical or sexual abuse tend to exhibit self-destructive behaviors, including running away, drug abuse, and touching or soliciting touching from adults including strangers.
- Sexually abused children show excessive and inappropriate sexual behavior, including sex play.
- Studies were inconclusive as to whether a child was harmed more by observing inter-parental violence or by receiving parent-child aggression.
- Exposure to violence and victimization in the community is directly linked to a child’s aggressive behavior.
- “The harsh and uncontrollable punishment and parental rejection found in an abusive home environment may cause learned helplessness, ineffectiveness, anxiety and depression in the child. Violence exposure can be interpreted by the child to mean not only that the world is unsafe but also that the child is unworthy of being kept safe.”
- One study (Tong et.al. 1987) found that sexually abused children self-rated lower than control-group children in intellectual and school status, physical appearance and attributes,

anxiety, popularity, happiness and satisfaction. But another study (Einbender & Friedrich 1989) found no correlation between sexual abuse and self-concept.

- Sexual and physical abuse have been linked to fear, separation anxiety, physical symptoms, elimination disorders, and social avoidance.
- Domestic violence between parents and maternal abuse have been correlated with phobias, fears and separation anxiety.
- Exposure to stress and trauma have been associated with developmental delays, difficulties in social relationships with peers, abnormal psychological development, hormonal problems, learning difficulties and the onset of puberty.⁹

Many different types of violence and the consequences for children

Outcomes associated with exposure to violence range in nature and severity. As the developmental psychopathology literature suggests, each type of victimization can lead to diverse outcomes, and alternatively, diverse types of exposure to violence can lead to the same developmental outcome. The effects of exposure to violence may be less dependent on the type of exposure and more dependent on the processes and pathways by which exposure affects individual children. Moreover, because the type and severity of outcomes experienced by a child may change as that child develops and matures, assessments of outcome must be viewed as highly time specific....

Much remains to be learned about how children's behavioral, cognitive, affective, and physiological processes are disrupted by exposure to violence and about how functioning in these different systems is interconnected. Continued attention to identifying the variability in children's reactions to violence and how the nature of response relates to developmental stage and environmental circumstances will assist in identifying important targets for intervention and prevention.¹⁰

III. THE DIFFERENT TYPES OF CRISES

Christian psychologist, writer and teacher Gary Collins identifies three types of crises:

- ***The accidental or situational crisis*** occurs when there is a sudden threat, intensely disruptive event, or unexpected loss—such as the death of a loved one, the diagnosis of a serious illness, unanticipated loss, rape or other violence, pregnancy before marriage, war or economic depression, loss of a job or savings, or a sudden loss of respect or status. When stress is caused by an external event (persecution, prejudice, natural disaster, fire, etc.) it can help a family draw closer together. But internal stress (suicide or attempt, extra-marital affair, child abuse, drug/alcohol abuse) can damage or destroy a family. Even more destructive are sequential crises or losses, in which one major disruption follows another.
- ***Developmental crises*** are those which occur during the normal course of life, such as beginning school, moving away to attend college, marriage and becoming parents, receiving criticism, retirement from work, health problems of later years, deaths of friends.
- ***Existential crises*** have to do with changes in one's perception of self as a result of life-disruption due to one or more of the first two types of crises. ¹¹

Understanding the nature and type of crisis is helpful for counselors who want to facilitate their clients' coping with and moving through crisis. H. Norman Wright, a Christian counselor, educator and author, links change and four phases that are typically involved in life-changing events or crises:¹²

Change and Crisis Sequence

	<u>Phase I</u>	<u>Phase II</u>	<u>Phase III</u>	<u>Phase IV</u>
<u>Impact</u>		<i>Withdrawal, Confusion</i>	<i>Adjustment</i>	<i>Reconstruction, Reconciliation</i>
<u>Time</u>	HOURS	DAYS	WEEKS	MONTHS
<u>Response</u>	Fight-Flight	Anger-Fear-Guilt-Rage	Positive Thoughts Begin	Hope
<u>Thought</u>	Numbness, Disorientation	Ambiguity, Uncertainty	Problem Solving	Consolidation of Problem Solving
<u>Direction</u>	Search for Lost Object	Bargaining, Detachment	Search for New Object	Reattachment
<u>Search Behavior</u>	Reminiscence	Perplexed Scanning	Focused Exploration	Reality Therapy
<u>Guidance Needed</u>	Acceptance of Feeling	Task-Oriented Direction	Support, Spiritual Insight	Breakthrough, Reinforce Hope

In addition to understanding the nature of crises, counselors must know which interventions to apply if they want to be of practical help to their clients who face crises.

IV. PSYCHOLOGICAL INTERVENTIONS FOR HELPING PEOPLE IN CRISIS

In medicine and in mental health work, we want to know what is most helpful in bringing the client to maximum recovery of normal functioning. One authority states:

The severity of the illness [P.T.S.D] depends in part on whether the trauma was unexpected, the severity of the trauma, how chronic the trauma was (such as for victims of sexual abuse), and the person's inherent personality and genetic make-up. With appropriate medication, emotional support, and counseling, most people show significant improvement. However, prolonged physical or sexual abuse and [trauma such as was suffered by] survivors of the Holocaust may cause permanent psychological scars.¹³

The majority of mental health professionals seem to agree that combining medication management and certain types of educative and supportive therapy is the most effective approach to treating people who suffer the affects of crisis.

Effective medications include anxiety-reducing medications and antidepressants, especially the selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (Prozac). Sleep problems can be lessened with brief treatment with an anti-anxiety drug, such as a benzodiazepine like alprazolam (Xanax), but long-term usage can lead to disturbing side-effects, such as increased anger. Therapy can help reduce negative thought patterns and self-talk. Cognitive-behavioral therapy focuses on changing specific actions and thoughts with the help of relaxation training and breathing techniques. Group therapy with other P.T.S.D. sufferers and family therapy can also be helpful.¹⁴

In a study of adolescents who attempted suicide, it was recommended that “Clinicians should ask adolescents directly about the cognitions behind their suicide attempt and should focus on thoroughly assessing depression, anger, and perfectionism, particularly when an adolescent attributes his or her suicide attempt to a desire to die.”¹⁵ The rationale for doing this is that reshaping the individual’s thinking process provides the best protection against a recurrence of deadly behaviors.

Children who have been severely traumatized by sexual abuse and thus show symptoms of post-traumatic stress disorder should be treated with cognitive-behavioral treatment (CBT) strategies, according to research that was conducted through a grant from the National Health and Medical Research Council:

In a manual-based, structured CBT program, children were encouraged to confront or deal with their abusive experiences. The intervention produced significant clinical improvements in relation to targeted PTSD symptoms (re-experiencing, avoidance, and hyper-arousal). Of course, manual-based programs for sexually abused children must be individualized in clinical practice, allowing for unique child, family, and sexual abuse influences.¹⁶

What must a counselor aim to accomplish when working with traumatized clients? Dr. Gary

Collins gives four counseling goals:

- To help the person cope effectively with the crisis situation and return to his or her usual level of functioning.
- To decrease the anxiety, apprehension, and other insecurities that may persist during the crisis and after it passes.
- To teach crisis-management techniques so the person is better prepared to anticipate and deal with future crises.
- To consider biblical teachings about crises so the person learns from the crisis and grows as a result.¹⁷

What specific steps are recommended for counselors who are helping a person who is in crisis?

H. Norm Wright writes the following about the process of crisis intervention:

- The first step is *immediate intervention*, because outcomes of crisis can be startlingly severe, including a high potential for suicide, homicide, running away, physical injury, psychosis, or family breakup. The counselor needs to work to help prevent such disastrous outcomes by assessing the urgency of the situation, forming a plan to help the person, limiting the initial conversation if it is a phone call so that the work of counseling will be done face-to-face, and working to establish a relationship with the client.
- The second step is action to *move the client toward “meaningful, purposeful and goal-directed behavior.”* The counselor needs to be very active from the first session: encouraging the person to express feelings and identifying the precipitating event; assessing the person’s strengths, weaknesses, support system, risk factors (to self/others); helping him/her consider possibilities or alternatives and obstacles to recovery.
- The third step is to “avert catastrophe and restore the person to a state of balance” by *helping him/her achieve a limited goal*, because “Just the simple task of completing some action can provide a sense of relief.”
- The fourth step is to *help the person gain some hope* and “positive expectations” by helping him/her accurately look at information about the crisis. This simple process establishes a sense of balance or equilibrium. In addition, the counselor can help the client consider choices and consequences of decisions on himself and on others.
- The fifth step is to *provide support* by being available and by helping the client to expand his/her support system.
- Step number six, *focused problem solving*, is the “backbone of crisis counseling.” As soon as the client is able to do so, he/she needs to be actively involved in establishing a plan of action to work through the crisis.
- In step seven *the counselor assesses the client’s view of self*, how the crisis affects it, and what counseling will do to affect it. The counselor is aware of issues of self-blame, anger, lack of control in the client’s life, and the hopelessness that crisis brings.
- Finally, step eight involves *building a sense of self-reliance*. A general rule to follow is to “Do nothing for the counselee that he or she can do successfully.”¹⁸

A similar checklist for “psychological first aid in times of mental health emergencies” also gives eight crisis interventions:

- Make eye contact and appropriate physical contact (“if in doubt, don’t” touch the client).
- Reduce anxiety.
- Focus on issues.
- Evaluate resources (spiritual, personal, interpersonal, legal, medical, psychological, financial, educational; temporary housing if needed; meals, childcare).
- Plan intervention.
- Encourage action: Listen and learn about the problem; list alternatives for action; decide on a course of action; take action; evaluate the results of action taken; based on the evaluation, continue on the chosen course or repeat the above steps.
- Instill hope.
- Follow up, once the crisis has resolved and the individual has recovered.¹⁹

Helping a suicidal person can be exhausting and emotionally demanding for the counselor, who must have a solid understanding of what to do (and what not to do) when a client is ready to kill himself. Although clinical guidelines are voluminous (and could easily provide material for another paper), counselor H. Norman Wright provides a straightforward standard to use when someone is suicidal:

Steps in Helping the Suicidal Person:

- Establish a relationship, maintain contact with the person, establish rapport, and obtain information.
- Identify and clarify the problem.
- Evaluate the suicidal potential or lethality: age and sex; History of the suicidal behavior (evaluate to suicide plan for lethality, availability of the means, specificity of the plan); Stress; Symptoms; Resources; Lifestyle; Communication with others; Medical status.
- Formulate a plan to help the caller.

Three Crucial Elements:

- Activity.
- Authority.
- Involvement of others.²⁰

In a study of what can be done to facilitate clients' recovery from trauma, researchers determined that an individual's growth or recovery occurs in three major areas:

[c]hanges in perception of self; changed relationships with others, and a changed philosophy of life that includes a deeper appreciation for life, along with new life directions and priorities.... Individuals' self-perceptions can be changed to that of a person vulnerable to difficulties in life... but also to that of a person who is self-reliant and capable of coping with difficult challenges.... Changes are also reported in the individual's relationships with others. These tend to include an experienced increase in interpersonal and emotional closeness with at least some other persons, a perceived increase in one's freedom to express emotions, and an increase in one's reported sympathy and understanding for the suffering of others.... Changes in philosophy of life involve for many persons a change in life priorities, an increased experience of existential wisdom, and a greater interest in and openness to spiritual and religious matters.... These reported changes are regarded by the individual as inherently positive, and they are reported... by at least some persons experiencing even the most horrible sets of circumstances....²¹

The significance of that statement, to me, is that it is possible for any person who experiences traumatic life-events to work through the psychological pain and move into a deeper life-experience—a transcendence to a higher understanding or philosophy. In other words, the person becomes deeper in terms of his/her personality and life-philosophy. The person whose faith is founded on God would be the one who is most likely to “transcend” trauma in this way.

V. BIBLICAL OVERVIEW OF CRISIS AND THE WORK OF THE COUNSELOR

“The Christian counselor is in a vital position to influence which direction the crisis resolution will take,” writes Dr. Gary Collins.²² The truth in that statement is what draws many Christians to the ministry of counseling and healthcare. Depending on the practitioner’s source of their professional training and his/her individual ability to apply the Scriptures to clinical work, the Christian professional may or may not be very different from secular counselors in what is done in therapeutic situations.

One established Christian counselor recommends the following approach to applying biblical principles with clients:

- Listening, as we see God listening in the Scriptures (Psalm 34:15-18; 116:1, 2; Jeremiah 33:3; James 1:19; Proverbs 15:31; 18:13; 21:28). “Listening is one of the most loving gifts you can give to another person whether it be counselee, friend, or family member.”
- Learning when to speak and when not to speak. (See Ecclesiastes 7; Proverbs 10:19; 17:27-28; 29:20).
- Keeping confidences builds trust (Proverbs 21:23).
- Saying the right words in the right way (Proverbs 25:20).
- Edifying and helping others carry their burdens (Galatians 6:2; Romans 14:19; 12:15; Proverbs 12:25; 1 Thessalonians 5:11, 14).
- Practicing empathy and agape love (1 Corinthians 13:4-8).
- Confronting appropriately and at the right times (2 Samuel 12:7-14).
- Being honest and accepting (Proverbs 28:23; 27:5; Galatians 6:1; John 8:7).²³

Christian psychiatrists Frank Minirth and Paul Meier provide scriptural truths regarding the spiritual basis of emotional problems.²⁴ These truths are appropriate, I believe, to work into our counseling sessions with people who are in crisis:

- Self-worth: because Christ commanded us to “love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind... and ... love thy neighbour as thyself.” (Matthew

22:37-39), we ought to help clients understand and move toward “a genuine love of self” as a person created by God for His purposes.

- Intimacy with God and others: numerous Scriptures, including the teachings of Christ (and the verse cited above), emphasize the need to live in loving relationship with our Creator and with our fellow created humans.
- The need to know Christ and grow in Christ through the frequent study of the Word of God and fellowship with other Christians.
- Dealing with sin and its effects in one’s life.

Although the context is not specifically about crisis counseling, Dr. Jay Adams teaches some general biblical guidelines that Christians should apply when overwhelming problems arise in their lives:

- *Think First of Christ.* Ask yourself, “How is this an opportunity to honor and serve Him?” This consideration will lead to a proper orientation toward the problem....
- *Seek Christ’s Wisdom and Strength.* Through prayerful study of the Scriptures ascertain His will in the matter. Christ has the solution to your problem in His Word and gives the strength to meet it by His Spirit. Ask Him to meet both needs. When you are sure of the biblical course of action that you should take, step out in obedient faith, whether you feel the strength to move ahead or not. The ability often is given in the doing.
- *Turn to Christ’s Undershepherd...* the church pastor.
- *Engage the Ministry of Christ’s Church...* the mutual ministry of other believers....²⁵

Certainly a person should turn first to the Lord and His Word, and to his/her pastor and the Church. But assuming the problem or crisis is so besetting and overwhelming that the individual cannot do these things, or does not have the personal or interpersonal resources to do so? In that case, whomever the person sees and no matter what theoretical approach the practitioner or pastor has in counseling, the characteristics of a Christian counselor should be:

- A deeply committed, Spirit-guided (and Spirit-filled) servant of Jesus Christ
- Who applies his or her God-given abilities, skills, training, knowledge and insights
- To the task of helping others move to personal wholeness, interpersonal competence, mental stability and spiritual maturity.²⁶

A well-trained and equipped counselor with these traits is very likely to be helpful to the person who, seeks help in a crisis situation. At such times, the Lord can work through the counselor to bring the hurting person to recovery and a renewed purpose to serve Him for the remainder of his/her days on earth.

VI. SUMMARY

Counselors face a bewildering and seemingly impossible task when asked to help those who experience trauma, especially when the suffering ones are children, who can be unimaginably devastated by abuse or tragic circumstances. But psychological research provides us with a virtual library of resources to help us understand both the effects of crisis and the interventions that are most helpful for recovery. Christian counselors have the additional resources of hope for healing that is based in Christ—and the fellowship of other believers who can come alongside the suffering person to help with the healing process.

BIBLIOGRAPHY

- ¹ Charles Swindoll, *Growing Strong in the Seasons of Life* (Portland, Ore.: Multnomah, 1983), pp. 274-275.
- ² Gary R. Collins, *Christian Counseling: A Comprehensive Guide* (Waco: Word, 1988), p. 65
- ³ *Diagnostic and Treatment Manual of Mental Disorders*. Washington, D.C.: American Psychiatric Association, Fourth Edition, 1994.
- ⁴ The National Center for P.T.S.D. “Seeking Help for Post-Traumatic Stress Disorder” fact sheet (www.ncptsd.org).
- ⁵ Ibid.
- ⁶ American Psychiatric Association, op. cit.
- ⁷ Carol A. Turkington, article in the *Gale Encyclopedia of Medicine*. Gale Research, 1999.
- ⁸ “P.T.S.D. and Relationships” fact sheet, the National Center for P.T.S.D. (www.ncptsd.org).
- ⁹ Gayla Margolin and Elana Gordis, “The Effects of Family and Community Violence on Children.” *Annual Review of Psychology*, 2000.
- ¹⁰ Ibid.
- ¹¹ Collins, op. cit., pp. 64-65.
- ¹² H. Norm Wright, *Crisis Counseling: Helping People in Crisis and Stress*. San Bernardino, Calif.: Here’s Life, 1985), p. 18.
- ¹³ Turkington, op. cit.
- ¹⁴ Turkington, op. cit.
- ¹⁵ Julie Boergers, “Reasons for Adolescent Suicide Attempts: Associations with Psychological Functioning.” *Journal of the American Academy of Child and Adolescent Psychiatry*, December 1998.
- ¹⁶ Neville J. King, et. al., “Treating Sexually Abused Children with Post-traumatic Stress Symptoms: A Randomized Clinical Trial.” *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 39:11 (2000), pp. 1347-1355.
- ¹⁷ Collins, *Christian Counseling*, p. 66.
- ¹⁸ Wright, op. cit., pp. 54-73.
- ¹⁹ Calvin J. Frederick, “Suicide Prevention and Crisis Intervention in Mental Health Emergencies,” in *Clinical Practice of Psychology*, Eugene Walker, ed. (New York: Pergamon, 1981), pp. 189-213.
- ²⁰ H. Norm Wright, *Training Christians to Counsel* (Eugene, Oregon: Harvest House, 1977), p. 99.

²¹ Lawrence G. Calhoun and Richard Tedeschi, "Beyond Recovery from Trauma: Implications for Clinical Practice and Research. (Thriving: Broadening the Paradigm Beyond Illness to Health)." *Journal of Social Issues*, Summer 1998.

²² Collins, p. 64.

²³ Wright, *Crisis Counseling.*, pp. 35-50.

²⁴ Paul D. Meier, Frank Minirth, and Frank Wichern, *Introduction to Psychology and Counseling* (Grand Rapids: Baker, 1982), pp. 345-360

²⁵ Jay E. Adams, *Shepherding God's Flock* (Grand Rapids: Baker, 1979), pp. 301-302.

²⁶ Gary R. Collins, ed., *Case Studies in Christian Counseling* (Waco, Tex.: Word, 1991), p. 4.