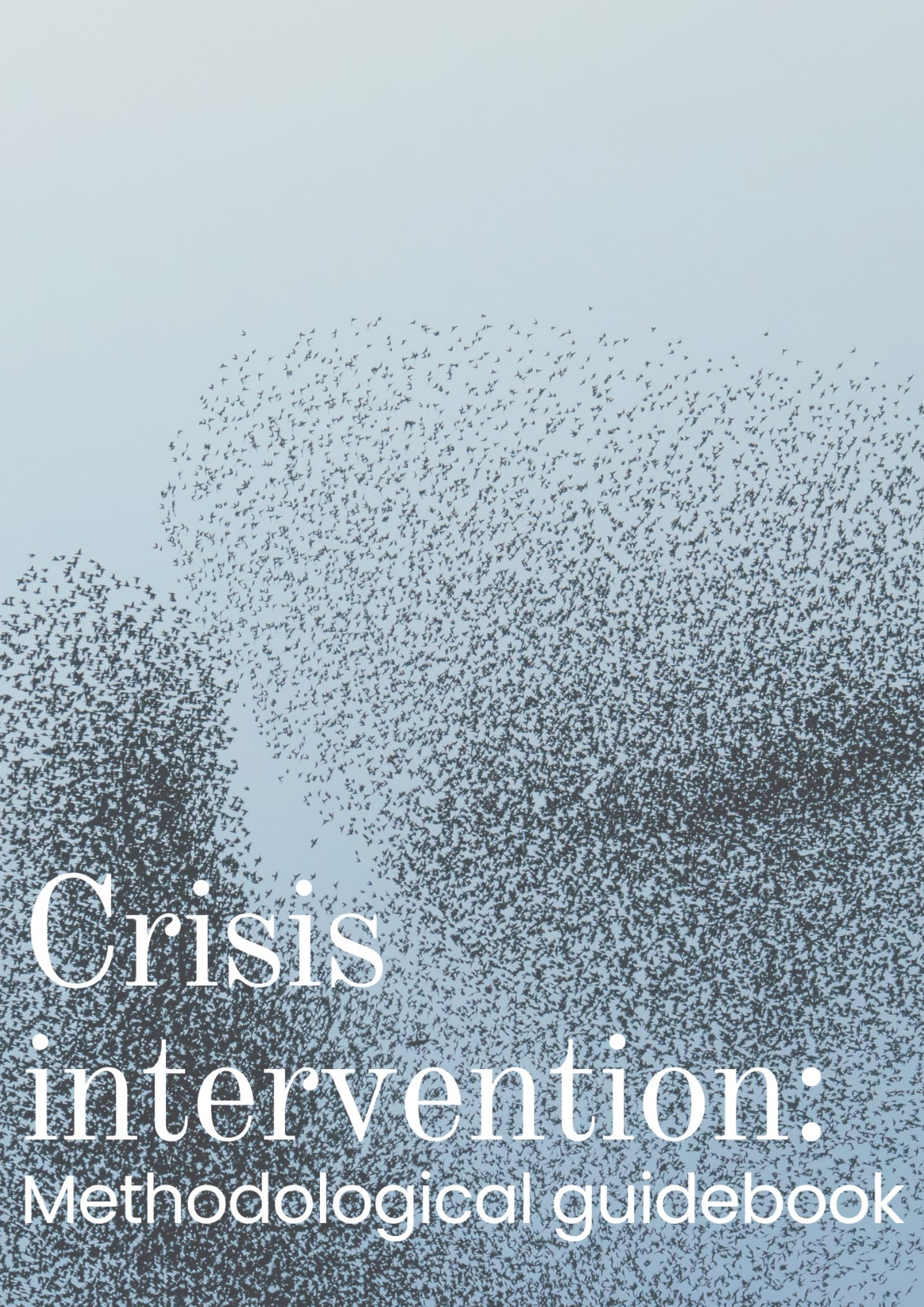


Crisis intervention:

Methodological guidebook

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Introduction

In this publication, we present crisis intervention as a method—a purposeful and structured approach grounded in a well-defined professional framework and guided by clearly articulated principles.

A well-developed method provides crisis interveners with both structure and confidence in their practice. It supports them not only in navigating complex situations but also in selecting appropriate interventions, choosing suitable tools, and recognizing the limits of their professional role. Working with people in crisis is inherently demanding and often emotionally intense. A clearly defined methodology enables interveners to feel competent, responsible, and secure in their professional practice. It helps them understand the intervention process, recognize its phases and objectives, and, above all, respond flexibly and sensitively to the changing needs of the person in crisis.

The crisis intervention method is applicable across a wide range of professional settings, including social services, healthcare, education, and emergency response systems. Crisis is not confined to any single discipline or profession; it is a universal human phenomenon encountered across sectors. We therefore considered it essential to develop a resource that could serve professionals from diverse backgrounds by offering a shared conceptual framework and common professional language. We believe that understanding this method is fundamental to the provision of high-quality and effective crisis intervention.

We deliberately conceived this publication as a comprehensive methodological guidebook intended to help practitioners, students, and other professionals develop a deeper understanding of crisis intervention. Our aim is not merely to describe *how* to perform crisis intervention, but also to explain the professional reasoning that underpins individual clinical decisions.

1 The Crisis Intervention Method

1.1 Definition of Crisis Intervention

Crisis intervention is one of the fundamental methods of psychosocial support. Its importance has been recognised in the professional literature since the mid-twentieth century (Lindemann, 1944; Caplan, 1964). Nevertheless, the term *crisis intervention* continues to be used inconsistently. In everyday practice, it is often understood broadly as any form of assistance provided to a person experiencing a crisis, regardless of the approach employed. In this publication, however, the term refers to a specific, methodologically grounded and time-limited professional method based primarily on structured verbal communication, with stabilisation as its principal objective.

Vodáčková (2002, 2013) describes crisis intervention as a brief, goal-oriented and structured professional approach designed to restore psychosocial equilibrium and reduce the risk of psychological decompensation. She emphasises a focus on the present moment, realistic short-term goals and the use of verbal communication as the primary intervention tool. Similarly, Špatenková (2011) defines crisis intervention as an intensive psychological process employing specific techniques to reduce emotional distress and mobilise the person's internal and external resources. According to her, crisis intervention is characterised by its immediacy, clear structure and the creation of a safe therapeutic space in which the person can gradually regain a sense of control over the situation.

The crisis intervention method is intended for individuals experiencing acute psychological or psychosocial distress whose usual coping strategies have become insufficient. Such crises commonly arise following sudden loss, traumatic events, threats to personal safety, difficult life decisions or other major life disruptions.

Beyond its supportive and stabilising function, crisis intervention also fulfils an important preventive role. Vodáčková (2013) emphasises that timely crisis intervention can substantially reduce the risk of developing longer-term psychological difficulties. It serves as a protective factor against the development of post-traumatic stress disorder and other forms of maladaptive stress processing. Research suggests that early stabilisation and the reduction of acute emotional arousal may help regulate the stress response and prevent traumatic reactions from becoming chronically established (McFarlane & Bryant, 2007; Everly & Mitchell, 2008). From this perspective, crisis intervention should be understood not only as a response to an ongoing crisis but also as an evidence-informed preventive intervention.

The crisis intervention method is designed primarily for work with individuals, responding to their immediate emotional needs and the dynamic nature of the crisis (Vodáčková, 2002). Although some crisis intervention techniques can be applied in other contexts—for example, following mass casualty incidents or disasters—the method as a whole is not intended for group work.

In practice, crisis intervention is sometimes confused with psychotherapy or trauma-focused treatment. However, its purpose is fundamentally different. Crisis intervention aims to provide immediate relief, restore psychological stability and support adaptive functioning; it is not

intended to treat underlying psychological disorders or facilitate long-term personality change. Caplan (1964, p. 83) described crisis intervention as a form of *direct intervention* that restores functional equilibrium during a psychological crisis rather than serving as a method of long-term treatment.

Its effectiveness is further supported by studies examining structured brief interventions delivered during acute psychological crises, particularly in emergency and crisis care settings. Such interventions have been shown to reduce the risk of subsequent suicidal behaviour (Doupnik et al., 2020; Nuij et al., 2021). In this respect, crisis intervention represents one of the evidence-based stabilisation approaches described in the literature (Roberts, 2005; Everly & Mitchell, 2008).

The effectiveness of crisis intervention is also rooted in Caplan's classical theory of crisis, which conceptualises crisis as a temporary imbalance between situational demands and the individual's available coping resources (Caplan, 1964). Crisis intervention seeks to restore this balance by reducing emotional distress, helping the person organise and understand the situation, and mobilising personal and social resources to support a return to adaptive functioning.

Crisis intervention may therefore be understood as a brief, structured and intensive professional method designed for individuals experiencing an acute crisis. It is fundamentally a verbal method whose primary aim is stabilisation, reduction of emotional distress and mobilisation of personal resources. Rather than providing psychotherapy or in-depth trauma processing, crisis intervention represents a key form of psychosocial support with substantial preventive potential.

1.2 Forms of Crisis Intervention

Crisis intervention can be delivered in various forms that differ primarily in the mode of communication, the degree of communication synchrony, and the complexity of information available to the crisis intervener.

In the Czech Republic, the basic legislative framework is provided by **Act No. 108/2006 Coll., on Social Services**, as amended. However, the Act refers to **crisis assistance** (*krizová pomoc*) rather than **crisis intervention** as a professional method. Crisis assistance is defined as a community-based, outpatient, or residential social service provided to individuals whose health or life is at immediate risk (§ 60). Within this framework, crisis intervention is understood as the professional method used in the delivery of this service. The legislation therefore classifies services according to their organisational setting (community-based, outpatient, or residential), rather than according to the mode of communication.

Further clarification is provided by **Decree No. 505/2006 Coll.**, which explicitly introduces the concept of **remote crisis assistance** in Section 20 (Telephone Crisis Assistance). The decree defines it as crisis work delivered through means of remote communication. In this publication, we therefore use the term **remote crisis intervention** as an umbrella concept encompassing all forms of crisis intervention delivered without direct physical contact, including telephone, chat, e-mail, and online communication.

From the perspective of communication, crisis intervention can therefore be divided into **face-to-face crisis intervention** and **remote crisis intervention**.

1.2.1 Face-to-Face Crisis Intervention

Degree of communication synchrony: High

Degree of contact complexity: High

Face-to-face crisis intervention takes place through direct personal contact with the person in crisis. It may be delivered in outpatient settings (e.g., crisis centres or counselling services) or in community settings (e.g., outreach work at the scene of a crisis or in the person's home).

Communication characteristics

- access to non-verbal communication (facial expressions, posture, gestures, overall appearance, and emotional expression),
- use of paralinguistic cues (tone of voice, speech rate, pauses),
- opportunity to work with discrepancies between verbal and non-verbal communication,
- broader use of physical presence and environmental regulation.

Limitations and challenges

Face-to-face intervention exposes the crisis intervener to the full intensity of the person's emotional experience. It requires continuous awareness of one's own non-verbal communication and, in some situations, consideration of personal safety.

Its principal advantage lies in the possibility of conducting a more comprehensive assessment and providing broader therapeutic support. Its main limitation is reduced accessibility, as both parties must be physically present (Roberts, 2005; Vodáčková, 2013).

1.2.2 Remote Crisis Intervention

Remote crisis intervention is delivered without direct physical contact through communication technologies. In the Czech Republic, this form has a long tradition, particularly through crisis helplines and emotional support services.

Telephone Crisis Intervention

Degree of communication synchrony: High

Degree of contact complexity: Moderate

Telephone crisis intervention is one of the most widely used forms of crisis intervention and is characteristic of crisis helplines.

Communication characteristics

- communication relies exclusively on spoken language,

- the absence of visual information increases the importance of active listening and structured communication,
- strong emphasis is placed on paralinguistic features such as intonation, speech rate, volume, and pauses,
- a higher degree of anonymity often facilitates openness and self-disclosure.

Limitations and challenges

The absence of visual information creates partial sensory deprivation, increasing interpretative uncertainty and the cognitive demands placed on the crisis intervener.

Although telephone intervention offers rapid access and excellent service availability, it also requires highly developed communication skills (Špatenková, 2011; James & Gilliland, 2013).

Chat-Based Crisis Intervention

Degree of communication synchrony: Moderate

Degree of contact complexity: Low

Chat-based crisis intervention takes place through written real-time communication and has become an increasingly important component of contemporary crisis services.

Communication characteristics

- communication is text-based, without voice or non-verbal cues,
- emotions and meanings must be expressed explicitly through language,
- the crisis intervener works with fluctuating communication rhythms (rapid exchanges versus periods of silence),
- interpretation of written text increases the risk of misunderstanding,
- anonymity remains high.

A distinctive feature of chat-based intervention is the need to adapt crisis intervention techniques to written communication while placing particular emphasis on clarity and precision of expression (Barak et al., 2008).

Online (Video-Based) Crisis Intervention

Degree of communication synchrony: High

Degree of contact complexity: Moderate to High

Video-based crisis intervention combines characteristics of both face-to-face and remote forms of intervention.

Communication characteristics

- partial access to non-verbal communication,

- simultaneous use of verbal and visual information,
- the need to actively establish psychological safety despite physical distance,
- management of technical limitations such as connection quality or interruptions.

The various forms of crisis intervention each possess specific strengths and limitations. Remote forms substantially increase the accessibility of services and make support available when face-to-face intervention is not feasible. At the same time, they place greater demands on the communication competencies of crisis interveners. Face-to-face intervention, by contrast, allows for a more comprehensive assessment and broader therapeutic work but is inherently less flexible in terms of accessibility.

The choice of intervention format should always be guided by the needs of the individual person in crisis, the nature of the crisis situation, and the availability of appropriate services. In practice, different forms of crisis intervention are frequently combined and often complement one another within the continuum of care.

1.3 Fundamental Principles of Crisis Intervention

As discussed in the previous chapter, crisis intervention may be delivered in a variety of forms that differ in the amount of information available, the mode of communication, and the demands placed on the crisis intervener. Regardless of these differences, however, all forms share a common methodological framework that determines how the intervention is conducted and what objectives it seeks to achieve. This framework is expressed through the **fundamental principles of crisis intervention**.

These principles provide general guidelines that support clinical decision-making throughout the intervention process and help crisis interveners select appropriate tools and techniques according to the needs of the person in crisis. They should not be understood as rigid rules or a fixed sequence of steps, but rather as professional reference points that ensure the intervention remains safe, purposeful, and responsive to the individual's needs. Defining these principles is therefore essential not only for the theoretical understanding of the crisis intervention method but, above all, for its effective application in practice.

A comparison of Czech and international literature demonstrates a remarkable consistency in the way these principles are conceptualised. They arise naturally from the very nature and objectives of crisis intervention and reflect the fundamental needs of individuals experiencing acute psychological crisis (James & Gilliland, 1997; Roberts, 2005; Špatenková, 2017). Based on Czech professional literature, international models of crisis intervention, and our own clinical experience, we identify the following core principles of the crisis intervention method:

- **Immediacy**
- **Accessibility**
- **Safety**

- **Individualised approach**
- **Present-focused intervention**
- **Holistic care**
- **Empowerment**
- **Continuity of care**

Immediacy

The principle of immediacy means that crisis intervention should be provided as soon as possible after the onset of the crisis. A rapid response is essential for minimising psychological harm, stabilising the affected person, and preventing further deterioration (James & Gilliland, 1997; Roberts, 2005).

In practice, immediacy is reflected in the continuous availability of crisis helplines, the rapid deployment of emergency or outreach teams, prompt assessment of urgency and risk, and early evaluation of the crisis situation combined with mobilisation of available resources (Everly et al., 2012; Špatenková, 2017). Typical interventions include brief stabilisation conversations, immediate telephone crisis intervention, outreach services, and prioritisation according to the level of risk. By facilitating an early response, the principle of immediacy helps prevent crisis escalation, reduces the risk of harm to health or life, and creates the conditions necessary for effective stabilisation (Baštecká, 2005).

Accessibility

Accessibility means that crisis intervention should be readily available to everyone in need, regardless of age, gender, education, ethnicity, disability, or other personal characteristics (Roberts, 2005; Vodáčková, 2007). Crisis services should minimise barriers that might prevent individuals from seeking help, including financial, geographical, temporal, or physical obstacles.

In practice, this principle is reflected in free-of-charge and anonymous services, the use of multiple communication channels, flexible service hours and locations, and measures ensuring accessibility for people with disabilities (Špatenková, 2017). Examples include 24-hour crisis helplines, online chat services, crisis centres, outreach teams responding to emergencies, online resilience-support programmes following major incidents, and collaboration with other organisations capable of providing additional support (Everly et al., 2012).

Safety

The principle of safety encompasses both the protection of physical safety before the intervention begins and the creation of a psychologically safe environment throughout the intervention process (Baštecká, 2005; Hermanová, 2024).

The practical implementation of this principle depends on the form of crisis intervention being delivered. The first priority is always to ensure physical safety—for example, by separating the

individual from an aggressive person or confirming that they are not at immediate risk of harming themselves. Safety also includes protecting the crisis intervener.

During the intervention itself, the aim is to establish a relationship characterised by trust, respect, empathy, and clear professional boundaries, while creating an environment in which the person feels able to express thoughts and emotions without fear of judgement or discrimination (Vodáčková, 2007; Hermanová, 2024). In practice, this may involve providing a calm and private setting, respecting the person's pace, establishing basic expectations for the intervention, using verbal de-escalation techniques, or developing a safety plan with individuals at risk of suicide (Špatenková, 2017).

Individualised Approach and Respect for Individuality

This principle is based on the understanding that every individual—and every crisis experience—is unique. Consequently, no single intervention strategy is appropriate for every situation (Roberts, 2005; Kanel, 2015).

Crisis interveners strive to understand and respect each person's experiences, values, needs, and strengths, thereby increasing the effectiveness of the intervention and fostering engagement in the helping process (Baštecká, 2005).

In practice, this requires a flexible approach in which the selection of tools and techniques is adapted to the person's specific circumstances rather than determined by rigid procedural rules. Common techniques include assessment through open-ended questions, choosing between more facilitative or more directive interventions, and empathic reflection (Vodáčková, 2007).

Present-Focused Intervention

Sometimes referred to as the **"here-and-now" principle**, this principle emphasises that crisis intervention should focus primarily on the person's current situation and immediate experience rather than on distant past events or long-term future concerns (James & Gilliland, 1997; Špatenková, 2017).

In practice, this means helping individuals identify their immediate problems and emotional responses, supporting emotional regulation and stabilisation, and focusing on concrete actions that can realistically be taken in the near future. Such an approach reduces feelings of overwhelm, enhances the person's sense of control, and facilitates practical problem-solving (Roberts, 2005).

Typical techniques include grounding, active listening, cognitive restructuring focused on current thoughts, and brief problem-solving strategies (van der Kolk, 2021; Hermanová, 2024).

Holistic Care

Holistic care reflects the understanding that crisis intervention should address not only psychological distress but also the biological, social, and spiritual dimensions of the person's life (Baštecká, 2005; Vodáčková, 2007).

Consequently, crisis intervention includes a comprehensive biopsychosocial assessment of the person's health, psychological functioning, social circumstances, and support system, followed by planning appropriate next steps.

In practice, this principle is often implemented through multidisciplinary collaboration—for example, between psychiatrists, nurses, psychologists, social workers, and legal professionals—as well as through referrals to complementary services and coordination of support according to the individual's needs (Špatenková, 2017). Relevant techniques include assessment of resources and risks, mobilisation of support networks, psychoeducation, and referral to follow-up services.

Empowerment

The principle of empowerment is based on the belief that every person possesses internal strengths and resources that can help them cope with adversity (Roberts, 2005; Kanel, 2015).

The role of the crisis intervener is therefore not to solve the person's problems or assume responsibility for their life, but to strengthen confidence in their own abilities, support autonomous decision-making, and facilitate the discovery of personally meaningful coping strategies. This approach promotes independence, resilience, and long-term adaptive functioning (Baštecká, 2005).

Techniques reflecting this principle include facilitating decision-making, strengthening intrinsic motivation, identifying personal strengths and coping resources, enhancing self-efficacy, using reflective interventions to support emotional regulation, and encouraging active participation throughout the intervention process (Vodáčková, 2007).

Continuity of Care

The principle of continuity of care recognises that crisis intervention should not end with immediate stabilisation but should facilitate ongoing support beyond the acute crisis (James & Gilliland, 1997; Roberts, 2005).

Its purpose is to reduce the likelihood of relapse into crisis while supporting longer-term recovery and adaptation. Opportunities for systematic work often emerge only after the acute phase has subsided, making follow-up care a crucial component of effective crisis intervention.

In practice, continuity of care may include arranging follow-up contacts, recommending psychotherapy or healthcare and social services, providing educational resources, and encouraging participation in peer-support groups (Špatenková, 2017).

1.4 Risks and Limitations of Crisis Intervention

As discussed in the preceding chapters, the effectiveness of crisis intervention lies primarily in its immediacy, accessibility, present-focused orientation aimed at stabilising the person's emotional and physiological state, and, where appropriate, the timely referral to follow-up services. These characteristics, however, also define the inherent limitations of crisis intervention and give rise to specific risks that should be recognised both theoretically and in everyday clinical practice.

1.4.1 Risks of Crisis Intervention

Risks Associated with Insufficient Professional Competence

Like any professional method, crisis intervention can lose its effectiveness and compromise safety when applied without sufficient knowledge or clinical competence. One potential risk arises from an inadequate understanding of specific intervention techniques. For example, a crisis intervener who lacks competence in working with emotions may fail to use techniques such as emotional reflection or validation appropriately, thereby overlooking or minimising the emotional experience of the person in crisis.

Another risk concerns the inappropriate selection of techniques. Even when a particular intervention is theoretically appropriate, it may not correspond to the person's immediate needs or current level of stabilisation. For example, introducing debriefing-oriented interventions before adequate stabilisation has been achieved may increase emotional overwhelm and frustration.

Finally, even an appropriate technique may be implemented ineffectively if the crisis intervener lacks sufficient experience, fails to explain the purpose of the intervention, or proceeds without the person's understanding or consent. In such situations, the individual may experience confusion, frustration, or reduced trust, thereby limiting the effectiveness of the intervention even if no direct deterioration occurs (Špatenková, 2017; Vodáčková, 2020).

Example

A woman experiencing intense anxiety after losing contact with a close family member is guided through a breathing exercise. The crisis intervener neither explains the purpose of the exercise nor checks whether she understands the instructions. Moreover, the technique is too demanding for her current level of emotional arousal. As a result, she becomes confused and increasingly frustrated.

Inaccurate Assessment of the Severity of the Situation

During an acute crisis, it may be difficult to assess accurately the seriousness of the situation, including suicidal risk, psychotic symptoms, potential violence towards others, or the need for psychiatric hospitalisation. Errors in assessment may have serious consequences, particularly because crisis situations often evolve rapidly. An inaccurate assessment may compromise the safety of the individual or others and reduce the effectiveness of stabilisation. Careful and systematic risk assessment is therefore an essential component of safe crisis intervention (Špatenková, 2017; Vodáčková, 2020).

Example

A 19-year-old student repeatedly failing university entrance examinations states, "I can't cope anymore." The crisis intervener interprets this as an expression of stress and does not explore suicidal intent, planning, or access to means. Within forty-eight hours, the student attempts suicide.

Risk of Re-traumatisation

Another important risk is the possibility of unintentionally re-traumatising the person in crisis. When crisis interveners move beyond the scope of crisis intervention and begin exploring traumatic experiences in depth without the possibility of subsequent therapeutic processing, they may inadvertently increase distress, destabilisation, or traumatic re-experiencing (Ogden et al., 2006; van der Kolk, 2021; Hermanová, 2024).

Premature exploration of traumatic memories, intrusive questioning, or pressure to disclose details may activate traumatic memory networks. This is particularly relevant for individuals with histories of abuse, interpersonal violence, or complex trauma. In such situations, priority should always be given to stabilisation and the restoration of psychological safety rather than detailed exploration of traumatic experiences (Hermanová, 2024).

Example

A 27-year-old woman presents following a serious road traffic accident. At the beginning of the consultation, the crisis intervener asks for a detailed description of the collision and what she witnessed. The woman becomes acutely distressed, begins hyperventilating, and the consultation must be terminated prematurely. The primary error was the premature exploration of traumatic material instead of focusing on stabilisation, emotional validation, and psychological safety.

Overreliance on Verbal Intervention

Crisis intervention is primarily a verbal method. However, in acute crisis, higher cognitive functions and symbolic processing are often temporarily impaired due to activation of the autonomic nervous system. Consequently, an exclusive reliance on verbal communication may limit the person's ability to process or benefit from the intervention.

In these situations, verbal interventions should be complemented by body-oriented stabilisation techniques (Ogden et al., 2006; Polyvagal Institute CZ, 2024).

Risk of Dependency on Crisis Intervention

Another potential risk is the development of excessive dependence on crisis services or individual crisis interveners. This may occur when interventions exceed their intended scope or when interveners assume excessive responsibility for the person's problems.

Support may gradually become dependency-maintaining rather than empowering, with the individual seeking repeated reassurance or relying on crisis services for everyday decision-making instead of mobilising personal coping resources or natural support networks (Vodáčková, 2020).

Example

Following the end of a relationship, a 35-year-old man contacts the crisis helpline every evening, insists on speaking with the same crisis intervener, and repeatedly asks them to make decisions on his behalf. Because clear therapeutic boundaries are not maintained and referral to appropriate follow-up services is delayed, the intervention gradually becomes dependency-promoting rather than supportive.

Secondary Traumatic Stress and Burnout

Crisis intervention also carries occupational risks for crisis interveners themselves. Prolonged exposure to highly demanding situations—including interpersonal violence, suicidal crises, and severe psychological distress—without adequate supervision or organisational support may contribute to secondary traumatic stress, compassion fatigue, and burnout.

These conditions may impair clinical judgement, reduce the quality of care, and increase the likelihood of errors. Under chronic stress, crisis interveners may become more prone to cognitive shortcuts, excessive control, or inaccurate assessments of risk (Baštecká, 2005; Vodáčková, 2020).

1.4.2 Limitations of Crisis Intervention

Time-Limited Nature of Intervention

Crisis intervention is, by definition, a brief form of professional support. It is typically delivered through a single consultation lasting approximately 50–90 minutes or a limited number of contacts over several weeks. It is therefore not intended to replace psychotherapy, trauma treatment, or long-term work focused on personality functioning. Instead, it addresses the immediate crisis and its current consequences. When difficulties persist or reveal a chronic course, referral to longer-term therapeutic or other specialised services becomes indicated (Špatenková, 2017; Vodáčková, 2020).

Focus on the Immediate Situation

Crisis intervention focuses on stabilisation in the present moment. Once contact ends, crisis interveners usually have little opportunity to monitor subsequent developments or determine whether agreed plans have been implemented. Long-term outcomes therefore depend largely on the person's own actions and the availability of follow-up care rather than on the intervention itself (Schore, 1994; Siegel, 2012; Vodáčková, 2020).

Working with Limited Information

Another important limitation is that crisis intervention necessarily operates with incomplete information. The assessment focuses only on aspects of the person's life that are immediately relevant to the crisis. Comprehensive history-taking is neither possible nor intended.

In remote forms of crisis intervention, additional limitations arise from the absence of visual information and other contextual cues that would normally assist clinical assessment. Consequently, there is an increased risk of incomplete understanding, oversimplified interpretations, or less appropriate intervention choices (Porges, 2011; Najavits, 2020; Vodáčková, 2020).

Professional Boundaries of Crisis Intervention

Crisis intervention is neither psychotherapy nor psychiatric diagnosis. Its purpose is not to process trauma in depth, resolve longstanding relational patterns, or provide comprehensive treatment for mental disorders.

Nevertheless, crisis interveners frequently encounter individuals whose immediate crisis is closely connected with chronic psychological difficulties, traumatic histories, or psychiatric conditions. Recognising these boundaries—and facilitating timely referral to appropriate healthcare, psychotherapy, or multidisciplinary services—is an essential professional responsibility (Špatenková, 2017; Vodáčková, 2020).

Situations Beyond the Scope of Crisis Intervention

Certain situations exceed the possibilities of crisis intervention and require immediate medical or multidisciplinary care. These include acute psychotic episodes, severe intoxication, profound dissociative states, and suicide attempts in progress.

Because crisis intervention is fundamentally a verbal method, its effectiveness may also be limited when communication itself is significantly impaired—for example, in individuals with severe cognitive impairment or marked intoxication. In such cases, the immediate priority is ensuring safety and facilitating access to appropriate emergency or healthcare services (Špatenková, 2017; Vodáčková, 2020).

Dependence on Follow-up Services

The effectiveness of crisis intervention depends to a considerable extent on the availability of appropriate follow-up care. When suitable social, psychological, psychiatric, or community services are unavailable, the benefits of short-term stabilisation may remain only temporary.

This limitation highlights the importance of an integrated system of care that enables smooth transition from acute crisis intervention to longer-term support, thereby ensuring continuity of care and promoting sustained recovery (Vodáčková, 2020).

1.5 Stages of Crisis Intervention

Crisis intervention, understood as a professional method, is not only defined by its principles but also by the dynamic process through which the intervention unfolds over time. While the principles describe **how** crisis intervention should be conducted, the **stages of crisis intervention** describe **how the intervention develops**, from the first contact to its conclusion. Defining these stages provides crisis interveners with a conceptual framework that facilitates orientation throughout the intervention process and supports the purposeful selection of appropriate tools and techniques.

By *stages* we refer to a sequence of clearly identifiable phases extending from the initial contact through the course of the intervention to its conclusion and, where appropriate, the arrangement of follow-up care. Although individual crisis intervention models differ in the number and naming of their stages, they share common overarching objectives—namely the restoration of psychosocial equilibrium and the strengthening of the person's capacity to cope with the crisis (James & Gilliland, 1997; Roberts, 2005).

Across contemporary crisis intervention models, there is broad agreement that these stages rarely unfold in a strictly linear fashion. Crisis interveners frequently return to previous stages,

omit certain elements, or modify their sequence according to the person's current needs and the evolving nature of the crisis.

Based on the models reviewed in the literature and our own clinical experience, we conceptualise the stages of crisis intervention as follows:

1. **Establishing Contact and Ensuring Safety**

The first stage focuses on establishing a therapeutic relationship while simultaneously ensuring the person's immediate safety. The crisis intervener introduces themselves, clarifies their professional role, and creates an atmosphere characterised by respect, trust, and psychological safety (Kanel, 2015).

This stage also includes explaining confidentiality, outlining the brief nature of crisis intervention, and conducting an initial assessment of immediate risk to life or health—whether directed towards the person themselves (for example, through suicidal or self-harming behaviour) or towards others. Whenever significant risk is identified, appropriate measures must be taken to ensure both physical and psychological safety (Everly et al., 2012).

2. **Assessing and Understanding the Situation**

Once initial safety has been established, the crisis intervener begins a structured assessment of the person's current situation.

The aim is to understand what has happened, when and where the crisis occurred, how the person is experiencing it, what difficulties and needs are present, and what coping strategies have already been attempted (Kleibl et al., 2021).

Beyond gathering factual information, this stage seeks to understand the personal meaning of the crisis and its impact on the person's current functioning (Lukasová, 2014; Kopřivová & Fleková, 2021).

3. **Working with Emotions**

This stage provides space for emotional expression and regulation.

The crisis intervener encourages emotional ventilation, helps the person identify and regulate their emotions, and uses techniques such as validation and normalisation to communicate that intense emotional reactions are understandable and expected within the context of the crisis (Kanel, 2015).

When appropriate, simple stabilisation techniques—including breathing exercises, grounding strategies, or brief behavioural tasks—may be introduced to reduce distress and restore a sense of control (Everly et al., 2012; Koucká, 2018).

4. **Clarifying the Presenting Concern and Defining the Goal**

At this stage, the crisis intervener and the person in crisis work together to clarify the reason for seeking help and to establish realistic expectations for the intervention.

The intervener assists in formulating a concrete, achievable short-term goal that reflects the person's immediate needs (Kleibl et al., 2021).

Particular attention is also paid to the **underlying presenting concern**—issues that may not be expressed explicitly but nevertheless represent the person's primary reason for seeking support. As the intervention progresses, both the presenting concern and the intervention goal may evolve (Kocourková, 2015; Koucká, 2018).

5. **Strengthening Resources and Planning Next Steps**

Once the intervention goal has been clarified, attention shifts towards identifying ways of coping with the situation and developing a realistic plan for moving forward.

The crisis intervener supports the person in mobilising both internal and external resources, including personal strengths, values, previous coping experiences, supportive relationships, and available professional services. At the same time, adaptive coping strategies are strengthened through practical guidance, psychoeducation, and referral to appropriate follow-up services.

The resulting action plan should be realistic, understandable, and tailored to the person's current capacities, values, and circumstances. It may include contacting supportive family members or friends, seeking professional assistance, or making use of community resources. When safety concerns are present, the plan should also incorporate elements of a safety plan (Everly et al., 2012).

6. **Concluding the Intervention**

The final stage brings the intervention to a respectful and supportive close.

Together, the crisis intervener and the person review the main points of the conversation, evaluate the progress made towards the agreed goals, and discuss any recommended follow-up support.

An important component of this stage is acknowledging the person's courage in seeking help and reinforcing their confidence in their own ability to cope with the situation. The aim is for the person to leave the intervention with greater clarity, strengthened self-efficacy, and a realistic understanding of the next steps available to them (Kanel, 2015; Kopřivová & Fleková, 2021).

Case Example

A middle-aged woman, Jana, contacts a crisis helpline following the recent end of a long-term relationship. From the outset of the conversation, the crisis intervener observes marked emotional distress manifested by crying, heightened tension, and expressions of hopelessness. Jana also reports persistent insomnia, profound sadness, and occasional thoughts of self-harm.

The crisis intervener introduces the service, explains their professional role, and outlines the confidential and time-limited nature of the intervention. A safe and trusting atmosphere is established while simultaneously conducting an initial assessment of immediate suicide risk.

Although Jana acknowledges having thought about self-harm, no evidence of imminent danger emerges, allowing the intervention to proceed with a primary focus on stabilisation.

The crisis intervener then moves to a structured assessment of Jana's current situation, using open-ended questions to explore recent events, her understanding of what has happened, and the impact on her daily functioning. Jana describes the relationship breakdown as the loss of both emotional security and an important source of support. She also reports having sought help from friends, although she feels that their support is currently insufficient.

As the intervention progresses, attention shifts towards working with emotions. Jana cries openly, and the crisis intervener validates her emotional reactions while encouraging healthy emotional expression. Together, they identify and name feelings of sadness, helplessness, and frustration. To reduce emotional arousal, the intervener introduces simple stabilisation techniques, including controlled breathing exercises, and supports Jana in practising them during the conversation.

Gradually, Jana identifies her immediate goal: to reduce her overwhelming anxiety sufficiently to manage everyday functioning. The crisis intervener helps translate this wish into a realistic short-term objective—emotional stabilisation and strengthening available sources of support. Jana's personal resources are explored, including her ability to seek help openly and the support of a close friend. Information is also provided about additional professional resources, including counselling and psychotherapy.

Building on these discussions, they jointly develop a practical action plan. Jana decides that after ending the call she will contact her friend, practise the recommended stabilisation exercises, and seek further help should her distress intensify. A preliminary safety plan is also developed, and the crisis intervener provides information about relevant follow-up services.

The intervention concludes with a brief summary of the conversation. The crisis intervener acknowledges Jana's openness and courage in seeking support, reinforces her active engagement throughout the intervention, and reminds her that the crisis helpline remains available should she need further assistance.

2 Attitudes, Roles, and Competencies of Crisis Interveners

Crisis intervention is distinguished not only by its objectives and methods but also by the demands it places on the crisis intervener. During the intervention, the crisis intervener does not assume the role of an emotionally detached expert whose task is merely to apply tools and techniques. Rather, crisis interveners themselves become an active instrument of support. Their current capacity to cope with intense emotions, resilience to stress, and more enduring characteristics—such as professional attitudes, ways of thinking, and decision-making abilities—substantially influence both the course and the effectiveness of the intervention. The professional literature consistently emphasises that the quality of the therapeutic relationship and the manner in which the conversation is conducted are among the most important determinants of effective crisis intervention (Roberts, 2005; James & Gilliland, 2013).

Professional Attitudes

A fundamental prerequisite for the role of a crisis intervener is a non-judgemental and non-evaluative attitude towards the person in crisis. This attitude involves respect for the person's experiences, values, and ways of coping, even when the issues discussed may be personally challenging for the intervener—for example, suicidality—or even conflict with their own value system. A non-judgemental stance creates the conditions for openness and trust, both of which are essential for effective crisis intervention (Rogers, 1957; Špatenková, 2017).

An equally important aspect of this attitude is respect for the autonomy of the other person. The crisis intervener does not direct the individual towards the "correct" solution but accompanies them throughout the crisis while supporting their own decision-making process. Metaphorically, this approach can be described as **walking alongside** the person, rather than walking ahead of them or behind them.

Authenticity and Readiness to Become an Instrument of Stabilisation

An essential component of the crisis intervener's professional role is authenticity—that is, the ability to be genuinely present in the interaction, while maintaining inner congruence and consistency. Authenticity does not imply self-disclosure; rather, it refers to the alignment between what the crisis intervener experiences internally and how they communicate externally (Rogers, 1957).

Another important professional requirement is the willingness to become fully available for establishing contact with another human being at the deepest neurobiological level. A calm, empathic, and well-structured interaction functions as a powerful mechanism of **co-regulation**. Through tone of voice, speech rhythm, responsiveness, and the capacity to remain emotionally present, the crisis intervener helps the person in crisis gradually reduce both physiological and emotional arousal.

From a neurobiological perspective, this process supports regulation of the autonomic nervous system and facilitates the gradual deactivation of the stress response. As a result, a more balanced interaction between activation and regulation becomes possible, allowing the

individual to experience emotions while simultaneously maintaining the capacity to think, orient themselves, and make decisions. In the literature, this state is commonly described as a return to the **window of tolerance**—the range within which a person can manage internal distress without becoming either overwhelmed or emotionally shut down (Porges, 2011; Siegel, 2012).

The regulatory effect of the crisis intervention conversation emerges through several interrelated processes. A predictable conversational structure and clear, understandable responses reduce uncertainty, which is one of the principal sources of stress activation during a crisis. The experience of being genuinely heard and emotionally understood alleviates feelings of loneliness and isolation. Likewise, the calm rhythm of the conversation promotes physiological down-regulation, while transforming chaotic emotional experiences into words enables a basic level of cognitive integration, allowing the individual to perceive their experience as something that can be named, understood, and contained.

Together, these processes constitute **relational co-regulation**. When a person's capacity for self-regulation is temporarily compromised, another individual—in this case, the crisis intervener—provides temporary regulatory support. This process is also associated with mechanisms of **social resonance**, sometimes explained in the literature through mirror neuron systems (Bonini, 2022). However, this should not be understood as simple emotional mirroring. Rather, it refers to interpersonal attunement, whereby the nervous system of one individual can temporarily rely on the stable and regulated state of another.

Through this experience, the person in crisis develops a fundamental sense of safety: *"Someone hears me, understands me, and remains with me."* This experience provides one of the essential foundations for emotional calming and the restoration of self-regulatory capacity.

However, effective stabilisation requires more than simple presence or a genuine wish to understand another person. It depends on specific relational qualities that facilitate co-regulation and create a safe framework for further intervention. Both Czech and international literature on crisis intervention and helping communication describe these qualities in remarkably similar ways (Porges, 2011; Špatenková, 2011; Vodáčková, 2013; James & Gilliland, 2013; Egan, 2014).

3 Comparison of Crisis Intervention Models Used in the Czech Republic and Internationally

Crisis intervention, as a professional method, is based on a structured process designed to stabilise the person in crisis, enhance their understanding of the situation, and facilitate subsequent steps towards resolving the crisis. This process draws on a number of theoretical models, which are presented below.

A fundamental principle shared by these structured approaches is their stage-based organisation—that is, a sequence of clearly defined phases extending from the initial contact through the intervention itself to its conclusion and the arrangement of follow-up care. The table below summarises selected crisis intervention models. Although these models differ in the number and terminology of their phases, they share common objectives: restoring psychosocial equilibrium, strengthening the person's capacity to cope with stress, and responding flexibly to the individual needs of the person in crisis through targeted professional support.

MODEL	STAGES OF CRISIS INTERVENTION
SIX-STEP CRISIS INTERVENTION MODEL (JAMES & GILLILAND, 1997)	1. Define the problem. 2. Ensure the person's safety. 3. Provide support. 4. Explore alternatives. 5. Develop an action plan. 6. Arrange follow-up care.
SEVEN-STAGE CRISIS INTERVENTION MODEL (SSCIM) (ROBERTS, 2005)	1. Assess the situation and establish safety. 2. Establish psychological rapport. 3. Identify the major problem. 4. Provide emotional support. 5. Explore alternative solutions. 6. Develop an action plan. 7. Arrange follow-up care.

RAPID MODEL (PSYCHOLOGICAL FIRST AID) (EVERLY ET AL., 2012)	**R – Reflective Listening (Reach Out/Rapport):** Establish contact, engage the person, listen actively, and build a supportive relationship. **A – Assessment (Assess Needs):** Assess immediate needs, safety, severity of the situation, and potential risks. **P – Prioritisation:** Identify the person's most immediate needs and priorities. **I – Intervention:** Promote psychological stabilisation, strengthen coping, provide practical information, and normalise reactions. **D – Disposition (Determine Follow-up/Debriefing):** Plan further steps, arrange follow-up care, and facilitate referral to additional services where appropriate.
ABC MODEL (KANEL, 2015)	1. Develop rapport. 2. Identify the problem. 3. Facilitate coping and problem resolution.
CRISIS INTERVENTION (BAŠTECKÁ, 2005)	**Assessment:** Assess the situation, available resources, needs, and risks, and establish an initial agreement regarding the goals of the intervention. **Planning:** Define realistic and achievable goals and concrete steps that reflect the person's values and circumstances. **Implementation:** Carry out the agreed plan, provide emotional and practical support, and strengthen personal resources. **Evaluation:** Review the intervention, evaluate outcomes, and determine further recommendations or follow-up care.
CRISIS INTERVENTION (ŠPATENKOVÁ ET AL., 2017)	**Initial Phase:** Establish contact and create a sense of safety. **Middle Phase:** Work with emotions, analyse the situation, and explore possible solutions. **Final Phase:** Summarise the intervention, agree on further steps, and conclude the contact.

CRISIS INTERVENTION (VODÁČKOVÁ ET AL., 2020)	**Beginning:** Establish contact, build trust and a safe environment, and assess risks. **Intervention Process:** Address the current situation, identify the precipitating event, work with emotions, activate support, and strengthen coping strategies. **Closure:** Summarise the intervention, plan subsequent steps, and reinforce stability and personal competence.

In this publication, these models are viewed through the lens of the **three core functions of crisis intervention** proposed in our conceptual framework: **regulation, orientation, and movement**. Across the various models, the initial phases typically focus on establishing contact, ensuring safety, and promoting stabilisation (*regulation*); the middle phases aim to enhance understanding of the situation and broaden available options (*orientation*); and the final phases focus on identifying concrete next steps and arranging appropriate follow-up care (*movement*).

3.1 Remote Crisis Services in an International Context

Telephone, chat, and text-based crisis services provide immediate support to people experiencing acute psychological distress. Worldwide, they constitute an essential component of crisis care systems and suicide prevention. We were interested in exploring the findings of recent international research on the effectiveness of these services and identifying examples of good practice that may inspire further development of crisis intervention.

International Research on the Effectiveness of Remote Crisis Intervention

Research on telephone crisis services indicates that many callers experience a reduction in confusion, helplessness, hopelessness, and other manifestations of psychological crisis during the course of the conversation itself. In a silent monitoring study of the 1-800-SUICIDE network, Mishara et al. analysed 2,611 calls across 14 crisis centres and identified significant short-term improvements in callers' decisiveness, perceived personal resources, and hopefulness. Empathy, respect, a supportive approach, effective rapport, and collaborative problem-solving were identified as the key elements associated with better outcomes (Mishara et al., 2007).

Hoffberg et al. (2020) conducted a meta-analysis of 33 studies published between 1990 and 2018 examining the effectiveness of crisis hotline services. Most studies focused exclusively on telephone crisis calls. Overall, the findings demonstrated immediate positive effects of crisis hotline interventions. However, approximately 80% of the included studies were judged to have a high risk of bias for various methodological reasons, resulting in an overall low certainty of evidence regarding effectiveness. Hoffberg et al. also highlighted the lack of research examining the long-term outcomes of crisis service contacts. Despite these limitations, the overall body of evidence supports the value of crisis hotline services. The authors further

recommend that future research should involve people with lived experience of using crisis services more actively in study design and evaluation (Hoffberg et al., 2020).

3.1.1 An Example of International Practice: The Danish Conversational Model

This section presents the conversational model developed by the Danish crisis helpline **Startlinjen**.

The model was primarily developed to increase the proportion of first-time callers while reducing the amount of time occupied by long-term frequent callers. At the same time, its aim was to ensure that conversations with frequent callers remained therapeutically meaningful by strengthening adaptive coping strategies rather than fostering dependence on the service.

The model (Figure X) is visually organised around the concept of **wholeness**. At its centre lies **Presence**, emphasising that the caller—and the human relationship established during the conversation—should remain the primary focus throughout the intervention. The entire process is framed by the concepts of **Resources** and **Relationships**, which should be considered during every stage of the conversation. The model follows a clear structure, beginning with the exploration of the caller's needs and concluding with a reflection on the value of the conversation.

The intervention itself moves through four key domains, while encouraging crisis interveners not to remain exclusively within the first:

What is Difficult?

The caller is given space to describe their situation and express emotions. The intervener's role is to provide safety, calmness, and acceptance while ensuring that the conversation does not remain focused solely on emotional ventilation. The aim is to gently guide the caller towards the following domains.

Coping with Difficulties

This domain explores the caller's current coping strategies. The discussion focuses on whether these strategies support or hinder the person's longer-term goals and whether short-term relief may unintentionally contribute to future difficulties. The objective is to identify behaviours that may need to be strengthened, reduced, or modified.

Values

Values serve as the compass for change. Because people often find it easier to describe what they do not want than what they truly desire, the intervener helps callers clarify their personal values. These values can then become a source of motivation for moving towards the kind of life the caller wishes to live.

Next Steps

The final domain focuses on identifying realistic next steps, even if they are very small ones. The pace is determined entirely by the caller, and not every conversation needs to conclude with a formal action plan. For many callers, simply exploring possibilities and gaining insight

into their own patterns of thinking and behaviour naturally leads to increased readiness for change.

The Startlinjen Framework

The professional approach adopted by Startlinjen is primarily inspired by **Acceptance and Commitment Therapy (ACT)** and its underlying theoretical framework, **Relational Frame Theory (RFT)** (Startlinjen, 2024).

The service is grounded in several core assumptions: that all people are capable of making meaningful changes in their lives; that pain is an inevitable part of human existence, and that it is often more helpful to focus on what gives life meaning than on eliminating pain itself; and that every caller should be met with genuine interest and respect for their inherent dignity and uniqueness.

Consequently, every conversation is directed towards some form of change—whether a new insight, an emotional shift, or a practical step forward. Such change should always be guided by the caller's own values and hopes for the future (Startlinjen, n.d.).

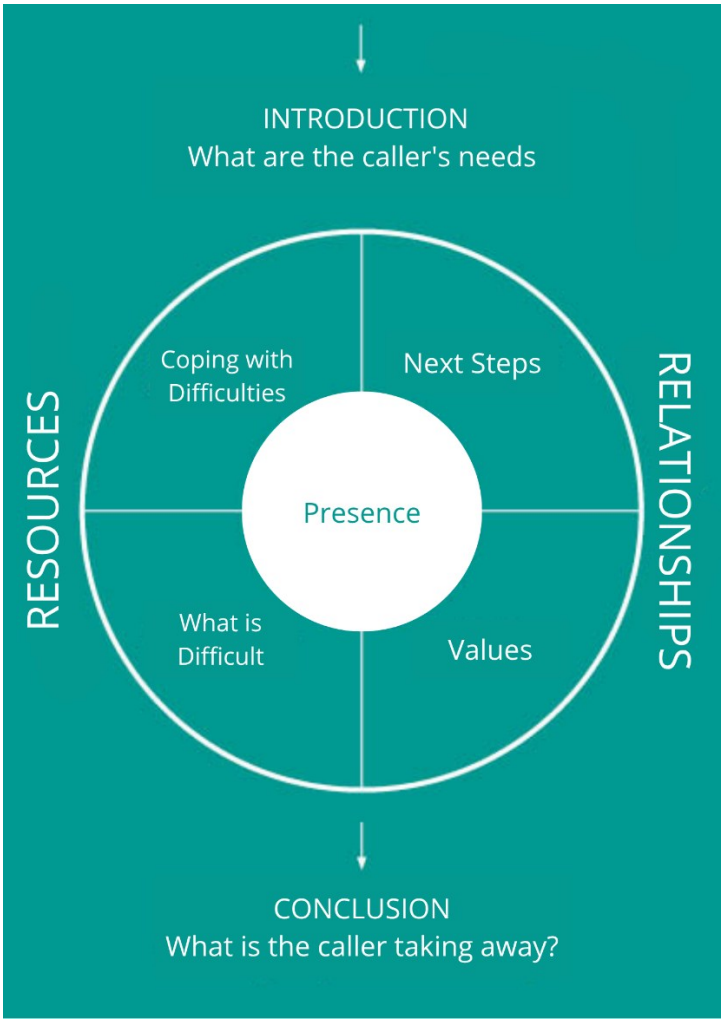


Figure 1: The Startlinjen conversational model. Source: Startlinjen (2024). English translation adapted from the Czech translation by Eliška Tupá.

Throughout each conversation, crisis interveners keep in mind not only the core principles of the service but also six overarching goals of the intervention:

- to facilitate new insights or understanding related to the caller's difficulties;
- to help callers clarify their personal values and aspirations for the future;
- to identify personal strengths and competencies that can support meaningful change;
- to increase awareness of effective coping strategies;
- to create space for reflection on interpersonal relationships and possible ways forward;
- to strengthen hope and confidence in taking steps towards resolving the crisis.

At the end of each conversation, callers are invited to reflect on the discussion and summarise what they are taking away from it. The intervener asks what has been most meaningful or helpful during the conversation.

The RÅDVILD Research Project (Denmark)

In 2023, the **RÅDVILD** research project was launched as a collaboration between the **Centre for Digital Pedagogy (Aarhus University)** and **RådgivningsDanmark**, the Danish association of non-governmental organisations providing free psychosocial counselling services. The project currently involves ten counselling helplines and one municipal counselling service.

The project has three primary objectives:

1. To gain a deeper understanding of why some individuals become frequent users of counselling services and under what circumstances they continue to seek support without clear signs of progress.
2. To identify when repeated use of counselling services is perceived as problematic by crisis interveners and/or by service users themselves.
3. To develop new communication strategies and organisational approaches that respond constructively to problematic patterns of repeated service use (Velux Fonden, 2023).

3.2 Other Methods of Acute Stabilisation in Crisis and Emergency Situations

This section presents selected approaches and brief stabilisation protocols used internationally when working with people affected by an acute crisis, an emergency, or a potentially traumatic experience. These approaches are not intended as comprehensive alternatives to crisis intervention. Rather, they offer specific ways of promoting safety in the early stages, reducing acute stress activation, stabilising the affected person, and connecting them with further support. The approaches differ in their degree of structure, training requirements, and strength of empirical support. They are included primarily as a source of inspiration for further study and the development of professional competencies.

3.2.1 Psychological First Aid

Psychological First Aid (PFA) is a standardised approach designed to provide immediate, sensitive, and practical support to people experiencing acute crisis. The World Health Organization recommends it as a fundamental approach for anyone providing support to people affected by crisis. Guides and facilitator manuals are available on the WHO website in more than 20 languages, including Czech (WHO, 2011).

PFA is a flexible model that emphasises adapting support to the needs of the people affected. Rigid manual-based protocols and standardised documentation of the intervention may, in some circumstances, be counterproductive. Flexible approaches are therefore needed that preserve the overall PFA framework while allowing for individual variation in both activities and outcomes (Hermosilla et al., 2023).

PFA frameworks are expanding rapidly, and an increasing number of models are being developed for use with a broad range of target populations (Shultz & Forbes, 2014).

The aims of PFA are to stabilise the person, protect them from further immediate harm, strengthen their sense of safety, connect them with additional sources of support, and reinforce their own coping mechanisms.

Core principles of PFA include a non-directive and respectful approach, the normalisation of common stress reactions, the protection of health, privacy, and dignity, and sensitivity to the person's cultural context.

Psychological First Aid consists of three basic steps, commonly referred to as the "3 Ls":

LOOK

Assess the situation, including possible threats, the person's immediate needs, and opportunities to ensure safety.

Observe the person's physical and psychological condition.

Identify potentially vulnerable groups, including children, older people, and people with disabilities or health-related limitations.

LISTEN

Introduce yourself, explain your role, offer contact, and allow the person space to express themselves.

Listen actively, communicate that you hear and understand them, and respect silence.

Do not minimise the person's experience, ask for unnecessary details about the traumatic event, or create unrealistic expectations.

LINK

Provide practical information and support, including contact details for relevant health, social, and crisis services.

Encourage the use of personal resources and social support networks, and offer to help the person connect with someone close to them.

Strengths: Basic introductory training can be delivered within a relatively short period, for example through a half-day course based on the WHO facilitator manual. PFA is generally well accepted and can be readily applied in the context of disasters and mass-casualty events.

Limitations: Although a number of scientific studies and meta-analyses report partial positive outcomes for people receiving PFA, broadly generalisable empirical evidence of its effectiveness remains limited.

3.2.2 Emotion Aid®

Emotion Aid® is a five-step method focused on working with acute emotional distress. It is a brief, body-oriented stabilisation protocol that addresses the physical manifestations of the stress response and supports self-regulation.

The programme was originally designed for people working in stressful environments, but it may also be used by members of the general public. It can be taught to people in crisis, who may then return to the method whenever they need to calm themselves and regain psychological stability (Emotion Aid, n.d.).

Strengths: According to the method's training materials, its main advantages are simplicity, portability, and applicability in both individual and group settings. Documented examples include its use with groups consisting of several hundred participants.

Limitations: Emotion Aid® addresses only the immediate, emergency phase of support for people affected by crisis, with the primary aim of reducing the body's acute stress response. Independent empirical support for the method remains limited.

3.2.3 ASSYST

ASSYST, or Acute Stress Syndrome Stabilization, is a structured intervention model based on the Adaptive Information Processing model used in Eye Movement Desensitization and Reprocessing therapy (EMDR) (Shapiro, 2025; Jarero, 2025). It is designed as an early intervention during the first hours, days, or weeks following a potentially traumatic or highly stressful event. Its primary aims are to reduce acute stress, stabilise the autonomic nervous system, and prevent the development of post-traumatic stress disorder and anxiety or depressive symptoms (Jarero, 2025; Shapiro, 2025).

In terms of both timing and purpose, ASSYST occupies the space between Psychological First Aid and comprehensive trauma-focused treatment. In practice, it may be delivered alongside crisis intervention or may precede it, thereby creating conditions in which crisis intervention can be used more effectively (Jarero, 2025).

The method draws on the neurobiology of trauma, according to which the acute stress response activates the autonomic nervous system and may contribute to the consolidation of traumatic memories. ASSYST follows a clearly defined protocol and has the advantage of requiring only minimal narration of the traumatic event or verbal processing of the past.

Instead, it focuses on the sensory, emotional, and bodily components of intrusive memories, which play an important role in acute stress reactions and the development of post-traumatic symptoms (Shapiro, 2025). ASSYST is based on the assumption that these fragments of memory activate the brain's alarm system and maintain the organism in a state of perceived threat (Shapiro, 2025).

The practical intervention consists of repeated cycles involving three steps. First, attention is directed towards a fragment of bodily distress associated with the memory. This is followed by bilateral stimulation, most commonly using the "Butterfly Hug" or another form of rhythmic alternation between the right and left sides of the body. After this phase, the person subjectively evaluates their current level of distress. The cycle is then repeated, supporting the nervous system's natural capacity to reduce activation gradually and allowing the information to be processed more adaptively (Jarero, 2025).

Strengths: The method enables direct, non-invasive physiological engagement with a distressing or pathogenic memory without requiring the person to describe it in detail. This may be particularly valuable in the acute phase, when the traumatic experience may be difficult or impossible to verbalise (Jarero, 2022). A further advantage is that ASSYST can be implemented rapidly in individual, group, and online formats, including in crisis intervention settings outside specialised trauma therapy.

Limitations: ASSYST has relatively few general contraindications. The pace of bilateral stimulation is determined by the person receiving the intervention, who therefore also determines the pace of their own processing and may stop the procedure at any time. The intervener must fully respect this decision. The method may only be used with informed consent.

Several general conditions must also be considered. The person must be in a safe environment, as immediate danger is a contraindication to using the method. They must be able to understand and follow verbal instructions, which may be limited, for example, by cognitive impairment. The person must also retain adequate contact with reality. The method should therefore not be used in cases of severe dissociation, acute psychosis, or intoxication.

The approaches described above focus on early stabilisation, reduction of acute stress activation, and the promotion of safety. They differ in scope, target population, training requirements, and strength of empirical support.

For crisis intervention, this leads to an important distinction: some approaches can be understood as general frameworks for initial support following an emergency, whereas others are narrowly focused stabilisation protocols. Such approaches may precede or complement crisis intervention, but they should not replace it.

3.3 Interdisciplinary Mobile Crisis Teams (MCTs)

Mobile Crisis Teams (MCTs) are interdisciplinary crisis teams that provide support in community settings. They represent a model of crisis care that integrates elements of crisis intervention, community psychiatry, and social support. Unlike remote services or brief

stabilisation protocols, they deliver assistance directly in the person's natural environment and focus on resolving the acute crisis, wherever possible without the need for hospitalisation.

MCTs should not be understood as a distinct crisis intervention technique. Rather, they constitute an organisational and systemic model of crisis care within which individual team members may use the tools and techniques of crisis intervention. Team composition varies according to the country, service system, and funding arrangements. A team may typically include a clinician, social worker, psychiatric nurse, peer support worker, psychiatrist, or other healthcare professional. Within a coordinated crisis care system, MCTs primarily fulfil the role of "someone to respond"—that is, a service that can be activated when telephone or online support is insufficient and rapid assistance is required at the location of the person in crisis (NRI, 2025).

From the perspective of the crisis intervention process, MCTs primarily fulfil the following functions:

Regulation: stabilising the person during the acute phase of the crisis, including the stabilisation of any underlying psychiatric condition.

Orientation: developing an understanding of the situation within the context of the person's natural environment.

Movement: arranging further care, often through referral to community-based services or outpatient treatment.

Research suggests that MCTs may reduce hospital admissions, emergency department visits, and the involvement of law enforcement, thereby supporting people to remain in their communities. At the same time, systematic reviews highlight substantial variation between individual teams, differences in the quality of implementation, and limited certainty regarding which specific components of the model are essential to its effectiveness (Wheeler et al., 2015; Peters et al., 2026). A report by the US-based National Association of State Mental Health Program Directors Research Institute summarises current MCT practice and development in the United States and describes mobile crisis teams as a key component of the mental health continuum of care, particularly within broader crisis response systems (NRI, 2025).

Strengths: Collaboration across several professional disciplines enables a comprehensive assessment of the person's situation and facilitates the integration of healthcare, psychosocial support, and community-based services. It may also reduce the need for hospitalisation or intervention by law enforcement.

Limitations: The limitations of this model include its organisational complexity, uneven availability, and dependence on the quality of local implementation. Collaboration may be hindered by communication barriers, unclear professional responsibilities, and wider systemic constraints. Not every crisis can be safely managed in the person's home or community environment, and hospitalisation remains necessary in some cases. From the perspective of crisis intervention, it is important to distinguish between the short-term stabilisation provided by MCTs during the acute phase and the longer-term treatment or social support to which the person in crisis should subsequently be connected.

3.4 Brief Structured Online Interventions

In recent years, a wide range of crisis and supportive interventions delivered in online environments has emerged worldwide. Alongside telephone and chat-based crisis services, structured online programmes and brief therapeutically oriented interventions have been developed to address crisis-related issues such as disasters, trauma, and suicide risk. A systematic review by da Silva, Siegmund, and Bredemeier (2015) identified 17 empirical studies of online crisis interventions and described three principal areas of application: disaster response, suicide prevention, and trauma. Most of the programmes reviewed were based on cognitive-behavioural principles, with a particular emphasis on psychoeducation, accessibility, and reducing barriers to seeking help.

These interventions should, however, be distinguished from conventional crisis helplines or chat services. Rather than consisting of a single crisis contact, they typically involve a brief structured programme or a therapist-guided intervention delivered either asynchronously (e.g., through written exercises, e-mail communication, or closed online groups) or synchronously via videoconferencing. Some programmes also incorporate procedures for referral to emergency face-to-face care when an immediate risk to safety is identified.

One example is **Brief Cognitive Behavioral Therapy for Suicide Prevention (BCBT-SP)** delivered via video telehealth. Rojas et al. (2022) described a case study involving a military veteran following a recent suicide attempt, examining the intervention's acceptability, feasibility, and changes in clinical symptoms during treatment. This report should therefore be regarded not as evidence for the general effectiveness of online crisis interventions but rather as an illustration of how a structured suicide-focused intervention can be successfully adapted to an online format.

Stronger evidence is provided by the more recent randomised controlled trial conducted by Baker et al. (2024), which found that BCBT delivered via video telehealth can effectively reduce suicide attempts among adults experiencing recent suicidal ideation or suicidal behaviour. During the 12-month follow-up period, participants receiving BCBT demonstrated a significantly lower rate of suicide attempts than those in the control group, corresponding to an approximately **41% reduction in suicide risk**.

Strengths: These interventions increase access to support for individuals who cannot or prefer not to attend face-to-face services. They may reduce stigma and other barriers to help-seeking, provide structured interventions targeting specific risks such as suicidal behaviour, and complement crisis intervention when more sustained and focused support is required than can be offered during a single anonymous crisis contact.

Limitations: The available evidence remains uneven. Some studies focus primarily on feasibility or short-term outcomes rather than long-term effectiveness. In addition, several protocols require specialised therapeutic training and are designed for relatively specific clinical populations.

3.5 Brief Structured Protocols

In international crisis intervention practice, both face-to-face and remote services increasingly employ structured protocols for developing **Safety Plans** or establishing **No-Harm Agreements**. These approaches are most commonly derived from cognitive-behavioural therapy (CBT) or dialectical behaviour therapy (DBT).

Bryan et al. (2017) compared three approaches: the **Crisis Response Plan (CRP)**, its enhanced version (**Enhanced Crisis Response Plan; E-CRP**), and **Treatment as Usual (TAU)**. TAU typically consisted of standard suicide risk assessment, supportive counselling, recommendations for follow-up care, and, in many cases, a no-harm agreement.

Compared with TAU, the CRP approach is more detailed and promotes greater engagement and shared responsibility for change. It focuses on collaboratively developing practical, individualised steps that help the person in crisis manage future suicidal crises—from recognising personal warning signs, activating coping strategies, and drawing upon social support to seeking professional help when necessary. Bryan et al. (2017) found that the CRP was more effective in reducing suicidal behaviour and contributed to a faster reduction in suicidal thoughts.

The enhanced version, **E-CRP**, additionally incorporates motivational elements, including the person's sense of meaning in life and personally important values. Research suggests that this approach may be particularly beneficial when individuals need additional support to tolerate intense emotional distress and to strengthen their motivation to seek help promptly if suicidal thoughts recur.

To encourage future adaptation within the Czech context, **Appendix X** presents a structured protocol for implementing the E-CRP approach, developed on the basis of Bryan et al. (2017).

Conclusion

Crisis intervention is a living professional method that continues to evolve alongside developments in society, advances in scientific knowledge, and the accumulated experience of practitioners. Although it has been an integral part of psychosocial support systems for decades, its methodological foundations still deserve further clarification and development.

The primary aim of this publication has been to present crisis intervention as a coherent professional method based on clearly defined principles. We hope that this framework contributes to a better understanding of what crisis interveners actually do during a crisis contact, why they choose particular interventions, and how these interventions work together to support the stabilisation of a person in crisis.

Another important objective has been to contribute to a shared professional language for describing crisis intervention. We believe that consistent terminology can facilitate education, supervision, research, and communication across different crisis services and professional disciplines.

The present volume is not a complete English translation of the original publication. It has been prepared within the framework of the Erasmus+ project and contains selected chapters that introduce the conceptual framework.

Although this framework was developed within the Czech crisis intervention system, we hope that may contribute to the ongoing international discussion on crisis intervention methodology.

Finally, we would like to express our sincere gratitude to all the people in crisis whom we have had the privilege to accompany throughout our professional careers. Their stories, their courage to seek help, and the trust they placed in us during some of the most difficult moments of their lives have taught us more than any textbook ever could. Without them, this publication would never have been written.

Crisis intervention is, above all, about people. This book is dedicated to them.

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