The Influence of Crisis Intervention Upon Agency Practice*

JUDITH S. SCHILD, *Administrative Supervisor*
D. JANE ZIMMERMAN, *Social Worker*
MARILYN COHEN, *Social Worker*
SUSANNA TAGLIACOZZO, *Social Worker*
The Jewish Children's Bureau, Chicago, Illinois

As social workers, we frequently are called upon to deal with the disruptive effects of both accidental and developmental crises in the lives of clients with whom we work. The literature on crisis intervention theory and technique discusses its use as a mode of brief treatment, initiated at the time of application for help and/or as a method of primary prevention in mental health work.[1] At this time, crisis intervention appears to be well-established as an important approach in short-term treatment. However, little has been written regarding this approach in relation to those clients for whom a short-term crisis oriented approach may serve as the beginning of long-term help, or for those clients, already engaged in treatment, who experience a crisis which may or may not be related to the original problems for which they sought help.

It is our thinking that there is a significant difference between the way in which client situations are approached and assistance offered, depending upon whether a crisis intervention or psychopathological frame of reference is used. This paper will address itself to identifying the client-worker-agency transactions involved in the shift from offering service based upon the psychopathologic frame of reference to that provided by crisis theory. Recognizing the possible danger of diluting crisis theory by applying its principles and practices too broadly, we propose that with proper attention given to differentiating between a crisis, an emergency, and exacerbation of a problem, the model can be appropriately adapted for use in many situations. The areas to be specifically explored include: intake procedures, diagnosis and treatment planning, parallel processes in response to a state of crisis, and the influence of agency structure upon case management.

Both Gerald Caplan and Lydia Rapoport have pointed out that crisis intervention theory is not radically different or new and is well-grounded in ego psychology.[2] "It exists as a framework for viewing individuals and families in situations of urgency and stress..."[3] ..."The term 'crisis' refers to the state of the reacting individual. The

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[1] For example see: Gerald Caplan. *Principles of Preventive Psychiatry.* (New York: Basic Books, 1964) Chapter 2: Gerald Caplan, editor, *Prevention of Mental Disorders in Children.* (New York: Basic Books, 1961); Naomi Golan, "When is a client in crisis?" *Social Casework,* 50 (July 1969); Howard J. Parad, editor, *Crisis Intervention: Selected Readings.* (New York: Family Services Association of America, 1965); Lydia Rapoport, "Crisis Intervention as a Mode of Brief Treatment" in Robert W. Robers and Robert H. Nee, editors, *Theories of Social Casework.* (Chicago: University of Chicago Press, 1970).

[2] *Principles of Preventive Psychiatry, op. cit.,* p. 12; "Crisis Intervention as a Mode of Brief Treatment", *op. cit.* p. 267.

[3] *Ibid.,* p. 267.

state is one of upset."[4] A crisis represents a threat, a loss, or a challenge. Case work treatment based upon crisis intervention "...makes use of all the principles and techniques which have been developed through case work methodology that are relevant and useful. However, there is a reordering of and greater emphasis on some techniques."[5] We believe that this reordering of, and emphasis upon some techniques, need not be restricted to short-term crisis treatment alone, but can be effectively applied at appropriate times in intake, during treatment planning, and in the course of on-going treatment. When a crisis erupts, workers should not continue "practice as usual," but should shift into employing crisis intervention techniques — providing rapid and ready access to help. However, there are difficulties in making this shift: Firstly, historically, agency structure has evolved the development of support systems for the provision of case work services based on individual personality theory and for the provision of specialized services. Therefore, intake procedures generally were devised to facilitate a rapid exploration of a problem to determine eligibility for service and consideration for assignment for more long-term work. Secondly, administrative demands that workers maintain a consistent case load usually mean that the worker has little free time to deal with crises; lastly, workers often have not developed a trained awareness to respond to the implications of a crisis.

Perhaps the most glaring example of a problem in providing appropriate help is in the all too frequent situation of a mother who must be hospitalized for psychiatric reasons, accompanied by the lack of planning for the care of her children. In the Jenkins and Sauber study *Paths to Placement,* it was discovered that in family after family, the mother's approaching need for hospitalization and for child care help was known long in advance and should have been obvious to several community agencies. But each time, the need for care for the children came as a surprise to all involved. Further, when crisis intervention help was offered, too frequently it stopped too soon after the crisis.[6] In contrast, when a request for service is viewed as a crisis in its fullest sense, there is a potential for mobilization of resources to provide help. Administrative direction and support is needed in such situations for the worker involved to be able to respond to the full implications of a crisis. If administrative support is not given to a worker, and the worker begins to move into using a "crisis" approach, that worker can easily be accused of becoming over-involved, over-reacting, engaging in nonprofessional behavior, devoting too much time to one case situation and not following agency policy and procedure. When both administrative and worker flexibility are present, creative approaches to offering help are possible.

For example, an urgent call on a Friday afternoon about 4:30 p.m. was made to the agency by Mrs. S. upon referral from her private therapist. Mrs. S., in an agitated tone began explaining that following her recent divorce and subsequent move from her upper middle-class home to a small apartment, her youngest child, an eleven-year-old girl, had been refusing to attend school. Sandra ini-

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[4] Lydia Rapoport, "Crisis Oriented Short Term Casework", *Social Service Review,* Vol. 41 (1967) p. 35.

[5] Rapoport, *Crisis Intervention: Selected Readings, op. cit.,* p. 301.

[6] Roberta Hunt, "Parental Incapacity and the Welfare of Children" in Eleanor Pavenstedt and Viola W. Bernard, Editors, *Crisis of Family Disorganization* (New York: Behavioral Publications, 1971).

tially presented herself as a frightened, probably school phobic child, who was quite depressed. She was extremely hostile and nasty toward her mother whom she blamed for all of the unpleasant changes in her life style and whom she viewed as the cause of her transfer to the new unacceptable school. Both parents, still smarting from the divorce, consistently blamed each other. Sandra clearly had sided with her father against her mother. Both parents were immobilized in their ability to deal with Sandy's crisis, still being involved primarily with themselves and their own needs. A plan was immediately set up for two workers to see both mother and daughter early Monday morning. One worker, to work with the parents to help them change their approaches to Sandy, and the other for Sandy, to help her go to school. Through close collaboration with the school, Sandy's worker was able to provide her support in getting back into the school physically. Sandy's worker arranged to take her to school every day for a time-limited period of two weeks, after which Sandy would be expected to get to school on her own. As it became clear that Sandy was not a typical school phobic, that the phobia was masking a more serious disturbance, and that Sandy herself was acting out her severe hostility toward her parents by not attending school, it became impossible to get Sandy back into the full school program. Sandy was receiving virtually no warmth or support from her mother, and only seduction from her father. An unwanted child in the first place, Sandy had no one to turn to. She began turning to her worker, making daily phone calls for reassurance and help in solving everyday problems such as how to do the dishes, or to tell of her fear of going to bed and of not getting to watch her favorite television shows since now they only had one television set. Concurrent with the initial intervention, an on-going evaluation was also taking place. It became clear that neither parent wanted Sandra and that in Sandra's best interest she was in need of residential treatment where she would receive the kind of support and help she needed. As plans for residential treatment came closer to reality, Sandy was able to begin to attend school, albeit, sitting in an empty classroom all day doing school work.

The focus clearly shifted from a child unable to go to school to a child who has never been able to get along with her parents, other children, and often with herself. The intensity of Sandy's anger and symptoms disguised the underlying problems. Had a crisis intervention approach not been employed, one can predict that Sandy's symptoms would have become further disguised, and she even more difficult to reach. Frequently, with children, it is not just one crisis, but a culmination of crises in the family affecting the child, eventually leading to a crisis specifically with the child, disrupting his functioning as in Sandra's case.

For Sandra, we were fortunate to be called in early in the crisis. Most often, however, people ask for help when they are attempting to cope with the effects of a recent or long-past crisis, rather than in the midst of the crisis itself.

Fifteen year old Rachel's grandmother was beside herself when she phoned the agency about her granddaughter's behavior and lack of a place to live permanently.

Rachel had been the mainstay of her parents' disruptive marriage prior to their divorce four years ago. She attempted to help her mother, when the mother was profoundly depressed, baby-sat, took care of the house and attempted to be the "perfect child." As the mother finally sought treatment for herself following the divorce, and subsequently began to function appropriately, getting

a job and beginning to take care of her family, the role that Rachel had played in the family was no longer available to her. Combined with the onset of adolescence, and the loss of status within the family, a separate and new crisis developed for Rachel. Sensing that something was going wrong, Rachel had asked her mother to get help for her last summer, but the mother ignored her cry for help until Rachel deteriorated further. Rachel began to scream and fight with the mother and two younger siblings, became increasingly depressed, withdrew from her peers, and was unable to cope with the pressure of school work.

The mother took Rachel to her own psychiatrist, who excused Rachel from school in November, but offered no treatment. During the next month, Rachel threatened suicide and the mother had her hospitalized. Two weeks later, she withdrew Rachel from the hospital as she felt that Rachel didn't belong there and wasn't getting help for her problems. The parents then sent her to the grandmother as they thought this would be a neutral setting for her. Two weeks later, when the grandmother called the agency, Rachel was functioning on a fragile borderline level.

Rachel came in to see the worker the same day as the grandmother called. Arrangements were immediately made to see her twice a week. A phone call, prior to Rachel coming in, was made to set up an appointment with the mother and Rachel's father. Several hours were spent on the phone with both of them as their anxiety continued to be high. It was eventually decided that week, that Rachel should stay most of the time with her father and his new wife, who lived in a near-by city until a more permanent place could be found for her to live. Simultaneously, the worker mobilized community resources to provide Rachel with homebound tutoring and other opportunities to provide structure for her days. For the first time, Rachel had someone to turn to and the hope of a more stable therapeutic environment in the agency's residential setting.

It is well known that the disruptive effects of a crisis when not fully dealt with at the time of the crisis can lead to disorganization. All too frequently, families in a crisis state seek out help in a piece-meal fashion as can be noted in Rachel's situation. Although the crisis was relatively recent with Rachel, other situations often go from one state of crisis to another leading to further and further deterioration and increasingly less accessibility for major intervention. Such is the situation with Andrea and Richard. The P. family has been known to helping persons for some time. Mr. and Mrs. P., two seriously disturbed people, lived in a state of chronic and cyclical crisis. Andrea and Richard's lives have been characterized by chaos, corruption, and parental inadequacy. From an early age, Andrea began to hostilely nurture her brother Richard. A year ago, the children's father died, thus leaving no one to pick up and care for the children during the mother's periodic psychiatric hospitalizations. The children had been shifted from pillar to post for some time, being farmed out to different relatives who would temporarily become involved in supporting the children only to return them to their chaotic home as soon as the immediate crisis subsided. Each time, when the mother became ill, the family telephoned requesting temporary child-care help but refused help for more long term planning for the children. While mother was hospitalized, Jewish Family and Community Services placed a homemaker in the home and began to jointly work with the Jewish Children's Bureau in order to undertake making long-term planning for the children's care. The plan was to

be either one in which the mother would actively undertake parental responsibility or permit an appropriate support system for the children to be developed so that they would be helped. The original crisis long past, the chronic crisis pattern continued, but for the first time, the child's mother has permitted a helping person to work with them, with the understanding that the children's needs must be recognized and dealt with.

"From time immemorial, novelists and dramatists have stressed the significance of crisis periods in determining the fate of individuals and groups."[7] For better or for worse, a crisis provided "a second chance."

Mr. P.'s death created a major crisis in the family's chaotic existence, yet simultaneously offered a "second chance" to intervene on the children's behalf. As noted in our examples so far, a state of crisis may be super-imposed upon existing psychopathology, but the resolution of the crisis is more dependent upon the current ego strengths of the individual and family than upon the underlying disturbance.

This clinical observation is frequently the case in working with young girls with unplanned pregnancies. Anita was 16, and in the fifth month of her pregnancy when her father telephoned asking for help. The call for help was met with an immediate response, and an appointment scheduled at Anita's earliest convenience. Here, following the principle that one must offer rapid and ready access to help when a person is in a state of crisis, agency practice is to offer immediate assistance. Anita needed the full range of prenatal services. This included casework services, medical help and placement in a small group home for pregnant girls. As time passed, the immediate crisis of the unplanned pregnancy was seen to mask Anita's long-standing problems. Anita, a neglected adolescent with uncaring parents, had never received basic nurturing nor help in coping with life. The pregnancy in this instance became not only the entry point, but also symptomatic of a cry for help. As her immediate needs were met, it became possible to move into dealing with her underlying problems which in this situation eventuated in residential treatment and special schooling. Thus, short-term crisis-oriented assistance can be the beginning of long-term help for many individuals and families.

While agency practice must be geared to offer immediate service to those clients who seek help during or immediately following a major crisis, by providing a flexible and oft-times innovative response at intake, so too, must agency practice be re-examined in terms of crises erupting in the lives of clients with whom we have already been working on a more traditional basis. Good child welfare practice dictates that the agency must make provision for its clients to be able to reach help 24 hours a day. Thus, both workers and the agency accept the notion that there are some situations that cannot wait until 9:00 the next morning, but require an immediate response.

Rita, a reconstituted schizophrenic girl had been in residential treatment for approximately six years. As she was helped to move into living in the community in a girl's residential club, she began to explore the wider world, and her explorations led into an unplanned pregnancy. Since Rita could not sustain very many delays, arrangements were being made to obtain a therapeutic abortion for her immediately. This, however, was not soon enough for Rita. The evening that her pregnancy was confirmed,

[7] Howard J. Parad and Gerald Caplan "A Framework for Studying Families in Crisis", in Howard J. Parad, ed. *Crisis Intervention: Selected Readings, op. cit.* p. 55.

around midnight she made a superficial suicidal gesture. It was not a "real" suicide attempt and perhaps even could have waited until 9:00 the next morning or be dealt with by the house staff of the residential club, but would that really have been helpful to Rita? Two workers immediately went out to where Rita lived, one staying with her until she fell asleep, while the other telephoned psychiatric hospitals to find a bed for her. Finally, temporary arrangements were made until she could be hospitalized in the same hospital where the therapeutic abortion would be given.

Frequently, in crisis situations, one cannot work alone, but two must work in close coordination — one dealing with the persons in crisis, while the other engages community resources to deal with the situation. Such is how we dealt with Rita. Rita is now self-supporting and doing well. The six years' investment in therapy for Rita could easily have gone down the drain, had the agency not invested a great deal once more for a short period of time to help Rita through this crisis.

Nevertheless, we were disappointed when Rita seemed to be devastated by distress over which at that point she had little control, appearing to us to have lost all the gains we had thought she had made during the course of treatment with us. In other situations, we have also been struck by the way in which our clients may successfully cope with overwhelming stress, and tend to disbelieve their capacity to cope. We view such reactions on a worker's part as most likely to occur when we as workers have not shifted our understanding of our clients in the situation from the psychopathologic frame of reference to the frame of reference provided by crisis theory. In our experience, we find that we are more vulnerable to not shifting our understanding of the client's situation when we have been working with him on a long-term basis. Our relationship with and perception of the client blinds us from seeing that life situations are not static and that developmental and accidental stresses are part and parcel of human existence. Thus, we fail to focus upon the impact of current events in the current situation as explicitly as the situation requires.

Further, we have observed that a parallel process develops between the client's reaction to a crisis state and the worker's reaction to the effect the crisis has upon treatment. For example, at the peak of a crisis, the client feels helpless since his traditional problem-solving methods are overtaxed. Similarly, we postulate that the worker often feels helpless because his reliance at this time previously formulated treatment approaches render him of little assistance to his client. Frequently during a crisis, clients will fail regular appointments, and/or project the cause of their problems upon the worker and the ineffectiveness of the help that they have received, and act out in a variety of ways. Successfully or unsuccessfully, not only the client, but the worker as well, will call "...upon his reserves of strength and of emergency problem-solving mechanisms."[8] If a crisis is not perceived or solved at this juncture, disorganization will eventually take place. For the social worker, this means probable termination of treatment goals or of treatment itself, accompanied by a sense of professional failure, which may be defended against by focus upon a client's pathology and lack of treatability, accompanied by a great deal of anger.

At such times there is greater risk that the perceptual distortions experienced by clients during a crisis will be paralleled

[8] *Principles of Preventive Psychiatry, op. cit.,* p. 40.

by perceptual distortions on the worker's part. Distortions on the worker's part may take the form of confusing the client's emotional reactions and cognitive confusion, so characteristic of a state of crisis, as indication of major personal disorganization. For example, during a crisis one readily observes that the person is tense, anxious, ashamed, guilty or hostile. Often he is unable to be rational and he experiences the extrusion of unconscious and pathological material into awareness.[9] In contrast, the indices of major personal disorganization are usually used to refer to the most severe disorders; that is, the psychoses. Although psychotic episodes have not been viewed in crisis terms, this is not to say that a psychotic episode might not be experienced as a crisis not only by the individual involved, but by his family as well. Frequently, psychotic episodes lead to major alterations in a family's functioning.

When the parallel process in reacting to a crisis is averted by the worker shifting into the crisis model of treatment, the worker who has been involved in ongoing treatment with the client is at an advantage, since he would be familiar with the client's usual mode of functioning and with the underlying pathology which is being linked with the current crisis. The client of course has greater advantage, since he will secure more appropriate help from someone he knows well. Too often, however, counter-transference reactions develop and are reinforced and compounded by agency structure which implicitly requires that the client adjust his needs to the way in which services are rendered, rather than the agency flexibility adapting its services to the client's needs.[10]

The flexible adaptation of services to clients' needs is illustrated in the situation of Joshua. Joshua, a 13-year-old boy, the middle of three sons, had had a marginal school adjustment for many years following the death of his father. His difficulty with authority and his choice of an unsympathetic school administration to vent his rage upon had resulted, of course, in his exclusion from school and placement on a homebound tutoring program. This homebound tutoring was illegally discontinued after the winter vacation. At this point, after many years of successful casework treatment by the family agency, sustaining this family within the community, our agency was asked to consider Josh for our day treatment program. Josh was accepted for our day treatment program but, inasmuch as this entailed the transfer of funds from one school district to another, delays were inevitable. Josh's worker, who also had a background in education, immediately decided to provide therapeutic tutoring as she simultaneously put pressure upon the school to resume the homebound tutoring. The interchange between worker and supervisor at the point that the worker asked to provide this service is of note in viewing how the agency's attitude to such an unorthodox use of time would be dealt with. The worker approached the supervisor with the comment that other things could be temporarily pushed aside as she felt that Josh was rapidly deteriorating and without intervention at this point, he might not be able to

[9] Rapoport, "Crisis Oriented Short Term Work", *op. cit.*, p. 35.

[10] For a fuller discussion of the institutionalization of counter-transference reactions see: Judith Wallerstein and Arthur Mandelbaum, "Counter-transference in the Residential Treatment of Children" in Rudolf Ekstein, *Children of Time and Space, of Action and Impulse* (New York: Appleton-Century-Crofts, 1966).

continue to be maintained in the community without her providing this service. The supervisor's response was "all right, but don't keep it up too long and increase your pressure on the school district to provide the tutoring." The fact that the worker moved into the situation helped to increase the pressure upon the school district, such that they resumed homebound tutoring in one week. Thus, "a little help rationally directed and purposely focused at a strategic time" was provided.[11]

Clearly, the rubrics of agency practice have profound effect upon what a worker may or may not do in a given case situation and upon the way in which a client's request for service is both heard and dealt with.

In summary, the client-worker-agency transactions we have been discussing illustrate the utilization of the crisis frame of reference at different stages of agency involvement. At intake, exploration of the request for service must include consideration of the possibility of a state of crisis. In ongoing treatment, when a crisis erupts, one must rapidly change the approach to deal with the issues at hand. Obviously the use of a crisis approach demands that risk-taking on the part of a worker, not only be permitted by administration, but actively encouraged. The use of the psychopathologic frame of reference in dealing with crisis situations can impede resolution of the crisis and, at times, as illustrated in Rachel's case lead to disorganization. Further, countertransference problems can be minimized when administration not only encourages risk-taking, but in practice, supports worker judgments.

The crisis intervention model can be adapted for use in a wide variety of situations. It is a model for service with sensitivity to indications of the impact of a crisis and with encouragement of a worker's use of novel and initially time-consuming techniques within a flexible and responsive agency structure.

[11] Rapoport, "Crisis Intervention: Selected Readings", *op. cit.*, p. 287.