CRISIS-ORIENTED BRIEF TREATMENT: A SIDE-EFFECT OF THE WAR IN ISRAEL

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OCCASIONALLY professionals experience the excitement that comes with seeing practice theory put to the test in the maelstrom of world events. Such an occasion occurred during the summer of 1967 when some of the concepts and practices collectively labelled, "brief-term, crisis-oriented, crisis-focused casework" were applied to an *ad hoc* program with hospitalized Israeli soldiers recovering from injuries received during the Six-Day War in early June. While the tremendous pressures of the moment and the improvised nature of the service made accurate data-gathering and detailed record-keeping impossible, the project produced a number of experiential observations which tended to validate the crisis intervention approach under the most rigorous conditions.

After the first hectic days of combat, the Israeli Ministry of Defense decided to initiate its rehabilitation and post-discharge adjustment program for wounded soldiers as quickly as possible, while the men were still in active service. Authorities recognized that, in the past, men with service-connected disabilities had experienced long, anxiety-producing delays while they recuperated, were formally discharged from the armed forces, and only then transferred to the Rehabilitation Services of the Ministry.

To ease the pressure on its own limited social service staff, which had already recruited third-year students from the Baerwald School of Social Work to help in its program for bereaved families, the Ministry sent out a call to other welfare agencies for experienced volunteers. A staff of about nine social workers, largely from the National Insurance Program, which operated the civilian rehabilitation program, was quickly gathered into a loose task force to provide initial, short-term service to hospitalized soldiers and their families. One of the authors, on leave in the United States for graduate training, returned immediately after the outbreak of hostilities and was "lent" to the Ministry of Defense for this special project.

Goals of Project

The program swung into action at once. Outside of a brief crash course in rehabilitation procedures and benefits, no theoretical orientation was provided; it was assumed that these workers were accustomed to dealing with individuals and families in stress. Three primary goals, geared to the immediate emergency, were outlined:

1. To relieve the wounded soldier's concern over his family's current situation while he was hospitalized.
2. To involve him as quickly as possible in making future financial and vocational plans for himself.

3. To allow and even encourage him to ventilate his feelings about his disability and curtailed functioning.

While not specifically formulated, the key to the program lay in Gerald Caplan's dictum that, during the time-limited period of disequilibrium, the individual in an active state of crisis is more susceptible to influence than at periods of more stable functioning:

> When his normal balance is upset, a relatively minor force will tip him to one side or another. This means that the help offered him by significant others may have a major effect in determining his choice of coping mechanisms, which in turn will influence the outcome. Once the crisis is over, the individual returns to a new steady state and then is relatively less open to outside intervention and the influence of others.[1]

The people who most strongly affect an individual during crisis, Caplan points out, are those linked to him by the primary bonds of his basic needs for love and relationship and those who fit in with his needs for authority and dependence. Especially important are those whose advice is directed, not only to the individual himself, but to his family and other primary networks.

However, as Rapoport and Parad have repeatedly stressed,[2] constructive resolution of the crisis often depends on the availability and utilization of interpersonal and institutional resources. Since a little help, purposefully focused at a strategic time, is often more effective than more extensive help given at periods of less emotional accessibility, it must be made available quickly, before new, inappropriate defenses are called up, before maladaptive grappling patterns begin to harden, and before the secondary benefits of prolonged illness accrue.

The three most appropriate interventive techniques in this framework, as described by Oppenheimer in her work with cancer patients,[3] appear to be: helping the patient and family develop conscious awareness of the problem, assessing quickly and accurately the total situation for patient and family, and enabling them to make new use of existing ego-adaptive techniques or to develop new and more effective ones.

Initiation of Services

While responsible directly to the Central Ministry of Defense, each worker in the field operated virtually autonomously. Existing Army and Defense Ministry resources were utilized wherever possible; if these were not available, other governmental services, voluntary agencies, and informal improvisations were freely tapped. Every case was considered individually and activity was tailored to the specific situation at hand. The following account, while in no sense a review of the total program, might be considered characteristic of the services rendered.

The writer was assigned to cover fifty-one patients in two general hospitals, one in Ashkelon and one in Rehovoth. The men, from the Regular Army and the Reserves, ranged in age from their late teens to their early thirties and were, except for four or five, of "eastern" (North African or Asian) ethnic stock. Most had been wounded in the first two days of the campaign as

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[1] Gerald Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, 1964), p. 48.

[2] For example, Lydia Rapoport, "The State of Crisis: Some Theoretical Considerations." *Social Service Review,* Vol. 36 (June, 1962), pp. 216–17. Also Howard J. Parad, "Preventive Casework: Problems and Implications," in Howard J. Parad, ed., *Crisis Intervention: Selected Readings* (New York: Family Service Association of America, 1965), p. 293.

[3] Jeanette R. Oppenheimer, "Use of Crisis Intervention in Case Work with the Cancer Patient and His Family," *Social Work,* Vol. 12 (April, 1967), p. 45.

Israeli vehicles, speeding southward toward the Gaza Strip and the Sinai Desert, struck a number of buried land mines. They were bedded in orthopedic wards, since almost all had suffered leg damage involving, in about eight cases, amputation of one limb, in addition to other wounds. Some, with internal injuries or severe burns, lay in adjoining medical wards.

In the first days, morale was extremely high. After three weeks of increasing nervous tension, waiting in military outposts out in the hot desert sun for something to happen, the situation had finally exploded—for these men, literally. Their initial reactions were of relief and release; they all felt they had taken part in something tremendously significant.

During this phase of their hospitalization, the men were absorbed, for the most part, in their physical pain and had not yet begun to face the implications of their wounds. In keeping with current practice, rehabilitation specialists moved in as quickly as possible, not only to fit and demonstrate the use of artificial limbs, but to bring in amputees from veterans' organizations with matched disabilities to show that such injuries did not necessarily curtail normal functioning. However, as wounds began to heal, pain to subside, and leg stumps to grow accustomed to the pressure of prostheses, men began to struggle with their awareness of what had happened to them.

When the writer began to make her introductory rounds, two weeks after the first casualties had been brought in, it became apparent that the men were in varying states of emotional disequilibrium. The first interview, as noted by Oppenheimer, became a critical point.[4] Keeping in mind Perlman's proposition that what an applicant will do is heavily conditioned by his expectations as well as his conceptions of his own and the caseworker's roles,[5] she introduced herself simply to each patient as "from the Defense Ministry." For her opening gambit, she brought out an official-looking questionnaire and suggested that the two of them fill it out together. Most of the men were reservists and their families received dependency allowances while they served on active duty. Once they were wounded, however, regulations stipulated that they could either remain in the army for three more months, with continuation of their army pay and allowances, or be discharged immediately and transferred to the care of the Defense Ministry so that disability payments and rehabilitation services could commence. Not only was it important for the Ministry to know as soon as possible who its future clients would be in order to set up programs, but the men's own anxiety over their own and their families' future made this the most appropriate point of entry.

The use of this structured first interview made it easy for the men to begin to talk. The printed question, "How did it happen?" released, in many cases, a flood of memories and hitherto repressed feelings. They began to verbalize freely since it was now permissible to talk about the event: the way they were hit, their anger and incredulity at "catching it" in this unexpected way, their revulsion at the death and destruction around them. Other questions helped them focus, for the first time, on what lay ahead, what courses were open to them. Care was taken, not only to let each man know that the authorities in his soldier-role network were concerned, but to stress his right to make his choice, to become directly involved in the con-

[4] *Ibid.*, p. 47.

[5] Helen H. Perlman, "Intake and Some Role Considerations," *Social Casework*, Vol. 41 (April, 1960), p. 174.

sideration of alternatives and the decision-making process.

Families too went through a similar "coming to grips" with the situation. Their initial shocked disbelief at the news of the casualty had been followed with profound relief that their father, son, or husband was at least alive. Now they were experiencing a sharp rise in anxiety as they began to struggle with the implications of the patient's disability. Wives and mothers, putting up a smiling front during their bedside visits, would break down in the corridor and ask helplessly, "What will become of us?"

Ongoing Care

From this stage, the worker became increasingly involved in the affairs of the patients in her care. Taking advantage of the army structure, she formed an immediate alliance with the "welfare sergeant" stationed in each hospital. This woman soldier's duty was to tend to the men's daily needs and comforts, apart from their regular medical care. She dispensed cigarettes and newspapers, saw that they were supplied with fresh uniforms and transportation for home visits, got in touch with company commanders to trace belongings left behind in army camps, and arranged for a string of entertainers to keep up the men's spirits. A pattern of close cooperation soon developed as the young sergeant, whose spontaneity and sense of identification with her comrades made it easy for the men to confide in her, would brief the worker each morning on problems that had arisen during the night and situations which demanded immediate attention. In turn, the worker, out of her professional experience and understanding, would try to interpret to the sergeant what lay behind difficult behavior or to alert her to predictable after-effects of, say, a stretcher case's first visit with his family.

One by one the men would stop the worker as she made her rounds, to talk about their concerns: the tractorist who worried about who would drive his machine while he was laid up and whether it could be fitted with special mechanisms so that he could learn to maneuver it with only one leg; the eighteen-year old boy whose civilian jeep had exploded under him and who felt deprived of the glory of having been part of an actual army unit; the laborer's concern over his inability now to provide a real house for his family.

In some cases it became apparent that long-standing defenses were becoming weakened and earlier conflicts reactivated. One patient, who made a point of exhibiting his inability to contain his urine whenever the worker drew near, was obviously looking for acceptance of his changed body image as he finally queried, painfully, how a child would react to his father's losing his leg. Another, overwhelmed by the feelings of dependency and regression which had become reawakened during the weeks of hospitalization, wondered what was now happening to him. A third, who asked for a steady job to replace his former carefree career as a free-lance theater electrician, soon uncovered his fright over his impending marriage and his fiancee's pressure for security.

Problems which emerged covered a wide range, including disturbed family relations, housing difficulties, income and job maintenance, and conflict with authorities. A combination of empathetic listening, with an eye to the establishment of priorities, and reality-oriented supportive casework usually proved the most effective approach. Often discussion became rehearsals for reality as worker and patient considered

alternative solutions and weighed possible outcomes.

The worker, taking her cue from the patients themselves, carried a wide variety of roles. One case called for simply holding a cigarette to the mouth of a burn victim so that he could have his first real smoke in days. Another meant listening quietly while a man, after weeks of denial, cried out his fear that he might not be able to return to his precious job. Still another required a wearying round of visits to agencies looking for an answer to a patient's employment dilemma.

Whatever came to hand was picked up as part of the effort to re-establish equilibrium and restore social functioning. In one situation this became simply a matter of acquainting an individual with established community resources of which he was not aware; in another, it became a detailed process of helping a man work out a complex plan by which he could prepare for his entrance examinations to the university by studying English in the hospital.

Work with families was also carried out when appropriate and feasible. Effort was made to draw them into the current situation, to re-establish communication between them and the patient, and to consider with them the stresses brought on by the shift in familial roles. In most instances it involved provision of concrete services: working out with relatives their financial rights and available benefits, helping them set up reduced budgets, filling out loan applications on their behalf. Although underlying personality problems became evident at times, emphasis was placed throughout the project on healthy aspects of ego functioning within the family network.

Conclusion of Project

Over a seven-week period, each patient was seen for an average of five times. The extent of actual service varied but, by the end of this period, almost all the men had either been discharged from the hospital or transferred to convalescent centers. For most of them, the period of active emotional crisis produced by their having been injured appeared to have passed and they had become involved in ongoing programs of rehabilitation and vocational retraining. Some had been referred to other community agencies. Even for the few who still remained on the wards, the groundwork had been laid for future activity with the Rehabilitation Service. The Defense Ministry too had been able to obtain a realistic picture of the extent of service-connected injuries and the range of post-war programs needed.

Shader and Schwartz have pointed out that most of the immediate or acute psychological effects of a disaster clear up in minutes to weeks, with relief from the stressor and rest or sedation being the keystones of treatment.[6] Social workers can assist survivors by helping them face their distress and express their emotions. This was amply illustrated in this project.

While certainly no predictions as to ultimate outcome of the patients' eventual adjustment could be made by the time the special project was closed, it was felt that a valid short-term service, geared to the emergency situation and to the restoration of equilibrium, had been effectively carried out and that possible maladaptive patterns of adjustment had been averted.

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[6] Richard I. Shader and Alice J. Schwartz, "Management of Reaction to Disaster," *Social Work*, Vol. 11 (April, 1966), p. 103.