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# Uses of Clinical Sociology in Crisis Intervention Practice

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## ABSTRACT

Crisis intervention is a practice-oriented set of procedures designed to offer someone experiencing incapacitating stress emotional first-aid. Concepts and ideas found in the sociological tradition are quite applicable to crisis intervention practice. What has been offered are alternatives to the traditional psychological and psychiatric positions.

There are similar characteristics between crisis intervention and clinical sociology as change strategies. Particularly, the ideas found under the sociological social psychology purview serve well when practicing crisis intervention. The interpretation of crisis events is a social act in that the individual experiencing the crisis is influenced through social circumstances. Social circumstances play a vital role in crisis formation and intervention.

Intervention strategies are offered which integrate aspects of clinical sociology while using a case study for application. The crisis intervention steps include crisis assessment, information gathering, control, direction, progress assessment, and referral. Through these procedures, the intervener may work with the client toward the goal of socioemotional stability

For many years, crisis intervention has been a viable helping strategy. Beginning as a formal approach some 40 years ago (Lindemann, 1944), the field began to flourish. Crisis intervention was primarily attached to the medical profession as it employed a medical model. Logically, then, the major emphasis has been on psychiatric/psychological approaches of crisis definition and resolution. Recently, however, it has become apparent that there was a valuable social component to crises, which could be used in crisis intervention theory and practice

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As a helping strategy, crisis intervention includes theory (how crises are produced, types of crisis, etc.) and practice (skills for effective crisis resolution). This paper will present practical considerations for theory and practice while integrating principles of clinical sociology. The typology of crisis, crisis event interpretation, and crisis formation will be examined. A presentation of crisis intervention strategies will be offered with a case study application. What will follow, then, includes crisis theory and intervention which integrate aspects of sociological intervention.

### **Crisis Intervention and Clinical Sociology**

In approaching crisis intervention, it is useful to integrate some of the ideas of "sociological intervention" (Straus, 1984) and "social behavioral intervention" (Straus, 1982) into the existing operational framework (Byers and Hendricks, 1985; Hendricks, 1984). Clinical sociology is the use of sociological knowledge and concepts for positive change, while crisis intervention is emergency emotional first-aid. Although distinctively different in definition, the two areas can be usefully integrated. The ideas of the sociological tradition are compatible with crisis intervention practice; it should prove beneficial to integrate sociological knowledge with the existing psychological and psychiatric tradition. This will not only broaden the eclectic nature of the approach, it will also offer the client more effective treatment. In other words, using interventionist strategies from different perspectives increases the likelihood that the client will receive appropriate and effective attention. Intervention strategies are situational. No one approach is appropriate at all times. However, coupling sociological practice and crisis intervention allows for an effective effort. The contention that clinical sociology should be used in company with other counseling, therapeutic, change, and intervention strategies was posited early (Jaques, 1947; Lee, 1955; Link, 1948; White, 1947; Wirth, 1931). Furthermore, the utility of sociology in therapy has been suggested in a number of recent publications (Black and Enos, 1980; Church, 1985; Glassner and Freedman, 1979; Hurvitz, 1979; Moreno and Glassner, 1979; Polak, 1971; Straus, 1979a, 1979b, 1982, 1984). A unidisciplinary approach to the problem of personal crisis runs the risk of possibly missing important information that knowledge from another discipline might provide. As Glassner and Freedman (1979:12) have noted, "The work of crisis interventionists can be quite instructive for some aspects of clinical sociological practice." Taking this position a step further, there is a reciprocal benefit to be gained from the combined use of crisis intervention and clinical sociology. Individuals do not experience crises in a psychological vacuum; personal crises must be examined from a perspective which recognizes the role of society and the social forces which influence the individual.

Most people are thrust into crisis many times throughout a normal life cycle.

The intervener must be prepared to tend to individuals in crisis in order to help restore them, at the very least, to a stable level of functioning. This is an explicit goal of crisis intervention. Stable functioning may be defined as a constitutional state where the client is capable of understanding the crisis, demonstrating effective social and psychological functioning, and learning from the crisis and the intervention. This will leave the client better equipped for future crises. Intervention is on the micro level and should entail an understanding of the client's social environment as well as psychological, affective, and behavioral aspects. This understanding of the social realm is evidence of the importance of integration, as are themes that characterize clinical sociology and that are also well suited for crisis intervention. These include a practice orientation, focus on case studies, a diagnostic nature, change-orientation, a humanistic position (Freedman, 1982), and "minimal intervention" (Straus, 1982:63). In a minimal intervention the intervener monitors and keeps at a minimum the span of interventions, the helper's authoritarian role, and the expectations for change placed on clients. (See Straus, 1982:6-7, for a complete description of "minimal intervention.") These concepts help the intervener understand the dynamics that must be dealt with within the client's social environment.

Clinical sociology offers the intervener a wide array of interpretive strategies for problem identification and solution. These include such concepts as socialization, status, role, in-group/out-group, group dynamics, conflict, interactionism, situational analysis, definition of the situation, etc. Through a utilization of the sociological perspective, then, the intervener will gain necessary insight into the social nature and function of interpersonal and intrapersonal crisis. With this understanding, the intervener may step into the crisis situation with more than the customary level of knowledge associated with crisis intervention.

Although the intervener deals directly with the individual, the social reality of the client must be recognized. This may entail intervention which not only leads to change in the individual but also to change within a dyad, a family or a social group. The orientation of the clinical sociological approach affects the group level even when an individual is being treated (Glass, 1979; Lee, 1979; Moreno and Glassner, 1979). This type of influence may be desired as part of the intervention strategy, or it may be a therapeutic by-product of the encounter. The intervener must treat the individual as a social being on the micro level while taking into account the social and/or sociological variables which influence behavior and affect. Crisis intervention and clinical sociology are both intervention strategies, and both can be applied on the micro or individual level. Further, crisis intervention is active rather than passive or neutral, as is clinical sociology. As Fritz (1985) states, "Clinical sociology is intervention work." Both approaches are defined by explicit intervention, that is, intervention for positive change.

## Personal Crisis

A crisis might emerge when an individual experiences unpleasant socioemotional feelings, which result from the onset of a perceived insurmountable stressful life event. This is accompanied by an inability to cope with or adjust to the event. These are common components of personal *crisis definition* (Rapaport, 1962; Smith, 1978). The "socioemotional" basis of feelings assumes that there is a close connection between social reality and one's affective state. For our use, a crisis may be defined as:

The unpleasant psychological and social feelings/sensations, which result from the onset of a perceived insurmountable stressful life event, disrupting stability, and accompanied by an inability to adjust or cope.

According to Morrice (1976), emotional crises may present themselves in two generic forms: "accidental" or "developmental." These typologies aid the intervener in ascertaining the nature of the crisis and the appropriate intervention. The accidental form of crisis has been described by Morrice as those events in life which create an emotional impasse, cause emotional turmoil, and are temporarily incapacitating. Accidental crises are unexpected or unintended. This typology includes crises which result from sudden traumatic stress. Examples include: divorce, relationship conflict, school failure, loss of health, loss of work, death of a loved one. We all have ideals concerning how life should flow; however, the ideal is not always the reality. Even if one expects a crisis to materialize (e.g., a long-troubled marriage, terminal illness), the degree of trauma experienced when the event happens is not necessarily less. For instance, one may know cognitively that a loved one is dying of cancer, but that might not necessarily soften the impact of the stress produced by the loss. On the other hand, experiencing the long-term death of a loved one might produce more stress than the final demise. The death may be a relief rather than an incapacitating experience. Accidental crises include impasses that are not expected during an ideal life course. It is important to remember that individuals respond to stressful life events through a complex socialization process. Learning takes place through a myriad of life experiences and conditions. The response to stressful life events might hinge on how one's life situations and life chances have been formed.

The developmental category of crisis is characterized as consisting of events which are normal life experiences, but which may also produce crisis reactions. Some examples of developmental crises include growing old, getting married, sexual identity, graduating from school (high school or college), children leaving home (empty nest), value conflict, dominant-subordinate relationships. These events will not produce crisis in everyone experiencing them, of course. How-

ever, they may produce a crisis reaction under certain circumstances. The social and/or sociological nature of these two types of crisis is obvious. As stated by Burgess and Baldwin (1981:31): "Every emotional crisis is an interpersonal event involving at least one significant other person who is represented in the crisis situation directly, indirectly, or symbolically." Crises are produced in the individual through social circumstances. Social life is, at times, stressful. A certain degree of life stress is required and desirable. On a clinical level, the majority of clients treated by counselors and psychotherapists have stress-related problems (Straus, 1979a). Social circumstances set the stage for individual stress reactions and crisis event interpretation.

### **Crisis Event Interpretation**

Events which occur in one's life do not, alone, produce crisis. An *interpretation of the event* must take place. That is, the situation must be perceived as a crisis before the individual will react to the crisis. The concept of the "definition of the situation" is quite applicable here (Thomas, 1931). (Lydia Rapaport, 1962:211, a prominent crisis theorist, also cites W. I. Thomas as a useful social theorist in this area.) An individual presented with a potential crisis-producing situation must first define the situation or the context of the crisis. The situation may be interpreted as one of crisis or one of normalcy. It is through a definitional process that situations will be interpreted as a threat to emotional stability or as an event which poses no threat. As See and Straus (1985:66) have described, in order to understand another human being one must "discover (a) how he or she actually interprets the meaning of different kinds of situations; and (b) how he or she has come to analyze situations in that particular way." This type of analysis is useful because it enables the crisis intervener to make sense of the situation based on the social characteristics of the case. As mentioned above, the crises which characteristically affect individuals have either social influences or social causes. Individuals react to external stressors by cognitively internalizing the meaning of the crisis precipitator (hazardous event) according to personal interpretation. The crisis precipitator is any social event which has the potential to be perceived as a threat to socioemotional stability. The event is termed a "precipitator" because it precedes the crisis onset. For example, the death of a loved one may not be a crisis event until 1) the death notification has been made, and 2) the information is situationally defined. Points such as these make it important to examine the crisis situation from a clinical sociological perspective.

When describing the onset of crisis and the circumstances that produce the crisis, much of the literature describes the hazardous event, the perception of that event, the resulting feelings, and the inability to find immediate solutions (Smith, 1978). Thus, the nature of the crisis event and its interpretation, although

commonly found in the psychological or psychiatric literature, may be described well through the components of interactionism or sociological social psychology. The precipitating event is commonly a social event, or at least has repercussions on the social level, which provides a basis for a social psychological interpretation of the process.

### **Crisis Formation Process and Intervention**

In order to intervene effectively in a crisis situation, one must have an accurate understanding of the process through which a crisis is produced. This is the crisis formation process. Also, the intervener needs to utilize an effective and efficient intervention process, that is, a procedure designed specifically as a guide to intervention while providing help to the client in crisis.

**Crisis Formation Process.** This is the course through which the client progresses on the way to emotional instability. Before the process begins, it is often assumed that the individual has a balanced state of affect and thought. As mentioned earlier, this is not always the case. Examples include families which have been slowly destroyed by terminal illness, domestic violence, or an alcoholic family member. In these instances, structural factors within the family must be taken into account as possible and probable contributors to a crisis. Individuals do not go untouched by prior or current events. Crisis is not experienced in a psychological vacuum. Although, the client may have exhibited precrisis emotional stability, other factors often come into play to form a crisis.

Many early crisis theorists referred to the stress-producing nature of crisis situations. Partly due to ties to the medical profession, homeostasis and physiological reactions to stress were used to explain crisis (Caplan, 1964; Lindemann, 1944). It was not until the work of Howard J. Parad that it was recognized that "the event precipitating the crisis must be perceived by the person as a stressful situation before it can become a crisis" (Smith, 1978:397).

The *precipitating event*, or hazardous event, presents a threat to emotional stability. These events come in a variety of forms, such as the death of a loved one, relationship failure (divorce, breakup), interpersonal conflict, unfair social structure, or professional practices. However, it is not the event per se that produces the state of crisis. It is through a *definition of the situation* (Thomas, 1931) that the event is defined as an unpleasant occurrence. The individual first interprets the event in terms of its emotional and social consequences. Different events carry different levels of social and emotional impact depending on the nature of the event and the person experiencing it. For example, a relationship breakup might be very devastating for one person while for another it might be considered a blessing. The death of someone with a terminal illness may be a blessing, a relief, an end to a stressful life period for both the family and the

patient. These reactions depend on the circumstances of the event, the actors involved, and situational definitions. Although some events will probably be quite stressful for most persons, the definitional nature of the event largely determines the degree of the emotional reaction. The interpretation of precipitating events and the resulting definition occur on the cognitive level, which, in turn, becomes transmitted to the emotional level. The definition may be made in terms of how the event will affect the individual, how the event will be seen by others, or how the event will influence others' perceptions of the individual. One not only reacts in terms of the emotional component but also according to the interpretation by others. This is most likely when the event could result in some form of social stigma, such as legal arrest, divorce, mental hospital incarceration, cancer, AIDS. Here, one can incorporate Cooley's (1956) concept of the Looking-Glass Self, which claims that people develop self-images through a perception of how others view them. The notion is that individuals mirror, in affect and cognition, the believed perceptions of others. Thus, crisis formation has a major social component, and the sociological perspective offers the intervener a vantage point for examining these social aspects.

The next phase of the process, *internalization of the definition of the situation*, has already been touched upon. Internalization takes place when the client incorporates the definition of the precipitating event. In other words, the definition becomes part of the individual. The perceived nature of the precipitating event and a weighing of the personal and social consequences are incorporated into the client's behavior and thought repertoire. Once the client tests regular coping mechanisms and discovers that regular adjustment strategies prove inadequate, the emotional turmoil is overwhelming. When this is realized, the client will often engage in self-destructive behavior which only perpetuates the already present emotional hazard. It is at this point that the crisis becomes manifest. The individual knows that the sensations experienced are not normal, but is unable to provide the necessary coping behavior to resolve the crisis and restore emotional stability.

Crisis resolution may take place through active and intentional efforts of the clinician using an *intervention process*. It has been posited that crisis intervention is most effective during the acute, or beginning, levels of crisis (Caplan, 1964; Morrice, 1976). The intervention strategy consists of several steps which enable the intervener to help bring the crisis to resolution. The process may be fairly smooth or extremely complicated depending on the situation, social dynamics, nature of the problem, client abilities, and intervener capabilities. The crisis intervention strategy is active, normally short in duration (usually 1 to 8 therapeutic encounters within 4 to 5 weeks),<sup>1</sup> specifically problem targeted (Caplan, 1964), and involves stabilizing the client while attempting to return the client to a stable socioemotional state. Intervention is a response to the onset of socioemotional crisis. Throughout the encounter, the intervener must remain



aware of the purpose and goal of crisis intervention—decisive interventive action which leads the client to a level of stable functioning or crisis resolution.

What will follow includes an integration of the crisis intervention process posited by Hendricks (1984) and Byers and Hendricks (1985) and the clinical sociological approaches of Straus (1982, 1984). A case study will be utilized in order to demonstrate the intervention process. The scenario is an actual one, but intervention was not possible at the time. Nonetheless, the case study offers a challenging set of circumstances for crisis intervention with a clinical sociological emphasis. A step-by-step process for crisis intervention will be introduced, utilizing sociological intervention strategies while integrating the case study information to demonstrate what could have been done.

### **Case Study<sup>2</sup>**

Mrs. F is a white, married, 30-year-old woman living in a small town. The community is predominantly middle-class, rather affluent, and has a strong protestant work ethic. Individuals there are often held responsible for their own life situations. Mrs. F has been divorced once and widowed once. Her current husband is incapable of working due to severe mental illness. Mrs. F has a job which pays minimum wage and has no advancement possibilities. She has an untidy appearance, does not appear intelligent, and has a nonassertive demeanor. She has been characterized as a member of the lower-class (SES).

Mrs. F has two children (both under 4 years old) and recently gave birth to a third. This baby was born in a local hospital; after the delivery, Mrs. F and her child were sent home. The baby was born with, and was sent home with, a jaundice condition. After a few days at home, the baby began to vomit, appeared sick, and lost weight. Mrs. F contacted her physician (Dr. P) and informed him of the developments. Mrs. F then took the baby to the office of Dr. P, per his instructions, for an examination. Dr. P recommended that she take the child to a specialist. She did. The baby was hospitalized for 2 weeks and showed improvement during the stay. The child gained 8 ounces in weight. At this time, the baby was diagnosed as having malabsorption. In this case, it was determined to be a genetically transmitted disorder—the patient cannot physiologically take and use nourishment. The social definition is the Failure to Thrive Syndrome. In this condition, the child appears malnourished, which sometimes has the social connotation that the mother has not properly cared for the child. With much improvement, the specialist released the baby from the hospital.

After about a week at home, Mrs. F noticed that the baby was developing the same symptoms again. She took the baby to the nearby hospital, and the child was admitted. During a stay of 3 days, the child maintained its weight. Dr. P released the child. Soon after the hospital stay, the child became sick with

the same symptoms. Mrs. F contacted Dr. P again. He told her to bring the baby to his office. It was discovered that the child had lost 14 ounces since the second hospital stay. Mrs. F was very concerned over the welfare of her baby. Dr. P told Mrs. F to take the child home; if the child weren't better by the next week, he would call the specialist again. Dr. P wanted Mrs. F to care for the child for 1 week at home before growing concerned. Mrs. F, very worried, obeyed the doctor's orders and took the baby home. During the week, the baby grew sicker. The mother called Dr. P, who said to take the baby back to the specialist. The baby died en route to the hospital. It was eight weeks old.

The coroner's report indicated that the mother must have been inadequate in caring for the child. This coroner claimed that Mrs. F was not even aware that the child was dead upon arrival due to her deficient mental capacity. Mrs. F, in fact, was aware that the baby died en route.

Mrs. F has another child 2 years, 6 months old. The child has developed the same symptoms of malabsorption. She is aware that this child may have the same genetic disorder, but she appears to lack the assertiveness and influence to pressure Dr. P, or any other physician, to give the care which she feels her child needs. She is currently in a confused, self-blaming crisis state not knowing what to do.

### **Crisis Assessment**

Crisis assessment is an ongoing activity in the intervention process (Smith, 1978). One of the main purposes is to arrive at decisions to facilitate the intervention process. It is an evaluative procedure between the client and the intervener; collaboration between counselor and client is essential during assessment and throughout the intervention process. The nature of the collaboration consists of beginning the therapeutic relationship, providing an atmosphere for open and honest talk, and maintaining a commitment for a positive outcome. In order to begin therapy, the intervener must "get a handle on" the problem through problem focusing. When focusing on the problem, the intervener should remain committed to the present difficulty, working in the "here and now." Through this activity, the helper will gain an essential understanding of the client's crisis. The activity of problem identification may prove to be therapeutic in itself. Through identifying the problem, the client may begin better to understand the situation.

From the data in the above case study, the intervener may gain valuable information (however, such chronological information is seldom available) in order to ascertain the overt nature of the problem. Mrs. F has been traumatized by her baby's death, which has been compounded by the possibility that her youngest child might be afflicted with the same disorder. Furthermore, she may have been victimized by medical personnel, and she lacks the personal and

financial resources to improve the situation. Through an assessment of this information, the intervention can be planned. New information is likely to emerge throughout an interventive encounter. Thus, assessment must be an ongoing intervention activity.

### **Intervention Steps**

**Information Gathering.** This begins with the client referral. It may be a self-referral, a referral from another person (such as a concerned individual or significant other), or a referral from an agency. In this case, we will assume that the referral was made by a concerned friend. If the referral has been made from sources other than the client (e.g., friends, family, police, hospital personnel, etc.) valuable information about the case may be obtained from these sources. However, the helper should use this type of information cautiously, being attuned to possible bias, stereotyping, labeling, and stigma. These sources of information are valuable, but it is necessary to exercise caution when using them.

The primary activity in this stage is interviewing the client.<sup>3</sup> This is similar in practice to the gathering of information in Straus' (1982:64) Social Behavioral Intervention Assessment Phase. Close interviewing with the client is also important. The intervener would want to speak with Mrs. F personally and engage in active reflective listening (Rogers, 1951), while recognizing the need to be attentive to possible class differences. It is important to remember that one of the roles "of the therapist is to match the individual with the social systems in which he participates" (Costello, 1972:421). In addition to these points, and important from a sociologist's position, the intervener will wish to use such concepts as symbolism, role, presentation of self, and interaction patterns (Blumer, 1972).

Interaction with the client (such as Mrs. F) is designed to get to know the client personally in order to build a trust relationship and to gain an understanding of the client's situation. The intervener should adopt a warm, empathic approach when interacting with the client. Role taking is applicable (Mead, 1934). By taking the role of the other, the intervener may better understand the client's social world. It should be understood that Mrs. F has been through much trauma. By demonstrating a caring demeanor, the helper reflects his/her understanding of the crisis, as assessed, back to the client in order to verify understanding. The intervener might say, "You seem to be in pain and confused about what to do next" or "I can understand that all of this is difficult and sad for you." If the intervener is not interpreting or understanding the situation accurately, the client will likely let it be known. Also, the intervener might wish to "negotiate a mutually acceptable definition of the situation with the client" (Straus, 1982:64). This will facilitate understanding and effective therapeutic interaction.

Always understand that the client has experienced a traumatic situation (or, in the case of Mrs. F, many situations). Through information gathering the intervener should get to know the client, get a handle on the presenting crisis, and seek all relevant information concerning the client's social and psychological world.

**Control.** The main emphasis here is on rationality and stability. That is, rationality of thought and stability of affect. Once the crisis has been identified and stability introduced, the intervener may wish to devise a set of intervention goals with the client (when the client is capable of doing so) designed to foster positive growth and change. This will serve as a good reference from which interventive efforts can be launched. Mrs. F and the intervener may decide to talk about the crisis. The intervener may emphasize alternatives to her current emotional state.

The degree or amount of stability utilized is dependent upon the lethality of the situation; of paramount importance is the reduction of potential danger. This might mean danger to the social-emotional self or to the physical self. It is in this stage that the *crisis is addressed*. The nature of the crisis is identified, by the intervener, through the collaborative efforts of both counselor and counselee. At this point, Mrs. F may tell the intervener that she cannot bear the sadness of losing her baby. She might even say, "I should have done more for the baby" or "It's all my fault; I should have left the baby in the hospital." These positions are reinforced by the nature of this situation, namely, the social connotation of the disorder, the appearance that the attending physician did all that could be done, the response of the coroner, and possibly the devalued nature of the social group to which she belongs. In this case, blame, although subtle, seems to be placed on Mrs. F. Here, the intervener may wish to draw on the individualistic nature of American society and how responsibility is meted out based on that structure (Ryan, 1971). It is understandable that she might blame herself given these social patterns.

When the nature of the crisis is identified, the *crisis is defined and this information is conveyed to the client*. What the intervener is dealing with, then, is the "operational definition of the situation" (Straus, 1984:32). When the crisis is defined by the client, the definition is based on precipitating factors and how they are interpreted and internalized. This results in unpleasant feelings or a state of crisis. Given the nature of our case study, this could be expected. Challenging a physician is not an activity which many feel comfortable with; this is especially true for our nonassertive client. As outlined above in the crisis process, crises do not suddenly materialize. Crises are produced in the individual through a "definition of the situation" (Thomas, 1931). For Mrs. F, the death of her child was defined, internalized, and reacted upon based on self-blame. It is normal for guilt to be present; however, Mrs. F needs to be guided away from this self-

destructive pattern. The client is encouraged to understand his/her ideation and the feelings being experienced. Intervention, at this point, might be done by sharing with Mrs. F the nature of physician-patient relationships, how authority tends to operate, and specifically, how socialization seldom advocates questioning authority. The intervener must, in this instance, be cognizant of physician-patient relationships and how they are formed (Kallen and Pack, 1985). Also, Mrs. F needs to be reminded of the steps that she did take when caring for her child, in light of the dynamics between key players in this situation. Furthermore, the intervener might wish to educate Mrs. F on the social interpretation and the genetic reality of the disorder. The above tasks may be accomplished through gentle encouragement and role taking designed to help the client understand the thoughts and emotions being experienced. Any form of open ventilation should be allowed here. This is not only a stage that emphasizes definition and control but also exploration and open catharsis.

The intervener may demonstrate control and emotional stability by being a strong and confident "role model." The client might need someone that she can learn from. In this capacity, Mrs. F may be shown that a stable emotional constitution is attainable. Intervention should be marked with a demonstration of confidence, patience, purpose, trust, competence, compassion, and empathy. This conveys to the client that socioemotional stability and control are possible. Warmth, positive regard, unconditional acceptance, and respect (Rogers, 1951) should be demonstrated continuously; the client must be treated as a feeling human being. Clients need to be assured that their ideas and feelings are not "abnormal" and that there are many adjustments and stressors which one must contend with in life. The labeling process has no use here and should be avoided. Labeling the client with a diagnostic category has the potential of being destabilizing.

The intervener needs to examine, with the client, the definitional nature of the crisis. That is, the crisis intervener, using the sociological method, may help the client to identify any inaccurate, faulty, or self-destructive definitions of the situation. This is necessary because of the nature of personal definition in the formation of crisis. It is not just the situation itself that produces crisis; it is the definition of that situation that contributes to crisis formation. For example, Mrs. F might believe that she was at fault for her baby's death because she defined the situation in terms of total personal responsibility. Mrs. F should be made aware of the strength of authority, prestige, and status when responsibility is meted out. Is Mrs. F defining herself as a failure? Based on situation definitions, she may have perceived the situation in a self-destructive way. Once the client has been introduced to the definitional nature of the crisis, it is then necessary to show the client that he or she has the ability to *redefine the situation* (Straus, 1979a, 1984) in ways which may be more emotionally productive. The client can be helped to interpret and act upon the situation in a way that does not have

self-destructing or self-limiting features. This is similar to what Straus (1982:69) refers to as "teaching control." In the present context, this includes suggestions or tactics designed to alleviate the client's stress and crisis. Through a redefinition of the situation, the client is given the skills to reduce levels of stress and crisis.

**Direction.** This step has an emphasis of decisive action. It is the step which puts into action the situation redefinition process. The main emphasis in direction is to encourage the use of alternatives to unpleasant thoughts, feelings, and behavior. The explicit goal is to help the client reach a level of socioemotional stability that promotes self-assured independence. It is important that this take place without an excessive time-lag. If this is not the case, the client runs the risk of falling deeper into the self-destructive behaviors that the therapeutic encounter was meant to change. When change does not take place within a relatively short time (1-8 encounters), one is no longer practicing crisis intervention. The development of direction is an important therapeutic goal. The intervener, during this and all stages, must be open, honest, and genuine. Above all, the intervener needs to be attentive (an active and caring listener) and intentional (devoted to a positive therapeutic outcome). With these points in mind, a productive encounter may ensue.

Direction puts into practice the redefinition process. A "direct mode" of intervention deals with the actual problem and tends to be "expedient" (Straus, 1984:55). When changing the definition of the situation, it is, of course, essential that the client understand the definition he or she already has. This clarification should take place during the "control" stage. Clients should be helped to understand self-destructive, self-defeating, self-limiting, and counterproductive definitions. Clients are then encouraged to define the situation in more positive and manageable terms. In other words, the intervener will attempt to reframe the situation through collaborative efforts with the client (Straus, 1982). Let us, again, take the case study example. Mrs. F defined the situation in such a way that she had taken the burden of the child's death. Through this reaction, Mrs. F was defining herself as a failure in mothering, irresponsible, and to blame. Our client can be guided through a redefinition process. Mrs. F needs to be shown that she is considering herself a failure due to the child's death. It can be demonstrated that thinking she is a failure will result in a "self-fulfilling prophecy" (Merton, 1968:477). This concept states that by falsely defining a situation one may evoke new behaviors that make the false definition true. The client can be shown that the definition, which may not necessarily be accurate, is causing pain. Mrs. F needs to be helped to understand that she cannot hold herself accountable for a genetic disorder and, furthermore, that she *did* take action on behalf of her child. The client may respond, "It's easier said than done" or "I just can't forgive myself." However, it is possible that once the client understands that her definition of reality has produced the emotional state

being experienced, personal empowerment will take place to alter existing definitions.

**Progress Assessment.** Once the situation has been defined in "control" and redefined in "direction," the intervener may wish to engage in progress assessment. This form of assessment is different than the aforementioned type. Here, the intervener examines the progress which has been made between the intervener and client toward the desired end. This may entail an examination by the intervener or a joint assessment between intervener and client. This is also a good opportunity to compliment the client on progress made; positive reinforcement will work to the advantage of the client and the desired therapeutic outcome. Also, if the therapeutic encounter was not successful in its goal, the intervener will wish to approach the crisis again. This would mean returning to the control step. If deemed appropriate, the intervener may wish to introduce confrontation with the client, such as that explained by Jones and Polak (1968). For instance, it may be necessary to confront the client if, in the intervener's judgment, the client is not taking the necessary degree of responsibility in the relationship. One must, however, use caution when introducing confrontation. Client ability to manage confrontation must be assessed in order to avoid a reaction marked with defensiveness and resentment. In short, then, this stage gives the client and intervener the opportunity to review the progress, or lack thereof, in the encounter.

**Referral.** The final step in the crisis intervention process is referral. At this time, the client is either referred to another helper or agency for more specialized treatment, or the case is closed. Referral is made for more specialized services and assistance that cannot be provided by the intervener. Referral should be made as the situation warrants it. A referral might have been made, in our case study, to an agency specializing in bereavement counseling, a local health department, or to legal aid (the latter due to possible legal encounters with Dr. P). Most important would be to ensure that the surviving child, which had developed the same symptoms, received medical attention. This should be sought from a different physician, if possible. Often some form of follow-up is useful, beneficial, and therapeutic. The separation of intervener and client need not be stamped with a seal of finality. If it is desirable for both parties, continued contact has a place in the therapeutic relationship as long as the contact does not evolve into dependency, namely, client dependency on the intervener. However, it is a beneficial practice to address separation issues early. These should be attended to early in order to avoid problems of dependency when separation becomes a reality. The crisis intervener has a limited role in providing aid to those in emotional turmoil. This role has, as its main emphasis, the tasks of gathering information, providing control and direction, and arranging referral.

## Summary

Many sociological concepts are applicable to crisis intervention practice. The two approaches are quite compatible. Individuals are social beings, affected by social circumstances. Crisis is not experienced in a psychological vacuum; social forces aid in the formation of crisis. Personal crisis is formed through an interpretive and definitional framework. Precipitating events are given meaning through interpretation which, in turn, leads to a crisis state through a perceived threat to socioemotional stability. It is through the precipitating events and the definition of the situation that the crisis is produced.

Once the clinician understands the social psychological basis of crisis formation, effective intervention strategy can be developed. The intervention process includes crisis assessment, information gathering, control, direction, progress assessment, and referral. A case study illustration was used to clarify suggested crisis intervention strategies. Through these steps, the intervener will be able to work with the client in order to reach stable socioemotional functioning.

## NOTES

1. Beyond this duration, one might be practicing brief psychotherapy or beginning an extended therapeutic relationship.
2. The images of the client, which are presented, are not intended to be demeaning or stereotypical. The author believes the information to be important for understanding the case.
3. The intervener may find it useful to review interviewing skills (especially the proper uses of open and closed ended questions). This information is available in many qualitative sociology texts. Also, *The Helping Interview* by Alfred Benjamin (1981) offers a good presentation of effective communication skills.

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