A SOCIOLOGICAL THEORY OF CRISIS INTERVENTION

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INTRODUCTION

The word *crisis* has become part of the terminology of psychiatry, psychology, social work, and sociology, and it is found in standard dictionaries in these fields (Dushkin 1974 64). The concept of *crisis* usually refers to certain events or conditions which have clear negative consequences for an individual or for society. Such events and conditions are endemic to modern post-industrial societies. They can also be viewed as part of the biography which is outside the normal world, and hence can be considered time-limited. These events and conditions may require counseling, the development of new norms, or initiation of special social policies to cope with the dysfunctional consequences associated with crisis. There is a clear practical need for better understanding of crisis situations and treatments, but the literature in sociology affords little more than definitions. Theoretical explanations of crisis have come mainly from psychology and psychiatry, as have the clinical counseling methods.

Some of the more worldly professions and occupations have developed a clear understanding of the need to deal with concept of crisis, both in academic and applied aspects. But these agencies have turned to the micro approach to crisis intervention offered by psychology and psychiatry. In recognizing the practical importance of preparing for crisis situations, communities and organizations from small cities to police departments and political bureaucracies have developed strategies to cope with crisis. These strategies include crisis management teams, and telephone crisis centers.

Most of the literature and practice concerning crisis intervention has a particular set of assumptions which disregard a substantial part of collective human behavior. Analysis of many of the definitions of crisis and crisis intervention yields both psychological and social dimensions, but clinical methods have generally avoided any meaningful component from the sociological perspective. The lack of sociological imagination becomes increasingly problematic when major forms of crisis are identified, because they are to some degree social in character, and many stem directly from larger social institutions and cultural arrangements.

DEFINITION OF CRISIS

Behavioral science definitions of crisis include the following elements: a crisis-producing stimulus; a disruption of normal psychological functioning; and a set of negative or ineffective behavioral responses resulting from them. Figure 1 depicts these elements and some common examples. Not all societies provide as many crisis-producing stimuli as post-industrial societies, and some individuals are more able than others to cope with crisis. Those more able to cope have learned coping techniques from previous experience with crisis events, or they may be in a more favorable position in the social system relative to coping ideation. At the same time, the behavioral response is a function of several components, including role placement and various sociocultural factors. There is a chance of crisis resolution even with a severe stimulus and poor coping. However, the general assumptions of the model are that one can learn coping techniques or one can benefit from crisis counseling. This learning or counseling may greatly enhance a person's behavioral response.

While this model seems straightforward, the crisis model literature is not uniformly clear regarding the definition of the term *crisis,* which, as a single phenomenon, and separate from other considerations, seems to evade most theoretical schemes (Burgess, Baldwin 1981 25). Perhaps the confusion results from the way the term is used, because at times it is used as a substitute for the more general crisis model designation. As Figure 1 indicates, the crisis model contains three stages, whereas the crisis concept in psychology identifies the specific point within the model where psychological functioning is impaired. There is usually a time frame specified in most crisis models. The stimulus may precede the actual crisis by as much as three weeks, and the behavioral response may follow as much as two months later (Dixon 1979). And the crisis itself has several

FIGURE 1: A CRISIS MODEL BY STAGES, WITH EXAMPLES

Stage:	Pre-crisis	Crisis	Post-crisis
	Crisis stimulus	Psychological disequilibrium	Behavioral problem
	Precipitating factor	Cognitive dysfunction	Response problem
Example 1	Divorce	Fear	Isolation
Example 2	Combat	Anxiety	Shock
Example 3	Failure	Depression	Suicide

(Adapted from Dixon, 1979.)

psychological symptoms which include anxiety and depression. However, these symptoms should not be viewed in isolation from the other components of the crisis model.

Another point of confusion stems from the consequences of crisis. The outcomes are multidimensional. A crisis can result simultaneously in danger and opportunity (Aguilera, Messick 1978 1). A crisis can also converge with other life events and yield anything from personal devastation to self-realization. These consequences depend in part on how the individual copes with the stimulus and the opportunities for self-realization.

The crisis model involves a linear progression from stimulus to crisis, and finally, to behavioral response. The crisis is "... a functionally debilitating mental state resulting from the individual's reaction to some event perceived as to be so dangerous or problematic that it leaves him/her feeling helpless and unable to cope effectively by usual methods." (Dixon 1979 10) The psychological disequilibrium is highly individualized in the person in crisis. While the crisis definition is a subjective process, there are events which typically cause crises. In the United States, death, loss of status, divorce, and marriage can cause crises. But the psychological tools for coping are socially bestowed and culturally transmitted. The crisis associated with death is more severe in our society than in most others. We deny death, and usually hide it from children in real life, though not in the unrealistic dramatized versions in the media. In preindustrial societies, where death is a normal part of the life process, and is not

particularly age-specific, the crisis is diminished because the culture has a more positive view of death (Charmaz 1980 87). Each step in the crisis model can be seen as dependent on the nature of the society in which crisis occurs.

MAJOR FORMS OF CRISIS

The forms of crisis are classified by typical precipitation events. A quantitative evaluation of the intensity of certain stressful events has been used to create the *Social Readjustment Rating Scale* (Holmes, Rahe 1967). There is some evidence that this scale may be used on a cross-cultural basis, but these forms should be taken as most relevant for people in the United States, since they comprised the population in which the scale was tested (Arthur 1971 87). It is a rank-ordered scale of life events ranging from death of a spouse to minor law violations.

Many of these events are part of the roles within social institutions. Of the 43 events, 26 are related to social institutions; 7 are biological in nature; and 10 of the events are not readily classified. Many events have social aspects, and some relate to personal factors. The next step in the model suggests that the events will increase the chances of a crisis response.

THE CRISIS

It follows that the crisis itself is a psychological response to events which often have institutional ties. However, the psychology of crisis has yet to be discussed in a sociological frame of reference. There are macro and micro level determinants of

FIGURE 2: A CRISIS MODEL WITH SOCIAL FACTORS
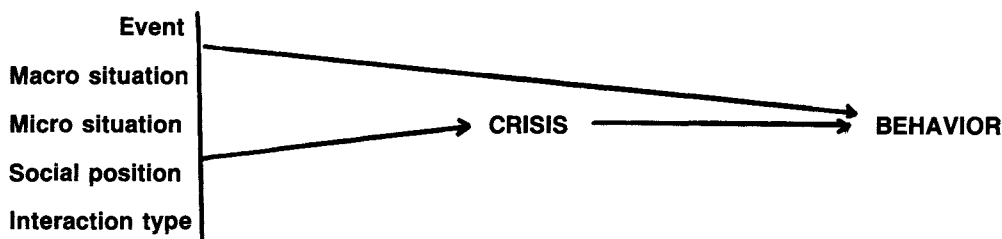
anxiety, depression, and general psychological functioning. Factors related to rates of mental illness and to mental well-being include social class level, micro environment, status accumulation, and positions of relative powerlessness (Hollingshead, Redlich 1982; Kessler 1982; Kadushin 1983; Thoits 1983; Morowsky, Ross 1983). Situation correlates of psychological distress are also noted, such as situations which are highly repetitive or which involve sensory deprivation and produce psychlogical dysfunctions (Sheff 1966 42). Such findings come both from traditional studies in sociology, but also from contemporary journals, and these findings have been replicated by sociologists of different generations and diverse schools of thought.

Social factors influence the events leading to a crisis and to the crisis itself. The behavior which is seen to be a result of the event and psychological response is clearly influenced by these social forces, which indicates that the model in Figure 1 is inadequate. Figure 2 represents the crisis model more adequately, and clarifies the social forces that affect both the psychology of the person in crisis as well as the person's behavioral and social responses in that crisis. We can now offer a sociological perspective relative to crisis intervention.

CRISIS INTERVENTION

Crisis intervention involves a set of assumptions as well as a treatment or clinical methodology. The methodologies and assumptions differ by model (Burgess, Baldwin 1981 8). The assumptions generally involve the idea that early intervention in the form of counseling will not only relieve the crisis, but will also reduce the chance of subsequent, and more serious pathology. And failure to relieve the crisis can lead to serious psychological distress. The model also assumes a substantial amount of self-determinism or *voluntarism*. The aim of crisis intervention is to restore the individual to prior levels of functioning.

The methodology in the crisis model usually stresses the importance of expressive feelings. Some models also try to improve cognitive functioning by assessment of the problem and its development. Other models are more oriented to the present, and suggest that behavioral change is the most salient aspect of crisis treatment. Finally, some models involve some combination of the previous models, such as the *convergence model* to offer the best therapeutic tactics (Burgess, Baldwin 1981).

In most models, the practical and clinical aspects are well-stated, while the theory is either not given or poorly stated. Most of the models give lip service to the sociocultural factors which influence crisis situations, but the clinical method remains almost exclusively psychological (Aguilera, Messick 1978 46; Dixon 1979 55). Therapeutic models which take a macro view by suggesting that most psychological problems result from institutions are regarded as radical (Agel 1971). While it is true that clinical sociology is radical in the sense that such a perspective differs from the psychological and the psychiatric approach, there is nothing in the sociological approach which demands any other radical element from practitioners.

The sociological approach to intervention would involve the clinician in locating problems within a larger context. Client's goals should be analyzed with respect to the sociocultural system in which the client exists. The crisis should be viewed in terms of these

goals as well as in terms of the larger context. The client's feelings, cognitive functioning and particular behavior may concern the clinician, but the main focus is on the systematic roots of personal crisis. While all therapy involves change, sociological intervention seeks either to change the social forces linked to the crisis or to change the client's relation to these forces. The social nature of the problems should be identified, and treatment should be centered at the group or institutional level.

Unemployment exemplifies a critical problem. If a client cannot find or keep a job, family problems and other personal problems are intensified. Instead of talking about the client's feelings, psychological functioning, or behaviors in this situation, sociological intervention might seek to relate the individual's unemployment to larger forces in society, such as changes in technology, corporate mission, and organizational structure. The client's feelings about work would be viewed in the larger cultural context of the work ethic and family values.

Behaviors can be viewed in the role and group context. Cognitive functioning could be viewed in the existential context and the sociocultural forces which penetrate the client's life. Again, the focus is on the institutions and groups in the client's frame of reference. Changes in these larger forces or in the client's relation to them, is the aim of intervention. Job placement in another setting, vocational training, migration, and transformation of the former job setting are examples of possible tactics for the clinical sociologist. The sociologist realizes that social and cultural forces will always place restraints on real alternatives for interventionists.

The crisis of divorce in modern families deeply involves private feelings and behaviors. The sociological approach places these individual factors in a larger setting. The terminated marital relation occurs in a particular environment. Divorced persons can often help each other by joining singles groups, and by peer counseling. The interventionist can point out the consequences of a change in family roles for the individual's other roles. And the interventionist can help to combat the client's social isolation by involvement in community activities.

Many problems have a much more macro sociological cast. Poverty, hunger, poor medical care, lack of adequate infrastructure, and other conditions are more clearly the target of sociological observation and action. But we must begin the critical and creative process of relating personal unemployment to the economic institution, mental illness to institutionally created problems in living, and other problems to their sociocultural referents. This is just the kind of activity that is central to the sociological perspective, but peripheral to psychology, social work, and psychiatry.

There are several reasons why the more micro oriented disciplines have dominated clinical work. American culture tends to be individualist. The individual is seen as responsible for his/her own fate. Thus, the individual must be both the cause and the solution to the problem. The person is expected to overcome any sociocultural obstacle. The micro perspectives often fit neatly into the individualist frame of reference. A more macro level of analysis has a greater potential for social change, as opposed to individualist adjustment to the social system.

The other disciplines have a rich tradition of applied research and practice. This tradition is coupled with licensing and certification procedures, and this legitimizes these fields and enhances social acceptance of clientele for these professions. Sociology, in contrast, never has had much regard for applied practice or even applied research. By this token, licensing and certification efforts have been resisted. Finally, a code of ethics has evolved only after years of study.

If sociology is serious about developing a clinical practice based on its theories and assumptions, it must become acceptable to a wide variety of clients. Such acceptance usually comes after selling the discipline to service agencies and to other professions. We must show that sociology can add something distinctive to solving human problems in society. Sociology should not become an understudy for another profession, such as medicine. Rather, our perspective should add a unique dimension to clinical work.

This dimension will evolve naturally from a direct application of sociological theory to the crisis model and to other clinical models. This application will differ substantially from the micro perspectives, just as sociological theory

differs from psychological and psychiatric theory. Professions such as business administration, management, public administration, and the behavioral sciences have used sociology to enrich their practice. Some of these professions have performed admirably well given their sophistication level vis-a-vis sociological theory. We need to merge our theory with a rigorous clinical training. Only then will we add something new to the existing clinical practices.

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