Crisis intervention, the challenge to change a comparative evaluation of individual and family crisis intervention.

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CRISIS INTERVENTION, THE CHALLENGE TO CHANGE:
A COMPARATIVE EVALUATION OF INDIVIDUAL
AND FAMILY CRISIS INTERVENTION

by

Alexander Fraser Anderson

A thesis
submitted to the Faculty of Graduate Studies
through the School of Social Work
in Partial Fulfillment of the
requirements for the Degree
of Master of Social Work at
the University of Windsor

Windsor, Ontario, 1984
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THESIS COMMITTEE

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ABSTRACT

The purpose of this study was to evaluate the difference in outcome between two modes of crisis intervention: a) individual crisis intervention and b) family crisis intervention.

The sample included fifty client families of adolescents selected from clients of the Adolescent Crisis Service in Windsor, Ontario. The clients were randomly distributed between two treatment groups for comparison. Treatment was implemented by the researcher, a social worker.

The literature review provided an overview of crisis theory and crisis intervention. The discussions considered individual crisis intervention, family crisis intervention, crisis intervention with adolescents and evaluation of crisis intervention.

The hypothesis was developed to assess the difference in outcome of treatment.

A statistical analysis on selected characteristics of the sample showed the two groups were similar on most variables. Treatment outcome was measured with Goal Attainment Scaling using four subscales and a composite scale. The subscales were crisis problem resolution, individual contributing problem resolution, family contributing problem resolution, and treatment administration. One treatment group received individual crisis intervention and the other received family crisis intervention. Statistical analysis of the outcome scores demonstrated a
statistically significant difference between the outcome of the two groups. Treatment choice was more strongly correlated with the family problem resolution and composite score. Treatment choice was correlated with a small difference in the crisis problem resolution and individual problem resolution score. Findings strongly suggested that family crisis intervention was likely to correlate with higher outcome scores than individual crisis intervention.

The researcher concluded that a difference in treatment outcome had been found between clients of family crisis intervention and individual crisis intervention. The hypothesis was accepted. Recommendations were made in three areas: crisis intervention, further research and the social work profession.
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Chapter I

PURPOSE AND OUTLINE OF PROJECT

Crisis intervention has become a major form of treatment available to social workers in the past two decades. It has enjoyed widespread application in all fields of practice and has demonstrated applicability to a large range of problems. This popularity of use has been matched by development of several forms of crisis intervention treatment. The diversity reflects the different theoretical stances and innovations of practitioners.

In spite of this burgeoning practice knowledge social work has not contributed a similar quantity or quality of research concerning the efficacy of the different models of crisis intervention. As a result the literature and field is congested with confusing concepts of crisis, and crisis intervention that provide little foundation for the social worker attempting to develop the most effective treatment plan or program for specific situations.

The purpose of this research was to evaluate the relative effectiveness of two modes of crisis intervention. The treatments compared were individual crisis intervention and family crisis intervention. It was hoped that fulfilling this purpose would provide sufficient foundation for determining the treatment of choice for future crisis intervention cases.
This treatment evaluation was carried out with clients of the Adolescent Crisis Service. The crisis service is a short term counselling program designed specifically to meet the needs of adolescents and their families. In operation since January, 1983, this small service remains flexible enough to benefit considerably from this evaluative research. A secondary objective of the project was to develop a method for monitoring the quality of intervention provided. A further objective was to increase the credibility and accountability of the service to its funding sponsor, the Ministry of Community and Social Services.

The remainder of this report is divided into four chapters. In the first chapter, the literature pertaining to crisis intervention is reviewed. The second chapter describes the methodology of the research. The third chapter provides the data analysis and findings of the research. The final chapter contains the Summary and Recommendations.
Chapter II

REVIEW OF THE LITERATURE

The purpose of this review of the literature is to present and discuss the theories and models from which the central concepts of the research were developed. This review includes literature relating to crisis, individual crisis intervention, family crisis intervention, crisis intervention with adolescents and evaluation of crisis intervention.

CRISIS

Most literature on crisis intervention theory and practice included a discussion of crisis, usually focusing on crisis theory (Aguillera & Messick, 1978; Fine & Platt, 1978; France, 1982; Golan, 1978; Puryear, 1979; Wicks, 1978). The models of crisis have provided the foundation for the development of crisis intervention practice models. In this review the central concepts will be presented from the work of Lindemann and Caplan. Model developments and refinements will then be identified.

Erich Lindemann and Gerald Caplan

Through practice, teaching and theoretical works Lindemann and Caplan are credited with developing the practical definitions of psychosocial crisis that led to implementation of crisis intervention

**Definition of crisis**

Lindemann (1944) described the symptoms of acute grief reactions which included overactivity, acquisition of symptoms associated with the deceased, medical disease and agitated depression. Caplan grouped these and other behavioural manifestations together as:

an upset of a steady state where the individual is faced with an obstacle, usually to important life goals, that cannot be overcome through ordinary methods of problem solving (1964, p.39).

The steady state, known as homeostasis, is considered essential to mental health. The individual or family would strive to maintain this state and react when it is threatened. This crisis reaction will continue through predictable stages for a limited period of time unless interrupted.

Caplan identified four stages which reflect a progressive worsening of the crisis. First there is an initial rise in tension brought on by the precipitating event. Second is an aggravation of the tension and the use of emergency problem solving skills to reduce tension. The third stage is marked by immobilization, depression and the sense of being lost. Finally, there is either a serious breakdown in functioning or the adoption of a maladaptive behaviour (eg. suicide attempt) that decreases tension but may impair future functioning.

Caplan then described different types of crisis. Using Erikson's model of developmental and accidental crisis (1956) he conceptualized
developmental crisis as a transitional period in personality development. Accidental crisis was described as serious behavioural or psychological upset brought on by life hazards. These typologies have provided the foundation for other authors to explore the wide range of crisis stimuli.

The model focused on factors outside of the individual especially the family. Using concepts from sociology of the family Rueben Hill (1965) identified five possible family influences.

1. A dysfunctional family group will be severely disrupted by one member’s crisis.

2. The disruption of the group is partly controlled by the role and status of the member in crisis and the degree to which the member is impaired.

3. The group’s previous success or failure in dealing with problems offer or deny alternatives to the individual in crisis.

4. The socio-cultural environment of the family will contribute to the meaning of the problem (eg. crisis or chronic situation).

5. The interaction of family members with the evaluation of the problem will provide realistic or maladaptive input.

Further Developments

Theorists have refined these basic concepts that make up Caplan’s model of crisis. The modifications affect the distinction of crisis from other problem types, the identification of the precipitating event, and the concept of homeostasis.
The distinction of crisis from other problems

Rapaport (1962) identified a crisis problem as a threat, loss or a challenge. The distinguishing factor is the precipitating or hazardous event that can be identified as separate from other life experiences. Bloom (1963) demonstrated that, even with this concept, crisis is difficult for clinicians to discriminate consistently from other problem definitions.

Homeostasis

The Caplan model of crisis hinges on the two major concepts of the threat to the unit and the disrupted or upset state. It is the upset state that is considered the force behind maladaptive or panic reactions. Taplin (1971) and Lindsay (1975) argue that the concept of homeostasis is unnecessary. They see crisis as a result of overload of coping ability based upon resources, previous experience and opportunity. Lindsay presents a cognitive model of crisis as an alternative. Developed from stress theory (Lazarus, 1966) the threat to the individual is considered the pivotal factor in arriving at a crisis state. The family or individual appraise and begin to cope with the threat. The factors controlling the result of the appraisal are:

1. the degree of threat

2. the configuration of the source of the threat, its characteristics and available alternatives

3. the motivational pattern of the person which determines the "price" of the various alternatives (Lindsay, 1975).

The concept of homeostasis has been controversial in its application to understanding the individual and the family. Recent
theoretical developments in family theory indicate that it may be an unnecessary concept for understanding the process of stress and crisis reactions. Dell (1982) has developed a concept of coherence between the family's expectations and reality. When this coherence is disrupted by inconsistencies, a crisis exists. This crisis will be resolved when expectations and reality are reconciled. This reconciliation is similar to the reappraisal and problem solving described by Lindsay (1975).

In summary, the theories of crisis have a central place in the understanding of crisis intervention. The initial theories of Lindemann and Caplan still form the core of crisis models. Modifications have been provided through elaboration and expansion over time.

MODELS OF INDIVIDUAL CRISIS INTERVENTION

The discussion of individual crisis intervention literature will be focussed on basic assumptions, goals, assessment and treatment. The purpose of this section is to identify components of individual crisis intervention models. The literature contains several models of individual crisis intervention with a variety of theoretical and practical implications.

Basic Assumptions

Kalis identified five assumptions developed from stress research and psychoanalytic theories of ego functioning (Kalis, 1970).

1. The individual personality is the key in the crisis situation. It must be examined for several variables of functioning such as competence, coping ability, rigidity-flexibility.

2. Crisis may inspire either personality growth or regression.
3. the individual's personality strengths and weaknesses must be accurately assessed.

4. positive outcome depends upon identifying and working through issues from the client's history relevant to the current situation.

5. the regression and disequilibrium must be dealt with by providing support, hope and a means to work through previous trauma (Umana, 1980).

These assumptions bear a close resemblance to those underlying traditional individual psychotherapy.

Samuel Dixon (1978) presented assumptions that distinguish crisis therapy from the traditional psychotherapies.

1. the spectrum of human crisis behaviour is wide enough to allow individuals to benefit from crisis therapy without identification of psychopathology.

2. underlying conflicts do not have to be dealt with unless they have been reactivated in the unsuccessful attempts to resolve the crisis.

3. the precipitating event breaks the boundaries between the client's internal and external worlds causing temporary social dysfunction.

4. the crisis will be resolved in less than seven weeks. Other problems should be dealt with by traditional intervention.

Further comments on the individual in crisis are offered by France (1982). He stated that crisis intervention "is a technique to limit the duration and severity" of distressing episodes (1982, p.20). He identified two additional principles.

1. the person is more receptive to change during crisis because of the unpleasantness of the present circumstances.

2. crisis intervention emphasizes the competency of the client in dealing with problems.
Goals

The goals of individual crisis intervention are stated either in terms of the client or of the crisis. France stated that the intervention is to limit the severity and duration of the crisis and its attendant suffering (1982). Others identified that "the minimal goal... is a return of the individual to his precrisis level of functioning" (Umana, 1980, p. 72; Aguillera, 1978, p. 16). They commonly add the goal of increasing the client's resistance to similar stress agents.

Langsley (1968, p. 17) stated that the goal is to "recompensate a patient who is acutely falling apart". His objectives are to:

1. prevent rather than promote regression.
2. promote rapid behavioural change.
3. seek out and implement more adaptive solutions for acute problems.

These goals have a focussing and limiting function for intervention with individuals. The assessment methods continue that function when dealing with the client.

Assessment

The intervention model differs from traditional therapeutic practices by emphasizing the immediate causes of the client's state. This can be done in two ways. In the psychoanalytic model the emphasis is on the intrapsychic processes of the person experiencing the crisis. This would involve identification and exploration of the present emotional state (France, 1982) and conscious mental functioning (Langsley, 1968).
The alternative model presented for individual crisis intervention is behavioural. With a similar goal, the exploration is of the type, duration and magnitude of the major crisis stimulus. The stimulus is analyzed and tasks are determined that will resolve it. This process is part of an integrated behavioural model for individual crisis intervention.

**Generic Models of Treatment**

Langsley identifies two models within this theoretical field. Both focus exclusively on the patient/client.

The recompensation approach is focussed on the present falling apart of the patient in reaction to stress. This decompensation is in sharp contrast to previous functioning. He has identified eight principles and techniques for recompensating the individual (Langsley 1968, p.18-22):

1. Establish a therapeutic alliance:
   a) maintain a positive relationship
   b) respond to expectations of help
   c) identify present suffering as motivational factor
   d) be accessible to patient.

2. Focus on present illness:
   a) emphasize present symptoms and precipitating event
   b) work at conscious level of functioning
   c) set realistic goals.

3. Take an active role:
   a) reassure the patient
   b) structure the immediate situation to reduce stress
c) represent reality to the patient

d) discourage self-destructive or regressive patterns.

4. Use eclectic and pragmatic methods:
   a) availability of varied techniques and resources
   b) use of "whatever works" approach to treatment modality
   c) willingness to adapt to changing situations by changing techniques.

5. Enhance self-esteem:
   a) identify coping behaviour (including request for help)
   b) provide positive reinforcement for this behaviour.

6. Manipulate the environment:
   a) exercise control over resources extensively to support and protect the patient.

7. Utilize drugs:
   a) provide relief through psychoactive medication
   b) continue in conjunction with other therapy.

8. Terminate with "open door":
   a) plan termination from beginning of intervention
   b) end on positive note
   c) encourage return for future crisis.

Langsley set his model in contrast to brief psychotherapy. With that model, treatment begins by identifying the past traumatic events that have contributed to the crisis reaction. The essential steps are to:

1. Identify the relevant trauma
2. Establish through insight how they have triggered this crisis
3. Develop the insight to the level that the patient can deal with this crisis.
France provides a similar model to the recompensation approach of Langsley. He added and emphasized different principles (1982, pp.30-40).

1. Communicating effectively:
   a) use of advice, analysis, sympathy/reassurance, interrogation, reflection
   b) recognition of nonverbal communication.

2. Consideration of alternatives:
   a) development of realistic choices
   b) emphasis on patient's responsibility in deciding the relative merits and choosing the best one.

3. Follow-up:
   a) planning of further contacts
   b) evaluation of treatment outcome.

Aguilera (1978) has developed a principle that must be considered central to the implementation of the above principles. She stated that crisis intervention is the best alternative for a crisis situation. It is not to be considered a fall back, band-aid, or second best treatment but rather as the necessary form of intervention. This principle is extremely important in the operationalization and practice of crisis intervention.

The literature of individual crisis intervention has been surveyed and a wide range of concepts relating to assumptions, goals, assessment and treatment was found. The vanguard of crisis intervention literature deals with crisis from an individual basis. These concepts have established the knowledge base and practice methods of crisis intervention.
MODELS OF FAMILY CRISIS INTERVENTION

Working with a family is usually the best way to approach crisis intervention (Puryear, p. 2).

This principle has been advocated by several theorists and practitioners of crisis intervention (Everstine & Everstine, 1983; Fine, 1978; Langsley, 1968; Umans, 1980). They have developed family focused approaches from psychoanalytic, behavioural, and systemic foundations that can be collectively called family crisis intervention. Family crisis intervention will be discussed in this section in terms of the assumptions, goals, and treatment.

Assumptions

Umans identified the major assumptions of family crisis intervention as consistent with Caplan's model of crisis. The key change in emphasis in family crisis intervention is that family crisis intervention assumes that the family is the most influential context in which crisis occurs. Specifically, the family is viewed as having the greatest impact on the production, maintenance, and resolution of a particular crisis (1964, p. 6).

There are in the literature three separate models related to family crisis. The models are derived from three separate theoretical foundations of family therapy. The psychoanalytic model focuses on the family trauma history and resolves crisis through successful coping with that trauma. The problem-solving or behavioural model focuses directly on the crisis stimulus and the family response, providing specific strategies for each problem. The system model identifies problem patterns of family function and interaction and works to modify those most relevant to the crisis.
Psychoanalytic model

The basic tenet of this model is that in a crisis:

the illness and the symptoms of family member are in part an expression of family conflicts (Langsley, 1968, p.10).

The family will be regressing into a state of disequilibrium that can be extremely destructive to members and the family unit. Crisis will be continued or repeated until family coping mechanisms are regained and past trauma is dealt with to reduce the vulnerability (Umuna, 1980).

Behavioural model

This model works from a significantly more specific set of assumptions.

1. The family is a major source of reinforcement and can serve to increase/decrease specific behaviour

2. The crisis stimulus is a major variable to be examined including its magnitude, duration, intensity, and proximity.

3. Family members can be taught behaviour principles and techniques.

4. These principles can be equally applied to interactive as well as independent behaviour.

5. Crisis can be changed either by altering events or methods of dealing with events.

6. Tasks for crisis resolution can be specified.

7. Intervention is more effective when it is practical rather than insight oriented.

8. Intervenors need extensive behaviour management training not psychosocial understanding (Umuna, 1980).

With this focus on learning there is considerable demand on the intervenor to work within the context of the ongoing situation. This precept is evident also in the systems models.
Systems models

These models assume that:

any family has the potential to develop a crisis if the right event occurs, regardless of family strength (Dixon, 1978, p.162).

When this event occurs to a family it is:

perceived to be so dangerous to its existence or to its equilibrium that it is unable to fulfill its obligations or to meet the needs of its members (Dixon, 1978, p.162).

Signs of dysfunction in a family system are assumed to be reflected in family processes and structures. These include:

1. coercive strategies of interpersonal control
2. low level of inter-member reciprocity (Alvezios, 1976, p.143)
3. crisis as a symptom necessary to maintain homeostatic balance
4. conflict in reaction to family separations (Horowitz, 1978, p.7)
5. a reversed parent-child power relationship (Held & Bellows, 1983).

Since the family is a major part of the social context for a crisis it will also be viewed as a major source of stress, a major resource for resolution and a major learning vehicle for intervention behaviour (Baron, 1976).

Goals

The goals of family crisis intervention parallel the goals in individual crisis intervention except for the conceptualization of what will be changed when the crisis is resolved. The theoretical models provide a wide range of possible goals for family crisis intervention within the overall goal of crisis resolution.
Psychoanalytic models

The overall goal of treatment in the psychoanalytic models is to return the family unit to their previous level of functioning. This will reduce its vulnerability to whatever event has triggered reaction to previous trauma. A further goal would be to develop insight to the nature of the crisis in the family and probably a recommendation for long term treatment (Umana, 1980).

Behavioural models

Behaviour models are founded on the belief that:

- intervention will be doomed to failure if the purpose is to change the basic family foundation, rather than build upon it (France, 1982, p.118).

The goals are oriented toward behaviour.

1. the family to learn and apply skills to resolve immediate crisis
2. change behaviour in relation to the crisis stimulus
3. resolve crisis
4. generalization of skills for the resolution of future crisis (Umana, 1980).

Systems models

The goal of systems intervention is to alleviate suffering through modification of existing patterns and structure of family functioning.

It is believed to be helpful in returning a family to the previous level of functioning and preventing maladaptive response patterns from becoming fixed points of interaction (Horowitz, 1978).

In particular the intervention will be dependent on the present family context of the crisis rather than the specific nature of the crisis stimulus.
Treatment

Psychoanalytic models

These models set out three stages of treatment oriented toward recompensation. First the intervenor will provide support and work to reduce anxiety in the system. Then the relevant experiences from the family history will be explored and the bridges between past and present behaviour clarified for the family. At this point the intervenor encourages the reassertion of former functional defense and coping mechanisms (Langsley, 1968).

Behavioural models

The role of the treatment provider in these models is to focus attention of the behaviour related to the crisis stimulus. The intervenor will:

1. manipulate the relevant behaviour directly
2. manipulate the relevant behaviour indirectly through family and other system members
3. train family to use cooperative problem-solving skills and to generalize them
4. use behaviour techniques (eg. shaping, positive and negative reinforcement) to complete the manipulation (Umana 1980; Alevizos, 1976).

Systems models

Using the system model the intervenor will work within the family system. This will be accomplished by:

1. unblocking family communication processes (Baron, 1976)
2. relabeling symptoms, providing paradoxical instructions
3. meeting with the family as a unit
4. identifying communication and behaviour patterns

5. temporarily interfering with those patterns (Held and Bellows, 1983).

The literature pertaining to family crisis intervention has been reviewed and has been found to be a mix of crisis intervention theory and family therapy theory. The three major branches of theory were psychoanalytic, behavioural, and systems. They included a series of distinct assumptions, goals and treatment methods.

CRISIS INTERVENTION WITH ADOLESCENTS

In this section the literature relating to adolescent crisis intervention will be surveyed. The major assumptions and implications for treatment will be identified.

An adolescent crisis is a family crisis and generally the therapist should involve the adolescent's family for the best resolution (Dixon, 1979, p.175).

This assumption is frequently found in the literature dealing with adolescent crisis. The rationale for this assumption is found in the crisis intervention techniques for adults by Baron and Feeney (1976). Their central ideas are that:

1. problems should be dealt with immediately as they occur

2. problems are best dealt with in the context of the family rather than the person who is the immediate focus of attention.

Authors have developed more specific distinguishing factors that lead to considering family crisis intervention as the preferred treatment. Horowitz (1978) describes some reasons that family crisis intervention is considered the appropriate treatment. He finds that adolescent symptoms maintain the homeostatic balance in the family and
adolescent crisis is another form of symptom. Adolescent behaviour may also reflect previous adolescent and parental problems with separations. Specific factors have been identified by Held and Bellows (1983) that are derived from systems thinking. These high risk factors are:

1. a family in which aspirations or achievement have been thwarted
2. a adolescent is replacing a sibling miscarriage or death
3. adolescent is the eldest or youngest.

Further factors have been presented by Pfeffer (1982) as common in family diagnosis of adolescent suicide crisis:

1. family is organized to inhibit change.
2. separation of adolescent is perceived as threat to family integrity
3. lack of defined generational boundaries and unresolved tri-generational conflicts
4. high spouse conflict
5. projection of inappropriate parental feelings onto the adolescent
6. sexual or physical abuse
7. mother-adolescent symbiosis.

Alternative models of crisis intervention with the adolescent reflect an individual intervention focus. Polin (1978) has developed a relationship and problem-solving model. This is supported by an understanding of the adolescent's need for separation from family and growth of and integrated identity. Hoff (1978) believes that many of the helpers of an adolescent are found outside of the family system. As such they are unable to become involved with the family without alienating the adolescent. The concept underlying this belief is that help should be provided most effectively by the people already in the adolescent system.
EVALUATION OF CRISIS INTERVENTION

Crisis intervention has developed at a time when evaluation and research have become significant to treatment programs. This section will examine the current knowledge of evaluation of crisis intervention.

Ewing has observed that:

there is as yet no conclusive evidence regarding the efficacy or utility of crisis intervention as psychotherapy. As this review indicates, so far there have been only relatively few serious efforts to evaluate this modality, and most of these have been so thoroughly plagued with problems of control and other methodological difficulties as to preclude any unequivocal interpretation of their findings (1978, p.64).

Lindsay (1975) and Umana (1980) identified serious problems that weakened the validity and reliability of most studies. The problems included undefined treatment modes, no control for factors unrelated to treatment, and imprecise outcome measures.

Langsley (1968) did complete a large study that dealt with some of these research problems. The study compared the efficacy of traditional psychiatric hospitalization to family crisis intervention. It was found that family crisis intervention was more likely to prevent further psychiatric hospitalizations. This finding has been supported by other studies comparing forms of crisis intervention with traditional intervention (Decker & Stubblebine, 1972; Stratton, 1975; and Ewing, 1975). Umana (1980) also noted that there are no studies comparing different forms of crisis intervention for their relative impact.

A significant problem in all studies pertaining to crisis intervention is the lack of usable outcome measures. Goal Attainment Scaling (Kirseuk, 1968) has been suggested to measure the outcome of crisis intervention. Ewing (1978) and France (1982) propose this method
because it allows the researcher to measure goals for each client during treatment and evaluate the attainment of these goals among many clients. Woodward, Santa-Barbara, Steiner, Goodman, Levin, & Epstein (1981) found in a study of family therapy that G.A.S. was the most dependable measure of outcome when it was compared with eleven other common scales and measures. This method does not require the use of lengthy standardized tests, questionnaires, or interviews that are common to treatment evaluation. Yet it does allow for monitoring and comparative analysis necessary for hypothesis testing.

Harris (1981) used G.A.S. in school social work because it "offers an explicit, individualized treatment contract" (p. 17). Heavlin, Lee-Morrow, & Lewis (1982) found that G.A.S. responds to the two program needs of accountability and outcome measures that are relevant to clients. They concluded that:

G.A.S. may be thought as attempting to measure what would be an intelligent consensus of clinicians' judgement of outcome (p. 240).

In summary, the literature offers only the beginnings of an accepted methodology for testing the efficacy of crisis intervention.

**SUMMARY**

In this chapter the literature relevant to the project was reviewed. Topics covered included crisis theory, crisis intervention, family crisis intervention, individual crisis intervention, crisis intervention with adolescents and the evaluation of crisis intervention. The literature was found to be wide-ranging with a core of common concepts. Little evaluation or model construction literature was available.
Chapter III

METHODOLOGY

The purpose of this chapter is to describe the method for evaluating the hypothesis. The evaluation was carried out in response to the following research question: Will there be a difference in treatment outcome between clients of individual and family crisis intervention?

HYPOTHESIS

There will be a difference in treatment outcome for clients who receive individual crisis intervention and those who receive family crisis intervention.

DESIGN CLASSIFICATION

The hypothesis was tested by means of a two group comparison experiment. This study is a modification of the classical experiment noted by Tripodi as:

the classical experimental design... controls for all internal validity factors. It involves the manipulation of the experimental variable by introducing it only to an experimental group (1981, p. 200).

The modified design has been noted by Campbell and Cook (1979) as being more practical in situations where withholding any form of treatment is untenable for ethical reasons. Rather than a treatment group and a no treatment (control) group clients are randomly assigned to two treatment
groups. The internal controls for validity are assured through the use of randomization. The treatments are then compared to find the one that most affects the dependent variable. With this design it is important to use two accepted treatments for comparison rather than one that is already preferred to another. This assures that all clients receive adequate intervention. This design was used because it was not considered feasible to withhold treatment from clients in crisis.

SAMPLE

The sample was drawn from new clients of the Adolescent Crisis Service during the months of January to March, 1984. All cases that were opened for treatment were included until 25 eligible clients had been gathered for each treatment group. The rationale for excluding certain clients relate to treatment contamination and are discussed in the section on "Implementation problems". Clients were randomly assigned to two independent treatment groups of either individual or family crisis intervention. Randomization was implemented by the use of a day schedule for assignment dependent upon day of first contact. The schedule was rotated regularly to compensate for weekend effects.

OPERATIONAL DEFINITIONS

The major concepts relevant to this investigation are: crisis, crisis intervention, family crisis intervention, individual crisis intervention, outcome. The operational definitions of the concepts are explained in this section.
Crisis

Crisis is a concept with a wide range of meanings both in society and in social work. Its dictionary definition includes:

1. a turning point
2. a paroxysmal attack of pain or distress
3. an emotionally significant event
4. a radical change of status
5. an unstable state of affairs
6. a psychological condition of unusual instability caused by excessive stress.

These definitions are used inconsistently and interchangeably in the crisis literature. The differences appear to have no significant or documented effect on the conceptualization of crisis intervention. Since this project pertains to crisis intervention, not crisis theory, all definitions of crisis were used in the operational statements.

Crisis Intervention

This concept was used with several meanings. These include: anonymous distress lines, psychotherapy begun within six weeks of a crisis request for help, hospital emergency departments, and drop-in centres. A considerable part of the literature agrees on certain identifiable operationalizations of crisis intervention. These are:

1. immediate access to treatment
2. rapid beginning of intervention (within 24 hours)
3. immediate focus upon help asked for and crisis problems rather than contributing and underlying problems
4. identifying most significant problem contributing to the crisis
5. flexibility of treatment structure (hours, location, frequency)
6. intensive involvement with client and client system
7. evaluation of relief of crisis problem
8. termination within six weeks of initial contact (sometimes within 48 hours)

These characteristics will form the general framework for crisis intervention for this research. It should be noted that these characteristics pertain to the format and timing of intervention, not to specific treatment modalities.

Treatment process for research project

The treatment process that was implemented for each client during the research project was:

1. identification of crisis problem
2. assessment of:
   a) personality functioning
   b) importance of the crisis for the client
   c) resources and capacity of the client
   d) family functioning
   e) importance of the crisis for the family
3. treatment mode (explained further)
4. evaluating the outcome of intervention with the client or client group in terms of the contracted goals
5. evaluating the intervention overall
6. termination of intervention

The treatment mode was further specified as:

1. individual crisis intervention:
   a) framing the crisis in terms of the individual's functioning
   b) focusing on the individual contributing problem
c) negotiating a treatment contract to deal with the crisis and the individual contributing problem

d) involving only the individual requesting help in treatment

2. family crisis intervention:

a) stating the crisis in terms of the family's functioning

b) focusing on the family contributing problem

c) negotiating a treatment contract to deal with the crisis and the contributing family problem

d) involving at least one other member of the family in treatment

Outcome

Outcome of crisis intervention is the most challenging concept to define. There are two major problems:

1. difficulty obtaining information especially on standardized tests because clients are seen at unpredictable times, with little time for testing and they terminate treatment very quickly.

2. it is extremely difficult to set baselines because the crisis or problem matures rapidly to self-resolution

For these reasons outcome was conceptualized in terms of the resolution of the crisis' problem, the individual contributing problem, the family contributing problem and the administration of treatment. These terms are defined as:

1. Crisis problem - the serious, immediate problem that dominates the client’s functioning (e.g. suicidal thoughts, parent-child conflict, lack of shelter/money).

2. Individual contributing problem - the problem of personality functioning that is most related to preconditions of crisis (e.g. depression, anxiety, anger).

3. Family contributing problem - the problem of family functioning that is most related to preconditions of crisis (e.g. parent-child conflict, marital conflict).

4. Treatment administration - this is a standard scale measuring the degree to which the entire treatment process is completed.
5. Total outcome - this a composite of all the other goals measuring overall client outcome.

Variables

The following client information was also collected to provide an understanding of sample characteristics.

1. Age of adolescent was reported by year (range: 13-19)

2. Sex of adolescent

3. Family Type was of the adolescent's most recent home (range included two natural parents, one natural and 1 stepparent, one natural, other relative).

4. Family Income Source was used as a simple indirect indicator of family social functioning (range: one parent contributing employment income or parent dependent on external support). Appropriate grade level for age or not.

5. Place of Residence included alone, with family, with peer, institutional and unknown. It will also determine how long in present status.

6. Referral Source - this was the person or agency that put the family/client in touch with the crisis service (eg. the family itself, child welfare agencies, education system).

7. Person Requesting Help - this was the member (or members) of client system asking for help from the crisis program (eg. child only, child and parent, parent not child).

8. Crisis Problem was the problem area most closely identified with the help requested rather than to contributing or preceding problems.

   a) parent-child conflict
   b) child-other conflict
   c) suicide—any thought or action
   d) shelter—lack of food, place to stay, money
   e) emotional disturbance — any form of neurosis, depression, psychosis, reactive or other
   f) legal conflict — involvement with criminal justice system
g) substance abuse

9. Contributing Problem was the problem seen to be most associated with the crisis problem.

10. Crisis Level was a simple distinction of the seriousness of crisis experienced by the client at intake (range from none to high-emergency).

11. Involvement with Intervention identified which members of the client system were involved with intervention (e.g., child only, parent and child, parent without child). This pertained to any form of direct involvement (interviews, phone calls).

12. Length of Service was the period of time from beginning contact to termination (e.g., one day, seven days, thirty days).

DATA COLLECTION METHOD

Data were collected using a Goal Attainment Scaling (G.A.S.) system. This system was recorded on a Goal Attainment Record (G.A.R.) which was completed for each treatment or intervention goal. Goals were set as early in intervention as possible, usually within the first 24 hours.

Reasons for using G.A.S.

Crisis intervention requires adaptability to rapidly changing situations (Kiresuk, 1968; Harris, 1983). Assessment, treatment goals and evaluation of outcome must be flexible yet consistent to be effective. Feedback is most relevant if it is closely related both in time and content to the ongoing progress of the case. There is no means or time to reliably establish careful baselines with complicated measurement protocols.
The Goal Attainment Record (G.A.R.)

To use G.A.S. in this research project a tool was developed to record the process. The instrument contained the following information:

1. client name
2. goal description
3. problem that the goal was related to
4. a description of the possible levels of attainment toward the goal (much worse than expected, worse than expected, expected level, less than expected, much less than expected)
5. measurement grid for recording the actual outcome and when it was recorded
6. the final score coded for that goal including any weighting factor (See Appendix A for sample G.A.R.).

Goal Content

The goal statement itself was critical to the validity of this measure. The goal was clearly defined, simple, realistic, relevant and observable. The levels of attainment were consistent, measurable and mutually exclusive.

G.A.R. Monitoring

Monitoring was carried out by experienced social workers. They were not directly involved in intervention and were not informed of the research hypothesis.

If goals were rated to be inadequate they were not used in the analysis. The purpose of this monitoring process was to test for the appropriateness of the goal for the case, and for the clarity and consistency of goal setting.
Design concerns

It is necessary to establish some method for controlling the consistency of the goals set and measured across clients. This issue is basic to the design and parameters of any non-standardized test. They are best dealt with by internal controls rather than by refusing to accept the limitations of the test. Woodward has stated that:

with careful attention to technical problems at time of scale construction, reliable and meaningful results can be obtained across a variety of populations (Woodward, 475).

Weighting of client goals

In order to establish standardization as much as possible in this research four goals were scaled for each client. These were:

1. The crisis problem goal was the minimal expectation of service. This goal was weighted to reflect its relative importance to intervention. The weight will be three times the raw score.

2. The two contributing problem goals were to deal with the problem that appeared to have precipitated the crisis. They were weighted twice the raw score to reflect their importance to the course of treatment and outcome. To ensure comparability between treatment groups an individual and family goal was set and measured for each case.

3. The treatment administration goal reflected the completion of the intervention process as planned. It was given a relative weight equal to the raw score.

The purpose of this weighting format was to give the emphasis to the main point of crisis intervention in a total client score. This kept administrative success, for example, from unrealistically inflating scores when the crisis problem was not successfully relieved. Pretest data indicates that this format accurately reflects the researchers assessment of positive outcome.
Special Design Concerns

Though this design used randomization to control several threats to validity and reliability there are other limitations that were identified and planned for. Campbell and Cook (1979) identified potential obstacles to randomized field experiments. The three that are most pertinent to this design are:

1. treatment related refusal to participate
2. treatment related attrition from the experiment
3. uncontrolled or unplanned treatment in the comparative group.

In order to deal with these and other potential problems several contingencies were developed.

Treatment related refusals

If a client refused treatment mode offered they were scored 'less than expected' on administrative goal and not be scored for the other two goals.

Additional family involvement

If more than one member of the family requested help when treatment is individual then the added person will be seen separately. They were considered a separate client and separate case goals were set outside of the experiment.

Additional crises

If client had another crisis after termination the case was opened again and kept outside of the sample.
Information not available

If a client dropped out before outcome information was collected, the case was removed from the experiment.

Uncontrolled treatment

The possibility of involvement with additional services during the course of intervention in many forms required the following range of responses.

1. if additional treatment was family oriented when experimental was individual then outcome was measured at the point of introduction of the new treatment.

2. if additional treatment was individual when experimental was family then outcome was measured as planned.

3. if additional treatment was family based when experimental was family based then outcome was measured as planned.

Individual crisis intervention consisted of:

1. assessment— in terms of personality functioning and the importance of the crisis for the client

2. contributing problem— framing the primary contributing problem in terms of the individual

3. treatment— including only the person requesting help in treatment

4. goal— establishing an individual goal to deal with the contributing problem

5. evaluating success in terms of the individual.
LIMITATIONS

The research project must be undertaken, reported, and discussed within the context of design limitations. These pertain to generalizability, validity, and reliability.

Generalizability

This study is generalizable only to clients of the Adolescent Crisis Service. The sample was informally compared on key characteristics (age, sex, family type, and problem type) to previous cases. It appears to be representative of that population. However, there is no foundation available to allow generalization to clients of other crisis services, or any other population.

Validity

The outcome measures may not reflect the true outcome of intervention. The monitoring method may not have been stringent enough especially in the explanation of the G.A.S. system. The use of standardized pre- and post- treatment tests would have allowed more certainty in concluding that the problems actually were resolved. Unfortunately these were not available in a form that would have been appropriate for all the clients of the Service.

Reliability

The reliability of the measurement of outcome could have been weakened by unknown observer error. The goal statements could have been set and measured to favour one treatment mode over another. Though
goals were tested for consistency, appropriateness and measureability there is the possibility that they were significantly different from one client to another. This is especially a threat because the researcher was also the person providing treatment. This limitation has been noted by Seaburg (1977), Ewing (1978), and Fiester (1979).

SUMMARY

This chapter has described the methodology of the research project. The hypothesis was stated and the design for testing was classified as experimental. The sample method and the procedure for random assignment to two treatment groups were described. The operational definitions of the relevant concepts were set out including the description of the treatment methods. The data collection method and outcome measure were explained as well as the contingencies developed to deal with any possible implementation problems. Finally, the limitations of the project were examined.
Chapter IV
FINDINGS AND DATA ANALYSIS

This chapter will present a description of the client sample and an analysis of the results of the experiment.

DESCRIPTION OF SAMPLE

The sample was taken from new clients of the Adolescent Crisis Service. Fifty eligible clients were randomly divided between the two treatment groups. Selected characteristics of the sample are statistically described and examined for representativeness in the treatment groups. Sample size is fifty and differences of distribution between treatment groups are statistically insignificant unless otherwise noted.

Age of clients

The age of clients is presented in Table 1. The clients were predominantly over 15 (70%). The modal age of clients was 16 years. This age is extremely significant to both the adolescent and the mental health and social service systems. The adolescent becomes able to act more independently from parental legal authority. At the same time several potential supports (Children’s Aid Society, child mental health and juvenile justice systems), become unable or unwilling to help.
TABLE 1

Frequency of clients by age

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>3</td>
<td>6.00</td>
</tr>
<tr>
<td>14</td>
<td>5</td>
<td>10.00</td>
</tr>
<tr>
<td>15</td>
<td>7</td>
<td>14.00</td>
</tr>
<tr>
<td>16</td>
<td>22</td>
<td>44.00</td>
</tr>
<tr>
<td>17</td>
<td>7</td>
<td>14.00</td>
</tr>
<tr>
<td>18</td>
<td>4</td>
<td>8.00</td>
</tr>
<tr>
<td>19</td>
<td>2</td>
<td>4.00</td>
</tr>
</tbody>
</table>

Sex of clients

The sex of clients was found to be almost evenly distributed as shown in Table 2. This characteristic was found to be non-randomly distributed between the treatment groups. As seen in Figure 1 females were under-represented in the family crisis intervention group. Because this finding is statistically significant it must be kept in mind when studying treatment results. The phi coefficient (.32) can be converted to a coefficient of determination of .096. This indicates that over 9% of the difference in distribution of sex between treatment groups was beyond the limits of random distribution.
### TABLE 2

Frequency of clients by sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>24</td>
<td>48</td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>52</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>18+</td>
<td>⭐⭐⭐⭐⭐</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>14+</td>
<td>⭐⭐⭐⭐⭐</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>10+</td>
<td>⭐⭐⭐⭐⭐</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>6+</td>
<td>⭐⭐⭐⭐⭐</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>2+</td>
<td>⭐⭐⭐⭐⭐</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Individual</th>
<th>Family</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[ \chi^2 = 5.12 \quad df = 1 \quad p < 0.05 \quad \phi = 0.32 \]

**Figure 1:** Distribution of sex between treatment groups
Place of residence

The clients place of residence at the time of intake is described in Table 3.

**TABLE 3**

Frequency of clients by residence

<table>
<thead>
<tr>
<th>Living status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>2</td>
<td>4.00</td>
</tr>
<tr>
<td>Family Related adults</td>
<td>31</td>
<td>62.00</td>
</tr>
<tr>
<td>Unrel'd. adults</td>
<td>2</td>
<td>4.00</td>
</tr>
<tr>
<td>Peers</td>
<td>5</td>
<td>10.00</td>
</tr>
</tbody>
</table>

Most of the clients (60%) were living in the family home. Other places of residence included with other relatives, peers, unrelated adults, and alone.

Family structure

The structure of family that the clients had been most recently or were still living in is shown in Table 4. Family structures were grouped according to dimension of parental separation. Most clients
(64%) came from single parent families or families in which one parent was a step parent. The large number of single parent (44%) families may indicate the strain adolescent problems put on these families. With more limited resources a situation may more rapidly develop into crisis.

**TABLE 4.**

Frequency of clients by family structure

<table>
<thead>
<tr>
<th>Family structure</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth/step parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>36.00</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>44.00</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>20.00</td>
</tr>
</tbody>
</table>

**Geographic location of family**

The location of the client's family is presented in Table 5. The majority of clients (60%) came from Windsor. A significant group (38%) came from Essex county either in rural or urban settings.
TABLE 5

Frequency of clients by family location

<table>
<thead>
<tr>
<th>Family location</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Windsor</td>
<td>30</td>
<td>60.00</td>
</tr>
<tr>
<td>County</td>
<td>19</td>
<td>38.00</td>
</tr>
<tr>
<td>Ontario</td>
<td>1</td>
<td>2.00</td>
</tr>
<tr>
<td>5 10 15 20 25 30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family income

In Table 6 the source of family income is presented. In a large majority (86%) of the families at least one member of the family was contributing employment income. External income includes family benefits, welfare; pension or child support. Though this is an indirect measure of family social functioning it does indicate adolescent crisis does frequently occur in middle class families.
TABLE 6

Frequency of clients by source of family income

<table>
<thead>
<tr>
<th>Income source</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employ't</td>
<td>43</td>
<td>86</td>
</tr>
<tr>
<td>External</td>
<td>7</td>
<td>14</td>
</tr>
</tbody>
</table>

| 10 | 20 | 30 | 40 |

Referral source

The source of referral is presented in Table 7. The major source was the family (40%). The other sources included educational resources, income support services, children's services, the client, hospitals, unrelated adults, mental health services, criminal justice system, or peers. The adolescents rarely referred themselves (8%) but were dependent upon outside agents for direction towards help. The schools (20%), child (8%), and welfare (8%) were the organizations most likely to become aware of teens in need of help.
TABLE 7

Frequency of clients by referral source

<table>
<thead>
<tr>
<th>Referral source</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>4</td>
<td>8.00</td>
</tr>
<tr>
<td>Family</td>
<td>21</td>
<td>42.00</td>
</tr>
<tr>
<td>Unrelated Child services</td>
<td>3</td>
<td>6.00</td>
</tr>
<tr>
<td>**</td>
<td>4</td>
<td>8.00</td>
</tr>
<tr>
<td>Schools Health services</td>
<td>10</td>
<td>20.00</td>
</tr>
<tr>
<td>Welfare</td>
<td>4</td>
<td>8.00</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.00</td>
</tr>
</tbody>
</table>

---

Person requesting service

The person originally requesting service is shown in Table 8. The family requested service in 56% of the cases, with or without the adolescent’s cooperation. Other requests came from the client alone, the client and an unrelated other, or an unrelated other without the client. One of the challenges to crisis intervention with adolescents is represented in the 32% of cases in which the teen requested service without the family. Often in these cases the other family members do not see themselves as part of the problem. In some of these cases the teen is so alienated from the family that family resources are refused.
The teen also sought support from a non-family person in 10% of the cases. It is also notable that service was requested for the adolescent client in 18% of the cases without the teen's cooperation.

### TABLE 8

Frequency of clients by person requesting service

<table>
<thead>
<tr>
<th>Person requesting</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen alone</td>
<td>16</td>
<td>32.00</td>
</tr>
<tr>
<td>Teen + family</td>
<td>20</td>
<td>40.00</td>
</tr>
<tr>
<td>Teen + other</td>
<td>5</td>
<td>10.00</td>
</tr>
<tr>
<td>Family not teen</td>
<td>8</td>
<td>16.00</td>
</tr>
<tr>
<td>Other not teen</td>
<td>1</td>
<td>2.00</td>
</tr>
</tbody>
</table>

---

**Crisis problem**

The crisis problem is presented in Table 9. The crisis problems were mainly divided between family conflict (36%) and client out of the home (32%). The rest were suicidal behaviour, emotional disturbance, and abuse. Conflict or separation are frequent responses to family stress. Most of the teens out of the home (32%) had left home rather than been "kicked out" by parents (4%). It is significant that suicide attempts and threats (18%) though of great concern to the community are not the common form of adolescent crisis.
**TABLE 9**

Frequency of clients by crisis problem

<table>
<thead>
<tr>
<th>Crisis problem</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family conflict</td>
<td>16</td>
<td>32.00</td>
</tr>
<tr>
<td>Teen out of home</td>
<td>18</td>
<td>36.00</td>
</tr>
<tr>
<td>Abuse</td>
<td>1</td>
<td>2.00</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>4</td>
<td>8.00</td>
</tr>
<tr>
<td>Suicide thought</td>
<td>5</td>
<td>10.00</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
<td>4.00</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1</td>
<td>2.00</td>
</tr>
<tr>
<td>Grief</td>
<td>3</td>
<td>6.00</td>
</tr>
</tbody>
</table>

---

**Crisis level**

The level or strength of the crisis at the time of intake is found in Table 10. The table shows that the large majority of clients (84%) came to the Service during a moderate to high crisis. Moderate crisis was a very recent event serious to the adolescent or family but not of a life threatening nature. Low crisis level (16%) indicates events that are no longer producing a serious effect on the client's life.
TABLE 10

Frequency of clients by crisis level

<table>
<thead>
<tr>
<th>Crisis level</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>8</td>
<td>16.00</td>
</tr>
<tr>
<td>Moderate</td>
<td>37</td>
<td>74.00</td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>10.00</td>
</tr>
</tbody>
</table>

Contributing problem

Table 11 demonstrates the type of problem seen to be primarily contributing to the development of a crisis. In most cases (78%) this was a family conflict. The remainder were emotional disturbance or abuse (20%). The preponderance of family conflict as a contributing factor indicates the significance of the teen/family relationship in the development of a crisis. This contributing problem was usually identified readily by both adolescent and family.
TABLE 11
Frequency of clients by contributing problem

<table>
<thead>
<tr>
<th>Contributing problem</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family conflict</td>
<td>39</td>
<td>78.00</td>
</tr>
<tr>
<td>Abuse</td>
<td>2</td>
<td>4.00</td>
</tr>
<tr>
<td>Emotional disturb.</td>
<td>8</td>
<td>16.00</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.00</td>
</tr>
</tbody>
</table>

Length of treatment
The categories of length of treatment are presented in Table 12. The bulk of cases (76%) covered from two to four weeks of intervention. The length of treatment did not necessarily reflect success of outcome. The nature of crisis intervention is that problem resolution leads to immediate termination. This is reflected in the equal number of 1 week (12) and 4 week (12) interventions.
TABLE 12

Frequency of clients by length of treatment

<table>
<thead>
<tr>
<th>Length</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 days</td>
<td>8</td>
<td>16.00</td>
</tr>
<tr>
<td>1 week</td>
<td>12</td>
<td>24.00</td>
</tr>
<tr>
<td>2 weeks</td>
<td>10</td>
<td>20.00</td>
</tr>
<tr>
<td>3 weeks</td>
<td>8</td>
<td>16.00</td>
</tr>
<tr>
<td>4 weeks</td>
<td>12</td>
<td>24.00</td>
</tr>
</tbody>
</table>

Persons involved in treatment

Table 13 presents the data on the members of the client social system actively involved in treatment. In 52% of the cases both the client and the family were involved in treatment. The "Other" category includes client alone, client and unrelated other, and family without client.

Persons involved in treatment was found to be unevenly distributed at a level of statistical significance between treatment groups. Data were grouped with client and family involved together in one group and all other combinations in the "Other" group. The phi coefficient (.48) can be translated into a coefficient of determination of .21. This indicates that 21% of the "persons involved" difference can be explained
TABLE 13

Frequency of clients by persons involved in treatment

<table>
<thead>
<tr>
<th>Persons involved</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen only</td>
<td>14</td>
<td>28.00</td>
</tr>
<tr>
<td>Teen + parent</td>
<td>26</td>
<td>52.00</td>
</tr>
<tr>
<td>Parent only</td>
<td>5</td>
<td>10.00</td>
</tr>
<tr>
<td>Teen + other</td>
<td>5</td>
<td>10.00</td>
</tr>
</tbody>
</table>

by the difference in treatment assignment. This finding validates the expectation that family crisis intervention was more likely to involve the family and the client together in treatment. This difference is represented in Figure 2. This correlation (23%) indicates that persons involved was correlated with treatment type.
Figure 2: Distribution of persons involved by treatment group

**ANALYSIS OF TREATMENT OUTCOME**

The purpose of this section is to analyze the outcome of the two treatment groups. The tool for outcome measurement was the Goal Attainment Record (GAR). The levels of attainment are measured for the subscales of the crisis problem resolution, the individual problem resolution, the treatment administration, the family problem resolution, and the total of all subscales. The data is grouped for scores below the expected level of attainment and scores at or above the expected level of attainment. The analysis is presented for the total score first then each of the subscores.
Total goal attainment score

The distribution of total scores between treatment groups is depicted in Table 14.

**TABLE 14**

Distribution of total scores between groups

<table>
<thead>
<tr>
<th>Treatment mode</th>
<th>Score</th>
<th>Ind’ual</th>
<th>Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below expected</td>
<td>9</td>
<td>2</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18%</td>
<td>4%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Expected or above</td>
<td>16</td>
<td>23</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td></td>
<td>32%</td>
<td>46%</td>
<td>78%</td>
<td></td>
</tr>
</tbody>
</table>

$\chi^2=10.27$  \(df=1\)  \(p<.001\)  \(\phi=.45\)

The table demonstrates that treatment affected total outcome at a level of statistical significance. Family crisis intervention was more likely to produce total scores at or above the expected level. The phi coefficient (.45) can be squared to produce a coefficient of determination of .20. This figure indicates that .20 or 20% of the difference in total treatment outcome was correlated with choice of treatment. In other words treatment type explains 20% of the difference in the composite score.
Crisis problem goal attainment score

The distribution of crisis problem scores between the treatment groups is depicted in Table 15. The results show that difference between treatment affected crisis problem resolution at a level of statistical significance. Family crisis intervention was more likely to produce crisis problem scores at or above the expected level. The phi coefficient (.33) can be squared to a coefficient of determination of .099. This statistic indicates that almost 10% of the difference in crisis problem resolution score was predicted by the choice of treatment.

TABLE 15

Distribution of crisis problem scores

<table>
<thead>
<tr>
<th>Treatment mode</th>
<th>Score</th>
<th>Ind’ual</th>
<th>Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below expected</td>
<td>9</td>
<td>18%</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
<td>Expected or above</td>
<td>16</td>
<td>32%</td>
<td>46%</td>
<td>78%</td>
</tr>
</tbody>
</table>

χ² = 5.71 df = 1 p < .02 φ = .33

Because of the non-random distribution of sex in the sample the correlation of this characteristic with total outcome was tested. Any findings or conclusions based on that analysis must be tentative because
the sample was not large enough to effectively test this relationship. When sex was controlled total outcome was significantly different for treatment groups with male clients. This finding may indicate an interaction with the match between the social worker (male) and the client. The experience of the worker with cases beyond the sample does not support this possibility. It does suggest the need for further exploration.

Individual problem goal attainment score

Table 16 presents the distribution of individual contributing problem scores between treatment groups. The results show that difference between treatment affected individual problem resolution at a level of statistical significance. Family crisis intervention was more likely to produce intervention problem scores at or above the expected level. The phi coefficient (.41) can be squared to produce a coefficient of determination of .16. This indicates that choice of treatment type explains 16% of the difference in individual problem resolution score.
TABLE 16

Distribution of individual problem scores.

<table>
<thead>
<tr>
<th>Treatment mode</th>
<th>Score</th>
<th>Ind'ual</th>
<th>Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Below expected</td>
<td>11</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>22%</td>
<td>4%</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expected or above</td>
<td>14</td>
<td>23</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>28%</td>
<td>46%</td>
<td>74%</td>
<td></td>
</tr>
</tbody>
</table>

$\chi^2 = 8.42 \text{ df}=1 \text{ p}.01 \text{ } \Phi=.41$

 Treatment administration goal attainment score

The distribution of treatment administration scores between the treatment groups is provided in Table 17. These results reveal that treatment choice did not affect the administration of treatment. Neither group differed at a level of statistical significance in receiving treatment at or above the expected level.
TABLE 17

Distribution of treatment administration scores

<table>
<thead>
<tr>
<th>Treatment mode</th>
<th>Score</th>
<th>Individual</th>
<th>Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below expected</td>
<td>7</td>
<td>5</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>10%</td>
<td></td>
<td>24%</td>
</tr>
<tr>
<td>Expected or above</td>
<td>18</td>
<td>20</td>
<td></td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>36%</td>
<td>40%</td>
<td></td>
<td>76%</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.43 \text{ df}=1 \ p>0.5 \ \phi=.09 \]

Family problem goal attainment score

Table 18 presents the scores of family problem attainment between treatment groups. These results indicate that difference between treatment affected the resolution of the contributing family problem at a level of statistical significance. Family crisis intervention was more likely to have outcome scores at or above the expected level. The phi coefficient of (.48) squares to a .21 coefficient of determination. This finding indicates that 21% of the difference in family problem resolution score was predicted by the choice of treatment.
TABLE 18

Distribution of family problem scores

<table>
<thead>
<tr>
<th>Score</th>
<th>Ind’ual</th>
<th>Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below expected</td>
<td>17</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>34%</td>
<td>10%</td>
<td>44%</td>
</tr>
<tr>
<td>Expected or above</td>
<td>8</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>40%</td>
<td>56%</td>
</tr>
</tbody>
</table>

\[
\chi^2=11.68 \text{ df}=1 \text{ p}<.001 \ \phi=.48
\]

FINDINGS

The hypothesis for the project was that:

There will be a significant difference in outcome between a family crisis intervention group and an individual crisis intervention group.

The total outcome scores were analyzed and a correlation of 20% was found at statistical significance of .001. On that basis the hypothesis is accepted. The outcome subscales of crisis problem, individual problem, and family problem also demonstrate significant differences. The treatment choice correlates with small differences for crisis problem resolution (9.9%) and individual problem resolution (16%). The choice correlates with family problem resolution (21%). In all scales family crisis intervention is associated with higher outcome scores than individual crisis intervention.
SUMMARY

This chapter statistically described the sample and analyzed the research data. The sample was found to homogeneous on almost all independent characteristics. Sex was unequally distributed between groups and had a small correlation with outcome.

The outcome scores were analyzed and differences were found between the two treatment groups. Statistically significant differences were found on the problem subscales and the overall scale. The hypothesis of difference in outcome between groups was accepted. Family crisis intervention was associated with higher outcome scores.
Chapter V

SUMMARY AND RECOMMENDATIONS

SUMMARY

This study was a treatment evaluation of two forms of crisis intervention: individual crisis intervention and family crisis intervention. The purpose of the project was to determine if there was any difference in outcome between the two treatments for clients of the Adolescent Crisis Service. Further objectives included: determining if there is a treatment of choice for adolescents and their families; developing a method of treatment evaluation for ongoing use; and demonstrating the credibility of the Adolescent Crisis Service to its funding sponsor, the Ministry of Community and Social Services.

The literature was reviewed and topics relevant to the research project were discussed. These topics were: crisis theory, crisis intervention, individual crisis intervention, family crisis intervention, crisis intervention with adolescents, and evaluation of crisis intervention. It was found that crisis theory has generally provided a core of concepts for intervention practice. From this core a wide range of treatment models and modalities have developed. The development of treatment models in individual and family crisis intervention was found to be the result of combining crisis intervention techniques with various individual and family therapy theories. Though this has promoted the use of crisis intervention in many settings, it
has not led to the investigation of the comparative efficacy of crisis treatment models in either their theoretical or practical manifestations. It was found that only a few methodologically sound studies had been done to support treatment or theory improvements.

The method to evaluate the effect of outcome was a modified experimental design. The sample of fifty was drawn from new clients of the Adolescent Crisis Service. The clients were randomly assigned to two treatment groups: a) those receiving individual crisis intervention; b) those receiving family crisis intervention. Treatment was provided by the researcher during the months of January to April 1984. The design was constructed so that the only planned difference between the two groups was the form of treatment. During intervention relevant demographic, social, family and treatment information was also recorded.

Demographic characteristics were age and sex of the teen client. Social factors were residence of teen and geographic location of family home. Family information included family structure and income source. Treatment information collected was referral source, crisis problem, crisis level, contributing problem, persons involved with intervention, and length of treatment.

The method of data collection was Goal Attainment Scaling. Four scales were created and measured for each client using pre-set levels of attainment for each goal. The range of possible outcomes was constructed during the initial stages of treatment. Scores were calculated on the basis of actual attainment at the end of treatment. The goals and scores were recorded on a Goal Attainment Record. Scales were set for sub-goals that measured the resolution of:
1. crisis problem
2. contributing individual problem
3. contributing family problem
4. of treatment course.

A total score was also calculated as a composite of the four sub-scales.

The sample was found to be significantly different only for the characteristic of sex. Female teen clients were under-represented in the family treatment group. The outcome scales all showed statistically significant differences between individual crisis intervention and family crisis intervention groups. The difference in treatment type accounted for:

1. 9.9% of the difference in crisis problem resolution
2. 16% of the difference in individual problem resolution
3. 21% of the difference in family problem resolution
4. 20% of the difference in overall client outcome.

On this basis the hypothesis of difference for clients who receive individual crisis intervention and family crisis intervention was accepted. The findings also demonstrated that clients of family crisis intervention were more likely to have goal scores at the expected or above level on problem resolution scales.

RECOMMENDATIONS

The following recommendations are made for crisis intervention, further research, and the profession of social work. They should be considered within the context of this research and its limitations as discussed in the Methodology chapter.
1. Crisis intervention has several modes of treatment that should be differentially applied with the expectation of different outcomes.

2. Family crisis intervention is sufficiently more successful in outcome to be the treatment of choice for the Adolescent Crisis Service.

3. Family crisis intervention should be seriously considered as a possible treatment of choice for all adolescents and their families in crisis, individuals in crisis, and other families in crisis.

4. Further research for the Adolescent Crisis Service should be conducted using Goal Attainment Scaling and the methodologies developed for this research project.

5. The Goal Attainment Scaling tool should be improved by development of standardized scales for specific problems.

6. Research should be conducted to investigate the relationship among crisis intervention outcome, treatment type, crisis level, crisis problem, and other significant factors.

7. Social work should develop the modalities of crisis intervention as a significant segment of the treatment repertoire.

8. Social work should use research as a major knowledge, skill, and profession building tool.

9. Social workers should conduct treatment evaluation at all levels of practice.
## GOAL ATTAINMENT FOLLOW-UP GUIDE

### CRISIS PROBLEM

<table>
<thead>
<tr>
<th>LEVELS OF ATTAINMENTS</th>
<th>Scale 1: (weight = 3)</th>
<th>Scale 2: (weight = 2)</th>
<th>Scale 3: (weight = 1)</th>
<th>Scale 4: (weight = 2)</th>
<th>Scale 5: (weight = )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much less than the expected level of outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat less than the expected level of outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected level of outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat more than the expected level of outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much more than the expected level of outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY


VITAE AUCTORIS

Alexander Fraser Anderson was born in Ottawa, Ontario on August 19, 1952. He attended S.S. No. 4 Beckwith School and Carleton Place High School in Lanark County. On August 27, 1976 he married Kathy Bassett. He graduated from Carleton University in the fall of 1977 with a Bachelor of Arts, majoring in Sociology. In the fall of 1977 he entered the Bachelor of Social Work program at the University of Windsor and graduated from that program in the spring of 1980. He began employment with the Children's Aid Society of the County of Essex as a Family Services worker. He entered the Masters of Social Work program part-time in the fall of 1980. In September, 1982 he obtained the position of Program Coordinator of the Adolescent Crisis Service. He expects to graduate in the fall of 1984.