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Disequilibrium and COVID-19: Effectively Applying Crisis Intervention

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Abstract

Crisis intervention is widely understood as a response to life-threatening emergencies and therefore often limited in its application to natural disasters, severe physical violence, suicidal ideation, and similarly dangerous incidents. While crisis intervention is appropriate for these scenarios, historical definitions of crisis suggest the term and related interventions have much broader application. The ramifications of the novel coronavirus and related cultural fallout increase vulnerability and impair coping capacity in such a way that individuals are significantly more likely to enter crisis states, demanding a prompt reconsideration of the breadth of this practice technique. Successful application of crisis intervention reduces the long-term psychological implications for individuals encountering sudden loss, unexpected traumas, and other hazards that overwhelm traditional coping strategies, outcomes all made more likely by this pandemic. Crisis intervention is a structured, time-limited, problem-oriented treatment modality that is well suited to a remote practice environment because it is directive in its approach and requires few contacts at a time when client access is potentially limited. This paper examines the course of crisis with or without intervention, assessment and intervention tactics, social work values when applying crisis intervention, and the implications of the use of this modality as it relates to COVID-19.

Keywords: crisis; crisis intervention; COVID-19; coronavirus; disequilibrium; coping

Disequilibrium and COVID-19: Effectively Applying Crisis Intervention

The emergence of coronavirus disease 2019 (COVID-19) and ensuing global pandemic has yielded health risk, resource shortages, social distancing protocols, substantial financial repercussions, and profound uncertainty. These outcomes together represent unprecedented combinations of stress, vulnerability, and related mental health impairment (Pfefferbaum and North 2020) and notably increase the likelihood of individuals experiencing a crisis. This paper invites a reconsideration of how crisis intervention is understood and applied and supports widespread dissemination of crisis intervention tactics in response to the conditions of COVID-19 by seasoned social workers and new practitioners alike.

Crisis intervention models are widely understood as applied in response to acute crisis episodes such as the sudden loss of a loved one, a terminal diagnosis, or a school shooting (Roberts 2013). Within this understanding, the terms *crisis* and *emergency* might be used interchangeably, and the criteria of a crisis are only met when an event is potentially traumatic. For these reasons, crisis intervention is perhaps more well understood as an area of practice than as a treatment model with crisis occurring primarily in domains such as disaster mental health, domestic and sexual violence, and psychiatric emergency. The use of crisis intervention in these environments is undoubtedly appropriate, however these examples do not adequately describe the scope of this treatment modality. The function of crisis intervention is to identify and intervene when the conditions of crisis are met, conditions that do not hinge exclusively on the perception of severity in the crisis-inducing event.

Defining Crisis

A crisis intervention treatment strategy calls for the identification and timely response to individuals experiencing a crisis, a mandate necessitating clear guidelines on what constitutes a

crisis. One of the earliest and most widely-used definitions of crisis describes a disruption to an individual's steady state in which an obstacle is encountered—one that usually represents a threat to that individual's life goals—and which cannot be overcome through traditional problem-solving strategies (Caplan 1961). Further, when this steady state is threatened, individuals attempt to utilize existing coping strategies but find that they are ineffective (Caplan 1961). The obstacle is understood as a threat to a “fundamental need satisfaction” and crisis occurs when traditional coping does not succeed within the expected timeframe (Caplan 1964). Rapoport (1962) refined this definition by identifying three components of a crisis: a hazardous event, a threat to life goals, and an inability to respond with adequate coping mechanisms.

A more careful examination of each element of the described definition highlights the utility of a crisis intervention approach. The impetus for a crisis is described as a hazardous event which need only have the potential to disrupt a person's steady state, or sense of equilibrium. What is perhaps more relevant is the degree to which individuals experience hazards as threats to their own life goals, which is also described as a threat to the individual's steady state and an individual's fundamental need satisfaction. In all cases this frames the hazard as having subjective meaning to the affected individual which has a clear bearing on the likelihood that the event will be experienced as a crisis. Whether hazardous and threatening events ultimately manifest as crises depends largely on the individual's attempts to cope using what are described as traditional or existing coping strategies. It is noteworthy that the failure of coping described in these definitions do not indicate that an adaptive coping response is required to avoid a crisis outcome, but simply one that overcomes the threat and restores the individual's sense of equilibrium. In this way, our understanding of coping is non-judgmental. Maintaining one's composure, addressing problems directly, and engaging in realistic appraisals of difficult

circumstances will likely enable a restoration of equilibrium and would be understood as a healthy and productive response to distressing circumstances. However social isolation, substance abuse, co-dependency, and self-harm, while likely to be perceived as maladaptive, may also enable the perception of control over the hazardous event and a restoration of equilibrium.

The course of crisis. One of the key concepts of crisis theory pertains to the trajectory of a crisis: these are time-limited phenomena without a predetermined outcome (Jacobson 1979). While the precise length of disequilibrium associated with a crisis cannot be known, one of the early ideas within crisis theory indicates a six-week timeline (Lindemann 1944). Jacobson (1979) suggests what is now a timely analogy of a virus to understand the course of a crisis: a virus cannot be cured but rather monitored and treated, and the outcomes of being infected with a virus vary significantly, with a timely course of treatment improving the likely trajectory of the virus but without any guarantee of a desirable outcome. Crises are similar in that they warrant a targeted intervention, the timeliness and effectiveness of those interventions has a bearing on the eventual outcome of the crisis, and the range of potential outcomes is broad. Caplan (1961) states that following the onset of a crisis, “a period of disorganization ensues, a period of upset, during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved which may or may not be in the best interests of that person.”

The variations in outcome and degree of adaptation is highlighted in a core concept of crisis theory: a crisis event represents not only a threat but an opportunity. Roberts (2013) explains that crises “can serve as a challenge and opportunity for rapid problem resolution and growth, or as a debilitating event leading to sudden disequilibrium, failed coping, and dysfunctional behavior patterns.” The analogy of the virus is telling: a more dangerous and

harmful outcome of contracting a virus may be prolonged medical impairment or even death, while the opportunity exists for the development of antibodies and a strengthened immune system. Applying this analogy to crisis intervention, crisis can yield significant and protracted psychological impairment and even suicide death but may also enable increased resilience and new coping capacity. Therefore, the sole ambition of crisis intervention should not be to successfully resolve the harmful ramifications of a crisis-inducing event, but should also represent an attempt to facilitate growth and change.

Crisis and trauma. Given the wealth of literature pertaining to trauma, and the potential overlap between crises and traumatic events, understanding the similarities and differences between these terms is pertinent. The most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) defines trauma as exposure “to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association [APA] 2013), with exposure understood as first-hand experience with the event, witnessing the event, or learning that the event happened to a close family member or friend. This aligns closely with a conventional understanding of crisis as related primarily to the significance of the hazardous event and is not concerned with the subjective impact or coping experience.

Horowitz’s (1997) influential stress response framework of post-traumatic stress challenges the explicit emphasis on death, injury, and violence outlined in the DSM. Horowitz understood trauma as a response to serious life events followed by attempts at coping which may prove unsuccessful if the intensity or duration of distressing thoughts, feelings, and actions are too great, an interpretation not dissimilar to described definitions of crisis. Perhaps more importantly, Horowitz indicates that a trauma need not involve actual immediate danger but rather can result from a threat to one’s sense of self, others, or the world, a concept closely

aligned with the notion of a threat to life goals. Where Horowitz observes the emergence of trauma is in the coping response: the use of defense mechanisms such as “denial, repression, suppression, isolation, numbing, dissociation, use of drugs, or flight” prolong a traumatic response through a cycle of avoidance and symptom intrusion.

Yet another variation on the interaction between crisis and trauma is identified by the Substance Abuse and Mental Health Service Administration (SAMHSA), which indicates that “trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual wellbeing” (SAMHSA’s Trauma and Justice Strategic Initiative 2012). This statement also resembles the described definitions of crisis, differentiated only by the existence of negative outcomes, suggesting that trauma occurs when a crisis has “lasting adverse effects.” Within this definition, any crisis may have the potential to become traumatic depending entirely on the effects of the crisis on an individual’s functioning.

Developmental crisis. The onset of a crisis is the subject of some varying interpretations. Golan (1978) suggests that a crisis can follow a catastrophic event or a series of significant stressors but reasserts that the effect is one of disrupted homeostasis which, if not successfully resolved, will yield disequilibrium. Caplan (1964) indicates that crisis may result from failure to successfully cope with predictable change at various stages of the life course, such as the eight stages of psychosocial development described by Erikson (1950). Rapoport (1967) expands this concept, indicating that, in addition to accidental crises/hazardous events, there are two other types of crisis: developmental crises such as those proposed by Caplan and crises of role transition e.g. retirement. Other theorists have made similar contributions broadening and

specifying types of crisis. While these interpretations of crisis are widely accepted, for the purpose of this paper, crisis is understood as precipitated by a single event or obstacle that becomes the subject of a targeted intervention.

If crises are understood as precipitated by a single hazardous event, major developmental stages are perhaps best conceptualized as setting events. Setting events, a concept used primarily in functional behavior analysis, are events that occur hours or sometimes days prior to an unwanted outcome and that increase the likelihood of that outcome (Iovannone 2017). For example, a parent becoming impatient with their child may be made more likely if the parent failed to get restful sleep the night prior, with the lost sleep understood as the setting event. Setting events do not guarantee an unwanted outcome but are often understood as the first event in a sequence of events that may yield an unwanted outcome, when one occurs. Aspects of predictable life course development may influence the likelihood of a hazardous event, the degree to which it is experienced as a threat, and the individual's ability to adequately cope, and represent a setting event for crisis. For example, adolescence is a developmental period characterized by role confusion (Erikson 1950), a condition in which personal critiques may be understood as particularly threatening and difficult to manage whereas the same critiques in a different stage of life may be non-threatening or easily managed. This notion of a setting event exacerbating crisis risk is supported by Sifneos (1960) whose definition has four components: a hazardous event, a state of vulnerability which is necessary for crisis to manifest, the subjective factor which makes the event unbearable, and the active crisis state.

Crisis and COVID-19

The circumstances of the COVID-19 pandemic represent a generationally unique setting event in which the probability of an individual experiencing a crisis significantly increases.

While the pandemic will rarely represent a crisis-inducing event on its own, its consequences are profound: the risk of illness and death, the implications of social distancing, the resulting economic hardship, the broader sense of uncertainty and loss that accompanies an event of this magnitude, and others. While some hazardous events that emerge during the pandemic, as well as the threat they represent, may not be entirely unfamiliar—such as loss of life, financial hardship, or the potential for disease—the circumstances are unique and stressors occurring so rapidly that traditional coping may not apply. The implications of COVID-19 also pose new threats; for example, public grieving for deceased loved ones is threatened by social distancing demands. The pandemic also creates entirely new and unfamiliar hazards, such as the sudden and prolonged closure of schools, abrupt cancellations of certain rites of passage—graduations and weddings, for example—and extraordinary demands on medical personnel and other first responders.

Additional unique elements of the COVID-19 pandemic increase risk for crisis. The absence of a vaccine or effective antiviral treatments for COVID-19 has resulted in widespread adoption of social distancing and quarantine protocols which, while seemingly effective at reducing the spread of the virus, dramatically increase experiences of isolation and its psychological ramifications. The combination of ambiguity, novelty, and unpredictability associated with COVID-19 increases risk for anxiety (Whalley and Kaur 2020) and is a combination of challenges for which many people are ill prepared to cope. Balancing the need to meet basic needs and earn a livelihood with mitigating exposure to illness and disease is a significant concern for a majority of people.

Perhaps the clearest hazard is the illness itself. While social workers and other mental health practitioners are not positioned to explicitly intervene when a person is sick—this

obviously being the domain of medical personnel—the trusting nature of our relationships with clients enables us to promote preventive efforts in regards to the illness including adherence to social distancing protocols, hand washing, wearing a mask in public, and others promoted by public health entities. Promoting these actions has the added benefit of decreasing the feelings of uncertainty and powerlessness that can accompany the pandemic and potentially enhance coping to a degree that reduces the risk for crisis outcomes.

Many general coping practices have been widely promoted following the onset of the COVID-19 pandemic. Examples of these practices include the limitation of information intake regarding the pandemic; taking care of one's body e.g. eating well, exercising, and limiting substance use; prioritizing enjoyable activities; and safely maintaining social ties such as through the use of technology (The Centers for Disease Control and Prevention 2020). While these tactics cannot be understood as having the capacity to overcome significant hazardous events that may occur, they can potentially enhance coping in such a way that prevents less provocative hazardous events from evolving into crisis.

The importance of these practices and others like them may be more pronounced in populations made particularly vulnerable by the conditions of the pandemic. Individuals with pre-existing mental health conditions may not only have an especially difficult time managing stress and anxiety but are also made vulnerable by disrupted access to mental health providers and, when applicable, psychotropic medications. Parents of young children are managing the unprecedented demand of meeting the educational needs of children where schools are closed as well as disturbances to the routines and peer contacts that enable healthy social development in their children. Older adults and their caregivers may be uniquely fearful of the implications of COVID-19 given the correlation between age and severe illness. Individuals in recovery are

experiencing disrupted access to peer support networks such as Alcoholics Anonymous.

Undoubtedly, other populations are made uniquely vulnerable, too, and will benefit from coping enhancement exercises to prevent stressors from being experienced as unmanageable and becoming crises.

Crisis Intervention

Parad (1971) defines crisis intervention as “a process for actively influencing the psychosocial functioning of individuals during a period of disequilibrium.” The goals of such an intervention are foremost oriented to the restoration of an individual’s steady state, which at the time of the intervention is understood as disrupted. Ewing (1978) identified a core purpose of crisis intervention as the modification of relevant characteristics including feelings, attitudes, and behaviors that are understood as maladjustive in response to a crisis. France (1982) indicates that a primary aim of crisis intervention is the restoration or improvement of an individual’s adjustment. The intervention has been described as “psychological first aid” (Hafen and Peterson 1982).

Most responses to a client in crisis include an effort to minimize and resolve any immediate problems, emotional conflicts, and distress through a time-limited and goal directed process (Roberts 2013). Several models have been developed to outline the crisis intervention process, including the ABC Model of Crisis Intervention which focuses on three steps for intervention: establishing rapport, identifying the nature of the crisis and altering perceptions regarding the crisis, and offering coping skills (Kanel 2015). Similar intervention tactics can be found in Roberts’ seven-step crisis intervention model (Roberts and Ottens 2005), the most “authoritative and comprehensive” statement regarding crisis intervention from the field of social

work (Payne 2014). The following section utilizes the Roberts seven-step outline, exploring the ramifications of each of the steps in regard to the COVID-19 pandemic.

Assessment. The first step in the model is assessing a client for crisis. Even this initial process may at times be preempted by the unique conditions of the COVID-19 pandemic because social distancing demands have impaired our ability to identify when individuals may be experiencing a crisis. Many of the service providers that may identify an individual who is unable to cope with a hazardous event and has not sought out their own mental health support—doctors and school personnel being two primary examples—are either closed or operating under protocols where interactions are limited. Fewer interpersonal contacts with family, neighbors, and co-workers mean that concerning symptoms may go unnoticed. Many mental health providers may be experiencing delays in intakes due to adjustments to care provision imposed by COVID-19. These various barriers are noteworthy in that many cases may go unnoticed and, if crisis outcomes are detrimental, may impair future psychological functioning in a way that increases the risk for additional crisis.

Helplessness, anxiety, frustration, inadequacy, and depression often accompany the onset of crisis (Caplan 1974). Lindemann (1944) indicated five crisis reactions: somatic distress, preoccupation, guilt, hostile reactions, and loss of patterns of conduct. Myer and Conte (2006) describe reactions to crisis events as occurring across three domains: affective, behavioral, and clinical. Affective reactions are defined as anger and hostility, anxiety and fear, and sadness and melancholy, with some combination of these reactions occurring across domains ranging from negligible to extremely severe. Behavioral responses are defined within three categories: immobility, avoidance, and approach. Cognitive reactions are defined as perceiving the crisis as a transgression, threat, or loss, with the area of life affected by these thoughts including physical,

psychological/self-concept, social relationships, and moral/spiritual. Myer and Conte's framework is applied in a publicly available triage assessment tool where clients are rated across each of the described domains and assigned a severity rating.

Crisis assessment indicates whether a client is indeed in crisis; if so, clinicians either proceed with a crisis intervention approach or triage when more urgent services are required, such as a suicide assessment in an emergency room. Impairment in affect, behavior, and cognition may indicate the existence of a crisis state but may also indicate other issues entirely; the presence of a hazardous event that yielded the change in functioning is what most clearly indicates the occurrence of a crisis. Aguilera et al. (1970) differentiate between a diagnostic assessment, a process which characterizes the majority of initial client/practitioner interactions, and an accurate assessment of the crisis-inducing problem, which is demanded in crisis intervention.

Rapport building. The importance of relationships as a vehicle for supporting client change and facilitating the helping process is a core principle of social work practice (National Association of Social Workers [NASW] 2017a). This principle is understood as a particularly crucial element of crisis intervention due to the high likelihood that the intervention is applied during an initial contact with a client, the probability of a short-term relationship, and the vulnerability of the client. Further, clients engaging with a practitioner in a crisis situation are seeking competent and immediate support, demanding a speedier and more targeted rapport building process. With many therapeutic contacts happening virtually during the COVID-19 pandemic, this demands teletherapeutic competence including a recognition of when teletherapeutic services can be delivered safely, protocols for emergency situations, mastery over

technology, adaptations in communication approach, sensitivity to cultural and linguistic issues, and others (NASW 2017b).

Safety planning is a noteworthy consideration when conducting crisis intervention remotely. Safety concerns during the COVID-19 pandemic are likely to resemble those that social workers are familiar with, including danger to self and others, symptoms worsening or decompensation, and medical emergencies that may occur during therapeutic contact. However, there is the possibility that connection issues may interfere with the clinical contact, that the client's whereabouts at the time of the contact are not explicitly known, or that a client simply hangs up. These barriers unique to a teletherapeutic environment warrant a reconsideration of how safety is maintained, both to ensure ethical practice and to communicate to clients that the social worker is proactively addressing safety concerns thereby enhancing rapport. Important additional considerations for a teletherapeutic environment include backup communications if connection is interrupted or lost, presence of firearms in the home, and a greater emphasis on resources in the vicinity of the client (Washington State Department of Social & Health Services 2017).

What will perhaps be an overlooked consideration in the process of projecting competence and establishing rapport is the social worker's own sense of wellness during this extraordinary time. While the notion that COVID-19 "does not discriminate" or is an "equal opportunity killer" has been emphatically refuted (Laurencin and McClinton 2020; Yancy 2020), the fact remains that conditions of the pandemic are likely to be felt to some degree by everyone, including social workers. This is a discipline that traditionally has complex and perhaps ambivalent feelings toward the notion of self-care for a number of reasons including a lack of organizational emphasis, a sense of selflessness as helping professionals, and perceived

weakness related to self-care, amongst others (Pyles 2018). The COVID-19 pandemic is perhaps the ideal moment to address and overcome the field's ambivalence, as the unique and even overwhelming mental health demands of the moment, if not proactively managed, will have a bearing on the quality of services social workers provide. This is an opportunity not only to improve our own practices in self-care but to model for clients how to manage shared stressors.

Problem identification. In this step the social worker seeks to collaborate with the client on identifying what event yielded disequilibrium and ensuing help-seeking behavior. The ability to identify the existence of a precipitating event is one of central elements in practitioners' ability to identify a client in crisis (Bloom 1963). This event is sometimes referred to as "the last straw" (Yeager and Roberts 2015) because a series of events may have increased vulnerability and exacerbated the risk for a crisis outcome but only a single event is understood as ultimately pushing a client into a state of disequilibrium. The identification of the last straw provides both the client and the practitioner a needed target for the intervention. It is in understanding the nature of this event and the failure of traditional coping to overcome it that enables the client and practitioner to proceed with a shared and targeted understanding of what problem demands resolution.

While many crises will be understood as evolving from the circumstances of COVID-19, it is unlikely that the pandemic itself can be understood as the last straw in most instances. Further, many clients will be experiencing several stressors concurrently, making the identification of the last straw a challenge. Practitioners may be tempted to address the stressor that appears the most serious or is interpreted by the practitioner as being the most significant and therefore the most likely to yield crisis. However, to support a client in restoring their equilibrium, the model calls for an explicit examination of the event that led directly to the crisis.

Other issues that are described as precipitating the crisis event may be targets for future intervention or, ideally, may become easier to manage if clients experience empowerment through successfully resolving the conditions of the crisis-inducing event.

Validation. While identifying and understanding the problem has the potential to contextualize related emotions, there is risk in such a targeted and time-limited intervention to bypass the work of recognizing and exploring a client's emotional state. There is a sense of uncertainty regarding the appropriateness of one's emotional response that can follow a crisis. The risk for continued harm due to this sense of uncertainty demands an intervention that validates a client's emotional reaction in an accepting, supportive, private, and non-judgmental manner (Yeager and Roberts 2015). This can be accomplished in part via active listening techniques familiar to any social worker such as paraphrasing, probing, non-verbal affirmations, and reflective responses. These techniques are effective at creating conditions where clients feel understood and satisfied in an interaction with a helping professional (Weger et al. 2014).

However, the process of validating complex emotional reactions may extend beyond this basic technical response and into how practitioners understand and intervene regarding the client's interpretation of events surrounding a crisis. Widespread recognition and emphasis on the mental health ramifications of the COVID-19 pandemic may tempt social work practitioners to combat seemingly unhealthy negative thought patterns in clients by emphasizing more positive or optimistic perspectives. This approach might highlight the value of gratitude, the likely time-limited nature of the pandemic, or the client's relative privilege as understood by the practitioner. Enhancing an individual's positive subjective experiences and strengths is defensible within a positive psychology framework (Seligman and Csikszentmihalyi 2000) and resolving irrational thought patterns is a core tactic of cognitive theory (Ellis 1994). However,

given crisis intervention's emphasis on validating a client's emotions, these efforts may be premature if not erroneous and potentially damaging. Rather than understanding seemingly problematic emotional responses as fundamentally negative or irrational in some way, practitioners might understand complex or "negative" emotions as important and valid indicators of an individual's experience with the conditions of the COVID-19 pandemic (Parker-Pope 2020).

This failure to validate difficult emotions in an effort to promote positive thinking has been described as "toxic positivity" (Lukin 2019). The danger of toxic positivity is that, in an effort to support a client adapting their thinking in such a way to successfully overcome difficult stressors, it invalidates clients and suggests that their feelings are somehow misguided. The perils of toxic positivity are felt acutely during the COVID-19 pandemic, where fear, worry, sadness, grief, and other difficult emotions may be more pronounced, and practitioners may feel compelled to address these feelings as problematic. However, lessons from toxic positivity and the tenets of crisis intervention demand practitioners acknowledge and validate these feelings as appropriate and potentially healthy responses to uniquely distressing circumstances.

Coping skills. This step incorporates both an examination of previous unsuccessful attempts at coping and strategies to more successfully cope moving forward. The ability for the client to recognize which coping attempts were attempted and ultimately why they were unsuccessful is critical (Yeager and Roberts 2015). This may yield considerations of client pathology in terms of how stressors are routinely managed—or not managed—but the demand of the intervention is to look exclusively at what coping attempts were made in response to the problem understood as yielding the crisis. Clients will begin to consider what options may be available going forward when emotional balance has been re-achieved. The development of

potential future coping responses is a collaborative one; clients may struggle to understand both why traditional coping was inadequate and how best to proceed, but social work practitioners cannot be familiar enough with a client's strengths and resources to unilaterally impose solutions. Yeager and Roberts (2015) suggest a solution-focused orientation here, with an explicit use of techniques relevant to that treatment modality, including *the miracle question* and scaling techniques.

The conditions of the COVID-19 pandemic are so unfamiliar that a reliance on traditional coping may be understood as faulty, particularly when this step seeks to understand what coping responses were successful in previous similar situations. This is where having successfully identified the crisis-inducing problem drives the intervention: if the problem is understood as the conditions of COVID-19 then no prior coping may appear adequate, but if the problem is identified in a more targeted manner, existing resources can be more readily understood as having the potential to be effective. For example, the harm from the end of a romantic relationship during the COVID-19 pandemic may feel like an insurmountable problem given limited access to interpersonal support from family and friends, restrictions on activities that may be utilized to cope, and financial implications if the couple was cohabitating. As disequilibrium occurs and thought processes become distorted, the individual may experience increased fear of disease and cultural decline and begin grappling with more existential concerns about their ability to experience love and intimacy, questions relevant to early adulthood (Erikson 1950). Having successfully supported the client in identifying what exactly the breakup meant at the problem identification stage—for example, the client is simply experiencing a sense of loss—allows the client and practitioner to consider coping responses not to the conditions of COVID-19 but to previous instances where the client experienced loss.

Action plan. During this step, a concrete plan based on agreed upon coping strategies is adopted. Yeager and Roberts (2015) also indicate that a cognitive element is demanded, so that not only has a client identified what happened but also what it meant and how understanding the event differently may shape how the client interacts with it going forward. Yeager and Roberts (2015) describe this as occurring in three steps: the client first obtains a realistic understanding of the crisis-inducing event, followed by an examination of the specific meaning of the event to that client, before finally developing a new and more adaptive understanding of the crisis event. This process is understood as not only enabling mastery over the crisis but enables the client to more successfully manage hazardous and threatening events in the future. If prior steps to the intervention are successfully completed, this process of cognitive restructuring is less likely to be perceived as an example of toxic positivity or similarly invalidating interactions but rather as one that flowed naturally from the intervention and that enhances their problem-solving capacity through a process of understanding.

Follow up. Contact should be reestablished at an agreed upon point following the implementation of the action plan to determine the degree to which the plan was followed and its effectiveness in terms of mitigating the client's crisis state. Follow up contact may also include reassessment for crisis and any new stressors the client may have encountered as well as how they are responding (Roberts and Ottens 2005). Follow up also often includes referrals to needed services including medical support, housing, legal services, or additional mental health support if a need was identified in the course of the intervention. This will often require a referral to an outside provider, however as previously described, not all applications of crisis intervention will necessarily occur in isolated crisis-oriented treatment environments. Parad (1971) argues that any client seeking mental health support may be a candidate for crisis intervention, as individuals

often seek this support when an event has made their lives feel difficult to manage. In this regard any social work practitioner may consider crisis intervention when initiating services with a new client, and so rather than refer to a different provider when the intervention is complete, can decide whether to simply continue services. In these instances, the social work practitioner may consider using the follow up stage of the intervention as a mechanism to terminate the crisis-oriented relationship and re-contract for new treatment goals adopted once the crisis has been resolved.

Social Work Value Considerations

Crisis intervention is a multi-disciplinary treatment approach, spanning social work, psychology, and psychiatry, among others (Payne 2014). However, social workers may be uniquely positioned to apply the crisis intervention modality in a thoughtful and targeted manner. This is due in part to the presence of social work practitioners across diverse helping domains and the increased likelihood that we will encounter clients in crisis. However, the value of social workers applying crisis intervention is not simply a matter of client access but also pertains to our discipline's values. For example, social work's person-in-environment emphasis is well applied in a crisis situation, given the understanding that an interaction between an external hazardous event and internal experiences of threat and coping have the capacity to lead to crisis. Further, the examination and utilization of a client's existing and at times unseen coping resources is well aligned to a strengths perspective, another core social work value (Kim and Bolton 2015). Not all social work values fit this neatly. Two other social work values that may be vulnerable in the use of this modality will be examined here: client self-determination and social justice.

The promotion of socially responsible client self-determination is a central social work value (NASW 2017a). This can represent a challenge when a client's psychological state is impairing their ability to make decisions in their own self-interest. Jacobson et al. (1968) describe two approaches to crisis intervention. The first is a process of mutually directed problem solving activity designed to accomplish a series of standard psychological tasks, including acceptance, emotional expression, and cognitive restructuring; the second places greater demand on practitioners and their ability to objectively determine the circumstances of the crisis, specifically the reasons a client's coping attempts have not reestablished equilibrium and what adaptation must occur in order to accomplish this task. The challenges of this dichotomy persist today, where the balance between a client's right to self-determination and the demand for a more directive approach is a delicate one. This may be exacerbated as a result of the COVID-19 pandemic, a period in which a client's opportunities may feel stifled and their goals and sense of self may be unexpectedly upended, as well as the increased likelihood of maladaptive coping adopted in response to unfamiliar stressors. Social workers should use their own judgment but remember that the goal of the intervention is not to end the crisis but rather support the client in navigating the crisis to a more desirable conclusion.

Crisis intervention models consider the interaction between individual and environment but largely understand solutions as attained by the response of the individual. In this way the nature of the hazardous event is not subject to any judgment but rather is accepted as part of the crisis trajectory, creating a complicated relationship with the core social work tenet of social justice if hazardous events are unjust in nature. For example, if a client loses a job not due to the financial conditions of the COVID-19 pandemic but due to workplace discrimination, an explicit emphasis on the client's adaptation and response to the event might be understood as

perpetuating unjust conditions. Perhaps the most pronounced example of this threat in our current circumstances is the disproportionate impact of COVID-19 on African Americans (Laurencin and McClinton 2020; Yancy 2020). While crisis intervention demands a client-driven response, social work practitioners should be mindful of the broader societal implications when collaborating with clients on problem definitions and coping responses. Further, social workers from privileged demographics—for example white, cisgender, and others—should be aware that clients may be tentative about vocalizing the ways in which the COVID-19 pandemic has had a disproportionate impact on them. One example of this dynamic is the perception among African Americans that therapy is the domain of older white males who are likely to be insensitive to the African American experience (Thompson et al. 2004). Social workers using crisis intervention must be aware of the ways in which hazardous events, the subjective experience of a threat to life goals, and understandings of coping are all framed within particular social and economic circumstances.

Conclusion

Understanding crisis not as a term that is interchangeable with emergency but rather as a subjective and particular response that may emerge in the presence of a hazardous event enables a broader application of the crisis intervention modality than what is often considered. A recalibration is urgently needed around our understanding of crisis as widespread use of this modality is necessitated by the conditions of the COVID-19 pandemic, including new or more frequent hazards, unfamiliar threats to people's goals, and the need for enhanced coping to maintain equilibrium. The pandemic creates these conditions in many ways, not least of which being the very vulnerable relationships many of us have with death, security, and related feelings. We are all likely to feel threatened and overcome by losses of many kinds during this

challenging time. Crisis intervention may be the ideal modality of the moment, not only due to the likely increase of crisis events, but also the time-limited and structured nature of the intervention. This modality has the potential to meet client needs in a more expedient and targeted manner.

Crisis intervention demands that social work practitioners do not create an expectation of a return to normalcy. We must be cautious with clients in their progress toward regaining equilibrium and how much we can reasonably expect in terms of coping. It is not uncommon or even unhealthy for clients to experience significant emotional distress as a result of these remarkable circumstances. The crisis intervention modality equips social work practitioners with a strategy not to guarantee optimal mental health for our clients but to identify and address those stressors that feel insurmountable and ideally to support clients in overcoming these stressors and enhancing their ability to cope in the process.

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