Crisis theory is discussed in relation to a mental health consultation project with visiting teachers. Case illustrations of preventive intervention are offered, and characteristics of cases which best lend themselves to this type of intervention are delineated. The adaptability of the supervisory model in social work to the consultation task is demonstrated. Caplan's theory of the theme interference type of consultee-centered case consultation is illustrated in the visiting teacher project.

The increasing use of crisis intervention in social agency practice can be combined effectively with concepts of mental health consultation to form strategic preventive programs in community mental health. This paper will discuss crisis theory in relation to a mental health consultation project with visiting teachers and the adaptability of the supervisory model in social work to the consultation task.

**CONCEPT OF CRISIS**

The individual, in the course of his life span, experiences a number of developmental and accidental crises, which we have come to know in clinical practice as the precipitating stresses leading to emotional disorder or mental illness. The developmental crises relate to such episodes as the child's first leaving home to attend school, biological changes at puberty, the establishment of an independent existence away from the parental home, marriage, childbearing, old age, and death. The accidental crises include such matters as separation and divorce, abandonment, pregnancy out of wedlock, unemployment, etc.—problems characteristically presented to social agencies. In these critical moments, the manner in which the individual copes with, or is helped to cope with, the stress...
may have far reaching consequences for his future mental health as well as that of other persons who may be caught in the problem network with him. At these times, when he is struggling to find some resolution and when his coping system is still open and fluid, he may achieve mastery of the problem without future restriction to his personality; he may compromise with the situation and find some sort of adjustment; or he may use regressive devices which will be detrimental to his future mental health. Under the emotional impact of the crisis the individual, still in the throes of problem solving, and not yet settled (or perhaps only tentatively settled) on a coping system, is more receptive to help and more subject to influence than he is once a coping system has evolved and become crystallized. Professional intervention at this point, by aiding the individual to adopt reality-based adjustive or adaptive devices, will usually yield maximum results for minimum efforts. If one succeeds in helping the individual to choose an effective coping system, it is fair to say that he has accomplished a bit of preventive psychiatry in that he has helped the individual to avert psychopathological sequelae which would result from maladaptive or maladjustive patterns.

Now it is usually assumed in clinical practice that the defensive or coping pattern, which the individual uses when confronted with significant stress, is determined by predisposing factors in the individual personality. Epidemiological research done in recent years by community psychiatrists, however, call this assumption into question. These studies have concluded that the vulnerability of the individual to neurotic resolution in a crisis situation is more significantly related to factors in the social system in which the crisis occurs than to predisposing factors in the personality. For instance, Caplan (1964) cited a study done in the late 50’s by a group of military psychiatrists, oriented in community psychiatry, which bears on this point.

These psychiatrists have emphasized the significance for the onset and continuation of mental disorder in a soldier of the emotional milieu of the military unit of which he is a member. Glass (1959) has shown that epidemiological data indicate that the incidence of “combat neurosis” is related to the circumstances of the combat situation rather than to previously existing personality factors in the individual exposed to stress. These situational circumstances relate to the intensity and duration of the battle, but more significantly to the degree of support given the individual by buddies, group cohesiveness, and leaders. Moreover, he showed that the defensive patterns adopted by individuals in the face of stress are molded by the social pressures of the group.

A related study done in England by Brown (1959) concluded that the prognosis for the discharged psychiatric patient is more significantly related to factors in the social environment to which the patient returns than to the clinical diagnosis. Such studies as these stimulate a great deal of reflection regarding possibilities for preventive concepts in mental health in agency programming and administration, leadership roles, group process, social action, and community organization. Our society is equipped with a great many health, welfare, social, religious, legal, and other institutions which have direct and immediate contact with individuals in crisis situations. Mental health consultation with the caretakers who operate these institutional programs can be an effective means of preventive psychiatry.

Case Illustrations

Two case illustrations of crisis intervention, selected from a group consultation project with visiting teachers, will be presented. These cases, along with similar ones not here discussed, will be used as the basis for inferring some generalizations about the characteristics of cases which best lend themselves to crisis intervention.

A Case of “School Phobia.” A visiting teacher brought in a case of a ten-year-old, fourth grade girl, an only child, who had refused to attend school for two successive weeks at the point of referral. She was a somewhat retiring, timid little girl with tentative speech. She had good intelligence and had performed quite well academically. She was presenting the initial symptoms of the so-called “school phobia.”