Family crisis intervention
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The role of crisis in family crisis intervention:
Do crisis experience and crisis change matter?4

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Abstract

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Abstract
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Introduction
Threats to the safety and developmental opportunities of children are obvious reasons for a suitable and quick response to families experiencing a crisis (Callahan, 1994; Feiguine, Ross-Dolen, & Havens, 2000). Evaluation studies of family crisis intervention, or intensive family preservation services, have examined prevention of out-of-home placement of children and/or promotion of healthy family functioning. Even though family crisis intervention is grounded in crisis theory, none of these studies has focused on crisis change or even addressed crisis as a factor that might have an impact on the efficacy of family crisis intervention. The present study, therefore, focuses on the role of crisis in family crisis intervention.

The field of crisis intervention has developed extensively in the past few decades. An important paradigm shift in crisis intervention can be found in the seventies of the last century. Opposed to residential or foster care for children of families with severe and acute problems, intensive in-home services became preferable in terms of both costs and psychological advantages of family preservation (Lindsey, Martin, & Doh, 2002; Veerman, Janssens, & Delicat, 2005). Early in-home crisis intervention studies reported extremely favorable results, with a high 97% prevention of out-of-home placement of children (e.g. Kinney, Madsen, Fleming, & Haapala, 1977). These results were criticized when it was acknowledged that percentages of out-of-home placements were as low in control groups (Lindsey et al., 2002). Despite this critique, family preservation programs kept their popularity, spread to different parts of the world and are now commonly used for families in crisis.

An explanation for continued optimism for these short and intensive interventions can be found in renewed attention for the choice of outcome measures. More and more results were evaluated in terms of family functioning instead of (just) prevention of out-of-home placement. Positive changes in family functioning after crisis intervention were reported in both studies using a control group (e.g. Evans et al., 2003; Lewis, 2005) and in uncontrolled studies (e.g. Roberts & Everly, 2006; Van Puyenbroeck et al., 2009). However, all studies showed that after intervention families were still confronted with substantial problems. Evaluation results proved to be mixed and Lietz (2009) even found that 40% of the families receiving crisis intervention did not attribute positive changes to the intervention.
To conclude, research shows that there is considerable room for improvement of family crisis intervention. It is therefore not surprising that research on family crisis intervention is dominated by remarks on the urge for specification of subgroups of clients and clarification of optimal intervention designs, duration of the intervention and place of crisis intervention within the care system in order to promote its effectiveness (Bagdasaryan, 2004; Bath & Haapala, 1993; Campbell, 2002; MacLeod & Nelson, 2000; Staudt & Drake, 2002). More knowledge is necessary in order to attune family crisis interventions to the needs of families in crisis.

Although family crisis intervention is aimed at families in crisis, evaluation studies did not explicitly address family crisis as an inclusion criterion for intervention and/or crisis change as an evaluation criterion. Neither was a role given to clients’ experience or definition of crisis. This is remarkable since it is argued that the combination of the intensity of the crisis and clients’ interpretation of and reaction to it should be taken into account when diagnosing a crisis (e.g. Lewis & Roberts, 2001; Tracy, 1991). To be sure of the appropriateness of family crisis intervention, it should be ascertained that clients receiving crisis intervention are indeed in crisis at the start of the intervention.

Literature does offer a clear definition and description of crisis that is leading in crisis intervention: a disturbance of balance between demands and resources of a family system due to a rising tension, where former coping mechanisms as well as the social support system are insufficient or failing (e.g. Caplan, 1964; Hoekert, Lommerse, & Beunderman, 2000). Caplan formulated characteristic behavior, feelings and cognitions that people show during crisis, like aimless or risky behavior, emotional unstableness, fear, anger, distorted interpretation and a preoccupation with problems. Ista & De Smit (1977) added some characteristics of the crisis itself: a sudden onset, a threatening, chaotic, unpredictable situation and at the same time a process of change with beginning and end that can result in a restored balance that can be more or less adaptive. Golan (1987) pointed out that a crisis can either be a shock crisis, started after a sudden event, or an exhaustion crisis, provoked by a long period of (too) high demands, both leading to an acute onset of crisis.

Despite the existing theoretical framework for crisis, the role of crisis in family crisis interventions is yet unclear. Whether clients define a crisis the same way as it is described in literature and whether or not they experience a crisis at all needs explicit attention. Staudt and Drake (2002) pointed out that clients and intervention workers may
have different perceptions of the same ‘crisis’ situation. For example, parents may not experience family crisis at all, and perceive intervention as an unnecessary interference, whereas child protection workers may have observed acute child and family problems justifying family crisis intervention. Different classifications of a crisis situation by families and intervention workers seem problematic, in particular because the client’s treatment motivation is at stake when he or she does not experience a crisis situation. Notably, treatment motivation has been reported to be an important determinant of treatment success (Bitonti, 2002; Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997).

Crisis intervention is built on the assumption that families in crisis are in need of help. Whether clients experience a substantial need for help themselves should be explored. Specification of the needs is necessary in order to formulate intervention goals that are relevant to the family. According to Jacobson (1986) it is not only important to distinguish types of support, but also to consider timing of support. A model of three stress phases with related types of support was presented: the crisis phase in which emotional support is primary, the transition phase in which cognitive support (information and advice) needs a central place, and the deficit phase in which material/practical support is essential. As the social support system is considered to be insufficient in a family crisis, parents may have an unfulfilled need for emotional support. The question arises whether cognitive and material help that family crisis interventions offer are appropriate in the crisis phase. It is therefore essential to establish the extent and type of need for help. Knowing the exact needs of the families involved could promote fine-tuning of crisis intervention.

Start and duration of crisis intervention is related to the presupposition of a sudden onset of crisis and its ending. If disturbance of balance in the family is the essence of a family crisis, as the literature suggests, a pattern can be expected of disturbed balance: low balance at the start of the intervention opposed to a higher balance in the months preceding the intervention (Rapoport, 1962). Furthermore, it is emphasized that crisis is time-limited: a crisis usually ends after 4 to 6 weeks and comes to some sort of equilibrium, either adaptive or maladaptive (Golan, 1987). Although it was recognized that underlying problems may call for specific additional help after crisis intervention (Reisch, Schlatter, & Tschacher, 1999), a start within 24 hours and a short duration is considered to be suitable for crisis intervention (Callahan, 1994). Many crisis interventions indeed have a short duration. Seemingly inconsistent with the time span assumption, however, social workers often designate chronic problems in multi-problem families as ‘a chronic state of crisis’ or a
‘lifestyle of crisis’ (Fraser, Pecora, & Haapala, 1991; Rapoport, 1962; 1970). Staudt and Drake (2002) pointed out that, in this respect, the duration of crisis intervention may be called inconsistent with crisis theory. According to Besharov (1994), a limited intervention period of one month is too short for many families.

To be sure about the optimal duration and aims of family crisis intervention it is necessary to examine whether the assumed crisis period of 4 to 6 weeks represents reality: whether the family crisis has indeed ended or, in other words, the balance has been restored after crisis intervention. Just assuming that some sort of new equilibrium, a post crisis situation, has been developed after crisis intervention is problematic. The family may be deprived of adequate help, not only because it is not established whether the family has recovered from the crisis after 4 to 6 weeks, but also because even if aftercare was considered necessary, it is not always used by families or may not be available to them immediately (Staudt, Scheuler-Whittaker, & Hinterlong, 2001). Judgments on (the existence of) crisis and balance by both clients and intervention workers are needed to first establish whether there is a crisis, and subsequently, to confirm that the crisis has ended after 4 to 6 weeks. The distinction between a crisis situation and problems that can be addressed by other intervention than crisis intervention, such as less intensive individual therapy or family counseling, is essential for adequate referral to interventions. Crisis intervention should operate in an effective system of services, in which interagency collaboration between services can provide the intervention that is tailored to the needs of the family at the right moment (Campbell, 2002).

The present study explores crisis experience and crisis change explicitly for clients who are referred for the Family Crisis Intervention Program (FCIP). Additionally, clients’ definitions of crisis are collected and the target population’s need for help is explored. The time span assumption is addressed by establishing the existence of crisis at baseline and post test from the perspective of both clients and intervention workers. Either intervention or other factors could be responsible for crisis change, but according to the time span assumption, the ending of the crisis should be the case after the intervention period either way.

The questions to be answered here are: Do the definitions of crisis provided by clients who are referred for the Family Crisis Intervention Program concur with crisis definition in literature? (1), is there a family crisis and according to whom? (2), how is
crisis related to the need for help? (3), and is the crisis ended after intervention, within a time span of 4-6 weeks? (4)

Methods

Participants
All families invited to participate in the study \( (n = 435) \) were referred for and involved in The Family Crisis Intervention Program. At least one family member of 183 families participated in the study (a response rate of 42.1%). Because each family member could participate individually, single participation of either a parent or child and different combinations per family were possible. Participating mothers \( (n = 114) \) and fathers \( (n = 59) \) had an average age of 39 years \( (SD = 9.08) \) and 43 years \( (SD = 8.87) \), respectively. A total of 88% of the mothers and 81% of the fathers were the biological parent. Furthermore stepparents, foster parents and other caregivers participated. A total of 80 children participated, of which 55 girls and 25 boys. The average age of the children (0-18) in the participating families was 12 years \( (SD = 4.90) \). The majority had a Dutch ethnical background, 53% of the mothers, 63% of the fathers and 79% of the children. Most ethnic minorities had a Surinamese, Antillean, Moroccan or Turkish background.

Reasons for non-participation were registered and analyzed and file information was used to detect possible differences between participating and non-participating families. Primary reasons for not participating were: lack of time, too much stress, or resistance to other involvement. The child was more often subject to a supervision order in non-participating families than in participating families at the start of the intervention \( (\chi^2 = 12.93, p < .05) \), which was only a weak relation \( (Cramér's V = .14, p < .05) \). No differences were found for sex, age, cultural background, education, place of living and recommended aftercare.

The 35 social workers who participated in the study, of which 63% were female and 37% were male, had an average age of 37 years \( (SD = 9.76) \). Their work experience was on average 3 years \( (SD = 2.00) \) within FCIP and 7 years \( (SD = 6.37) \) within the youth care organization. The majority had a Dutch ethnical background: 77%.
**Procedure**

Between November 2007 and December 2008, clients referred for FCIP were asked to participate by their intervention worker during the first home visit. The target child (from the age of 8) and its parents or caregivers could individually choose to participate. Clients received written and verbal information. If family members agreed to participate, one of the researchers approached them the next day by telephone to plan a home visit for the baseline test soon after the start of the intervention, attentive to the client’s preferences with respect to time and place of the visit. After the intervention, the same researcher approached the client(s) to plan the post test visit. Clients received a small present at the first visit to show appreciation for their participation.

Participation was voluntarily. All participants signed an informed consent form. After introduction and explanation by the researcher, clients filled out the questionnaire (individually, if possible in separate rooms). For questions they could turn to the researcher. All researchers were carefully informed about procedures and trained for this specific study and were provided with a list of explanations that could be used if clients did not understand a particular question. Intervention workers reported the extent of crisis for each participating family.

**Measures**

Separate questionnaires were used for parents, children and intervention workers. There was one questionnaire per case for intervention workers to be completed after FCIP and there were two measurements for clients: baseline and post, containing both multiple choice and open-end questions.

**Crisis.** To measure the extent of crisis, the following question was included in the questionnaires for parents and children: “There is a crisis in our family” at the baseline and “There is a crisis in our family now” at post test, where the word now was added to emphasize that the question was directed at the current situation. Possible answers were 1 (*not at all*), 2 (*not really*), 3 (*a little*), 4 (*I think so*) or 5 (*very much*). Intervention workers were asked: “To what extent was a crisis the case at the start?” and “To what extent was the crisis ended at the end of FCIP?” This question was scored on a scale of 1-5, in which 1 = *not at all* and 5 = *very much*.
To study how clients define crisis, the following open-end question was included in the baseline test questionnaires for parents and children: “Crisis is …”, with a few lines for their personal answer.

For a better understanding of the onset of crisis, the following question was added in these questionnaires: “When was the transition to this crisis/ situation for you and how did you notice?”

**Balance.** To measure balance in the family, the following items for parents and children were used: “Our family is in balance”, “Our family was in balance one month before the start of FCIP” and “Our family was in balance half a year before the start of FC”. Possible answers were 1 (*not at all*), 2 (*not really*), 3 (*a little*), 4 (*I think so*) or 5 (*very much*).

**Need for help.** For parents subscales of the NVOS (Nijmegen child-rearing questionnaire; Wels & Robbroeckx, 1996) were used to measure the extent of need for help. The subscales that were combined in the scale were: need for change, need for help and internal help expectation. Questions about the partner were excluded, leaving 12 items in total, on a scale of 1-5, referring to 1 = *I don’t want that for sure*, 2 = *I don’t want that*, 3 = *I doubt if I want that*, 4 = *I do want that*, 5 = *I want that for sure*, or 1 = *I totally disagree*, 2 = *I don’t agree*, 3 = *I doubt if I agree or disagree*, 4 = *I agree* and 5 = *I totally agree*, dependent on the question involved. Examples of items are: “I would want that someone comes to help in the family with raising this child” and “I could use some more understanding or support”. Internal consistency reliabilities were $\alpha = .80$ at post test.

Additionally, parents were asked to choose a maximum of three preferred types of help: Conversations in which I can tell my story, Practical help, Advice on raising my children, Someone who brings rest/ peace in the family, Acknowledgement of my situation, Emotional support, Financial support, Order in the chaos and Intensive help. This question was included only in the baseline questionnaire.

Children were asked to answer the following questions to be answered with either ‘*yes*’ or ‘*no*’: ‘I want that someone helps my parents to improve our contact”, ‘I would like to talk to our social worker about the problems that we have at home”, ‘I think our family as a whole needs help”, ‘I think my parents need help”, ‘I think I need help”, ‘I think the situation at home should change”. A principal component analysis showed that these six questions form one dimension: need for help. Internal consistency reliabilities were $\alpha = .69$ at baseline and $\alpha = .80$ at post test.
Results

The study results are presented separately for each research question. First, scores on crisis, balance and need for help of mothers and fathers were compared by means of paired t-tests and correlations at baseline and post test in order to examine the degree of agreement between fathers and mothers. The results of these analyses are presented in the Appendix. No significant differences between means were found, and correlations ranged from $r = .21$ (balance one month before the start of the intervention) to $r = .71$ (need for help at baseline), which generally indicated moderate agreement between fathers and mothers. The hypotheses were tested for mothers and fathers separately and for parents as one group. Results are presented for parents as the unit of analysis, unless different effects for mothers and fathers were found.

(1) Do the definitions of crisis provided by clients who are referred for the Family Crisis Intervention Program concur with crisis definition in literature?

In order to examine the meaning of crisis, clients’ definitions were analyzed and categorized. Answers to the open-end question “crisis is” were analyzed by two researchers separately. Both researchers collected answers to create response categories. After categorization, all answers were placed in the respective categories. These categories contained at least ten answers. After this analysis, differences between the categorizations were detected and discussed and one division of categories was selected. The comparison did not lead to an important change in categorization. The final categorization scheme consisted of seven categories: (severe) problems (1), feelings of losing grip and desperateness (2), specific problems of one person (3), communication problems/ fights (4), unsafety, a threatening situation (5), an urgent situation where help is required (6) and escalation, a situation that got out of hand (7). Examples of definitions are: “Many and severe problems” (category 1), “No normal conversations anymore, just fights” (category 4), “Domestic violence” (category 5) and “A situation when a person needs help and cannot carry on alone” (category 6).

Following this categorization, each category was judged in order to establish whether or not it matched the definition or characteristics of crisis found in literature. All categories matched aspects of crisis theory, such as problematic functioning regarding feelings, cognition and behavior (e.g. Caplan, 1964) or situational aspects related to
escalation, urgency and a lack of grip, which can lead to safety risks (e.g. Hoekert et al., 2000). Clients’ definitions concurred with crisis characteristics in literature. However, it should be noted that clients mostly referred to only one aspect of crisis instead of a combination of the characteristics described in literature. The definitions of children were generally shorter and formulated less abstract than those of parents, but could be included in the same categories. An example: “a severe problem that substantially disturbs daily life” (parent) versus “problems at home” (child).

(2) Is there a family crisis and according to whom?

Answers of parents, children and intervention workers to the question to what extent the family is in crisis at the start of the intervention are presented in percentages in Figure 1.

The results show that 63.3% of the parents (N= 139), 64% of the children (N= 75) and 61, 9% of the intervention workers (N= 160) state that there is a crisis (‘I think so’ or ‘very much’). There were clients experiencing little crisis too: 17.3% of the parents, 20% of the children and 24.4% of the intervention workers stated that the family is ‘a little’ in crisis. There were scores indicating that there is ‘not really’ or ‘not at all’ a crisis, according to 19.4% of the parents, 16% of the children and 13.8% of the intervention workers.
To test whether there were families who received FCIP without anyone considering the situation as a crisis, we analyzed the 53 cases in which someone answered ‘not really’ or ‘not at all’. This analysis showed that there was only one family where all involved reported there was ‘not really’ a crisis. In the remaining cases, always one of the participants involved (child, parent or intervention worker) scored higher than the one who scored ‘not really’ or ‘not at all’. In these cases someone else did consider the situation to be a crisis. Most participants scored 4 (‘I think so’), clients as well as intervention workers, and the results showed primarily high scores.

Scores of parents, children and intervention workers were analyzed by means of paired t-tests and correlational analyses to examine possible differences and agreements in their judgment. At baseline and post test, no significant differences in mean scores were found between clients and intervention workers. At baseline, no significant associations were found. At post test, scores of intervention workers and parents \( r = .23, p < .05 \) \((N = 77)\) and intervention workers and children \( r = .53, p < .001 \) \((N = 40)\] were significantly associated. Parent- and child-reported extent of crisis were positively associated at baseline \( r = .43, p < .01 \) \((N = 54)\] and post test: \( r = .56, p < .01 \) \((N = 29)\]. At the same time a difference in judgments was found between parents and children: parents scored higher \((M = 3.77, SD = 1.27)\) than children \((M = 3.41, SD = 1.16)\) at baseline: \(t(53) = 2.05, p < .05 \) (two-sided), \(d = 0.30\) and a trend was found at post test, \(t(28) = 1.89, p = .070 \) (two-sided), \(d = 0.33\) (respectively \(M = 2.38, SD = 1.27; M = 2.00, SD = .96)\).

In sum, the crisis situation was not convincingly experienced in the same way by all involved parties, although a crisis situation was reported for each family but one.

(3) How is crisis related to need for help?

Extent of need for help. Parents’ and children’s need for help was measured differently. Therefore the scores were incomparable. For parents, on a scale of 1-5, the mean score was 3.34 \((SD = .85, N = 136)\), which can be considered moderate (score 3 = I doubt if I want that help). For children, as a mean of six dichotomous no (1) or yes (2) choices, the need for help was 1.67 \((SD = .29, N = 74)\). To all questions, most children answered ‘yes’: ‘I want that someone helps my parents to improve our contact’ (66%), ‘I would like to talk to our social worker about the problems that we have at home’ (56%), ‘I think our family as a whole needs help’ (51%), ‘I think my parents need help’ (72%), ‘I think I need help’ (77%), and ‘I think the situation at home should change’ (81%). The
mean score for children combined with the generally high percentages of children who reported to need some kind of help indicated a substantial need for help.

Correlations showed that crisis and need for help were related for both parents \((r = .54, p < .001, N = 139)\) and children \((r = .37, p < .01, N = 75)\), which means that a higher extent of crisis was accompanied by a higher need for help.

Dependent t-tests (two-tailed) showed that the need for help decreased, both for parents \([t(72) = 4.57, p < .001; d = 0.34]\) and children \([t(36) = 5.75, p < .001; d = 1.00]\). However, need for help was not absent after FCIP at post test for both parents \((M = 3.14, SD = .83)\) and children \((M = 1.38, SD = .33)\).

**The preferred type of help.** The preferred type of help of parents was scored at the start of the intervention; parents were asked to choose at maximum three most preferred types of help out of nine. The level of significance was set at \(p < .001\) to prevent chance capitalization due to multiple testing (9 comparisons for each respondent group). Scores of the Chi Square test showed that participants who reported a high extent of crisis (score 5) as well as participants who reported a lower extent of crisis (score 1-4) did not prefer one type of help specifically; emotional support was not the primary need. Clients preferred a variety of types of help, as indicated by the percentages found for each type of help separately which shows that 23% up to 49% of the parents chose ‘Conversations in which I can tell my story’, ‘Practical help’, ‘Advice on raising my children’, ‘Someone who brings rest/peace in the family’ and ‘Acknowledgement of my situation’ as help they preferred. ‘Emotional support’, ‘Financial support’, ‘Order in the chaos’ and ‘Intensive help’ were chosen by 9% up to 25% of the parents.

(4) Is the crisis ended after intervention, within a time span of 4-6 weeks?

Dependent t-tests showed that the extent of crisis decreased for all client groups, with mostly large effects (see Table 1). Nevertheless, it cannot be said that the crisis was completely ended/absent after intervention.
Table 1

*Judgments about the extent of Crisis at Baseline and Short After FCIP according to Parents, Children and Intervention Workers.*

<table>
<thead>
<tr>
<th>Group involved</th>
<th>Baseline test</th>
<th>Post test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
</tr>
<tr>
<td>parents</td>
<td>74</td>
<td>3.74</td>
</tr>
<tr>
<td>children</td>
<td>38</td>
<td>3.74</td>
</tr>
<tr>
<td>intervention workers</td>
<td>153</td>
<td>3.75</td>
</tr>
</tbody>
</table>

Note. *p < .05. **p < .01. ***p< .001.

*Time span.* With respect to the time span assumption, besides crisis change from baseline to posttest, pre-crisis disturbance of balance was tested. Repeated measures analyses (Greenhouse-Geisser) for balance in the family showed differences in balance between the start of FCIP and a month or half a year before both for parents \([F(2, 239) = 3.56, p < .05]\) and children \([F(2,135) = 2.77, p < .10].\) These differences were not in line with the expected pattern: a lack of balance around the start of the intervention and a higher extent of balance beforehand. Quadratic patterns were found for both parents \([F(1, 134) = 6.34, p < .05]\) and children \([F(1, 73) = 6.79, p < .05]\) showing a decrease in balance between 6 months and 1 month before intervention according to both parents \([F(1, 134) = 8.31, p < .01]\) and children \([F(1, 73) = 6.54, p < .05]\) and an increase in balance between 1 month before to the start of intervention according to children \([F(1, 73) = 4.88, p < .05].\) See Table 2 for descriptive statistics.
Table 2

Mean balance in the Family, according to Family Members around the Start of FCIP and their Judgments about Balance one Month Before and Six Months Before [scale 1 (not at all) to 5 (very much)].

<table>
<thead>
<tr>
<th>Balance in the family:</th>
<th>Around the start of FCIP</th>
<th>One month before FCIP</th>
<th>Half a year before FCIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
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<tr>
<td>Parents</td>
<td>135</td>
<td>2.72</td>
<td>1.19</td>
</tr>
<tr>
<td>Children</td>
<td>74</td>
<td>2.28</td>
<td>1.07</td>
</tr>
</tbody>
</table>

Negative associations were found between the extent of crisis and balance for parents \([r = -.48, p < .001 (N = 136)]\) and children \([r = -.21, p < .05 (N = 75)]\), indicating that as the extent of crisis was higher, balance in the family was more disturbed.

Qualitative analysis of the question “When did the transition to the crisis/this situation occur and how did you notice?” (for parents) showed that the vast majority of clients could point out an inducement (like an escalated fight or runaway of a youngster) to the crisis. With respect to the moment of transition to the crisis, parents often referred to a moment in time much earlier than the start of the intervention, up to eight years before. The transition to the crisis was mostly typified as an escalation of longer existing problems rather than a totally new situation.

Discussion

The aim of the present study was to examine the concept of crisis and its role in family crisis intervention with clients who were referred for FCIP. While crisis intervention is based on crisis theory, crisis definition, needs and time span were not addressed with data in prior research. The results of this study show that clients’ definitions of crisis concur with (separate) aspects of crisis that are described in literature, and reveal that crisis is a multidimensional construct. The present study also shows that families were in crisis at the start of the intervention according to at least one of the participants involved, although perception differences existed. Clients did not only report a need for emotional support, but also for other types of help, such as advice and financial support, at the start of the intervention. Increased need for help was related to a higher extent of crisis, and a decrease
intervention. Increased need for help was related to a higher extent of crisis, and a decrease of the need for help was found after the intervention. Furthermore, this study showed that, even though clients could refer to an inducement of their crisis, severe problems and disturbed balance existed (long) before that moment. A negative relation between crisis and balance was confirmed. Crisis was not totally absent after the crisis intervention, although a strong decrease was found.

Client’s definitions pertained to different aspects of crisis theory. Some clients emphasized characteristic feelings, thoughts and behaviors (e.g. Caplan, 1964), others referred to crisis characteristics such as urgency and escalation (e.g. Ista & De Smit, 1977). This diversity implies that crisis should be seen as a multidimensional construct with emotional, cognitive, behavioral and situational aspects, differing in impact. Clients mentioned one aspect of crisis rather than a combination of aspects, which raises the question whether every aspect of crisis appears in every family crisis. Therefore, it is important to assess the seriousness and characteristics of each individual family crisis as well as related needs. The experience of all family members should have explicit attention at the intake. Furthermore, both parents and children often mentioned fights and communication problems in their definitions. This pleads for recognition of conflicts as a primary feature of family crises, which should be assessed and targeted by family crisis interventions.

Classifications of the family as being ‘a little bit’ in crisis were given by both clients and intervention workers. These classifications show, in combination with the varying scores on extent of crisis, that crisis seems to be a construct with different levels of intensity rather than a dichotomy: presence or absence of crisis. Although there was no general agreement on the extent of crisis among parents, children and intervention workers, the majority of clients did experience a crisis at the start of the intervention; mostly a severe extent of crisis. In the cases where someone involved did not report a crisis, either one of the other family members or the intervention worker involved did recognize a crisis situation. The existence of a family crisis was acknowledged by at least one of the parties involved, except for one family, which suggests that crisis intervention was generally indicated. Considerable attention is needed to clarify what it means when intervention workers do not perceive a crisis when clients do and vice versa, and what this implies for intervention.
Judgments of parents and children on the extent of crisis in their family were positively related, which shows that there was still a sense of agreement in the family. Interestingly, at the same time, parents generally experienced a greater extent of crisis than their children did, although children still reported a high extent of crisis. With respect to behavioral problems and related distress, Phares and Danforth (1994) reported comparable findings of parents being bothered more than their children. The differences in judgments between parents and children require additional research in order to examine whether these differences reflect a systematic incongruence and if so, how this can be explained.

The lack of agreement between clients and intervention workers about the extent of crisis at the start of the intervention should be taken seriously. Hawley and Weisz (2003) stressed that not having child-parent-therapist consensus on target problems, as they found to be the case on a large scale, could diminish the efficacy of intervention. This could be also the case for crisis intervention. Perception differences raise the question whose judgment – the child’s, parent’s or intervention worker’s – should be leading when intervention choices have to be made. Even though from a child protection perspective intervention workers should overrule parents when they do not perceive risks for their children, the perception of family members of the (crisis) situation should not be ignored. Family members are an indispensable source of information with regard to the crisis. Acknowledging their perception may be a prerequisite for treatment motivation.

Many clients ended their definition of crisis with a statement like ‘when help is needed/missing’. Such remarks seem to have not that much to do with a core definition of crisis as a construct, but emphasize that in a crisis situation help is needed. The expected need for help was convincingly confirmed for children; for parents the need for help seemed to be less explicit, contrary to their crisis experience. This may be explained by the focus on child rearing problems in the questionnaire that was used. Possibly, parents prefer broader help, because they experience other problems (as well). Clients indeed preferred a variety of types of help, such as advice or financial support, whereas the expected importance of emotional support was not that primary to most of them.

The finding that emotional support does not seem to be a central need could relate to the phase of crisis the families are in. Jacobson (1986) pointed out that emotional support is needed primarily in the first of three phases after the onset of crisis. Whether clear distinctive phases exist in family crises and which different types of help are preferred over time cannot be examined with these data and requires additional research. If distinctive
phases do exist, we must conclude that either the different needs in a family crisis are not sequential or not all clients referred for FCIP were in the first crisis phase at the start of the intervention. Clients who reported other types of preferred help than emotional support could have been in a later phase of crisis despite the escalation that invoked the referral to crisis intervention. Different phases of crisis at the start of intervention, dependent on the moment of referral for intervention, could explain the diversity in needs. Our findings on balance favor such an explanation.

It was found that more disturbance of balance was associated with increase in crisis. Interestingly, balance in the family was not clearly disturbed around the start of the intervention according to clients. Balance seemed to be most disturbed at one month before intervention, which might tell us the intervention came too late. Additionally, it was found that clients often referred to an onset of the crisis long before the intervention started. Furthermore, although the crisis had decreased, the crisis was not absent after the intervention, where literature assumes that a crisis is time-limited. The time span assumption is challenged by these findings. A sudden upset in a steady state that ends clearly in a post-crisis situation does not seem to reflect reality. As many clients referred to an escalation of longer existing problems in their definition of crisis and in the answers to the question of when the transition to the crisis occurred, exhaustion crises seem to be exemplary. This is in line with the description of families in crisis as a group that is often confronted with multiple and chronic problems (Fraser, Pecora, & Haapala, 1991; Rapoport, 1962; 1970). As a crisis period is seen as an optimal timing for intervention by client’s increased openness to change (Staudt & Drake, 2002), specification of this state is even more important. Exhaustion crises may need a different approach than shock crises. These outcomes force us to reconsider assumptions about timing and duration of crisis intervention. Possible crisis patterns are shown in Figure 2.
Crisis intervention is usually designed to start shortly after the peak. Practically, our findings plead for more specific crisis diagnosis at the start of the intervention and intervention considering the stage of crisis, and a longer duration of crisis intervention if needed. The type of support that is needed should be part of this crisis analysis with each family member involved. In order to be able to intervene at the optimal moment in time, a different referral path and improved availability of the youth care system for families that are prone to (exhaustion) crisis might be needed. Theoretically, we are still left with important questions of when severe problems turn into a crisis and what the differences in reported extent of crisis by children, parents and intervention workers mean. Are there severe problems for a long time before escalation into a crisis comes in, and could intervention in an earlier stage prevent a crisis? Or are there peaks of crisis repeatedly in a chronic problematic situation, and is renewed intervention indicated with each peak? Aims of family crisis intervention should be sharpened, regarding the characteristics that
distinguish crisis intervention from other interventions. Timing and focus of intervention deserve a central place in establishing what can be adequate crisis intervention with realistic goals. An analysis of crisis patterns could contribute to a distinction between preferred forms of help related to the type and stage of crisis. This implies that diagnosing the type and stage of the crisis by explicitly discussing the pre-crisis situation and the primary needs of the family is essential.

Clients’ need for help had decreased after intervention. It is plausible to suggest that this can be a consequence of FCIP meeting the needs of the families. Interestingly, the judgments of clients and intervention workers on extent of crisis were not related at the start of the intervention, but were related after intervention, which could be a sign of such effective attunement. Alternatively, the assumption that increased openness for help occurs especially in times of crisis could explain the decrease in the need for help if it just accompanied the decrease of crisis. It should be noted, however, that in many cases a need for help remained. This is not surprising, as a necessity of aftercare for families after crisis intervention is common. In that sense, crisis intervention could still have been effective when there is still a need for help after crisis intervention. In fact, sometimes motivating clients to accept other specific help could be one of the main requirements in a crisis when risks are not acknowledged by clients. Clearly, the link between crisis, the (type of) need for help and intervention deserves more attention.

Several limitations of this study are worth mentioning. First, the non-response rate showed a substantial percentage of non-participants. Children in non-participating families were more often subject to a supervision order than children in participating families, which is an indication of selection bias. It should be noted, however, that participants and non-participants were comparable with respect to most background variables, including sex, age, cultural background, education, place of living and recommended aftercare. Second, as the constructs studied here were usually not addressed in crisis intervention research, no reliable and valid instruments were available in order to assess several of the core constructs of the present study. We were therefore forced to develop new instruments, of which the validity and reliability are not established yet. Third, balance was reported retrospectively as the indicator of the onset of crisis. It would be advisable to clarify the distinction between crisis and balance, which are related constructs but may not be each others exact opposites. Fourth, as the present study was not conducted as an effectiveness study and did not use a control group, it remains unclear what exactly can be held
responsible for the crisis change: whether the intervention actually contributed to the decrease, and if so, how. Finally, this study was not directed at different types of crisis, such as possible distinctive characteristics of crises provoked by a sudden stressful life event (illness/death), escalated fights or acute psychiatric problems. Relating types of crisis and differences in intensity of crisis experience to need for help and, for example, safety risks within the family, would be valuable in future research. The issue of crisis definition is not a closed chapter. It would be premature to draw strong conclusions about changes in the intervention system on the basis of our study findings.

Notwithstanding these limitations, the findings of this study indicate that the role of crisis in crisis intervention needs explicit attention and current assumptions about adequate help for families in crisis must be reconsidered. Intervention may be more attuned to the exact needs of these families when the concept of crisis is optimally explored. Consequently, crisis experience and crisis change should be addressed explicitly in both intervention and research to be sure that family crisis intervention can be fine-tailored to the specific needs of families in crisis. In this, not only inclusion criteria for family crisis intervention are relevant; especially the role of intervention with respect to crisis change needs exploration. To evaluate the effectiveness of family crisis intervention, crisis change is not the only outcome to be valued, as improvement of the pre-crisis situation is usually needed. The post-crisis situation should reflect better family functioning rather than just restored balance. It is therefore necessary to address (improvements in) family functioning as well, but as urgent a crisis situation is, as urgent it is to consider the construct of crisis itself and its differences in appearance, seriousness, onset and duration.
Appendix

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