This article describes the crisis intervention techniques used by the San Fernando Valley Child Guidance Clinic to help families deal with the traumatic events experienced in the 1971 earthquake in California.

Crisis intervention in an earthquake

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Crisis intervention is now a recognized and valuable addition to the repertoire of treatment modalities of many mental health agencies. In line with Caplan's formulation, a crisis can be characterized as an emotional reaction to an external hazardous situation, with the possibility of ensuing disorganization of behavior.[1] The individual in crisis initially calls on habitual coping mechanisms in an attempt to resolve his difficulties. If these behaviors fail, additional internal and external resources are called on. If these, too, fail, major disorganization of the personality can occur.

It is generally thought that a person in crisis is motivated to seek help and is uniquely susceptible to therapeutic intervention. Timely intervention during a crisis, therefore, can have a significant positive impact on a person's functioning.

In the San Fernando Valley Child Guidance Clinic in California parents usually present their children as manifesting a variety of symptoms, many of which are chronic in nature. Rarely do they present a clearly defined immediate problem that is readily identified as a crisis. Thus a primary focus of the initial interview is to identify the crisis, if one is present, and to distinguish between the crisis and the hazardous event that precipitated it.

A common problem encountered by most professionals who work in child guidance settings is that although children are identified as the clients, they often do not experience discomfort. Rather, it is the parents who are experiencing discomfort and seeking help because of difficulties in relating to the child or for personal problems. For these reasons, application of the crisis model in working with children presents difficulties, particularly in identifying the hazardous event that precipitated the crisis.

On February 9, 1971—the day of the earthquake—the clinic was presented with the opportunity to work with a large number of children and their families who were experiencing crisis reactions. At the time of the earthquake (6:00 A.M.) most families

were in bed. They were awakened by a severe shaking of their homes; many were thrown out of their beds and were unable to stand during the thirty seconds of the initial violent shock. This prevented many parents from reaching their children until after the initial shock had subsided. When the families did reach each other, most clung together, either in a doorway or huddled in bed. Because of the damage to telephone and power lines, many homes were without electricity and the families were unable to find out if relatives and friends had been injured. Fortunately, radio and television communication remained unimpaired, and information given over the air was reassuring. Those staff members who lived in San Fernando Valley reacted quite similarly to the families seen at the clinic. This common experience undoubtedly helped the staff to empathize with the families.

On the day of the earthquake the clinic's director of clinical services went on the radio to offer help to parents and children who were frightened by the quake. In a staff conference it was decided that staff members would speak on the phone with all parents and others who called for help and that groups of such parents and children would be formed when this seemed clinically indicated. The following questions were kept in mind: When a hazard of the enormity of an earthquake occurs, what are the reactions of children and their families? Does a common hazard of such intensity lead to similar behavioral reactions in children and their families? Which crisis intervention techniques are appropriate to large numbers of people immediately following such a natural disaster?

Of the eight hundred parents who phoned, most only needed reassurance that they were reacting appropriately. The workers gave them advice about helping their children unwind by talking with them, giving them some warm milk or hot chocolate at bedtime and reading to them, using a night light, and reminding the children they were safe and the parents would take care of them. They also urged the parents to have their children return to usual sleeping, eating, and play patterns as soon as possible. If the parents continued to express a need for further help, they were invited to come to the groups.

The choice of group counseling techniques was based on two considerations: (1) It was anticipated that many families would avail themselves of the service, many more than could be served by individual counseling and the usual intake procedures. (2) The clinic had extensive experience in developing and using crisis-oriented groups for children and their parents, e.g., the drop-in group, and more recent experience in brief family therapy.

The first group of twenty-two parents and children met the next evening. Similar groups, totaling three hundred families, met with various workers over a five-week period. The groups met for this length of time because for weeks after the initial shock, hundreds of aftershocks occurred, which re-created the horrors of the initial quake. About 85 percent of the families attended only one session. The remaining 15 percent either returned for an additional meeting or were referred for immediate short-term individual or family treatment or behavior modification groups in which desensitization techniques were used.

COMMON FEARS

Most of the children and parents reported remarkably uniform reactions. Their fears were quite similar and appropriate. However, their behaviors, which were also similar, were inappropriate. The most common problem for the children (aged 3–12) was a fear of going to sleep in their own rooms; of those who did go to their own rooms, most were unable to sleep through the night. Many were persistent in their demands to sleep with their parents and would cry, stand at the door of their parents' room, or climb into bed with their parents. This behavior was quickly reinforced by

[1] Gerald Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, 1964).

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the majority of mothers who took these children into their beds.

The other major problem was that many younger children (aged 3–6) were afraid to remain alone in one part of the house during the day, even though their mothers were present in another room. They were also afraid to play with other children, preferring to remain with their mothers, to whom they clung. These reactions constituted the vast bulk of complaints, although there were scattered reports of regression in toilet and eating habits. These behaviors were indicative of severe separation anxiety and represented the children's attempts to maintain contact with parents who provide safety and security.

Small children take their cues from their parents. It is difficult for frightened parents to convince frightened children that they should relax and feel safe. In addition the parents' fear interfered with parental roles. The parents expressed much uncertainty about and hesitancy in setting limits or dealing with the children's maladaptive reactions to fear, e.g., continued demands to sleep with them. It seemed that the parents were afraid to assert themselves because this would have negative and perhaps permanent psychological effects on their children. When the children continued to make demands, the parents felt angry and guilty, which confused them and made it more difficult for them to help their children. In short, most had become temporarily immobilized in their roles as parents.

INTERVENTION

In the groups intervention was geared toward both the children and their parents. The first task was to help reduce the level of anxiety in both parents and children. The goal was to have the family reestablish itself as a unit and for the family members to reassume their usual roles as soon as possible. This involved such concrete interventions as reinstituting sleeping arrangements and helping parents reassert themselves as the guiding and steadying influences in the family.

The interventions directed toward the children basically were designed to make the children aware of their fears of losing both their parents and the stability of the home. In the group the children were encouraged to verbalize and share their thoughts and feelings about their earthquake experiences, especially their fears of losing their parents and how frightened they were when their beds shook and furniture and dishes were smashed. Even the youngest children were relieved when another child haltingly spoke of his terror. Children were pleased to discover that both their peers and their parents had similar feelings and reactions.

The knowledge that parents could talk about their fears seemed to reassure the children. They came to understand that mobilization of physical and emotional resources in emergencies is a healthy and necessary reaction. Children were able to recognize too that their regressive behavior was an attempt to get the protection and care they needed from their parents until they could feel secure enough to function as before. It was found that the quickest recoveries from the quake experience occurred in those children whose parents could understand and for the necessary brief interval accept their regressive behavior. These parents were secure enough

to encourage and help their children talk about their thoughts and feelings.

Intervention with parents was primarily aimed at rousing them from their uncertainty, and in some cases their immobility, and helping them reestablish normal family patterns as quickly as possible. Although the workers stressed that the parents should not take a punitive approach to their children's maladaptive behavior, parents were urged actively and firmly to encourage their children to resume their usual routines. Parents also were encouraged to involve their children as much as possible in family decision-making concerning both earthquake-related and other matters and to make more time available to them. Also it was suggested that the families discuss whatever factual information about the earthquakes was available in the media and in books.

Crisis counseling, both in the groups and in phone conversations, helped the parents resume functioning in their roles as parents. Most parents seemed to be seeking support to deal with their children as they had before the quake. The counseling also helped the parents reestablish the family as a unit and restore the usual parent-child, child-sibling, and child-peer behavioral patterns to provide the child with the security and certainty of the familiar.

Although the primary focus was on the children, the workers intervened directly with the parents when necessary. For example, one mother's complaint about her children's behavior exhibited a strong nonverbal undercurrent of overwhelming feelings of inadequacy and guilt. She blamed herself because they were still upset. The worker told her: "We're not heroes—we can only do so much." Other mothers provided feedback that said in effect: "You're all right. Like us, you've done all you could on your own and now you're here to get a little additional help." Another mother was overworked and at the point of collapse. She had a physical disability that made it impossible for her to take care of her children at that time. The workers encouraged her to arrange for the children's care while she went to her mother's home to rest. This sanction was all she needed to make these arrangements without a heavy load of guilt.

FURTHER QUESTIONS

Lack of funding prevented the clinic from doing a formal follow-up evaluation of its crisis intervention service. However, several clinical research questions, pertinent to crisis theory and crisis intervention, were raised by observing the families who had experienced the earthquake. For instance, each person maintains his emotional balance by means of specific behavioral patterns and is more prone to move into crisis if the hazardous situation corresponds to a long-standing problem area unique to him. However, if the hazard is a common one and of the enormity of an earthquake, do the reactions and coping mechanisms unique to the individuals subjected to the trauma fail, and are they replaced by reactions and coping behaviors that are similar to those of all persons who experienced the hazard? Further, how are coping mechanisms reinstituted? What course do they take as persons affected by a natural disaster go about reestablishing their homes and family units? What about the timing of the therapeutic intervention—is there an optimum point during such a crisis when the intervention will be most effective? Can crisis intervention programs be woven into the established fabric of existing emergency disaster programs?

These are only a few of the questions relevant to crisis intervention. The clinic's experience does not conclusively demonstrate that the crisis intervention model is the most appropriate and effective short-term treatment modality. However, it does show that crisis intervention is an effective technique for alleviating the negative effects of psychological trauma on those persons who have experienced a natural disaster.