Understanding the Accident Process: Crisis Intervention for the Industrially Injured

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UNDERSTANDING THE ACCIDENT PROCESS:
CRISIS INTERVENTION FOR THE
INDUSTRIALLY INJURED

BY

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RESEARCH REPORT

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ABSTRACT

Understanding the concept of the accident process plays a significant role in determining the course of treatment for the industrially injured. The accident process suggests that underlying psycho-social factors may result in the occurrence and/or maintenance of a state of disability. This disabled state provides greater needs satisfaction for the individual than his habitual behavioral repertoire. The development of the accident process suggests a state of crisis, either as a result of chronic difficulty or an acute reaction to sudden onset of illness or injury. Total rehabilitation of the individual is facilitated by a crisis intervention approach.
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INTRODUCTION

The impetus to further examine this particular topic, that of the rehabilitation of the industrially injured, was derived from feelings of inadequacy and frustration experienced in the day-to-day work with this population. Although interested parties (i.e., physicians and other medical personnel, insurance claims representatives, attorneys and rehabilitation specialists) seem to agree that the goal of rehabilitation is to increase the level of functioning and productivity of the injured worker to the highest possible level subsequent to illness or trauma, there appears to be significant discrepancy concerning the most effective means to achieve this common goal. Traditionally, rehabilitation has been divided into either physical restoration or vocational replacement, and was typically provided in a consecutive fashion. For those individuals who were not "successfully" rehabilitated subsequent to these services, they were labeled as "chronic" patients and may or not be referred for psychological assistance. These non-successful clients were also frequently given the label of "functional overlay", especially when their degree of subjective complaints exceeded the expectancy for their particular physical impairment.
Unfortunately, it soon becomes apparent that the particular needs of this population and the demands placed upon psychological intervention are inadequately met by traditional psychotherapy. Additionally, the involvement and frequent interference of the workers' compensation process serves to further complicate the client-counselor relationship. Too often, the injured individual is either not provided or is receiving inappropriate psychological assistance. Continuing cash payments to the disabled--because they are disabled and unable to work--have imposed a cost in excess of $20 billion dollars on the working population of this country. Yet, total public expenditures within the rehabilitation programs in fiscal year 1970 were less than $.7 billion dollars. There exists a tremendous imbalance in the use of resources for income maintenance and rehabilitation. When the loss of earnings of potentially rehabilitative persons are added to other contributions from family and care programs, the comparison is even more staggering (Reedy, 1972).

The purpose of this review, therefore, is to facilitate a deeper understanding of the rehabilitation effort by taking a look at the processes occurring before, during and after a work-related illness or injury, and to suggest intervention techniques which more closely respond to the needs of this particular population.
This review will follow the format of three separate, but inter-related, theses concerning the rehabilitation of the industrially injured. Each thesis will be addressed individually and then interwoven in the concluding statements with a proposal for additional research.
CHAPTER I
THE ACCIDENT PROCESS

Occupationally related injuries and illnesses occur with increasing frequency in both the public and private sectors of this nation. The impact of these injuries and illnesses can best be assessed through lost work days resulting in reduced productivity. Each year, approximately two million Americans suffer a work injury involving at least one day of lost work time. During each year, work injuries cause about 15 thousand deaths, 85 thousand lifetime disabilities, almost two million temporary disabilities, and five to six million minor disabilities requiring medical care only (Cheit & Gordon, 1963).

Approximately 4.9 million industrially related injuries and illnesses occurred in 1982, with an all-industries incidence rate of 7.7 per 100 full-time workers. The total number of days lost to injury and illness was 36.9 million, with an average of 17 lost workdays attributable to an individual injury (Daily Labor Report, 1983).

Although it is relatively easy to accumulate and analyze data concerning the incidence and impact of these cases upon measurable outcomes; i.e., lost work days, lost earnings, and reduced productivity, the effect upon the
individual involved has greater variance and therefore, is more difficult to assess. Traditional attempts at assessment have been initiated subsequent to the actual occurrence of injury or illness, although more recent theories suggest the importance of understanding the potential involvement of stimuli preceding the incident. In many cases, the etiology of an industrial accident occurs long before any physical injury is incurred. There is a growing awareness that the continuing nationally high accident rate is a reflection of personal rather than machine failure (Rogg & D'Alonzo, 1965).

As a result of this acknowledgement, it now becomes of interest to understand the factors that influence an individual's potential for injury or illness. The potential is not, however, to be equated with the term "accident proneness", which has historically been applied to individuals who have become repeatedly involved in accidents and are thought to possess a certain propensity for such involvement. This concept of cause and effect provides an incomplete acknowledgement and/or understanding of underlying psychological processes (Hirschfield & Behan, 1963).

The influence of psychological factors upon the occurrence of accidents and the maintenance of disability has been more accurately described by the term "accident process", which states that under special circumstances, when certain conflicts exist, many individuals tend to cause
their own accidents and will probably hold on to the injuries they have sustained as a solution to their life problems (Hirschfield & Behan, 1963). From a review of 300 cases of industrial accidents and injuries, Hirschfield and Behan reveal that physical injury resulted from a psychological process that can be defined and documented in nearly every case. However, rather than a single causative factor, they suggest the interplay between various emotional, socio-economic and sometimes legal reasons. Thus, the accident process is a continuum, acting before, during and after the injuring event.

With the steadily growing phenomenon of chronic pain complaints, it has become increasingly acceptable to acknowledge a psychological aspect of disability, as suggested by the accident process. The exact nature of this inter-relationship between psychological and biological factors continues to be a point of disagreement, however, and can be characterized as a "cart and horse discussion" (Burk, 1971). Irrespective of the causal relationship, it is difficult to deny that the psychologic element can very often predominate to the point of obscuring the impact of anatomic-physiologic injury upon the individual's ability to function.

That an individual would subconsciously seek to cause an injury to self or attempt to prolong a period of disability can be initially understood by examining the sociological impact of an injury or illness. A state of
impaired physical functioning can be used as a socially acceptable alibi for many things (Myers, 1965). From Gardner and Taylor's (1975) review of the subject, they discovered individuals, with what in objective medical terms are minor physical impairments, who seem to bear a grudge against life, society and their medical condition. Much of their time is spent in illness or consulting with one hospital or specialist or another. Other signs of maladjustment to life can also be detected. This is not to say that an individual has not experienced an original injury, but failure to achieve anatomical resolution consistent with medical expectations does suggest that the patient has brought his physical symptoms into the service of his psycho-social, economic and legal conflicts (Hirschfield & Behan, 1963).

The onset of physical symptoms and the treatment for them seems to mark the beginning of a chain reaction. With each increment of treatment effort, the patient appears to become more disabled, requiring more extensive treatment. Due to the combination of increased symptoms and attempts at alleviation of these symptoms (drugs, surgical intervention, physical therapy), the patient is unable to work or carry on with his usual activities at home, withdrawing from the usual social interactions (Brodsky, 1970).

The state of disability may serve many purposes. The individual may wish to ensure the continuing financial
compensation provided by his disability, he may welcome the dependency it facilitates or the social sanction for avoiding competitive striving (Wright, 1960).

Underlying Psycho-social Factors

Accepting the premise that psychological and social characteristics of an individual, at the very least, impact the course of the accident process and more liberally, have causal relationship with the onset of "illness", it becomes important to examine these underlying factors in greater detail. Every individual may experience times of increased susceptibility towards having an accident without it necessarily being a life-long pattern of behavior. Therefore, the type of personality of the accident-involved individual is as wide as the range of the entire population (Rogg & D'Alonzo, 1965). The susceptibility to psychological complications arising from an injury may occur to some people only under special conditions, such as a life crisis or a period of emotional stress. Others may be unusually prone to develop such complications, while there are still others whose psychological state makes them especially prone to accidental injury (Enelow, 1968).

Unfortunately, research to date has failed to demonstrate a clear relationship between diagnostic label, personality and behavioral functioning. Specifically, (a) personality types do not parallel or accompany disease,
disability or deviancy syndromes, (b) people with the same type of deviancy show a wide range of behavior, and (c) severity of deviancy is not related to eventual ability to function in productive activities (Jacques, 1970).

Research has demonstrated, however, that a response to a given situation (i.e., accident) is frequently determined not by the nature of the situation itself, but rather by the individual's interpretation of that event (Goldfried & Davison, 1976). These expectations with which an individual enters a situation will not only spotlight what he sees, but will also delimit the degree of incompatibility with objective fact that can be tolerated. The more relevant the confirmation of an expectation may be to the satisfaction of needs, the stronger the expectation will be. It will be more readily aroused, more easily confirmed and less easily repudiated (Wright, 1960).

The strength of this need satisfaction provides the motivation to persist in the disabled state, despite objective medical findings to the contrary. Patients enter a "disability process", defined as a condition of functional disability which significantly exceeds the sum total of objective clinical findings, after appropriate qualified medical investigation (Gresham, 1977).

Except when clearly explained by a normal response to anatomical defects, chronicity in injury cases should be considered psychogenic unless proven otherwise (Hirschfield
& Behan, 1963). The discrepancy between observed or inferred pain behaviors and physiological stimuli should be examined in terms of an underlying personality or motivational problem (Fordyce, 1976).

The pain experienced from physical injury shares a commonality with other states of distress—anxiety, depression, guilt, anger and hostility. These responses are similar in their subjective feeling states and the capability of elicitation by common stimuli. The amount of distress experienced through each response may be altered or reduced by similar environmental circumstances or inter-personal communication. Therefore, a patient may confuse the experience of distress due to poor stimulus discrimination through their history of learning (Fordyce, 1976).

The interplay of these related responses is apparent both pre- and post-accident. Poorly-developed behavioral repertoires, in which the individual lacks the necessary coping skills to deal with situational demands, may lead the individual to subconsciously seek a socially acceptable defense against the continued onslaught of these demands. Their illness operates as a cultural safety valve, allowing the individual to withdraw from the multiplicity of problems experienced in living. The disability serves as a tangible focal point for the organization of anxieties and hostilities which the disabled person harbors towards himself and significant others (Thoreson, 1971).
In examining the pre-accident process, Hirschfield and Behan (1963) noted behavioral patterns of increased carelessness by historically skilled workers who often ignored safety rules with multiple and simultaneous infractions. Many of these workers offered predictive statements of impending doom. Inability to face their state of conflict resulted in an increased frequency of absenteeism, complaints of fatigue, hypochondriacal pre-occupation and an appearance of indecisiveness (Enelow, 1968).

As an obvious reaction to physical injury, patients may experience anxiety associated with fears of being unable to cope with the unknown future (Moses, 1971). This affect may be accompanied by a sense of depression or of loss. Similarly, depression may follow loss of some source of positive reinforcement from the environment. Each of these emotional states are likely to have had at least some early occurrences in conjunction with pain (Fordyce, 1976). The incidence of childhood experience with pain and conflict are reported with greater frequency by chronic pain patients than by non-chronic patients (Musky & Spear, 1976). Further, acute and chronic pain patients, with or without physical findings, show markedly elevated depression scale scores on the MMPI (Steinback, 1976).

As a reaction to anxiety, depressed individuals avoid anxiety-provoking situations by ceasing to strive, compete or place value on anything. Illness and disability offer a
rationale or alibi for passivity, inactivity and lack of accomplishment. A strong sense of guilt may accompany the depressive affect. As an important component of all neuroses, it has been established in psychiatry that guilt-ridden patients seek punishment, which is afforded by the self-destructive nature of the accident process (Rogg & D'Alonzo, 1965). When after punishment there is restoration or reassurance, depression and guilt are relieved concomitant with a naturally occurring reduction of pain. This pattern promotes punishment and pain as a cue to be followed by the reduction of guilt (Fordyce, 1976).

Hysterical personality types, dependent, immature persons or those with a false sense of self-sufficiency may also find relief through the accident process (Enelow, 1968). Poorly-developed coping capabilities, unwillingness to accept responsibility, feelings of inadequacy, and a desire to be cared for characterize this participant in the accident process. The resulting enforced dependency provides these individuals with the "secondary gain" of attention and ministration of others (Levine, 1971).

Maintenance of the Disabled State

Traditionally, the course of disability is thought to begin with an injury or disease, known as the medical condition. This condition may result in an impairment of bodily function(s). The disability reflects the loss or reduction
of the individual's ability to undertake certain activities (Gardner & Taylor, 1975).

Although physical impairment can be determined objectively within certain limits, disability is a highly subjective and personalized process (Brodsky, 1970). Research data does not support a clear or consistent relationship between the degree of physical disability and the psychological consequences of that disability. Nor has it been demonstrated that certain disabling conditions produce certain specific psychological results. The extent of the impact experienced by each individual is related to the significance which the disability process possesses for him (Levine, 1971). Christopherson's (1968) research with the physically handicapped of both sexes indicates an independence between the relative seriousness of the physical impairment and the disability of the individual.

As in conversion reactions, in which the dysfunction is not based on anatomic principles but on the individual's "idea" of dysfunction, so too with the idea of disability. The patient has a concept of himself as a disabled person and will behave in accord with this idea. In many instances, this behavior will not be consistent over time nor necessarily conform to any functional or anatomic pattern (Brodsky, 1970).

The degree to which this distortion or misperception will exist for an individual will depend in part on the
extent the individual has utilized such distortion in the past to bring the world in line with his wishes (Levine, 1971). For some individuals, it is more appealing to attribute their difficulties to physical impairment than to face any implications of a psychogenic disorder (Myers, 1965).

Yet, the usage of this disabled state is not a conscious act. As Brodsky (1970) observed in his study of the impact of antecedent sexual factors in compensation cases:

A typical male patient had not "decided" to have an accident and did not "realize" immediately after the accident that it could lead to disability. He finished his shift and drove home. It was only when he saw his physician, was x-rayed and told to rest for a few days that his symptoms came to the fore in full force....Consequently, he no longer had to perform at his job or in bed. (p. 301)

The disabled role becomes a comfortable state, allowing for the satisfaction of needs of which a patient may be unaware and removing him from threatening situations that had not been consciously thought of as being dangerous. From a systems theory viewpoint, there exists very little psychological distance between wanting, thinking, feeling, and willing. The subconscious desire to avoid confrontation and be cared for becomes a reality through disability, which will be defended in the face of factual data. When this
state of illness furthers his personal values more advantageously than would a state of health, it becomes logical for the patient to prefer disability.

The acceptance by the individual of the disabled state is further enhanced by society's acceptance of physical disability and relative rejection of emotional disturbance. A disability that is obvious or visible is perceptually easier to adjust to, both by the involved individual and society, than the "hidden" and therefore unknown aspect of the emotional disturbance. The locus of control for a physical disability obviously does not rest with the individual, who may otherwise be charged with a fault of character or control of an emotional nature. There also exists a greater abundance of knowledge concerning the cause-effect relationship of physical impairment resulting in more highly developed treatment programs versus those available for emotional disorders (Jacques, 1970).

**Impact of the Industrial Injury**

The industrial injury appears to be particularly susceptible to psychological complications. An understanding of this susceptibility is facilitated by an appreciation of the importance of work in our culture. This importance dates back to the formation of the "Protestant work ethic" in which productive activity was the core of one's being. Work provides the capacity to make life more purposeful and
as evidenced by the lack of leisure time activities developed by the middle- and low-class workers, it continues to supply the major portion of daily activities (Hirschfield & Behan, 1963). The importance of the economic benefit derived from gainful employment is overshadowed by its role as a social phenomenon. Work is accomplished within a sociocultural environment which has its own unique set of social norms, customs, rituals and demands. Adaptation to work requires the internalization by the worker of certain culturally determined values and goals (Neff, 1968).

Central to the self-concept of almost every adult in our culture is the image of himself as worker. In casual conversations, one tends to offer his identification in terms of his occupation. It determines to a large extent where one lives, what one does in his leisure time, his perceived social status and who he chooses as friends. The value that an individual has for himself may be partially determined by the status he has had or hopes to have as a worker (Levine, 1971).

The factors that influence the accident process are present in the work environment before, during and after the injuring event. As previously discussed, psychosocial factors which may predispose an individual to injury or disease are called into play by employer-employee relationships and fellow worker relationships. Depressed individuals may experience an increasing sense of inability to
care for themselves, leading towards a lack of caution, psychomotor control and decreased vigilance in the work environment (Enelow, 1968; Hirschfield & Behan, 1963). The aging worker may view disability as a type of early retirement, when continued employment appears to be an intolerable situation. Individuals who have failed to develop the capacity for work accept the dependency offered by prolonged disability (Enelow, 1968). Often, these workers do not have the long-standing employer-employee relationships and consequently, may not have jobs to return to. This lack of job security may lead to an overemphasis of the disability and fear of losing benefits afforded by the compensation system (Gulledge, 1963).

Successful adaptation to work requires a complex set of interrelated factors—many of which are social and interpersonal in character (Neff, 1968). Yet for many people, there exists an internal dynamic situation that works against the continuation of adaptation to the job (Brodsky, 1970). In some instances, workers are able to perform adequately for a long time, then either slowly or suddenly, they themselves or others judge a lack of job competency. A breakdown of the homeostatic devices which have maintained the work relationship occurs, and something happens in the job that becomes identified as the injury or traumatic event (Brodsky, 1970). This event is used to explain all the resulting deterioration, whether physical, emotional and/or social in
nature, as well as the previously unacknowledged problems.

The legal approach to the industrial injury serves to further satisfy the unmet needs of the individual involved in the accident process. The individual is provided with the status of an officially disabled person who is injured while engaged in honorable work (Brodsky, 1970). Workers' compensation laws are based on the principle of employer liability without review of fault and fully subsidized medical treatment. The structure of the workers' compensation system often has the physician, patient, claims adjuster and lawyer working at cross-purposes (Enelow, 1968). The system, instead of achieving rehabilitation for the injured worker, stands as an obstacle in the path of the worker's restoration (Cheit, 1963). Temporary disability benefit payments are viewed only as an interim measure, with each party to the case striving to achieve a more permanent resolution. Disputes may occur over the need for and level of permanent disability ratings, with the worker seeking to maintain medical and compensatory benefits. The physician, whose efforts toward physical restoration, although technically successful, have not resulted in total rehabilitation, becomes frustrated by the continual somatic complaints of the patient and may overcompensate for his feelings through multiple test procedures and treatments.

Careful attention to the psychological climate of treatment procedures and administration of the claim is
required but too often absent (Enelow, 1968). The apparent reluctance of the patient to vigorously pursue total rehabilitation may not simply be a matter of malingering, but rather the subconscious acceptance of the benefits provided by the disabled state in lieu of the doubtful possibility of successful return to employment and resolution of underlying problems. The rationale of "no one will hire me" is not acceptable to the injured worker and is replaced by the more socially reinforcing concept of "my pain is too severe to permit work" (Fordyce, 1976).

Crisis Development

The accident process which is maintained through and by medical, vocational and legal reactions to injuries, especially those whose onset is within the industrial milieu, is most evident subsequent to the traumatic event, although the theory proposes an antecedent influence. At present, it is unrealistic to anticipate that the potential for an accident can be reasonably predicted. Attempting to prevent psychologically involved accidents by assessment and counseling would be comparable to preventing forest fires by watering an entire forest on a continual basis. It would not be cost-effective or reasonable to consider such an all-encompassing prophylactic measure. Treatment should be provided, however, at the first sign of a spark or smoldering fire--reacting to the injury or illness as one would to a
crisis in the forest. The sudden loss or threatened loss of basic supplies may precipitate an individual into a state of crisis (Bartolucci, 1973). The psychological shock reaction to physical impairment has also been described as a period of mourning comparable to that of bereavement (Wright, 1960). At the very least, the person whose life has been suddenly shifted by the onset of illness or injury can be expected to pass through some critical moments (Lietner, 1974).

Crisis is defined by Lietner (1974) as "a breakdown of thinking resulting from a physical or psychological overload" (p. 19). The dysfunction in handling incompatible information can lead to a breakdown of coping and problem-solving capabilities.

The precipitant for a crisis may be either "accidental" or "developmental" (Ewing, 1978, p. 24). An individual may have been able to master the threatening situations, whether emotional, social or physical, with minimal self-awareness and strain through the use of habitual methods, thereby successfully coping with the problem. When the threatening situation can not be mastered by habitual methods, then the individual begins to experience a crisis. Rather than being a "victim" to the crisis, the individual may be the originator, precipitating the crisis to meet his needs to control his environment (Korner, 1973).

The difficulty experienced by an individual in response
to his interdependence with his environment may not be due to internal disturbance or illness, but rather to inability to cope with the stresses of living (Gill, 1972). The emotional reaction to a current threat, identified as the "crisis", may be in part rooted in or directly affected by the individual's past experience with threats to his basic needs (Ewing, 1978).

The interplay of the accident process and the crisis reaction may occur at several phases within crisis development. Initially, the individual is confronted with problems that may pose a threat to certain needs. If the feelings of tension and the problem are not reduced by habitual methods of problem-solving, then increased tension may lead to greater feelings of distress and ineffectuality. Trial and error tests at resolution may result in heightened susceptibility to accidents through reduced vigilance and caution.

With continued failure at resolution, the rising tension acts as a stimulus for mobilization of emergency and novel problem-solving measures (Ewing, 1978). Subconsciously, the "escape" of an injury may provide the required answer. The individual has reached a turning point in which development must move one way or another (Leitner, 1974). Unfortunately, the accident process does not serve to avert the crisis, but merely to give it a new definition.

Korner (1973) describes two types of crisis reactions: the "exhaustion" crisis in which previously successful
coping behaviors have collapsed under prolonged conditions of stress, and "shock" crisis as a reaction to sudden changes in one's environment. The explosive release of emotions created by these changes overwhelms the individual's available coping mechanisms. The precipitative and reactive features of these two types of crises can be compared to the antecedent and maintenance components of the accident process.
Early intervention into the accident process, at the time the crisis is evident, is necessary to facilitate adaptive resolution of the precipitating emotional state as well as the traumatic event. The amount of fear an individual experiences or emotion he expends during the onset and duration of the illness or accident leading to the disability will determine the psychological impact of the disability. Generally, the greater the amount of emotion expended, the better the psychological adjustment to the disability (Cull, 1972). Intervention designed to foster the atmosphere for direct confrontation of emotions will also serve to impede the development of chronic problems not directly associated with physical impairment.

The crisis reaction is typically self-limiting and will achieve its resolution, with varying degrees of success, within three to five weeks (Ewing, 1978). The crises of rehabilitation clients, however, tend to be longer-lasting and more traumatic due to the permanent nature of the precipitating event of illness and trauma (Leitner, 1974).

The outcome of the crisis, which refers to the individual's emotional reaction rather than the threatening situa-
tion itself, is dependent chiefly upon the actions of the individual and the intervention of others. If the individual has unsuccessfully faced previous threats, he may be at a disadvantage in his attempt to deal with current stresses. Conversely, successful resolution of a crisis can mean an increase in the probability of future successes when faced with similar obstacles (Ewing, 1978). Timely and appropriate intervention with the current crisis will enrich the individual's ability to cope with stress.

Ewing (1978) and Leitner (1974) have discovered an increased desire to receive help expressed by individuals experiencing a crisis. These individuals tend to be more open and amenable to outside intervention than at times of stable functioning. This characteristic is of particular interest when applied to individuals who may be utilizing their physical impairment to respond to underlying emotional need. The trauma or illness becomes a "red flag" to signal their readiness for assistance. Positive resolution of the crisis will have lasting effect upon the individual and his assumptive world (Leitner, 1974).

Psychological Reactions to Disability

As previously discussed, studies have failed to provide a classification and categorization of individuals who display a propensity to accident involvement. The same holds true for an accounting of the psychological responses to
physical injury, although some generalities have been dis-
covered. In examining the diversity of responses, it is
important to realize that the reaction may have little rela-
tion to reality and in many instances, the emotional reac-
tion may be more disabling than the primary or physical
disorder (Myers, 1965). Fear and uncertainty may be more
difficult to deal with than pain and shock (Cheit, 1963),
allowing a minor disability to become a major calamity.

Following the onset of the disability, the individual
can be expected to mobilize and focus his energy onto his
immediate hurt and uncertainties (Levine, 1971). The dis-
ability is typically seen as a loss, with ensuing grief and
depression, although the guilt-ridden person may view it as
a form of punishment, thereby eliminating the depression
(Myers, 1965). Depression may lead to heightened anxiety
toward physical limitations, loss of body integrity, manhood
or womanhood. In cases of severe loss (i.e., amputees,
paraplegics), the initial reaction to disability is similar
to the feelings of mourning and bereavement (Neff, 1968).
In fact, this period of mourning, if resolved, appears to be
a necessary condition for eventual adequate adjustment. The
first step in this adjustment process requires the develop-
ment of "functional orientation" (what is left) as opposed
to "anatomical orientation" (what is missing) (Cull, 1972,
p. 424). As with the crisis reaction, the grief process is
generally acute following an identifiable onset and may be
endured for only a relatively brief period (Ewing, 1978).

The sense of loneliness and separation from others that may occur in conjunction with the disability is also dependent upon the individual’s perceptions. Suddenly, social cues which have not been noticed in comfortable surroundings become highly significant. The injured person will develop a heightened perceptiveness as to how he is being treated by family, friends and professionals (Cull, 1972).

To foster a successful rehabilitation program, it is essential that the isolation experiences be held to a minimum and that the possibility of psychopathological development is precluded by a climate of identification, understanding and mastering of the tasks ahead.

**Early Intervention**

There exists considerable theoretical and empirical information to support the importance of the time element to rehabilitation programs. Jacques (1970) and Gardner and Taylor (1975) strongly suggest that the rehabilitation process should begin as soon as the deviance or disability is discovered, typically at the onset of illness or injury. Only seldom is this goal actually achieved and indeed, the involvement may come after a considerable time lapse and after the state of crisis has been superseded by a psychopathological condition (Hankoff, Mischorr, Tomlinson & Joyce, 1974). Early intervention can prevent these deterio-
rative effects which may become irreversible and chronically interfere with the individual's ability to function (Jacques, 1970). The more information an individual has relating to his disability, the less impact the disability will have (Cull, 1972).

The emotional state of the individual at the onset of the disability will have a profound impact upon the course of medical, psychological and vocational rehabilitation. Without exception, a person's "will to recover" is a necessary condition for restoration (Cheit, 1963, p. 304). Yet, that set of characteristics may be different for each person. The key to success appears to involve not only innovative and progressive medical techniques, but timely introduction of psychological attention. Rehabilitation in this sense is a continuing part of medical care and fulfills an important preventive function (Lewis, 1963).

The patient's anxiety about his physical state may encourage behavior ranging from a fear of overt expression of concern to a craving of care and solicitude. Each reaction may serve as a sustaining factor in the accident process. People will often avoid facing their present behavior by emphasizing how they feel rather than what they are doing (Glasser, 1976). In other cases, the individual may want to continue in the crisis situation, and perpetuation of the care and concern of other may prove to be an invitation for the adoption of the "sick role" (Korner, 1973, p. 37).
The development of the disability process and its inherent chronic behaviors can be understood from a learning and behavioral perspective. The premises are straightforward: (a) pain is subject to the influence of learning, (b) learning is automatic, and (c) if learning has occurred, unlearning can also occur (Fordyce, 1976).

In his in-depth study of chronic pain behavior, Fordyce (1976) provides a concise, summarative statement of the learning or conditioning process to which the injured person may be exposed. Accepting that behavior is sensitive to or responsive to, and therefore partially controlled by, a person's immediate environment, he proposes that:

Behavioral changes may be brought about by arrangement of consequences to operant behavior. Increase the rate or frequency of a behavior by arranging for systematic positive reinforcement contingent on its occurrence; decrease a behavior by arranging for nonreinforcement or for aversive or punishing consequences. (p. 38)

His review shows further that the opportunity for learning effects to become significant for an individual is an inherent part of chronic pain development. Conditioning requires the opportunity for practice and can maintain the pain reaction, with or without effective medical attention. Time and time again, the patient interacts with the physician or other therapist. These interactions, in addition to
whatever other characteristics they may have, are learning trials. As early as possible, the patient should receive frequent contact and information regarding the course of his care. Yet, the contact should not be pain or problem contingent, but should be provided before problems arise (Fordyce, 1976). Too often, in order to receive continued attention, the patient may act more and more irresponsibly to create validity in his complaints (Glasser, 1976). Contingent attention is of greatest importance in the early phases of treatment, directed towards helping the patient understand that there is more to life than being concerned with his own misery, symptoms and problems.

The skill deficits which appear in the disability process may have antedated the pain problem (as suggested by the accident process) or they may have arisen due to the interval of relative inactivity associated with the problem itself. This period of inactivity allows for the build-up of latent muscle tension, which may add to the experience of pain. Fordyce (1976) applies the learning or conditioning theory to the relaxation process. Patients can be taught to turn off tension or turn on relaxation rapidly and precisely in relation to the target muscles.

The positive behavioral changes which are required for effective and total rehabilitation are not easily made, nor are they made with exacting a price (Christopherson, 1968). Yet chronic pain and its associated functional impairments
are costly when they entail health care services or interference in the generation of income. A narrow approach to treatment that fails to consider the effects of learning or conditioning too often is followed by increasing medical costs (Fordyce, 1976).

The time interval between onset of illness or injury to introduction of psychological assistance not only affords the opportunity for inappropriate learning, but a host of other problems as well. Dr. Howard A. Rusk (cited in Cheit, 1963) observed that when delay exists in providing intervention, the patient goes through a cycle of "physical neglect, emotional trauma and vocational sterilization" (p. 308).

Slater (1969/1970) studied the relationship between early referral for vocational assistance and the attained vocational status on a number of variables. The findings show a negative trend between the length of time unemployed and the interval between onset and referral to successful vocational rehabilitation. Complications are often created through prolonged and unnecessary diagnostic and treatment procedures directed toward "fixing" the symptoms (Enelow, 1968), while ignoring the involvement of the psychosocial state of the individual. Briefly stated, what happens in the months, and even years ahead is often determined within the first few days after the accident (Cheit, 1963).
Rehabilitation Plans

To evaluate the importance of timely provision of rehabilitation assistance, it is necessary to determine the definition and goals of such intervention. St. Clair (1963) offers the definition as "the restoration of the handicapped person to the fullest physical, mental, social, vocational and economic usefulness of which he is capable" (p. 102). Myers (1965) suggests that "rehabilitation...has had the objective of minimizing residual disability while increasing function and adaptive skills" (p. 413). The objective of rehabilitation is not so much "curative", in the sense of complete elimination of the impairment in question, but "ameliorative", in the sense of bringing the person to a maximal level of functioning within the limits of a continuing deficiency of some kind (Neff, 1968).

Yet rehabilitation has come to imply a many-sided and multidisciplinary process which follows after the acute phases of an illness or disorder. The overwhelming and one-sided emphasis on vocational objectives separates it from the therapeutic goals of other helping professions (Neff, 1968). Consequently, many of the nonproductive disabled persons represent failures in the psychological and sociological aspects of rehabilitation rather than in the physical and physiologic aspects (Christopherson, 1968).

There appears to be no lack of support for the value of a total rehabilitation orientation throughout the treatment
process. Rehabilitation should be the guiding concept of both the treatment and the handling of the injured worker's claim (Enelow, 1968). It is a continuous process, influencing the patient from the time of injury to the point of gaining independence and returning to work (Steele, 1963). In his review of public policies regarding industrial injuries, Cheit (1963) found that:

Without exception, every group interested in the compensation process has endorsed the idea that rehabilitation must be an integral part of medical care of the injured worker from the beginning....

Insurance carrier use of trained rehabilitation advisors to visit the seriously injured worker shortly after injury has already proved to be an extremely helpful method of orienting him toward rehabilitation from the start. (p. 316)

Kessler (1963) calls for "a revolutionary change in methods ...orientation toward a rehabilitation system" (p. 376). This orientation must begin within the medical arena, in which nurses who have been trained to wait on the patient must be re-trained to examine the impact of their care. Somehow the principles of rehabilitation must be made to penetrate the stereotyped methods of medical care and to modify practices which tend to increase rather than decrease disability (Lewis, 1963).

Thus, even when the best rehabilitation services exist,
if they are used only after a long interim, it may be too late for them to be effective.

To effect this rehabilitation orientation within the treatment program, the team of professionals must incorporate a detailed consideration of what the post-treatment behaviors are likely to be and what they need to be. This consideration is clearly described by Fordyce (1976):

When behavioral concepts are woven into evaluation and management of chronic pain, among the most important added dimensions are the need to deal with the patient's current and post-treatment environment and the need to focus on strengthening well behavior as well as reducing sick or pain behavior. When these concepts are added to the treatment planning picture, the ideal treatment plan would try to do what it can to reduce or eliminate the current pain problem, respondent or operant, diminish gaps in well behavior repertoires that threaten the maintenance of treatment gains, work toward a patient-environment relationship that will optimize maintenance of performance and work with the patient and family to minimize the future development of operant pain. (p. 104)

The rehabilitation team which deals with patients who may be subconsciously utilizing the accident process designs a program based on false premises when they fail to acknowledge
that the disability is determined as much by antecedent problems as the accident itself (Brodksy, 1970).

Beals and Hickman (1972), in their study of the importance of the psychological evaluation for optimum rehabilitation effort, suggest the "whole man" concept in which it becomes "equally important not to neglect the psychopathological and other lifestyle problems that produce chronic disability" (p. 1594). Prevention of psychological complications becomes important as soon as the accident has occurred. Disability may be reduced, despite adverse psychological influences, through the application of a well-directed treatment program entailing early evaluation and continuous counseling (Larson, 1963).

Effective rehabilitation plans involving industrially injured workers require not only a rehabilitation focus by the physician, but the provision of rehabilitation facilities and personnel in the right places at the right time (Cheit, 1963). The individual in stress who is undergoing a major reorganization of his self-perceptions following a traumatic event requires the skillful intervention of a person whom he trusts. Early contact allows for the expression of concerns held by the patient and accurate identification of the problem. The greater the involvement of the patient in determining and developing alternate behaviors, the less likely the patient will resume inappropriate chronic pain behaviors leading to additional health care
costs (Fordyce, 1976). There can be no therapy until the patient recognizes that he has a problem that he has not coped with successfully (Rogg & D'Alonzo, 1965). Timely intervention with a rehabilitation objective should reduce the number of individuals who prefer the relatively radical approach of surgery, where they are passive recipients of treatment and encourage participation in counseling, where they must assume some responsibility for their improvement (Myers, 1965).

Heretofore, the "total rehabilitation" program as suggested by Lewis (1963), was comprised of (a) medical restoration or improvement and (b) vocational training, guidance and placement. Without an understanding of the accident process, which would suggest the need for the inclusion of psychosocial management and counseling, the rehabilitation effort directly attacks the patient's need to maintain his disabled state as a protection against the re-emergence of emotional difficulties. Medical and vocational treatment gains will soon disappear if the problem or aversive consequences that pain behaviors were developed to avoid are ignored or overlooked (Fordyce, 1976). If solutions to the underlying problems are not developed, the well behavior brought about by physical restoration and job placement will continue to lead to aversive consequences. Simply stated, the worker whose pain buys time out from repeated job failures will not experience sustained success simply by
re-entry into the work force. Among the other discomforts he may face is the threat of loss of the relative haven of illness, with no acceptable alternatives yet in sight (Fordyce, 1976). As an important prerequisite to vocational guidance and placement, the rehabilitation provider must offer assistance in organizing information and helping the patient develop new cognitive understanding (Leitner, 1974). The obstacles inherent in the workers' compensation process frequently require the counselor to function as an intermediary in interpreting, explaining, educating and sometimes interceding for the patient (Jacques, 1970). The eventual success or failure of the rehabilitation effort may well hinge on the extent to which the individual's feeling of psychological isolation have been halted or redirected by pragmatic counseling and planning with the patient.

Traditionally, the treating physician begins to look for social and psychological explanations after extensive tests reveal no physical basis for the continuing level of disability and trial therapeutic interventions have not impacted the problem. Therefore, it is not surprising that the patient who has been treated as if his problem is the result of physical dysfunction reacts with skepticism when he is referred for psychological treatment (Fordyce, 1976). Any treatment program is a communication and learning opportunity for the patient. When the patient is treated with medical intervention for complaints that in fact preceded
the trauma and are of social and emotional origin, his belief is reinforced that the disability is the result of physical problems.

The consecutive nature of traditional responses to industrial injuries, initially medical then psychological assistance, provides conflicting messages to the patient. Fordyce (1976) discovered that most chronic pain patients who have undergone a number of diagnostic exams and treatment programs report having received allusions or direct statements from their doctors that all or part of their pain problems were psychogenic. By definition, psychogenic pain refers to the low correlation between noxious stimulus and pain behaviors. Yet the term should be used only as a label for the discrepancy as it does not offer an explanation for its etiology. The frequent misuse of the term and the unvalidated assumptions that often accompany it can lead to a failure to understand the nature of the patient's pain problem. To attempt to categorize two kinds of pain, either organic, physical and "real" or non-organic, psychogenic and "imaginary" denies the consistent evidence that pain is what one feels when one hurts and what the patient experiences is real to him or her (Fordyce, 1976).
Rehabilitation of the industrially injured worker requires the philosophical acceptance of the holistic nature of man and a refusal to divide the individual into separate components of physical, psychological, cultural or economic problems. To be effective, it must work toward the development of coping behaviors involving the active participation of the individual on an equal basis with the medical care providers.

The nature of the antecedent problems, the sudden onset of illness or injury, and the goals for rehabilitation call for a crisis intervention approach. Ewing (1978) defines crisis intervention as "the informed and planful application of techniques derived from the established principles of crisis theory...with the intention of assisting individuals or families to modify characteristics such as feelings, attitudes and behaviors that are judged to be maladaptive or maladjustive" (p.6).

**Problem-solving Approach**

Crisis theory focuses specifically on the behavior of the individual and examines such behavior from a problem-
the individual and examines such behavior from a problem-solving perspective. The goals of this problem-solving approach are to provide a variety of potentially effective responses to the problem situation and to increase the likelihood of selecting the most effective response among the alternatives (Goldfried & Davison, 1976).

Ineffectiveness in coping with problem situations can result in emotional or behavioral disorders as suggested by the accident process. Enhancing the problem-solving skills of an individual in crisis becomes a crucial phase in a more general self-control process. Research findings by Goldfried & Davison (1976) indicate that an individual's expectation of being able to control his environment can greatly increase the likelihood that he will attempt to cope with difficulties when they occur.

As a response to individuals involved in the accident process, crisis intervention would facilitate identification of the precipitating stressors, whether limited to the physical injury or involving the pre-morbid emotional state. It is effective at several levels of the immediate situation by providing an assessment of the person and factors influencing the disequilibrium, specific therapeutic intervention and anticipatory planning (Hitchcock, 1973).

An individual who is receiving assistance in the development of effective problem-solving skills will be directed through five stages (Goldstein & Davison, 1976). Initially,
the individual must develop a general orientation to the purpose and scope of this process. This orientation is important, yet does not require that the patient develop insight into the historical origins of his problem in order to effect behavior change. He formulates the definition of his problem in behavioral terms, dealing with his emotional reaction to the present problem. Then begins the generation of alternatives and the decision-making process to select the most viable choice. This selection is subjected to verification by the individual within his own environment and with the input of significant others. This process is repeated as often as necessary and the individual may fluctuate between the stages.

Crisis therapy is not intended to be in-depth, but rather is oriented towards dealing supportively with here-and-now issues (Hitchcock, 1973). Crisis theory fits well with the behavioral framework of chronic pain in that instead of underlying biological or characterological defects, it proposes that disturbances in functioning are the result of a temporary inability to cope adaptively with overwhelming life stresses. The goal is to help the individual minimize the disorganizing impact of current stresses while developing stronger, more effective coping mechanisms (Ewing, 1978). Chronic pain is understood best not in terms of a patient's personality or motivation but in terms of his behavior (Fordyce, 1976). Therefore, it is practical and
productive to implement a crisis intervention approach to directly modify behavior without first attempting to uncover or modify underlying personality or motivational mechanisms.

**Crisis Theory vs. Disease Model**

In an effort to provide substance to what may appear to be a simplistic approach to psychological dysfunctions, one must first accept a behavioristic orientation that psychological disorders are not illnesses to be diagnosed, but rather learned maladaptive responses to be unlearned (Ewing, 1978). The disease or medical model would suggest that the problem or illness behavior is the symptom of underlying biological or characterological defects. The aim of the treatment would be to diagnose the underlying pathology and treat with testing, therapy, medications, hospitalization, etc. in an effort to cure the illness and restore the individual to health (Ewing, 1978; Fordyce, 1976).

The learning model (Fordyce, 1976) or crisis theory (Ewing, 1978), on the other hand, suggest that the illness behavior is an emotional reaction to a situation in which the normal adaptive coping mechanism has been overtaxed by life's stresses. Short-term crisis intervention would be aimed at determining the illness behavior-consequence relationships and to change these relationships by helping the individual to cope more effectively with current stresses while developing greater capacity for future coping. The
individual's vulnerability to future stresses would be modified by application of learning principles. With a decrease in external pressure, brought about by the active intervention of a counselor, some temporary decrease in anxiety accompanied by a corresponding improvement in adjustment is anticipated (Myers, 1965).

Crisis Intervention Techniques

The appropriateness of a crisis intervention approach with industrially injured individuals becomes more apparent as one examines some general characteristics of this therapeutic method. Following is a summarization of Ewing's (1978) descriptive listing of the general principles of crisis intervention.

Through training and orientation of the involved personnel, crisis intervention is readily available and brief. Enelow (1968) suggests that industrial nurses and industrial physicians may be able to provide more timely and efficient care if they are trained to respond with a concern toward the possibility of psychological involvement. This concept is further supported by Christopherson (1968), who notes that patient responses identify nurses as having marked influence on behavioral changes.

As previously discussed, the crisis reaction is of relatively short duration prior to achieving some form of resolution. Therefore, the goals of most crisis interven-
tion programs are ordinarily accomplished within three to twelve sessions. Drs. Parad and Parad (cited in Ewing, 1978) suggest that "A little bit of help at the right time may be more effective than a long period of help after the crisis has subsided" (p. 420).

Crisis intervention deals not only with the individual but with families and social networks. The counselor will manipulate the environmental influence by offering direct resources or referral resources (Leitner, 1974). Utilizing the increased receptivity of the individual to seek and accept help from others, the crisis counselor will encourage active participation of the family, which also serves to forestall family pressures to seek additional medical attention (Fordyce, 1976). Successful crisis resolution is facilitated by the presence and attitudes of significant others from the sociocultural environment within which the individual lives (Bartolucci & Drayer, 1973).

Crisis intervention does not limit its focus to a singular definition of the crisis, but rather addresses a wide range of problems. The diagnosis of the problem appears to be irrelevant as crisis intervention is applicable to all forms of psychopathology and has more to do with the goals and expectations of the patient than with diagnostic categories. The rationale for crisis intervention with the industrially injured is the belief that these individuals, by the very nature of their problems, are in a crisis and
are most likely to benefit from psychotherapy with a short-term crisis orientation.

Such orientation is focused upon the patient's present problems and rarely includes a full diagnostic work-up. There is, in fact, both theory and evidence suggesting that duration of the problem has no significant bearing on the applicability or outcome of crisis intervention. Patients with chronic, entrenched pathology can benefit from crisis intervention just as much as those with more acute difficulties (Ewing, 1978). Chronicity of pain behaviors following injury can be relieved if the attitudes of the helping professionals can be constructively altered, thereby eliminating the need for psychiatric evaluation of the patient (Hirschfield & Behan, 1963). For this specific population, crisis intervention may therefore accept the industrial injury as the precipitating event.

With its problem-solving orientation, crisis intervention seeks not only to resolve the presenting problem and relieve its symptoms, but also to help the individual develop more adaptive mechanisms for coping with future problems. As the counselor assists the individual in uncovering his feelings and thoughts about his previous beliefs, he (the counselor) seeks to instill a growth orientation to more positive assumptions (Leitner, 1974). Success in overcoming a crisis adds to an individual's strength and coping potential (Schneidman, 1973). Further, the
current crisis may provide the individual with a second chance for correcting earlier faulty problem-solving.

Of most importance when dealing with physical injury, crisis intervention is reality-oriented. The therapist enables the individual to directly confront the reality of the situation by discouraging the use of denial, avoidance or projection. These psychological devices, referred to as defense mechanisms, are used to distort reality and to satisfy motives which can not be met in reality (Cull, 1972). By helping the patient to become aware of these mechanisms, the counselor renders them ineffective.

This confrontation is accomplished in the atmosphere of empathy, understanding and unconditional warmth. The counselor continues to offer emotional support as he confronts the patient with the unrealistic and maladaptive nature of his disability. When the patient can be made to see that the disability runs counter to his important needs, its disabling aspects will be diminished through the communication of positive belief and expectations (Wright, 1960). These beliefs and expectations are strengthened by virtue of the shared verification with the counselor, who communicates hope and optimism without false reassurances.

In order to achieve the goals of crisis intervention, the counselor must be willing to accept a non-traditional role in dealing with the patient. The crisis counselor is viewed as an educator and advisor, providing information and
advice through direct suggestion and limit setting. Their appropriate management of the individual's current emotions will allow for tension reduction without interfering with the individual's effort to achieve mastery of the situation. Crisis intervention can also serve to prepare the patient for further treatment, including more intense individual counseling (Leitner, 1974).

The relationship of the theoretical and philosophical principles of crisis intervention to the industrially injured gains further support by its implementation and practice as compared to more traditional forms of psychotherapy.

The term "psychotherapy" is generally applied to a verbal form of interaction between therapist and patient (Myers, 1965). The objectives usually are to have the patient understand himself and gain insight into his personality. The desired outcome would be to develop a more positive self-image and more effective means of dealing with problems. By its very nature, traditional psychotherapy is not the preferred method for dealing with patients who may be experiencing the accident process. Typically, progress is achieved slowly, requiring a fair amount of intellectual and verbal capabilities on the part of the patient. Unfortunately, the greatest concentration of the disabled is found within the lower cultural and economic sectors of the population (Reedy, 1972). Among this group, one is not
likely to find the necessary insight into psychological dynamics to achieve success in psychotherapy (Thoreson, 1971), but instead the communication between therapist and patient becomes meaningless activity.

An additional obstacle to psychotherapy is found in the cost of treatment and the skill level required by the therapist. Crisis intervention, on the other hand, does not necessarily require the same intensity of training for its counselors. The crisis intervention counselor may rely on the human qualities of warmth and empathy to foster an environment of support and additional resources. Effective counselors can be developed through careful selection, rigorous training and continuous supervision (Schneidman, 1973).

Further, psychotherapy requires a large amount of motivation and drive, which is very often missing in the people who need it the most (Myers, 1965). Although the significance of the patient's motivation toward crisis intervention has been empirically suggested by Ewing (1978), this factor is difficult to assess clinically to be used as a determinant in patient selection. Motivational concerns are addressed through the short-term, highly focused nature of crisis intervention. Its practical and problem-oriented approach is viewed as more in line with the way of life of the lower socio-economic groups (Sebolt, 1973).
CHAPTER IV  
FUTURE IMPLICATIONS

The premise of this review is not to suggest the predictability of industrial accidents nor to identify those individuals who are predisposed toward chronic disability. Rather, it attempts to advance a greater understanding of the accident process and to suggest, both theoretically and empirically, the appropriateness of crisis intervention techniques for this population.

As evidenced by this review, there is no lack of information regarding the value of early intervention in the rehabilitation process for the industrially injured. From the learning theory model, one must accept the assumption that if given time, it is highly likely that conditioning will occur. Therefore, it becomes important to preclude or redirect this development to more positive outcomes through appropriate intervention provided in a timely manner. Such intervention should prove to be less costly and less potentially dangerous than multiple medical treatments.

Unfortunately, the traditional approach to rehabilitation has been untimely and couched only in terms of vocational objectives. Rehabilitation in this sense has not provided any substantial savings to the workers'
compensation system (Gulledge, 1963), in that it fails to address the entire problem. Such effort is further impeded by the workers' compensation system which has succeeded in destroying the desired incentives (Cheit, 1961). Very simply, the permanent disability problem exists because many industrial injuries are not resolved by a uniform application of legal and economic principles. Larson (1963) proposes the need for a change in the basic concept of workers' compensation to workers' restoration. This conceptual change would serve to dramatize the fact that compensation for the injury is no longer sufficient and must be replaced by an obligation to restore the injured worker through medical, psychological and vocational attention. A review of the impact of lump sum settlements on eventual vocational return by Morgan (1963) drew a major conclusion for the need for trained counseling.

The scope of such counseling is aptly described by Myers (1965):

If...emotional disorders are expressions of man's inability to cope effectively with the demands, responsibilities and problems of life, it follows that rehabilitative procedures are at the same time therapeutic procedures. As a person functions better and develops skills--be they vocational, social, educational, recreational,
communicative, use of the community— he is better able to cope with life. (p. 413)

As a response to the needs of the industrially injured, review of the available literature suggests a theoretical kinship between crisis intervention and the accident process, despite a lack of empirical data. Consideration for the usage of crisis intervention techniques should be preceded by an evaluation of various factors to facilitate appropriate client selection. Many of the factors have not yet been subjected to the critical review of controlled studies for this particular population.

As previously indicated, research has failed to produce a clear relationship between the severity of the injury and its psychological impact. Yet for crisis intervention assessment, it is important to note the patient's current level of functioning, duration and severity of the problem. Preliminary research with other populations suggests that patients who rate themselves as possessing "very" or "extremely serious" problems achieve significantly more favorable outcomes through traditional long-term psychotherapy versus crisis intervention (Ewing, 1978). It is difficult to support a generalization to this specific issue based on the subjective evaluation of the patient himself. Ewing (1978) further reports that among follow-up crisis intervention cases, dealing primarily with family and children problems, there were no significant outcome differences
between those presenting short-term problems (less than six month duration) and those presenting long-term problems of greater than six months duration.

The duration of the problem may be related to its severity or it may, in fact, be relatively non-serious and therefore not apparent to the person until the time of the crisis. Further, acute problems may be more or less serious than chronic difficulties depending upon their impact upon the individual. Because of the very individual and subjective nature of the crisis, it becomes of more value to consider the patient's emotional state and pre-trauma level of functioning. This is not to suggest that patients be provided crisis intervention counseling based on a classification of organic versus psychogenic pain complaints. Again, it is prudent to accept the difficulty of medically assessing how much pain or functional limitation can reasonably be expected from a given type or amount of physical findings (Fordyce, 1976). Secondly, clinical experience suggests that most chronic pain patients show a mixture of pain behavior, partially under the control of pathogenic stimuli and partially controlled by environmental consequences.

Fordyce (1976) cites several studies which fail to demonstrate any significant differentiation on MMPI test scores between patients identified as psychogenic or organic. In fact, these patients showed common elevation in
scales reflecting hypochondriasis, depression, hysteria and distress. The inference, however, is not that no differences exist between these groups but rather that the differences rest in the interactions between the occurrences of pain behavior and environmental cues and responses.

Accepting the accident process theory, it would be judicious to assume the potential for this process in each individual involved in a work-related accident. Yet to implement crisis intervention counseling for each individual would become a logistical and economic giant. Many of the steps required by a crisis intervention approach are inherent in the medical, legal and social responses to an industrial injury and would merely require heightened sensitivity and awareness of the values and a coordinated effort by the professional team to utilize them in a productive fashion.

The first stage of crisis intervention involves delineating and focusing upon the problem. The patient should receive an introduction and orientation to the medical, legal and vocational processes with a goal of achieving rapport with the involved team. This presentation should include a systems approach, taking into consideration life changes or event which may be temporally related to the patient's persistent complaints or symptoms (Ewing, 1978).

The typical interview which is conducted following an industrial injury contains much of the information required
for counseling, i.e. basis demographic data, brief history of treatment, current level of functioning (appearance, behavior, speech, thought and affect) and pre-crisis adjustment. The latter may be obtained by direct inquiry of the patient, family, employer or significant others.

The core of crisis counseling occurs in the intervention process—how the patient is communicated with and what goals are established. The team of professionals can all be charged with the responsibility to utilize the techniques of listening, advocacy, information giving and confronting inappropriate and conflicting behaviors. An identified counselor can serve further to utilize available interpersonal and environmental resources, explore alternative coping mechanisms and assign new behavioral tasks (Ewing, 1978).

It is anticipated that the timely provision of goal-directed crisis intervention by trained personnel would serve to minimize the impact and chronicity of the disabled state. The need for and value of early intervention in the total rehabilitation process has become an accepted fact. Traditional rehabilitation directed toward vocational replacement confronts the needs satisfaction of the individual involved in the accident process and, therefore, will be met with a lack of cooperation and short-range success. In theory and in practice, crisis intervention counseling fits the framework of the accident process and the workers' compensation system to provide the total rehabilitation required.
REFERENCES


