THE ROLE OF THE SCHOOL SOCIAL WORKER IN PREVENTING CRISIS SITUATIONS IN PRE-UNIVERSITY EDUCATION INSTITUTIONS

Carmen PALAGHIA
Senior Lecturer, PhD, "A.I.Cuza" University Iasi (Romania),
Email: carmenpalaghia@yahoo.com

Abstract: *The article presents the counseling principles in crisis situations, with emphasis on how pre-university education institutions can prevent and intervene when such situations occur. Researchers such as: Hillman (2002), Dupper (2003), Lines (2006), Openshaw (2008), Sandoval (2013), emphasize the fact that that students may also be affected by anxiety, depression, neuroses, suicide or self-injury -suicidal. In our country, there has been an increase in the number of juvenile mothers, cases of emotional and sexual abuse, rape, ill-treatment, consumption of alcohol and psychoactive substances among minors, addictions to digital games, even gambling, alcohol and other psychoactive substances, addiction to certain foods harmful to health, anorexia nervosa or bulimia nervosa. Victims of bullying can develop low self-esteem, depression and suicide attempts. For some students, it is necessary to work on the management of anger, aggression and acts of violence. All the previously mentioned situations, as well as any others, can be perceived by the students as extremely stressful and difficult to manage. They require the intervention of specialists at school: psychologists, school counselors, priests, specialists in pediatric psychiatry (if the situation requires) and school safety officers. The activity of the multidisciplinary team, made up of the aforementioned specialists, is certainly coordinated by the case manager, the school social worker, who becomes responsible for the speed and efficiency of the intervention, for each case separately.*

Keywords: School Social Worker, crisis, prevention, suicide, intervention.

1. Introduction

The mass media reports that there are many parents who seek counseling because their children have become neurotic. Online courses have a major effect on the psyche of students, there is a risk of emotional disorders that can occur after they are overexposed to the screen, isolation, repressed emotions and not discussing with parents or friends, so teenagers feel lonely, sad or angry. Alcohol consumption can be a factor triggering hostility. Aggressivity can be defined as verbal or physical behaviour that is characterized by the intention to harm someone. Castro-Blanco (apud Holdevici, 2011) states that between the ages of six and ten, children spend most of their time at school, therefore most of the crises they go through are found at school by teachers and by school counselors.

2. Ways to prevent crisis situations at school, with the school social worker as a prevention agent

A reaction to crisis situations at school (Mennuti, Christner, Freeman, 2016) should seek for universal prevention, for all students, early intervention for those at risk for maladaptive reactions, as well as intensive intervention for beneficiaries who show clear symptoms of emotional and behavioral disorders.

Primary prevention programs in schools usually aim at preventing the occurrence of learning or behavioral disorders, such as running away from school, dropping out, the consumption of psychoactive substances, juvenile-adolescent pregnancy, etc. School Social Assistance focuses on the resilience, on the emotional and physical health of students, parents and school staff.

Resilience is represented by the ability of beneficiaries to develop themselves, despite risk factors or the prolonged exposure to stressful situations. Among the protection factors that contribute to resilience, we find: constructive relationships with children of the same age and the presence of loving adults in children's lives. Crisis intervention services are based on activities designed to meet the needs of all students (for example: to discuss the traumatic event in class, to provide them with the opportunity to express themselves emotionally and to activate positive coping strategies). The purpose is to restore the sense of security, and then to resume teaching activities according to the timetable as soon as possible after the crisis situation has occurred. The natural reaction is that students no longer require further services from professionals in the mental health field.

Secondary prevention aims at an early intervention in which, when the crisis response plan is developed, it is important to identify students at risk, in order to implement additional support measures. Pre-existing vulnerability to stress and difficult life situations are risk factors.

Intensive third prevention refers to students with psychological symptoms and requires most of the resources targeting the mental health of the students at school. Third prevention refers to a limited number of students, namely those who have significant emotional and behavioral issues.

The social prevention (Cusson, 2006) has the goal of placing the child in a situation where he/she can acquire the ability to be sociable, conceived as the ability to live in the society. *The prevention by development* intervenes early in order to promote the normal development of students and to discourage any possible temptation to wrong acts

The crisis (Larousse, 2006: 288) represents "a violent rupture of the evolutionary process whose direction is suddenly masked, modified or reversed", and it marks a deep discontinuity. The term also includes the impressions experienced by the person who fails to overcome a conflict, and it represents the acute aspect of ambivalence. The adolescent crisis represents "a typical example of the double meaning, objective and subjective". Some theorists appreciate the crisis as a normal process of development. No matter how "abrupt" a crisis seems, there are successive phases in its overcoming:

1. The installation phase, which is marked by a destabilizing anxiety;
2. The "maximum" phase, also called acme, in which “the global disorder” is present;
3. The liquidation phase, in which the gradual "resolution" of bipolarity is revealed.

A "normal" crisis has "a joint date for all" the individuals of a society. The persistence of ambivalent or regressive conducts constitutes the sign of a disorder, but the opposite situation, the absence of crisis in a given period, can have repercussions that are difficult to overcome.

Ewing (apud Holdevici, 2011a) considers that intervention in a crisis situation is represented by any informed and planned approach, which aims at applying techniques meant to help a person who is in such a stressful and difficult situation, hard to manage. According to the author, the intervention in a crisis situation can be considered a short-term psychotherapy. Caplan (apud Holdevici, 2011b) elaborated the theory of psychological crises, which reveals the fact that human beings continuously face situations that threaten their balance and normal lives, which are usually short-term threats, but they can be managed through problem-solving skills. When faced with the stressor, the person is generally in a tension state that is of reduced intensity, because after previous experiences he/she is confident that he/she can cope well with the situation.

We speak of a crisis when the stress and threat are so great that they cannot be managed by the usual *problem-solving methods*. The crisis refers to the emotional reactions of the person and not to the threatening situation, whereas the way in which the person perceives the crisis situation depends on factors of a psychological and conjunctural nature such as: the

loss or change of the job, the loss of a close relationship, the transition to a new existence stage, such as adolescence.

The precipitating factor of the crisis is presented by the lack of balance between the perceived difficulty, the significance of the threatening situation and the resources available to manage it. The counseling offered by the school social assistants is predominantly psycho-social and differs, according to the time of the request. Thus, we refer to:

1. Counseling in crisis situations, such as counseling children and families in cases such as: the risk of dropping out of school, the consumption of psychoactive substances, suicidal thoughts or ideas, self-injury, refusal to commit suicide, suicide attempts, pregnancy in juvenile mothers, juvenile parenthood, cases of rape, sexual aggression, conflicts in the family, disasters such as floods and earthquakes, the stress of moving out to another house/town, or the divorce of the parents, cases of illness, mourning, bullying, ill-treatment, disability, incarceration; and at the international level, the specialized literature specifies a high vulnerability of the beneficiaries from LGBTQI category;

2. Pre-crisis counseling is offered in case of low school performance, prior to school dropout; this type of counseling could have a preventive character and it is characterized by providing support to students in risk situations and their families, aiming at the school integration of the children;

3. Post-crisis counseling is represented by the counseling that is offered after the resumption of the educational process and that aims at the re-adaptation and the integration of children into school life (for example, the post-crisis counseling for people who followed a rehabilitation treatment, in which it is important to prevent the fall) (Dumitrașcu, 2011).

3. Types of reactions to the psychological crisis situation

There are several *types of reactions to the psychological crisis situation*, such as: suicide, depression, anxiety disorders, mania and aggression. We will detail them in the following pages, one by one.

Suicide (Blumenthal, apud Holdevici, 2011) is the third cause of mortality among 15-year-olds and the fourth among the younger pupils. Substance abuse and violent behaviour are well-founded reasons why students are taken to psychiatric and psychotherapy medical practices. Psychological crises in children and adolescents can be generated by the exposure to violence scenes, which can subsequently generate anti-social behaviors. Problems such as poor school results or behaviour disorders can be based on certain undiagnosed psycho-pathological disorders. The cognitive-behavioral approach has very good results in working with this category of beneficiaries.

The suicide of a student is a traumatic experience for colleagues, relatives, the teaching and auxiliary staff of the school. The role of the School Social Worker is to support the children and adults who stay alive, to deal with the situation, *to prevent the contagion of the suicidal* phenomenon, by avoiding the valorization of the lost person or the suicidal act. Suicide attempts among students are not very frequent, but are suicidal thoughts and ideas are more frequent (Shaffer & all, apud Holdevici, 2011b). During the work with this category of beneficiaries, the technique of direct questions is the most indicated; among the risk factors are other suicide attempts in the past, as well as the presence of relatives or friends who had such attempts.

As for the risk of suicide, the School Social Assistant must have a direct intervention, aiming to calm the student, to notify the adults who are at home and to contact an emergency service specialized in pediatric psychiatry. Ivanof & Riedel (apud Krogsrud, Miley, O'Melia, DuBois, 2006) show that suicide is the main cause of death among people between the ages of 15 and 20. Proctor & Groze (apud Krogsrud, Miley, O'Melia, DuBois, 2006) conducted studies which showed that there is a two to three and a half greater chance of attempting suicide in the

case of LGBTQI youth (data belonging to the US Department of Health and Social Services), a fact generated by the reaction of the society to this category of social assistance beneficiaries.

The School Social Worker must know how to respond effectively to suicide threats, and the first step is to recognize the signs. Sometimes suicidal beneficiaries send direct messages, other times their messages are subtle and require more attention to be found.

Suicide messages (Krogsrud, Miley, O'Melia, DuBois, 2006) can be of 4 types:

1. A direct verbal message:

Example: "I will shoot myself if you leave me alone";

2. An indirect verbal message:

Example: "A life without love is a life without meaning";

3. Direct behavioral message which can be shown by storing medicines, in the case of a person suffering from a chronic disease or serious disability.

4. Indirect behavioral message that can be noted by the sale of the beloved objects, insomnia, the loss of appetite.

Also, previous events such as a series of attempts, or even an attempt of a close person, can signal an increased suicide risk. The suicidal tendencies of the preadolescents may be related to community violence (for example, neighbourhood violence), past abuse, the presence of aggressive thoughts against others or oneself, parental ambivalence and family issues, the lack of social support, as well as the psychological and/or sexual abuse in the past.

Indicators of the presence of suicidal thoughts can also be represented by sudden changes in appetite and sleep-related habits, personal care, the increased consumption of alcohol or drugs, agitation or tardiness, school failure, behaviours that involve risk-taking. Also, concerns about ideas related to death are noted.

The School Social Worker must know the fact that a sudden change in the mood of a depressed person can actually reflect the firmness of the decisions to end one's own life. Also, in the assessment of the suicide risk, a distinction must be made between the facts and the opinions of the beneficiary, having in view that the people who often talk about suicide could go all the way, and, after an unsuccessful attempt, they can try again. The professional who intervenes must talk directly with beneficiaries about the suicide prevention, since direct discussions do not rush to suicidal behaviour, but on the contrary, they can prevent it.

It is a myth that people who attempt suicide either come from wealthy families or have family members who have made this choice. Any person, regardless of their socio-economic status, if "caught in a network of circumstances" could be defeated by suicidal thoughts.

In the intervention itself (Krogsrud, Miley, O'Melia, DuBois, 2006, p. 244), when a client is considering suicide, social workers can ask direct questions, such as:

1. "Are you are thinking of harming yourself? "

2. "Are you telling me you're thinking about killing yourself?"

3. “I heard you mention the possibility of killing yourself. Are you really thinking of that?”

4. “I have noticed some changes in the way you behave, as if you let everything go. What are you trying to do?"

By asking direct questions, the beneficiary in a suicidal risk situation is offered the possibility to discuss their thoughts openly, during which the seriousness of the beneficiary's threats is evaluated, and the most important factor is the existence of a plan. Important elements of the evaluation are related to the method (Is it a relatively slow method?), to the means (Does the person have the necessary means at their disposal, by which to bring their plan to the end?) and to the plan (Is there a specific plan?). If there is a detailed, specific plan, and the chosen methods are at hand and with them, the suicide risk is an increased one. The social worker will immediately involve the support systems, will ask family members and friends to accompany the beneficiary permanently, until the self-destructive thoughts have

disappeared. Practically, the beneficiary is "under surveillance", not left alone, with their own feelings of despair and suicidal thoughts.

The incidence of depression is high among adolescents with suicide attempts, although a small percentage suffer from depression during the attempt. The predictors for the possibility of depressive episodes are cognitive variables such as: self-appraisals with negative content, pessimism and the lack of strategies to adapt to the demands of life. In the prevention and treatment of depressive disorders in adolescents, it is efficient to use techniques specific to the cognitive-behavioral therapy.

Suicide (Blumenthal, apud Holdevici, 2011) is the third cause of mortality among 15-year-olds and the fourth among the younger pupils. The substance abuse and the violent behaviour are the reasons why students are taken to psychiatric and psychotherapy medical practices. Psychological crises in children and adolescents can be generated by the exposure to violent scenes, which can subsequently generate anti-social behaviours. Issues such as poor school results or behaviour disorders can be based on certain undiagnosed psycho-pathological disorders. The cognitive-behavioral approach has very good results in working with this category of beneficiaries, whereas the crisis intervention within pre-university education institutions can have the following stages, principles and therapeutic model:

I. The intervention stages in crisis situations (Cadden & Wolberg, apus Holdevici 2011a) are:

1. Centering (focusing) on the problem;
2. Evaluation;
3. The contract;
4. The actual intervention;
5. Ending the counselling process;
6. Final evaluation.

II. Ewing (1990) outlines the principles of the crisis intervention:

1. The crisis intervention is short-lived and needs to be applied quickly;
2. The crisis intervention targets not only the beneficiary, but also the family and its social support networks;
3. Crisis counselling addresses "a variety of human problems", not just one type of crisis;
4. Crisis counseling focuses on the current issues, especially those that lead the beneficiary to request specialized support, with an emphasis on the factor that triggered the crisis;
5. Working with the beneficiary in a crisis situation is aimed at solving the problematic situation and developing new adaptive coping mechanisms;
6. Counselling in crisis is based on the reality;
7. Counselling in crisis is characterized by the fact that the specialist (the psychological therapist or the social worker) undertakes an active role;
8. Counselling in crisis can prepare the beneficiary for further interventions.

III. The cognitive-behavioral therapeutic model (Mennuti, Christner, Freeman, 2016) as the foundation of short-term intervention in crisis situations, presents the following steps:

1. Establishing the therapeutic relationship;
2. Assessing the physical danger or risk of injury the students are in;
3. Evaluation and mobilization of personal strengths and resources found at the cognitive-behavioral level;
4. Designing a positive action plan;
5. Consolidation of personal commitment to the plan for the development of adaptive (coping) strategies;
6. Evaluation of plan effectiveness.

Students, children and adolescents suffering from conduct disorders show a deficit in problem-solving skills, which triggers aggressive behaviors in physical and verbal terms. Hostility and anger trigger aggressive behaviors. Crisis intervention must target the immediate risk of an aggressive action. Similarly to suicidal risk, direct interviewing about aggressive thoughts or intentions is still the best strategy.

4. Conclusions

The activity of the school social worker is relevant in prevention. Cristina Neamţu justifies the fact that "in all the civilized societies, *the school is a child protection institution"* (Neamţu, C. 2011: 1024), and that the objectives of the social assistance service in the school are: "to prepare the social history and/or the development of students, to carry out *counselling activities, individually or in groups,* with students and their parents, to support the school adjustment of students with issues, both at school and at home or in the community, and to identify school and/or community resources, necessary to achieve the objectives of school education" (Neamţu C. 2003: 836). In social assistance, counselling is "a method of psychosocial intervention *in order to induce change in a client's attitude and situation* (Neamţu, G., 2016: 238). The cognitive-behavioral approach is distinguished by techniques in which the school social worker identifies problematic behaviours, their background, which are based on wrong beliefs, and later, in collaboration with the student, his/her parents and friends, and with the teaching staff, ends up by reducing them, by adapted behaviours, the problems the student faces. "A behavioural counsellor can have multiple roles, depending on the theoretical orientation and the goals of the client. While the client learns, forgets or learns again specific behavioral ways, the counsellor acts as a consultant, a professor, an advisor, a support person, a facilitator" (Gîrleanu, D.T., 2002: 52).

References:

1. Bowlby J. (1982). *Attachment and Loss*, New York.
2. Clark D.A., Beck A.T. (2012). *Terapia cognitivă a tulburărilor de anxietate. Ştiinţa şi practică*. Volumul I şi Volumul II, Cluj Napoca: ASCR.
3. Cusson (2006). *Prevenirea delincvenţei*.
4. DSM-5. *Manual de diagnostic şi clasificare statistica a tulburărilor mintale*.
5. Dumitraşcu H. (2012). (coordonator) *Consiliere în asistenţa socială*, Iasi : Polirom.
6. Dupper D. R. (2003). *School social work : skills and intervention for effective practice*, New Jersey : Hoboken.
7. Ellis A., Tafrate R.C. (2017). *Cum să îţi controlezi furia înainte de a te controla ea pe tine*. Bucharest: TREI.
8. Gîrleanu, D.T. (2002). *Consilierea în Asistenţa Socială*. Universităţii "Alexandru Ioan Cuza" Publishing House: Iaşi
9. Hillman J.L. (2002). *Crisis Intervention and Trauma*. New Approaches to Evidence-Based Practice, *Issues in the Practice of Psychology*, Springer Science Buseness Media, LLC.
10. Holdevici I. (2011a). *Psihoterapii de scurtă durată*. Bucharest: TREI.
11. Holdevici I. (2011b). *Tratat de psihoterapie cognitiv-comportamentală*. Bucharest: TREI.
12. Krogsrud Miley K., O'Melia M., DuBois B. (2006). *Practica Asistenţei Sociale. Abordare participativă*. Iasi: Polirom.
13. *Larousse* (2006). Bucharest: TREI.
14. Levy A.R., Ablon J.S., Kachele H. (2020). *Psihoterapia psihodinamică. Practica bazată pe dovezi empirice*. Bucharest: TREI.
15. Lines D. (2006*). Brief Counselling in Schools*. Working with Young People frim 11 to 18, SAGE Publication, London.
16. Luca C. and Pascaru G. (2017). *Managementul furiei pentru (pre)adolescenţi. Program*

psihoeducativ de grup. Universității "Alexandru Ioan Cuza" Publishing House: Iași
17. Mennuti R. B., Christner R. W. and Freeman A. (2016). *Intervenţii cognitiv – comportamentale în educaţie*, Cluj-Napoca: Asociaţia de ştiinţe cognitive din România.
18. Neamţu C. (2011). Specificul asistenţei sociale în şcoală, in Neamţu G. (coordinator). *Tratat de asistenţă sociala*. Iaşi: Polirom.
19. Openshaw (2008). *Social Work in Schools. Principles and practice*. New York: Guilford Press.
20. Palaghia C. (2021). Identities and crises. The school social worker, a professional of social intervention. *Analele Științifice de Sociologie și Asistență Socială ale Universității "Alexandru Ioan Cuza" din Iași*, Universității "Alexandru Ioan Cuza" Publishing House: Iași
21. Sandoval J. (2013). *Crisis Counseling, Intervention, and Prevention in the Schools*, New York : Routledge.
22. Visu-Petra, G., Buta M and Visu-Petra, L. (2016). *Psihologia copilului în context judiciar*, Cluj Napoca: ASCR
23. Vrasti R. (2012). *Ghid practic pentru intervenția în criză*, Huron Perth Healthcare Alliance
24. *** www.ziare.com
25. ***National Institute For Health and Clinical Excellence.