CHAPTER 13

Planning and Implementing Change-Oriented Strategies

CHAPTER OVERVIEW

Thus far, you have gained the knowledge and skills needed to complete a multidimensional assessment, to develop goals, formulate a contract or treatment plan, and select methods for monitoring and measuring progress. The step beyond this point requires that you plan and select an intervention associated with Phase II of the helping process. The content of this chapter includes a discussion of four change-oriented approaches and micro-level case management, a strategic method involving the coordination of services to address clients' needs. Learning objectives to help you develop the knowledge and skills necessary for planning and implementing an intervention strategy are:

- **Selecting a change strategy to facilitate goal attainment**
- **Understanding the importance of matching the strategy to the problem utilizing person in situation and person in environment framework**
- **Utilizing empirically supported change strategies with individuals, including with diverse groups and minors**
- **Becoming familiar with the major tenets and procedures of four change-oriented strategies and of the functions of case management**

EPAS COMPETENCIES IN THE 13TH CHAPTER

This chapter will give you the information needed to meet the following practice competencies.

2.1.1c Attend to professional roles and boundaries

2.1.1f Use supervision and consultation

2.1.2b Make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics and, if applicable, of the International Federation of Social Workers/ International Associations of Schools of Social Work Ethics in Social Work Statement of Principles

2.1.2d Apply strategies of ethical reasoning skills to arrive at principled decisions

2.1.3b Analyze models of assessment, prevention, intervention, and evaluation

2.1.4b Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups

2.1.4c Recognize and communicate an understanding of the importance of differences in shaping life experiences.

2.1.4d View themselves as learners and engage those with whom they work as key informants.

2.1.6b Use of research evidence to inform practice

2.1.7a Utilize conceptual framework to guide the process of assessment, intervention, and evaluation

2.1.7b Apply knowledge of human behavior in the social environment

2.1.9a Continuously discover, appraise, and attend to changing locales, populations, scientific and technological developments, and emerging societal trends to provide relevant services

2.1.10a Substantively and affectively prepare for action with individuals, families, groups, and communities

2.1.10b Use empathy and other interpersonal skills

2.1.10d Collect, organize, and interpret client data

2.1.10f Develop a mutually agreed-on intervention goals and objectives

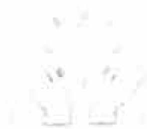
2.1.10g Select appropriate intervention strategies

2.1.10i Implement prevention interventions that enhance client capacities

2.1.10j Help clients solve problems

2.1.10m Critically analyze, monitor, and evaluate interventions

Change-Oriented Approaches



EP 2.1.10a

The change-oriented approaches presented in this chapter may be used in your work with individuals, families, and groups. Their aim is to facilitate the attainment of goals or respond to the mandate in the case of the involuntary client. Each of the approaches is supported by research and uses empirically based techniques or procedures that have demonstrated their effectiveness with clients of various ages, backgrounds, and needs. Each approach is organized around the systematic interpersonal and structural elements of the helping process and follows the distinct phases of engagement, assessment, goal planning, intervention, and termination. They adhere to the principles of social work practice, which emphasize mobilizing individuals and families toward positive action. Each approach encourages collaboration with clients, utilizing their strengths and increasing their self-efficacy, all of which are critical aspects of empowerment.

The approaches are:

- *The Task-centered system*
- *Crisis intervention*
- *Cognitive restructuring*
- *Solution-focused brief treatment*
- *Case management*

The change approaches are process-oriented and problem solving in nature, thus they are well-suited to the helping process discussed thus far. In addition, they are consistent with systematic generalist-eclectic practice as articulated by Coady and Lehmann (2008, p. 5). The elements are as follows:

EP 2.1.7a

- *A person and environment focus that is informed by ecological theory*
- *An emphasis on establishing a positive helping relationship and empowerment as well as a holistic multilevel assessment, including a focus on diversity, oppression, and strengths*
- *A problem-solving model that provides structure and guidelines for work with clients*
- *Flexibility in the use of problem-solving methods that allows a choice among a range of theories and techniques based on their compatibility with each client's situation*

Planning Goal Attainment Strategies

EP 2.1.10g

In planning goal attainment strategies, choose an intervention that makes sense to both you and the client and is also relevant to his or her situation. The operative word is *matching*. That is, in selecting the intervention you should ideally address the following questions (adapted from Cournoyer, 1991):

- *Is the approach appropriate for addressing the problem for work and the service goals?*
- *Is the approach relevant and appropriate to the person, family, or group?*
- *Is the approach compatible with the basic values and ethics of social work?*
- *Does empirical or conceptual evidence support the effectiveness of the approach?*
- *Am I sufficiently knowledgeable and skilled enough in this approach to use with others?*

Is the Approach Appropriate for Addressing the Problem for Work and the Service Goals?

EP 2.1.3b

During the assessment process in Phase I, you gained a picture of the client as a person and his or her problem, situation, strengths, and goals. The method selected to address these, however, requires an understanding of context, circumstances, and the nature of the problem and timing. The essential questions to be answered are, *what is the problem*, and *what are the goals?* To achieve a desired goal, the change strategy must be directed to the problem specified by the client or the mandate, as well as to the systems that are implicated in the problem. For instance, a minor's school truancy problem, will, by necessity, involve his or her family, individuals in the educational system, and perhaps

the juvenile justice systems. Other systems in which family involvement may be advised include health and mental health, correctional systems, and care institutions. The coordination of these various systems relative to the problem and the subsequent goal attainment activities is not a small task. At times, change strategies may require combining micro, mezzo, and macro strategies. Depending on your knowledge and skill level, there may also be instances in which you may appropriately combine techniques or tactics with the change approach that you have selected.

Is the Approach Appropriate to the Person, Family, or Group?

EP 2.1.4c

Individuals, families, and group members can vary in their levels of cognitive, social, and psychological development, gender orientation, and status. Additional factors that should guide your consideration include developmental age and stages and the family life-cycle, the latter of which can become exaggerated as a result of stressful transitions (Carter & McGoldrick, 2005; Halpern & Tramontin, 2007; James, 2008; Spoth, Guyll, Chao, & Molgaard, 2003). With respect to life-cycle and human development, culture and race are requisite factors to be considered. For instance, not all cultural or racial groups mark life-cycle or human development according to the normative Western expectations (Garcia Coll, Akerman & Cicchetti, 2000; Garcia Coll, Lamberty, Jenkins, McAdoo, Crinic, Wasik, & Valesquez Garcia, 1996; Ogbu, 1997, 1994). In considering culture, you should also be aware of the fact that significant differences can exist between cultural subgroups.

When selecting an intervention, the person-in-environment, the relationship to the problem, and the people involved should also be examined.

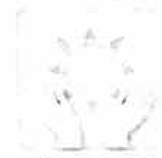
Specific questions to guide your selection decision are:

EP 2.1.3b

- *Does the approach purport to address the nature of the problem? What is the available supporting evidence?*
- *Does the approach acknowledge and allow for the integration of environmental factors as contributing to a problem, for example, the experience of minority or socioeconomic status and oppression, so as not to add a sense of being marginalized?*
- *Are modifications to the approach indicated in order responsive to diverse individuals, families, or minors?*
- *Is the individual, family, or group experiencing a situation or condition that has exceeded their resources and capacity to function and cope?*
- *Is the target of change the individual's thought processes or behavior?*
- *Is the problem for work related to family life-cycle transitions or developmental stages of minors?*
- *Can change be accomplished through the planning and coordination of resources or services to enhance individual or family functioning?*

The proposed questions are by no means exhaustive. Their intent is to prompt you to critically examine the change approaches discussed in this chapter as well as others to which you be exposed to over the course of your learning experience as a student and as a future professional. In some instances, the approach that you use may be determined by your practice setting. In either case, in planning and selecting an approach, you may want to use the opportunity of supervision to clarify or affirm your decision.

Diverse Individuals, Families, and Groups



EP 2.1.3b & 2.1.10g

In addition to the previously proposed questions, two additional questions can also figure prominently as factors that you would want to consider in selecting a change approach with diverse clients:

- *Is the approach flexible enough that it respects and can be adapted to the cultural beliefs, values, and worldview of diverse groups?*
- *Does the approach address the sociopolitical climate as a factor in creating and sustaining the client's problem?*

In considering the first question, Green (1999, pp. 50–51) informs us that "help-seeking behavior" is embedded in a cultural context as well as the experience of minority status. Exploring the client's cultural context to include consideration of gender relations and position in the family and in the community is important. In some ethnic cultural and racial communities, the act of asking for help, whether formally or informally, can be frowned upon. Suspicion of change strategies are well formed in many diverse communities. This dynamic can be so prominent that problems or feelings may be minimized or ignored for fear of being perceived as vulnerable or give the appearance of a cultural anomaly (Sue, 2006; Kung, 2003; Potocky-Tripodi, 2002; Nadler, 1996; Mau & Jepson, 1990).

EP 2.1.7b

In selecting a change strategy, diverse clients might deliberate on the cost-benefit trade-off of seeking help, essentially assessing whether the approach allows them to retain their sense of self and whether it is consistent with or a threat to their values and beliefs. (Williams, 2006; Sue, 2006; Potocky-Tripodi, 2002). As Potocky-Tripodi (2002) explains, immigrants or refugees with little or no prior experience with formal helping systems may perceive a change approach as a threat, especially if their prior experience involved contact with a formal system in which the strategies involved forceful or repressive tactics. Immigrants may also experience tensions with change strategies that require them to move from the familiar to the unfamiliar. For them, central challenges may involve unlearning familiar way of thinking and behaving in such matters as child rearing and discipline, customs such as arranged marriages, and the strangeness of interacting with formal helping systems.

EP 2.1.4d

As a learner, the concepts of discovery and cultural humility can aid you in your work with diverse clients. Green (1999) refers us to the "discovery procedure" in planning interventions with racial or ethnic minority persons. *Discovery* means to solicit clients' views of the problem at hand; the related symbolic, cultural, and social nuances of their concerns; and their ideas about an approach and whether it would remedy their difficulties. *Cultural humility*, encourages placing yourself in a student role. In this role, you are open to the family or individual as a teacher. Together, you and the person involved are partners in understanding and clarifying the relevance of the change effort to their particular problem (Tervalon & Murray Garcia, 1998). The discovery procedure and cultural humility are tools that will help you to understand the client and to ultimately select a change approach that is in harmony with his or her beliefs, values, and religion or spirituality.

EP 2.1.7b

The second question to consider is: Does the approach address the sociopolitical climate as a factor in creating and sustaining the client's problem? Minority and poor families, many of whom are involuntary in their contact with professional helpers, often face insurmountable odds in their everyday lives, some of which are the results of limited resources, pressures to conform to dominant societal norms, marginalized status, inequity, and constrained self-determination. Societal presumptions about people, their competence, or lifestyles are oppressive forces that create toxic environments for persons who are different and which they contend with on a daily basis.

In most instances, overt acts of discrimination and bigotry have diminished as a result of laws, except in the case of gay and lesbian people. Laws, however, cannot command positive interpersonal and social behavior, especially covert interactions. Covert interactions are those subtle acts characterized as microaggressions in which people are treated differently based on their race, ethnicity, sexual orientation, ability, or socioeconomic status (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). In nonminority families, conditions and circumstances that affect cognitive, physical, and psychological functioning would be to be considered extraordinary stressors. Any change strategy, should acknowledge this fact and take into account that given the circumstances of their lives, diverse individuals, families, and groups have strengths and resilience; including the fact that over time, they have coped with adversity (Connolly, 2006; Sousa, Ribeiro & Rodriques, 2006; Guadalupe & Lum, 2005).

What Empirical or Conceptual Evidence Supports the Effectiveness of the Approach?

EP 2.1.6b

An effective intervention approach is one that has the most promise for achieving goals identified by the client or the mandate. In evaluating an approach you are looking for evidence of its effectiveness: with whom did it work, under what circumstances, and what were the results? Furthermore, the evidence should specify the approach's effectiveness with respect to client status, developmental stage, cognitive ability, as well as its compatibility with diverse individuals, their culture, values, and beliefs.

Also, it is important that as you are exposed to novel or emerging strategies that you learn about evidence of their effectiveness. Ethical standards require social workers to use approaches with clients that respect their dignity and rights and that do not cause harm. Untested interventions, as well as those that are coercive, confrontational, or dangerous, should not be employed.

Is the Approach Compatible with Basic Values and Ethics of Social Work?

EP 2.1.2b

Professional social work ethics and values provide a foundation upon which knowledge and skills are used. Two specific

ethical standards are applicable in your decision making related to selecting an intervention approach: safeguarding client's right to self-determination and informed consent.

- *Does the approach safeguard clients' right to self-determination?*

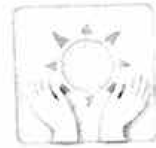
EP 2.1.2b

Promoting self-determination requires that clients are empowered to fully participate in decisions that will resolve their situation. You might ask, *"What if the client has limitations such as in language, cognitive, mental, or physical capacity that can hamper their ability to make decisions?"* While some individuals have limitations and may be unable to make decisions about certain aspects of their lives, their limitations are not the sum total of who they are nor does it mean that they lack the ability to process task-specific information. For example, you may propose a change approach, followed by an explanation: *"If we select this approach to resolve your concern, it would mean that you and I would develop tasks that we believe would best change your situation."*

Fostering self-determination in selecting a change strategy can be a challenge with certain client populations. Some individuals are reluctant to accept the notion of self-determination, believing instead that their lack of knowledge or power and in some case that their marginalized status has destined them to a life of constrained choices. The combination of involuntary and minority status can further fuel this perception. Promoting self-direction can be critical at this stage, beginning with you encouraging the client to participate in his or her case or treatment plan and alerting him or her to the ways to be self-directed. Of course, self-determination is not an unabridged right. For example, in the case of the involuntary client, his or her choice of a treatment approach may be constrained by a mandate. Some individuals will view the mandate as intrusive, in which case his or her emotional or reactive-based judgment limits their capacity to invest in a decision about an approach. Others may simply comply and insist that you tell them what to do so that they can regain control over their life. In either involuntary scenario, the rights of the individuals should be observed without their being unduly subjected to coercion or beneficent authority.

EP 2.1.2d

It is important to acknowledge that the work setting in which you are employed may determine the approach utilized with a specific client population. In highly regulated settings, for example, in correctional facilities, individuals have limited decision making about an intervention approach. In other settings, professionals acting as proxies can presume that an individual or a particular client population lacks the capacity for self-direction and for making decisions. Best interest, in many instances, has become a means to sacrifice self-determination, in which professionals act in a paternalistic manner. Fostering self-determination in such settings may present a challenge for you as a social work professional. Sommers-Flanagan (2007) and Fullerton and Ursano (2005), note that respecting self-determination in crisis situations can become overshadowed by a professional's strong desire to help, so much so that the client's rights and the outcome that he or she is seeking can unintentionally be circumvented. Whatever the circumstances might be, the defining question for which you may need to seek supervision is, what is the justification for a decision that ignores individuals' rights in making decisions about an intervention strategy?



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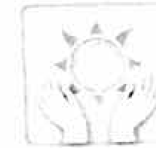
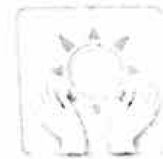
Non-Western Perspective



EP 2.1.4c

The ethical principle of self-determination is taken for granted in Western society. As such, this principle should be examined in a community and sociocultural context. The ideals of autonomy, self-direction, and independence can be values that are in sharp contrast to the beliefs of particular cultures. For instance, the freedom and success of the individual among Muslims is understood in terms of group or community success (Hodge & Nadir, 2008). Indeed, for some cultural groups, family, which can include a spiritual leader, relatives, or an entire community, may have a prominent role in intervention decisions (Palmer & Kaufman, 2003; Hodge 2005). In these situations, the selection process is a simple matter of respecting their decisions.

Self-Determination and Minors



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In selecting an intervention approach with minors, the right to self-determination is complicated. In most states, minors are presumed to have limited decision-making capacity; therefore, parents or legal guardians act as their proxy (Strom-Gottfried, 2008). Developmental stage, reasoning, and cognitive capacity are also significant factors that influence a minor's capacity for decision making and self-direction. Minors who are immigrants may be unfamiliar with the ideals of self-determination

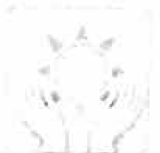
and being asked to make a decision may be outside of the realm of cultural expectations (Congress & Lynn, 1994). Nonetheless, you should not assume that a minor is unable to make choices. In general, most minors are able to express how they feel and what they want. Your task is to provide the opportunity for them to participate in intervention planning, which includes your explaining the benefits and potential risks using words that they understand (Green, Duncan, Barnes, & Oberklaid, 2003; Strom-Gottfried, 2008).

Informed consent is another ethical consideration with regard to choosing an intervention strategy. The following question and guidelines can facilitate the process of gaining consent: *Can the approach and the rationale for its use be explained to clients in a way that they are able to make an informed decision and give or decline consent?*

Informed Consent

EP 2.1.2b

Ensuring that clients understand and consent to an approach is essential to ethical and collaborative practice and is supportive of the principal of self-determination. So that clients are fully informed, you should explain the approach in language that they understand and provide them with information about the benefits and risks. The discussion must also include evidence of the approach's effectiveness with their problem. This same information should be provided to involuntary clients, even though they may lack the freedom to refuse. They can, however, be given information about their options and the consequences of their choices. Following your discussion with individuals in which you have described the appropriateness of a proposed approach to their situation, you should be guided by their responses to the following questions:


EP 2.1.10g

1. *Does the client understand the proposed approach?*
2. *Is the client in agreement with the proposed approach?*
3. *Did the client ask questions, or have reservation?*
4. *Did the client have concerns about the efficacy and effectiveness of intervention, strengths, and limitation related to his or her particular problem?*
5. *Was the client satisfied with the manner in which his or her progress would be monitored and measured?*

Informed Consent and Minors

Similar to self-determination, the ability to give consent is informed by developmental stage, cognitive ability, and reasoning (Strom-Gottfried, 2008). In particular, informed consent presumes that the individuals (for verb agreement) not only understand a proposed approach, but are also competent to weigh potential outcomes. A caveat for minors is that parents or legal guardians are presumed to act in their best interest and therefore they consent to the intervention approach (Berman-Rossi & Rossi, 1990; Strom-Gottfried, 2008). Although minors, for whatever reasons, are unable to give consent, they can, however, be provided with information about the approach and asked whether they assent; that is give an "affirmative agreement" (Strom-Gottfried, 2008, p. 62). Also, as a means to involve the minor, you can select appropriate questions to ask from the previous list. For instance, does the minor have questions or reservations, are they concerned about the efficacy of the approach, and are they are satisfied with how their progress will be monitored and measured?

EP 2.1.2b

Am I Sufficiently Knowledgeable and Skilled Enough in this Approach to Use with Others?

EP 2.1.1c

First and foremost, you are ethically obligated to have the requisite knowledge and skills to use an approach to resolve a particular client problem. The complexities of people's problems often necessitate having knowledge of and the ability to blend different approaches and techniques, and being skillful in how you use them. In many respects, techniques can transcend models. But, an addendum to the question of sufficient knowledge and skills in an approach is, *are you competent enough to make use of techniques of tactics from another approach with the one that you have selected?* For example, the approach that you are using is the task-centered model and it seems advisable to blend the solution-focused miracle or scaling questions to clarify a goal. Coady and Lehmann (2008) refer to this type of blending as *technical eclecticism*. In deciding to blend tactics or techniques, an essential question is whether you have the requisite skills and a level of competence in this form of eclecticism.

In working with minors, you may find that the blending tactics may be advisable. Very young children, for instance, typically lack the cognitive capacity to think abstractly. Therefore, it can be useful if you are skilled in such techniques such as play imagery or

storytelling (Morgan, 2000; Nader & Mello, 2008). School-aged minors, especially those in middle childhood, are influenced by self-evaluation, the evaluation of others, and their own sense of mastery (Hutchison, 2008). Hence the use of tasks consistent with the task-centered or the solution-focused questions can be combined to support and reinforce their sense of self-efficacy.

A word of caution is in order. Eclectic practice does not mean that you select a little bit of this and that from various intervention approaches irrespective of your skill level. Ethically, in the selection of an approach and techniques from another, you must consider if it is right for this client at this time, and further, whether you have the requisite knowledge and skills to implement the approach or technique.

EP 2.1.10g

Selecting an approach or blending techniques requires that you understand the appropriate use and the circumstances in which a particular technique is used. The solution-focused approach, for example, utilizes the strategic miracle question to assist individuals to identify solutions. It is, however, not advisable to use the "miracle question" in and of itself as an intervention. Nor would the miracle question be appropriate in the initial crisis stage, in which a solution would take precedence over attending to the client's emotional state (James, 2008). Similarly, the procedures of cognitive restructuring and crisis intervention are indicated when a certain set of conditions and circumstances exist. Crisis intervention responds to situations in which clients experience an event or situation that exceeds their capacity to function and cope (James, 2008). The focus of cognitive restructuring is an individual's problematic thought patterns, self-statements, and behaviors and in some instances in crisis and trauma situations (Cormier & Nurius, 2003; James, 2008; Smagner & Sullivan, 2005). Even so, a more integrative cognitive approach in which you attend to micro and macro factors that contribute and sustain problematic cognitions can be more effective (Berlin 2001). For example, cognitive procedures may be advisable with a client who is depressed, but you should establish the extent to which his or her depression is influenced by an impoverished physical and social environment in which he or she lives, and thus whether cognitive restructuring as a stand-alone intervention would be appropriate.

In specific circumstances and with specific populations, selecting and utilizing an approach may in fact require that you have knowledge of non-Western traditional healing systems (Al-Krenawi & Graham 2000; Hodge & Nadir, 2008; Sue, 2006). This knowledge can inform you whether adaptations or modifications of an approach are needed.

In general, it is advisable to use only those approaches in which you have the requisite knowledge and skills to implement them in a manner that is appropriate to the client situation and is consistent with ethical practice. In instances where you may lack these skills, you should seek ongoing supervision or consultation or refer the client to a professional with the applicable skills.

EP 2.1.1c & 2.1.1f

Models & Techniques of Practice

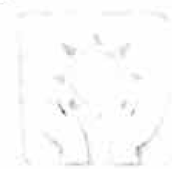
Having provided you with considerations for planning and selecting a change approach, this next section discusses the major tenets and theoretical frameworks of the task-centered model, the basic model of crisis intervention, the cognitive behavioral technique of cognitive restructuring, the solution-focus brief treatment, and case management.[1]

The Task-Centered System

EP 2.1.10a

The task-centered system is a social work practice model developed by William Reid and Laura Epstein. The model's contribution to social work practice is the specific focus on problems of concern identified by the client and its emphasis on tasks and the collaborative responsibilities between the client and the social worker. The model emerged when the prevailing view of the resistant client and open-ended models were the norm in social work and allied disciplines. Kelly (2008), credits the development of the model as strengthening the empirical orientation to social work practice.

Tenets of the Task-Centered Approach



EP 2.1.10a

The direction of the task centered approach with regard to goal attainment is both systematic and efficient. Termination is considered to begin at the initial point of contact, facilitated by specific goals and the completion of tasks. Within a brief time-limited period, the model is aimed toward reducing problems in living.

Central themes of the task-centered approach are that people are capable of solving their own problems and that it is important to work on problems that are identified by the client. Clients' identification of priority concerns and the collaborative relationship are understood to be empowering aspects of the model. The approach addresses an array of problems the including interpersonal conflicts, difficulties in social relations or role performance, reactive emotional distress, inadequate resources, and difficulties with organizations (Ramos & Tolson, 2008; Reid & Epstein, 1972; Reid, 1992; Epstein, 1992).

Theoretical Framework

EP 2.1.7a

Research by Reid and Shyne (1969) informed the development of the task-centered system as an action-oriented model in which problem-solving activities occurred within a limited time frame. Their research demonstrated that brief, focused contact and the conscious use of time limits were as effective as those strategies that required a longer time period and was consistent with other studies that supported the efficacy on time-limited treatment (Hoyt, 2000; Wells & Gianetti, 1990).

The development of the model was further influenced by Studt's (1968) conceptualization of the efficacy of utilizing tasks and the structural procedures of Perlman's (1957) problem-solving model. Similar to the problem-solving model introduced by Perlman (1957), the task-centered model focused social work practice on problems related to challenges in daily living and psychosocial factors that were observed to be common to a majority of social work constituents (Epstein, 1992; Reid, 1992). The use of tasks is supported by Bandura's (1997) research related to self-efficacy; ultimately enhancing the client's sense that through his or her efforts, he or she can be successful agents in solving problems (Reid, 1992).

The task-centered system is designed to be eclectic. Reid (1992), however, stresses selecting research-based theories and interventions. With this in mind, you are able to make use of various theories that are relevant to the client situation (Ramos & Tolson, 2008; Reid, 1992). For example, cognitive restructuring can inform task strategies when feelings, anxieties, and fears are influenced by beliefs or irrational thought patterns (Reid, 1992). Still, Reid cautions that you should first determine that the client's emotional state is consistent with cognitive theory, rather than stressors caused by environmental factors, conditions, or a crisis situation. In addition, the task-centered model allows for the advent of a crisis, in which techniques from the crisis intervention approach may be used.

Empirical Evidence and Uses of the Task-Centered Model

EP 2.1.6b

The task-centered system has been adapted to various settings in which social workers practice and its use has been empirically established with different client populations, including families, organizations, and communities Parihar, 1994; Ramarkrishman, Balgopal, & Pettys, 1994, 2008; Reid & Fortune, 2002; Pomeroy, Rubin, & Walker, 1995; Reid, 1987, 1997a; Tolson, Reid, & Garvin, 1994). Adaptations of the task-centered approach have been tested in most settings where social workers practice, including mental health, health care, and family practice (Alley & Brown, 2002; Epstein & Brown, 2002; Fortune, 1985; Fortune, McCallion & Briar-Larson, 2010; Reid, 1987, 1992, 1997a, 2000). Additional evidence of the model utilization and effectiveness include case management with minors and families, with elderly individuals in long-term care (Lee, Magnanano, & Smith, 2008; Neleppa & Reid, 2000; 2003; Parzaratz, 2000; Tolson, Reid & Garvin 1994), supervision and staff development (Caspi & Reid, 2002), and with groups (Lo, 2005; Pomeroy, Rubin, & Walker, 1995; Garvin, 1987; Larsen & Mitchell, 1980).

Utilization with Minors

Examples of the models application with minors include improving school performance, changing or modifying behavior in residential facilities, and reducing sibling conflict (Bailey-Dempsey & Reid, 1996; Caspi, 2008; Pazaratz, 2000; 2006; Reid & Bailey-Dempsey, 1995; Reid, Epstein, Brown, Tolson, & Rooney, 1980). Using the task-centered model as a guiding framework (R. H. Rooney, 1992; 1981) expanded its application to include social work practice with involuntary clients in child welfare and with minors in a school setting.

Application with Diverse Groups

According to Ramos and Tolson, the task-centered model has been used in agencies in which the client base consists of clients who are from "poor, racial and ethnocultural minority groups" (2008, p. 286). The model is thought to be sensitive to the experience

of diverse individuals and families because of the emphasis on the right of clients to identify concerns, including involuntary clients. The use of tasks is believed to empower clients who are marginalized, lack power, and are oppressed (Ramos & Garvin, 2003; Boyd-Franklin, 1989a). The model also responds to issues characterized by Sue (2006) as barriers to multicultural clinical practice because of its explicit acceptance of the client's view of the problem, a here-and-now action orientation, rather than insightful talking. In their evaluation of various models of practice, Devore and Schlesinger (1999) concluded that the basic principles of the task-centered system are a "major thrust" in ethnically sensitive practice (p. 121). Because the model accommodates different worldviews it has been translated into several languages in different practice settings (Ramos & Tolson, 2008; Rooney & Chou, 2010; Rooney, 2010).

Procedures of the Task-Centered Model

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Figure 13-1 presents an overview of the procedures of the model. The initial phase begins with the client identifying and prioritizing the target problem. It is recommended that priority concerns and goals be limited to a maximum of three. Goals are agreed upon and general and specific tasks are developed to achieve goal attainment. In keeping with the model's action orientation and brevity, termination begins with the first session. Specifically, you and the client agree to work together for a particular number of sessions (e.g., six to eight weeks), although there is an opportunity to extend contact or negotiate a new contract for a different problem. Progress toward the identified goal is monitored in each session as the client moves toward termination.

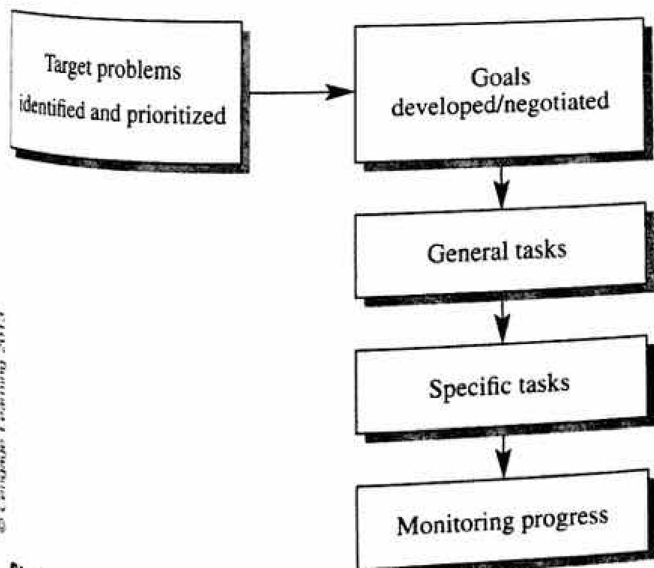

FIG-13-1 Overview of the Task-Centered System

Developing General Tasks

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As illustrated in Figure 13-1, when you and the client have identified a target problem and related goals, you are ready to develop general tasks. General tasks consist of discrete actions to be undertaken by the client and, in some instances, by you the social worker. Each general task has specific tasks that direct the incremental action steps to achieve goals. The case of the Corning family is used to illustrate how goals and the related general and specific tasks are developed. At this point, you will want to review the five video segments on your CourseMate related to the Corning Family. Other case examples in the *Practice Workbook* provide you with opportunities to practice and evaluate your skill in developing general and specific tasks. A brief review of the family's situation is summarized in the following section.

Target Problem

Angela and Irwin Corning, an interracial couple and their three children, are living in a transitional housing facility. Irwin lost his job eight months ago when the county agency where he worked for as a maintenance specialist hired a private contractor to reduce their labor costs. Their preference is to purchase another home, but their financial situation does not permit them to currently own a home. Consequently, the family will need to move into an apartment.

Goals

1. Move from transitional housing facility into an apartment.
2. Find employment for Irwin

The Corning family is faced with two competing needs. They had hoped that Irwin would find employment with a sufficient salary that would give the family the financial resources to move into their own home. He has temporary employment that may lead to a permanent position. Now that he is employed, however, the family is no longer eligible to remain in transitional housing. They have six weeks to move from the facility, thus their priority goal is finding an apartment, preferably one with three bedrooms. Irwin, in the meantime, will continue to look for more permanent employment.

To accomplish their goals the following general and specific tasks, including tasks to be completed by the social worker, were developed:

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General Tasks

1. Meet with the transitional housing case manager to obtain information about affordable three-bedroom apartments.
2. Plan to visit apartments located in the general area where they want to live.
3. Identify schools in the area for the children.
4. Develop a budget.
5. Explore permanent employment for Irwin

General Tasks for the Social Worker

From these examples, it is apparent that general tasks involve actions to be undertaken by one or both of the Corning spouses. General tasks can also require actions of you, either on their behalf or as joint endeavors. In this situation, providing employment resource referrals for Irwin was a general task for the social worker. A general task for Irwin was that he would continue to seek opportunities on his own.

Initially, general tasks may be disconnected and they may not follow a logical sequence. Therefore, they will need to be prioritized by you and the client. For the Cornings, it was important to determine which of the general tasks were most significant. They agreed that moving from the transitional housing facility was a priority.

It is important to settle on tasks for which the benefit is obvious and which have a good chance of being successful. Success with one task encourages clients' confidence in their ability to tackle another task. For example, locating and visiting apartments were tasks that seemed to be more easily completed than was finding a permanent job for Irwin. A benefit that Angela and Irwin identified in selecting the move as a priority goal was their belief that it would provide a more stable environment for their children.

Developing Specific Tasks

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Even general tasks can prove to be overwhelming for some clients. The key to the task-centered system is dividing general tasks into specific tasks that direct the actions that the client or you as the social worker will attempt between one session and the next. Specific tasks related to the goal and previously outlined general tasks are illustrated in the following example.

Goal: The Corning family will move from the transitional housing facility into an apartment within the next six weeks.

General Task: Contact the transitional housing assistance coordinator to obtain information about available and affordable three-bedroom apartments.

Specific Tasks

1. Schedule a meeting with housing coordinator to learn about housing options within the next week.
2. Plan to visit apartments located in the general area where they would like to live.

Specific tasks may need to be further partialized into subtasks. Meeting with the housing coordinator more than likely is a specific one time action step. Visiting apartments, however, may require additional actions or subtasks such as arranging for child care, depending on the time of the visits and transportation.

Notice that both general and specific tasks that Angela and Irwin are to complete are stated in positive term. Positively framed tasks highlight growth and potential gains. As such, people tend to be more enthusiastic and motivated about tasks oriented to progress h and achievement. In contrast, tasks that specify eliminating negative behaviors focus exclusively on what clients must give up. For example, in looking for a job, a negative task might be: In the job search, Irwin will eliminate his thoughts about his job loss.

Partializing goals into general tasks and ultimately into specific tasks can consume a substantial amount of time. The same is true in the preparation for accomplishing one or more specific tasks at a time. When multiple tasks are developed, it is important to focus on and plan implementation of at least one task before concluding a session. In fact, many clients are eager to get started and welcome homework assignments. Note that Angela Corning asked what the couple could do before the next session. While mutually identifying tasks and planning their implementation in each session is time intensive. the time spent from one session to the next can sharpen the focus on action steps that facilitate progress.

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Brainstorming Task Alternatives

Brainstorming is the creative process of mutually focusing efforts on generating a broad range of possible options from which the individual, family, or group may choose. Essential tasks are often

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readily apparent. Further, because clients are experts about their situation, their decisions are invaluable in developing both general and specific tasks. They are usually committed to tasks that they identify on their own. As with goals, if such tasks are feasible and realistic, they should be supported. With some clients, however, if tasks are less readily apparent to them, you can brainstorm with them to identify a range of alternatives.

Brainstorming can be particularly useful with minors to encourage their ownership of possible actions. There may be instances in which you will need to initiate the exploration of the task development process. Most clients will be generally receptive to your suggestions. Reid (2000; 1978) found that there was little difference in the rate with which clients' accomplished tasks suggested by the social worker when compared to those they proposed themselves.

When you suggest tasks during the brainstorming process, however, it is critical to check with the clients to ensure that they agree with and are committed to those tasks. You should be sensitive to nonverbal reactions to your ideas. Commitment and a willingness to engage in tasks are indicators of follow-through by the client (Reid, 1978). In some instances, especially with minors and involuntary clients, you may be tempted to assign tasks. For the most part, individuals of all ages, irrespective of their status, are unlikely to be motivated or receptive to assigned tasks. Assigned tasks, whether in the form of advice or a directive, are less likely to be carried out (Reid, 1997a). Reactance theory suggests that individuals are inclined to act to protect themselves especially when their choices are imposed (Brehm & Brehm, 1981; Miller & Rollnick, 2002). Even voluntary clients may react if they perceive that you have an agenda that is inconsistent with a direction that they wish to take. As a note of caution, when you encounter reactance, it is advisable that you don't confuse a healthy assertion of individuality with an individual's opposition to change.

In using brainstorming with families or groups, you should be attuned to dynamics that will require active facilitation on your part. Group or family members may indeed be able to assist others by suggesting options. The suggestion of tasks, nonetheless, should not circumvent the individual's right to choose which tasks he or she will undertake and, indeed, if he or she will complete any at all.

Task Implementation Sequence

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After agreeing on one or more tasks, the next step is to assist clients to plan and prepare to implement each task. When skillfully executed, this process augments people's motivation for undertaking tasks and substantially enhances the probability of successful outcomes. The task implementation sequence (TIS), as described by Reid (1975; 2000), involves a sequence of discrete steps. These steps (summarized in Table 13-1), encompass the major ingredients generally associated with successful change efforts. The results of research findings suggest that clients were more successful in accomplishing tasks when TIS was implemented than when it was not (Reid, 1975; 2000). Although Reid recommends that the TIS be applied systematically, flexibility is advisable so as to permit adaptation or modification of the sequence that is appropriate to the circumstances of each case.

TABLE-13-1 TASK IMPLEMENTATION SEQUENCE (TIS)

1. Enhance the client's commitment to carry out tasks.
2. Plan the details of carrying out tasks.
3. Analyze and resolve obstacles.
4. Rehearse or practice behavior involved in tasks.
5. Summarize the task plan.

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It would be simplistic to assume that merely agreeing to carry out a task ensures that the individual has the knowledge, resources, courage, interpersonal skills, or emotional readiness to successfully implement a task. Each step in the sequence is intended to increase the potential of a successful outcome. You will notice that the sequence is individualized to the client situation and considers his or her motivation. In addition to maximizing the potential for success, obstacles to task completion are analyzed and resolved in advance, and incentives or rewards for task completion are developed. In the following section, the sequential steps highlighted in Table 13-1 are discussed in greater detail.

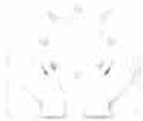
Enhance the Client's Commitment to Carry Out a Task

Step 1 in the sequence is directly aimed at enhancing clients' motivation to carry out a task. This step involves clarifying the relevance of tasks to clients' goals and identifying their potential benefits. To follow through with tasks, it is important that clients perceive that the gains of completing a task outweighs the costs (including anxiety and fear) associated with risking a new behavior or dealing with a changed problem or

situation. Because change is difficult, exploring apprehension, discomfort, and uncertainty is especially critical when clients' motivation to carry out a given task is questionable.

It is advisable to begin implementing Step 1 of the TIS by asking clients to identify benefits they will gain by successfully accomplishing the task. In many instances, the potential gain and benefit of carrying out a task is obvious, and it would be pointless to dwell on this step. For example, for Irwin Corning, the benefit and subsequent gain of completing the task of applying for permanent employment opportunities was evident. Ultimately, the gain of employment was a gain in economic stability for the family.

Rewards and Incentives for Adults. In enhancing clients' motivation to change ingrained behaviors or deal with difficult situations, it is sometimes necessary to create immediate incentives by planning tangible rewards for carrying out planned tasks.



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Rewarding oneself (self-reinforcement) can increase an individual's motivation for completing a task. Rewards and incentives are particularly relevant when a change in behavior or cognition is associated with the choice of pain over pleasure, such as in lieu of self-time, engaging in activities that may be perceived as unattractive (e.g., studying, cleaning house). Possible rewards can be identified with the client; however, to be effective they should be realistically within reach.

Rewards and Incentives for Minors. Rewards can motivate and create incentives for minors to complete tasks, when, like adults, their preference may be to do something else. Incentives and rewards can be particularly advantageous when tasks are related to a behavioral change, such as minimizing rivalry with siblings, being respectful of others, or waiting to be called upon in class. In addition, you can establish complementary tasks as rewards with parents or other significant persons in their lives. The intent of rewards is to help the minor to complete tasks related to a goal, preferably with their input.

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When you use incentives or rewards, it is important to observe incremental change, followed by an immediate reward; otherwise they may become discouraged or give up, believing they cannot meet expectations.

The following are guidelines intended to aid in setting up tasks with accompanying incentives or rewards for minors.

- *Frame tasks so that they understand explicitly what they are to do and when they are to do it. Specify the time frame and the conditions under which the task is to be performed (e.g., every 2 hours, twice daily, each Wednesday, once an hour for the next 4 days).*
- *Designate what can be earned for exhibiting the task, and establish a method for tracking in conjunction with the minor.*
- *Invite minors to choose the type of reward they wish to earn because they will choose rewards that have maximal value as incentives.*
- *Establish rewards for specified periods of time (e.g., if the child raises his or her hand for 4 of the 5 days in a week's class, he or she will be able to read a story or earn points toward something he or she values). Whenever possible, it is important to offer relationship rewards, rather than monetary or material items. Relationship rewards involve things such as going to the mall or spending time with friends or other significant individuals.*
- *Provide a bonus for consistent achievements of tasks over an extended period of time.*
- *Encourage task completion by providing consistent and positive feedback; for young minors, using visual indicators that mark progress on tasks as motivators.*

Plan the Details of Carrying Out Tasks

This step, the second one in the sequence, is vital in assisting individuals to prepare themselves for all of the actions inherent in a task. Most tasks consist of a series of actions to be carried out sequentially, and they may involve both cognitive and behavioral subtasks. For example, before carrying out an overt action, it may be beneficial to help a client prepare psychologically. To illustrate, in one of the sessions Irwin talked about himself as a low-skilled laborer, which he believed meant that he had few opportunities. Preparation for engaging in and completing tasks related to his job search could involve a review of potential benefits, addressing and resolving his fears by realistically appraising his situation. For some individuals, you may coach them to reflect on past successes or focus on their spirituality or faith. By including cognitive strategies in this step, you are assisting clients to cope with their ambivalence or apprehension over implementing actions.

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Planning overt actions requires considering the real-life details. For example, the Corning couple discussed whether or not to take their children with them while they looked for an apartment. If they were to schedule visits early in the day, the two older children would be at school. In the evenings, unless they had child care, all three children would go along on the visits, which might be difficult as they relied on public transportation. In addition, they would need bus fare for themselves and the older children. During the discussion, Angela advised that her sister was available for child care if needed. Discussing the details associated with completing tasks, and planning for the inevitable in advance, effectively increases the opportunity for the couple to be successful. In planning and discussing discrete actions with them, you are able to observe cues about their misgivings, fears, or lack of skills or resources, each of which can be addressed.

The Practitioner's Role in Task Planning.

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Task planning can involve certain tasks to be carried out by the practitioner; however, these tasks are coordinated with those of the client. Clients may also wonder about your role in task planning. Angela Corning, for example, asked the social worker, "What kinds of things can you do for us? I'm not clear about how you can help us." In planning the details of tasks, a practitioner's tasks can be developed when he or she has ready access to resources or information that will facilitate client work. In the Corning case, Ali agreed to obtain information about financial assistance for families moving from transitional housing. On the other hand, if a client would benefit from eventually completing a task on his or her own, you and the individual could walk through the steps together. In some cases, during the performance of a task, it can be beneficial for you to accompany the client or you might tap into his or her support system. For instance, if the task involved applying for financial assistance, which for some people can be intimidating, supporting task performance can involve assisting an individual with completing the application or having someone to talk to while waiting to be interviewed.

Conditions for Tasks Completion.

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Why specify the conditions and time for implementing tasks in such detail? Timing is an important condition for completing tasks. When a time frame lacks specificity or is vague or abstract, clients (and social workers) can procrastinate, leaving little time to effectively implement the requisite actions. Here you might think of a group project assignment in which the members of the group agree to meet within the next week. Without solidifying when and where the meeting is to take place, each individual can have a different idea about what next week means. Planning also involves specifying the conditions under which each task will be carried out. For example, a sixth-grade student who constantly disturbs his peers, speaks out in class without raising his hand, and irritates his teacher through boisterous teasing behavior may accept the following task: he needs to listen attentively when the teacher is speaking during the 1-hour math class and raise his hand three times to answer questions during that time. He agrees to carry out this task each day for the next 5 days. Although he exhibits the problematic behavior in other classes, the math class and specific time frame are the conditions in which the behavioral tasks are to occur. While the ongoing goal is the eventual change his behavior in all classes, a focus on behavior in the math class further partializes the change effort as it would be unrealistic to expect a drastic and immediate new behavior.

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In selecting and planning tasks pertaining to *ongoing* goals, you should observe an additional caution. Because progress on such goals is incremental, it is vital to begin with a task that is within the individual's capacity to achieve. In the classroom situation, for example, a task for the student to raise his hand for 5 straight days may be difficult for him to achieve. However, a task of raising his hand in math class for 2 out of 5 days may, with positive feedback from the teacher, have a greater likelihood of accomplishment. Being successful in completing this task, his chances of later gradually improved task performance, specifically raising his hand 3 or 4 days, has the capacity for greater success. Conversely, if he experienced failure on the initial task, his confidence and courage may decline, making him reluctant to work toward changing his classroom behavior. Thus, with ongoing tasks it is preferable to have the first task structured so that it is easily obtainable.

Analyze and Resolve Barriers and Obstacles

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Based on recognition of the inevitability of barriers that impede change, this step is aimed at acknowledging and addressing these forces. When implementing Step 3, you and the client deliberately anticipate

and subsequently analyze obstacles that have the potential to influence task accomplishment. Using the classroom situation as an illustrative example, in developing a task related to changing the student's boisterous behavior, it would be useful to explore potential obstacles, such as social, physical, or psychological barriers. For this student, his behavior has been reinforced by the attention he received from his peers, which he values, and it also ensured his social standing in the group.

For Irwin Corning, making a telephone call to inquire about available jobs or looking online for job postings seem to be relatively simple tasks. Nonetheless, the social worker should inquire about whether or not he had the resources for completing these tasks. To this point, Eamon & Zhang (2006) found that practitioners often overlooked economic resources as a barrier to completing tasks. A caveat should be observed, however: A simple action for some people, such as making a phone call, may prove difficult for others depending on their level of confidence, cognitive capacity, or social ability. In addition, fears and cognitions can pose formidable barriers to accomplishing a task and require careful exploration so that they do not impede progress. For example, although Irwin was eager to find employment, his confidence was hampered by the experience of "being laid off" and the fact that he perceived himself as a failure based on his belief that "a man ought to provide for his family."

When tasks are complex, obstacles likewise tend to be complex and difficult to identify and resolve. Tasks that involve changes in patterns of interpersonal relationships tend to be multifaceted, encompassing subsidiary but prerequisite intrapersonal tasks as well as a mastery of certain interpersonal skills. The psychological and social content inherent in the sixth grader resisting the impulse to engage in boisterous behavior involved his fear of being rejected by his reference peer group. Change for him involved not only mastering certain new behaviors, it also meant changing his patterned behavior of relating in the classroom environment in a manner that was less likely to be valued by his peers.

Resolving Barriers and Obstacles. People will vary in their capacity to resolve obstacles. They may overlook or underestimate the obstacles and barriers that can delay or cause needless difficulties in the accomplishment of tasks and lead to outright failure. With continuous engagement and collaboration, however, you can help them to identify and subsequently resolve possible obstacles to a planned course of action. Returning to the sixth grader as an example, it would be important to encourage his sense of self-efficacy by explaining that obstacles are common. Together, the two of you would brainstorm different *what if* scenarios that could hamper his ability to raise his hand before speaking in class. Otherwise, he can become frustrated and revert to the comfort of his old patterned behavior. What if he raised his hand and the teacher did not call on him? What would he do if he was eager to answer a question, but another student was quicker in responding? What if he became discouraged? In reviewing different scenarios with him, potential obstacles are identified and his possible responses are clarified in advance. For, example, "I would wait my turn," or "I could keep my hand up, even if the teacher called on another student first," or "If I felt discouraged, I might talk to the teacher after class." Equipping him with possible responses, in effect, maximizes his motivation to sustain his efforts to continually engage in tasks related to his targeted behavior.

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Psychological barriers to task performance are often encountered regardless of the nature of the task. Think of your cognitive appraisal of a situation in which you experienced intense emotions. For example, when you applied for a job, had to appear in court, or expressed your feelings. What about this experience was intimidating? Did your cognitive appraisal of the situation affect the quality and intensity of your emotions, which determined your perceptions and attributions or meaning associated with that situation?

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Whether real or perceived, beliefs about self or stereotypic perceptions of others can represent major obstacles to task completion. Recall that Irwin Corning, as he talked about his job loss, appeared to be preoccupied with personal struggles, the meaning the loss of income had for the family, and his belief about his responsibility as the head of the household. At one point he asserted, "Nothing is comfortable about this situation."

In examining the cognitive content of his message, there appears to be several layers. Understandably, he is experiencing intense emotions as a displaced, replaced worker, in which there is his realistic appraisal the economic climate, as well as his beliefs about employment opportunities as an African American male. At the same time, his notion that the company's preference for hiring individuals who are illegal as the cause of his becoming unemployed lacks concrete evidence. *What can you do when you encounter situations in*

which cognitions and intense emotions have the potential to derail an individual's plan of action? To begin, you and the individual can develop a subsidiary task of neutralizing his or her emotions. This can be accomplished (often in a brief amount of time) by eliciting, clarifying, and empathizing with the individual's apprehension and rationally analyzing his or her feelings. It may also be important that you examine their problematic emotions by helping them to identify their cognitive sources and assist them to align his or her thoughts and feelings with reality. In general, time and effort invested in overcoming and resolving barriers and obstacles are likely to pay dividends, the results of which are a higher rate of success of accomplishing tasks. Consider the economy of this process, as failure to complete tasks can have an affect on an individual's sense of self-efficacy, and it can extend the time required for successful problem solving.

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Assessing Clients' Readiness to Begin Tasks

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Just as identifying and resolving barriers to task performance is critical, so is assessing clients' readiness to engage in mutually agreed upon tasks. You should be alert to nonverbal behaviors as potential obstacles or as possible indicators of their apprehension about undertaking a task. When you detect such reactions, you should further explore the presence of this nonverbal barrier. You will have seen in the Corning family videos that initially Irwin seemed uncomfortable, at times he seemed annoyed, and he had very little to say unless prompted by Angela or in response to questions asked by the practitioner. He, however, became animated when Ali asked about his willingness to develop goal-related tasks stating, "I am ready to do something, instead of sitting here talking, I could be out looking for a job or a place for my family to live. So, let's get on with it."

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People's readiness for implementing tasks can be gauged by asking them to rate their readiness using a scale from 1 to 10, where 1 represents a lack of readiness and 10 indicates that the client is ready to go (DeJong & Berg, 2001). With individuals like Irwin Corning, you can easily judge a readiness level of perhaps 8–10. Conversely, if he had been less eager and indicated his readiness on the low end of the scale, for example, in the 1–3 range, his rationale should be explored. When individuals are hesitant to begin, exploring their reasons for a low rating can uncover vital information concerning potential obstacles to be discussed. Even when clients have indicated that they are prepared to move ahead, they can still experience a certain amount of tension and anxiety. It is neither realistic nor desirable to expect people to be altogether comfortable with tasks, despite the fact that they were involved in their development. Note that although Irwin indicated that he was ready to go, in the course of the discussion, he was nonetheless apprehensive about his job search. Had his apprehension involved an inordinate level of anxiety, his feelings would need to be explored, as a high level of anxiety can be a major deterrent to further action.

Rehearse or Practice Behaviors Involved in Tasks

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Certain tasks involve skills that people lack or behaviors with which they have had little or no experience. Step 4 of the TIS is aimed at assisting clients to gain the experience and mastery in performing skills or behaviors essential to task accomplishment. Bandura (1977) builds a strong case for mastery based on the results of research. Specifically, he asserts that the degree of an individual's positive expectation in his or her ability to perform will, in effect, determine how much effort they will expend and how long they will persist in the face of obstacles or aversive circumstances. It follows, then, that a major goal of the helping process is to enhance clients' sense of self-efficacy, which can be accrued through successful task completion. Successful experience, even in simulated situations, fosters the individual belief that he or she has the ability to be successful in performing a task.

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Supportive research cited by Bandura (1977) indicates that, once established, self-efficacy and skills tend to be transferred by individuals to other situations, including those which they had previously avoided. According to Bandura, people receive information about self-efficacy from four sources:

- *Performance accomplishments*: Major methods of increasing self-efficacy through performance accomplishment include assisting people to master essential behaviors through modeling, behavior rehearsal, and guided practice (discussed later in this chapter). An example of performance accomplishment would be assisting the sixth grader to master specific communication skills during an actual session.

- *Vicarious experience*: Insight may be gained by observing others demonstrate target behaviors or perform threatening activities without experiencing adverse consequences. Efficacy expectations can be bolstered by a client observing you, the social worker, or others who model the desired behaviors. Observing others, however, is clearly not as powerful as the sense of self-efficacy that results from the individual successfully performing a behavior or demonstrating a skill on their own.
- *Verbal persuasion*: Talking to individuals about their capacity to perform can raise outcome expectations, and can be persuasive. But talking to a person about expectations or attempting to persuade them about their competence does not in fact enhance self efficacy. To be effective, the appraisal of an individual's capabilities has to be based on his or her perceptions and assumptions about competence and their sense of self-efficacy.
- *Emotional arousal*: Self-efficacy can be influenced by emotions, which in turn affects how people perform. Individuals who are extremely anxious or fearful about performing a new behavior are unlikely to have sufficient confidence that they can competently perform. Verbal persuasion directed toward reducing anxieties or fears is generally ineffective. Emotional arousal obviously is an undependable source of self-efficacy because it can influence actual evidence of an individual's capacity. Indeed, perceived self-competence tends to reduce emotional arousal rather than the converse.

Of these four sources, *performance accomplishment* is thought to be the most influential because it is based on an individual's personal mastery experience.

Increasing Self-Efficacy through Behavioral Rehearsal, Modeling, and Role-Play. Having reviewed informative aspects about sources of mastery and of self-efficacy, behavioral rehearsal can be an important step in enhancing performance. Used in an actual session, behavioral rehearsal is intended to reduce anxieties and to assist individuals to practice new coping patterns under your guidance. Indications for using this technique include situations when a client feels threatened, inadequately prepared to confront a situation, or when he or she is anxious or feel overwhelmed by the prospects of carrying out a given task. Through role-play, the individual can practice the skills or behaviors in a simulation that involves his or her anticipated response to a given situation.

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Role-playing is the most common form of behavioral rehearsal. It allows an individual to rehearse desired behaviors or outcomes and encourages mastery. In a simulated situation, you and the individual can build on their existing skills, as well as assess potential barriers or obstacles. Modeling behavior through role-play, in effect, allows the individual to vicariously learn an expected behavior before actually having to do so in a real-life difficult situation.

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This use of the role-play technique to enhance performance accomplishment is illustrated in the video segment featuring Yanping.

VIDEO CASE EXAMPLE

Yanping, a graduate student from China, has decided to change her major from business to history. In the course of her studies, she discovered that history was her true passion. Her parents have expressed their displeasure with her decision to change her course of study. They questioned the value of a degree in history, which they consider to have low status with limited financial rewards. The parents own a business and had expected that Yanping would return home prepared to eventually take over the family business. She understands her parent's belief that a history degree has little value to the family. She is experiencing a high level of anxiety as a result of her parent's disappointment and the fact that she has caused them distress by not honoring her family obligation. During the course of several phone calls, Yanping has been unable to persuade her parents to accept her decision about changing her course of study from business to history. She anticipates that they will continue to resist. As the time for her to return home draws nearer, she has become increasingly anxious about having further conversations with her parents.

In the first segment of the video, observe that Kim, the social worker, attempted to understand the cultural meaning and implications of Yanping's decision, her parent's reaction, as well her prior coping efforts. Kim also inquired whether she has talked with or observed others in a similar situation (*vicarious experience*). Together, they brainstormed options regarding possible

ways that she could approach a conversation with her parents. This case is difficult for Kim as a social worker practitioner who is versed in the individual autonomy norms of Western society and the guiding principle of self-determination. Kim did not feel that she was able to be sufficiently sensitive to the difficulties and serious consequences that Yanping would encounter if she broke with her cultural traditions. Thus, she referred Yanping to Jilan, a colleague from China. Kim believed Jilan's familiarity with the culture would aid Yanping to navigate the cultural expectations and resolve her dilemma. The fact that she was able to refer Yanping to Jilan was fortuitous, as a referral for reasons related to culture, and perhaps any reason, may not always be an option. In the video session that takes place with Jilan and Yanping, they use role-play to simulate a conversation with Yanping's father in preparation for her eventual face-to-face encounter (*behavioral rehearsal*). As the two take a turn, either as Yanping or her father, Yanping had the opportunity to rehearse responses to anticipated questions from her father and also to observe Jilan as she modeled behavioral responses for Yanping to consider (*behavioral modeling*). Note that during the exchanges, Yanping appeared to be less anxious and more willing to approach her father. In fact, during the course of the roe-play, a new idea occurred to her; she would also study business history which she believed would appeal to her father as advantageous to the family business.

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Behavioral rehearsal need not be restricted to a session with you and a client. It and can include overt behavior like making a phone call, covert behavior like self-talk, or it can include expressing aloud defeating feelings or thoughts. These defeating feelings and thoughts can then be restructured into more encouraging language. It is often productive for clients to rehearse on their own by pretending to be involved in real-life encounters.

Modeling and behavioral rehearsal can also be integrated into family or group sessions in which members can model effective and realistic responses or coping for each other as they contemplate engaging in a particular task. As a rule of thumb, in implementing family or group role-plays, the intent is to tap into members' resources in a help-giving role.

If modeling or rehearsal proves to be ineffective, in the interim, you can help clients to develop coping efforts rather than achieve mastery. Coping emphasizes the struggles that a person might expect to experience in completing the task behavior or activity. Emphasizing coping rather than mastery is intended to lessen anxiety and, hence, the threat of having to perform without making a mistake.

Guided Practice Closely related to behavioral rehearsal, guided practice is another technique to aid task accomplishment. It differs from behavioral rehearsal in that it consists of in vivo rather than a simulated situation. It involves you observing the client as he or she engages in a task related to a target behavior. Afterwards, you provide immediate feedback and also coach him or her as they attempt to gain mastery toward task completion. For example, in a family session, as you observe problematic behaviors or interactions first hand, you would provide feedback and coach members to master problem-solving or conflict-resolution skills. Such an on-the-spot intervention enables you to clarify what is occurring as well as coach clients in engaging in more productive behavior.

EP 2.1.10i

Summarize the Task Plan

Summarizing the task plan is the final step of the Task Implementation Sequence. The summary, which takes place at the conclusion of a session, consists of a review of the actions or behaviors that an individual has agreed to engage in order to accomplish a task. In reviewing task agreements, you and the client confirm that you both have a clear understanding of what tasks are to be undertaken, in what sequence, and under what conditions or whether clarification is needed. Confirmation of the plan might proceed with you describing the tasks that your client will complete:

EP 2.1.10f

"I have agreed to contact the employment information specialist by our meeting next week."

In follow-up, you would ask the individual to review and summarize his or her plans:

"What are your plans for searching for a job by our next session?"

Individual clients may find it beneficial for you to provide them with a session by session written summary of goals and related tasks. You might also encourage clients to write their own summary as well. In either case, both you and the client should have copies. In keeping with the ethical obligation of documentation, this information is included in the case record or SOAP notes. Furthermore, documentation is essential to monitoring and evaluating during the duration and termination of the contact.

Failure to Complete Tasks

In actual practice, progress may not be as smooth as you and the client would prefer, despite the fact that barriers or obstacles have been anticipated and resolve, the individual is ready to begin, and all other possible impediments have been addressed. In the best scenarios, focus and continuity can be derailed for a variety of reasons, which are summarized in Figure 13-2. The reasons for low task performance are classified into two categories: *Reasons related to specific tasks; and, Reasons related to the target problem.*

EP 2.1.10m

Performance Problems Related to the Task

Occasionally, unforeseen circumstances or unanticipated obstacles may influence an individual's ability to complete a task between sessions. When this happens, the obstacles that blocked the task completion should be identified and resolved. By mutual agreement, tasks can be continued to the next session. The caveat, of course, is that both you and the client are in agreement that the task remains valid. If this is not the case, it is important to shift the focus to more relevant tasks.

Occurrence of a Crisis. There are instances in which certain situations may dictate taking a brief detour because of the occurrence of an event or situation. As a result, an individual's momentum may be slowed down and he or she may become unable to complete a task. Should this prove to be the case, it is appropriate for you to empathetically respond to the emotional state of the individual. It may also be necessary to focus on the more urgent difficulty and to develop a goal and tasks related to the unexpected situation. If possible, an agreement should be reached about the timing for resuming work on tasks that were designated for completion prior to the crisis. If in the course of your work with the individual you observe that his or her life appears to reverberate from crisis to crisis, the two of you can discuss whether or not it would be beneficial to remain focused on the initial tasks and see them through to completion.

Lack of Commitment. A lack of commitment has been documented as a statistically significant predictor of whether a client will engage in task performance (Reid, 1977; 1997a; 2000). However, a lack of commitment should not be confused with a lack of readiness. In the former, the willingness to change is absent. In the latter, the individual is willing, but is blocked from acting by other barriers. One frequent cause for a lack of commitment to undertake tasks is a covert unwillingness to own one's part of a problem. "I would raise my hand if the teacher called on me," is an example of paying lip service to carrying out a task. Unwilling individuals may use excuses to blame others for their behavior and instead they passively wait for others to initiate corrective actions. The technique of ethical confrontation (see Chapter 17) can be used to help clients recognize their responsibility for maintaining the undesirable status quo.

Unspecified or Vaguely Specified Tasks. The final step of the Task Implementation Sequence (summarizing), provides an opportunity for you and the client to clarify and reaffirm tasks. Even so, there can be occasions when, in spite of a review, an individual may end a session without fully understanding what he or she has agreed to do. As is the case of developing goals, tasks should be specific, stated in positive terms, and clearly stated as to what is to be done within a specified time frame.

Adverse Beliefs. An individual may agree to a task however he or she may not fully disclose information about their values or beliefs. For example, a parent who believes that children are to obey is likely to be hesitant to utilize reward systems, believing that parents should not bargain with their children. Respecting and honoring different beliefs is important. Thus, having listened to their reasoning, you and the parents would renegotiate a task in line with their beliefs, based on the information that they provided. In practice with families or couples, beliefs about the behavior or motives of another person can influence completing or even engaging in a task. As a solution, you might develop

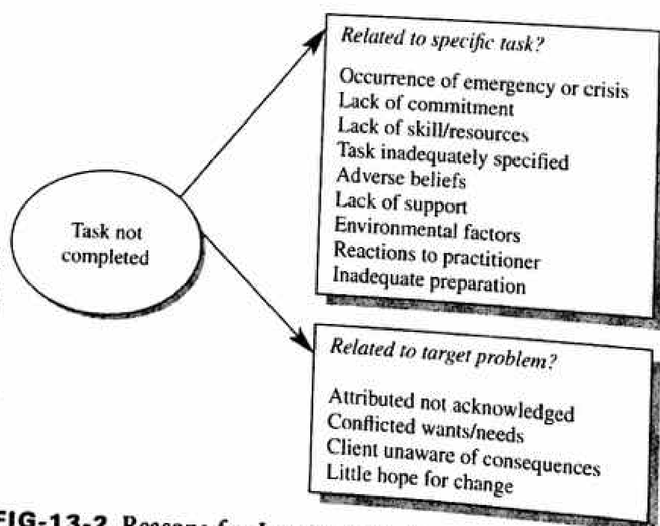

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FIG-13-2 Reasons for Low Task Performance

a contract that states that all involved will strictly monitor his or her own task performance regardless of whether the other person does or does not.

Lack of Support. When a problem involves others or another system, the relevant individuals should be involved in supporting task accomplishment. For example, the teacher of the sixth grader should be encouraged to call on him when he raises his hand or give him an indication that she will do so in time. Support for completing tasks can also be related to family or environmental factors. For example, finding a subsidized apartment can be dependent on the availability of such housing. These are difficult situations, in which a ready solution may not be apparent, and you and the client may need to explore interim options. It can also be useful for you and the client to look for others in his or her network to provide support.

Negative Reactions to the Social Worker. Negative reactions to the social worker, both verbal and nonverbal can affect an individual's ability to complete tasks. Reactions can result from, for example, the social worker's arbitrary assignment of certain tasks. People are unlikely to be invested in taking an action on a task in which they have not been involved in creating. The following statement from a client highlights the way in which a social worker's lack of accountability and reliability can hamper a client's progress: "She keeps telling me that she is going to make a referral to the child care resource center, but week after week, she tells me that she was just too busy." Without the social worker completing her task on behalf of the client, the client was unable to complete her work. Furthermore, the client in this situation observed that the social worker was often late, seemed to be disorganized, unprepared, and distracted, leading her to believe that her case was unimportant. The message is clear, specifically, honor your commitments, be prepared and organized, be on time, and show that you care. Of course, these are the same expectations that we have of the people with whom we work.

Inadequate Preparation. In developing tasks, the skills, behavior, or time needed for the successful completion of specific tasks may have been overestimated or underestimated. Actually, it is better for clients to not attempt a task than for them to make an attempt and fail because they are unprepared. If the issue is related to timing, the time frame for completing a task can be extended. Should a skill be the issue, for example, communicating with a landlord, you can coach the individual by using behavioral rehearsal or modeling to increase his or her confidence.

Performance Problems Related to the Target Problem

Attributed, Not Acknowledged Problems. Low task performance is most likely to occur when clients are mandated (involuntary) or coerced (nonvoluntary) to implement a certain change. The reasoning for his or her reluctance may be attributed to their beliefs about what constituted a problem: "I don't have a drug problem. Sometimes I do a little meth [methamphetamine] with my buds [buddies], but that don't mean that I'm a drug head." Furthermore, when problems are attributed to an individual by someone else, he or she tends to be less committed to their resolution. In these instances, you can begin by acknowledging this fact, and respecting their reactions, and exploring incentives that might encourage them to complete tasks. Persistent inaction certainly speaks louder than words and the benefits of continuing to work with the individual should be carefully weighed.

Lack of Understanding of Consequences. An individual's failure to perform a related target problem task may stem from a lack of understanding about the consequences of his or her failure. For example, the consequences of failing to complete a chemical dependency treatment program and providing clean urinalysis samples should be explained.

Conflicting Needs and Wants. Certainly, what can initially appear to be a lack of commitment may actually be that an individual is faced with a competing and more pressing concern. The initial task remains important, however another issue, either new or existing, demands his or her attention. The situation need not be a crisis. It may simply mean that even though a client had prioritized a goal and developed a related task, there are other issues competing for his or her attention. Flexibility in these instances is called for, as the individual is unlikely to be able to focus until the competing concern is resolved.

Little Hope for Change. In spite of the fact that an individual has agreed to undertake a certain task, he or she may feel that completing the task may have little or no impact on the situation. This is an opportunity for you to help the client build on his or her strengths by calling attention to past successes. For instance, "I understand that you are feeling some anxiety about getting a job, and I can't guarantee that you will. But,

remember how you felt about talking to the housing authority about rental assistance. You were able to do so, and you obtained a housing voucher." Crediting an individual with past successes is particularly useful to boost confidence when their perception of their ability to affect change is uncertain.

Even when preparation has been adequate and potential obstacles and barriers have been reviewed, the successful outcomes of task efforts are not guaranteed. The preceding discussion highlights valid reasons for low task performance. The intended message of this discussion is simple: A majority of the people with whom you work want relief from their difficulties and are motivated to take action. Nonetheless, their ability to do so can be hampered by their beliefs and other factors. To avoid or minimize the potential of them becoming discouraged, you should not interpret low task performance as a failure, but rather as an indication of the need for additional task planning. Another equally important factor is your use of empathy and your relationship with them to enhance their forward momentum.

Monitoring Progress

EP 2.1.10m

In the task-centered model, tasks are the instrumental action steps taken by the client and in some instances the practitioner. They are intended to alter or remediate the target concern and achieve the desired outcome. The continuous review of tasks maintains continuity and focus and monitors progress.

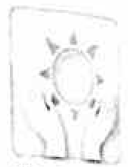
The following list of procedures outlines the systematic review of progress specific to the task-centered approach.

1. Once tasks have been identified and agreed upon, time in each session is devoted to a review of progress. In this process, both client and social worker are able to document which tasks have been completed and the extent to which the target problem has changed.
2. During the review process, if tasks have not been completed or have not had the intended effect on the target problem, barriers and obstacles and the reasons for low task performance are explored. When necessary, tasks are renegotiated or new tasks developed.

In reviewing task accomplishments, it is critical to discuss with the client the details about the conditions, actions, or behaviors that assisted them in achieving a task. Even when tasks have been only partially completed, it is important to connect the results they have achieved to their efforts. In doing so, you are highlighting and reinforcing their strengths and sense of competence.

In general, the systematic in-session review of progress provides immediate feedback of gains as well as alerting you and the individual as to whether adjustments need to be made. Afterwards, you and the individual move forward by mutually planning other tasks that will facilitate progress, albeit, incremental in some instances, toward the final goal. Ultimately, the completion of tasks related to the target concern is an indicator of progress toward goal attainment and the eventual move toward termination.

Strengths and Limitations



EP 2.1.10a

The task-centered system is the first empirically based social work model of a planned, short-term, problem-solving approach based on the principles and values of the profession (Kelly, 2008; Reid & Epstein, 1972). Conceptualized into three distinct phases, the approach begins with an identified target problem of importance to the client. In instances where an individual has multiple concerns, he or she is asked to rank them in priority. The selection of goals and the implementation of related tasks represent the second phase. In this phase, tasks are identified as the instrumental action steps to affect the target problem and to eventually achieve the desired goal. As tasks are developed and implemented, both the client and the social worker continually review progress to maintain focus and ensure continuity. The third and final stage involves reviewing and monitoring progress and termination of the contact.

With more than 30 years of practice, research, and further development, the efficacy of the model has been supported by empirical evidence. The results of the research has shown the model to be effective with interpersonal and family problems, emotional distress, drug use, mental health and health-related concerns, transitions, inadequate resources, minors, and involuntary clients (Ramos & Tolson, 2008; Reid, 1992; Tolson, Reid & Garvin, 1994). The model's effectiveness has been demonstrated with diverse populations and situations in worldwide practice settings (Ramos & Garvin, 2003; Ramos & Tolson, 2008; Reid, 2000, 1996, 1997). The emphasis on taking action on problems acknowledged by clients is believed to be appealing to racial and ethnic

minorities (Boyd-Franklin, 1989a; Devore & Schlesinger, 1999; Lum, 2004; Sue, 2006). Key aspects of the model, namely the use of tasks, have become foundational to increase the efficacy of a number of other types of interventions (Hoyt, 2000; Ramos & Tolson, 2008).

The model honors self-determination, strengths, and empowerment by allowing clients to define the problem, contribute judgment about goals and tasks, and participate in monitoring progress. To increase clients' self-efficacy and opportunity for mastery, obstacles to task completion and goal attainment are identified and resolved. When tasks are not completed, the reasons for low task performance are reviewed and new tasks, if indicated, are developed.

Opinions are mixed about the efficacy of the model with certain populations and in certain situations. Critiques of the central tenets of the model, in particular, time limits and the systematic structure, have led some to conclude that the development of a therapeutic relationship with clients is unlikely to evolve (Ramos & Tolson, 2008). Ramos and Tolson (2008) suggest that involuntary clients, especially those who refuse to identify a change or refuse to become engaged may not be good candidates for the approach. Of course, a central question might be whether any approach will work with such clients? Building on the basic thrust of the model, specifically the clients' view of the mandate and involving them in task implementation strategies, R. H. Rooney (2009) and Trotter (2006) demonstrated the model's applicability and effectiveness with this population. Both Rooney and Trotter found that the approach, when combined with other strategies, had the potential to reduce reactance and engage the client.

Crisis Intervention

EP 2.1.10a

The crisis intervention model discussed in this text is the equilibrium model, which is based on basic crisis theory. Knowledge of how to intervene with people who are experiencing a crisis is considered to be essential for skilled practice (Knox & Roberts, 2008). Depending on the nature of the crisis and the systems involved, it may be necessary for you to intervene at the micro, mezzo, and macro levels (Gelman & Mirabito, 2005). While multiple disciplines have played an important role in developing crisis theory, social workers have been responsible for advancing practice methods and skills and for formulating strategies for responding to crises (Bell, 1995; Fast, 2003; Komar, 1994; Lukton, 1982; Parad & Parad, 1990).

Tenets of the Crisis Intervention Equilibrium Model

EP 2.1.10a

The crisis equilibrium model is the basic approach to intervention. It is designed to reduce stress, relieve symptoms, and to restore functioning to the individual's pre-crisis state. Promptness of response, a key aspect of the model, is considered to be critical to prevent deterioration in functioning. It is during the acute period that people are most likely to be receptive to an intervention. The procedures of the model involve assessing the nature of the crisis, identifying priority concerns, and developing limited goals.

EP 2.1.10d

Assessment in the crisis situation, as outlined by James (2008), involves determining the following:

- *The severity of the crisis*
- *The client's current emotional status and level of mobility/immobility*
- *Alternatives, coping mechanisms, support systems, and other available resources*
- *The client's level of lethality; specifically, is the client a danger to self or others?*

James (2008) cites the Triage Assessment System developed by Meyer, Williams, Otten, and Schmidt (1991) as a "fast" and efficient way to assess and "obtain a real time estimate of what is occurring with a client" in a crisis situation (pp. 43–48). This three-dimensional assessment scheme provides a framework for you to assess the client's *affective, behavioral*, and *emotional* functioning, the severity of the situation, and to plan the appropriate intervention strategy. Where possible, you use the three **domains** to establish a baseline which could subsequently be compared to the Triage Assessment System results to determine the functioning level prior to and after the crisis (James, 2008).

Definition and Stages of Crisis

EP 2.1.10a

A *crisis* as defined by James (2008, p. 3) is "a perception of an event or situation as an intolerable difficulty that exceeds the resources or coping mechanism of the person." Prolonged, crisis-related stressors have the potential to severely affect cognitive, behavioral, and physical functioning.

In your work with clients, you have no doubt assisted them to deal with crisis situations some of which are related to their daily living. These situations may have ranged from everyday occurrences, for

example, job loss, death, eviction, divorce, domestic violence, or child abuse and neglect, crime or relocation, and in some instances, more extreme situations such as a natural disaster. Crisis situations inevitably have a subjective element because people's perceptions and coping capacities vary widely. A crisis that is severely stressful and overwhelming for some people may be manageable for others.

Referencing the case of the Corning family, you will recall that Irwin's job loss set in motion a series of stressful events that were significant threats to the family's stability. While the family was not in a crisis per se, the continuation of stressful events could eventually reach a crisis level. In contrast, the act of revealing one's sexual orientation to an unsupportive family (no doubt a dreaded high-anxiety producing event) can result in an unmanageable crisis, accompanied by additional stressors for which relief is uncertain. Uncertainty can become an unsettling emotional stressor for refugees, immigrants, and migrants. They may simultaneously experience demands related to their transition and the related sense of loss as a result of leaving their homeland, familiar networks, and culture. Despite the stress of having to adjust to the norms and values and language of another country, they tend to perceive their relocation as an opportunity, unless the transition was not of their choosing.

EP 2.1.9a

At the core of the definition of basic crisis intervention theory is the assumption of *the big event*. There are segments of the population, however, in which cumulative events or circumstances can result in a perpetual state of crisis. Consider, for example, the hyper-vigilance of people who have entered the United States or another country without the required documentation papers or the very real threats experienced by gay and lesbian individuals as a result of hate crimes, brutal beatings, and even murder. Intense anxiety related to threats and potential harm is pervasive in some poor minority urban communities. Residents of these communities are faced with violence, often times negative encounters with the police, poverty-related stressors, and inadequate services or resources. Studies have shown that the continuous exposure to violence can have an enduring affect on minors, resulting in depression, delinquency, or acting-out behavior (Voisin, 2007; Maschi,2006; Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006; Zeira, Astor & Benbenishty, 2003).

Emotional and psychosocial crises resulting from the experience of combat by military personnel, specifically post-traumatic stress disorder (PTSD), can pose a lifetime risk for the individual (Halpern & Tramontin, 2007; James, 2008). Stress-related symptoms may also be observed in professionals who work in highly stressful, emotionally charged situations (Bell, 2003; Curry, 2007; Knight, 2006; O'Hollaran & Linton, 2000).

EP 2.1.7b

The previously described scenarios are not closely associated with the "big event"; instead, they are woven into the fabric of everyday individual, family, work, and community life. The point that you should take away from these scenarios is that for those involved, life can be dominated by a series of ongoing crisis events that ultimately undermine the individual and community sense of self and organization, resulting in perpetual disequilibrium. Hence, a variety of clients may present the signs and symptoms associated with a crisis reaction as discussed in this next section.

Crisis Reactions

A *crisis reaction* may be described as any event or situation that upsets people's "normal psychic balance" (Lum, 2004, p. 272) to the extent that their sense of equilibrium is severely diminished. Examples consistent with the big event type crisis include terrorist attacks and natural and man-made disasters, such as tsunamis, hurricanes, and oil spills. In each of these circumstances, you might expect to find entire communities who feel particularly vulnerable and experience prolonged anxieties, physical, emotional, and cognitive distress, as well as an overall sense of grief and diminished coping capacity. When the big event occurs, all citizens are exposed to the trauma by constant media coverage and some can also experience a crisis reaction (Belkin, 1999).

EP 2.1.10a

Crisis intervention theory posits that people's reactions typically go through several stages, although theorists differ as to whether three or four stages are involved. The following description is a synthesis of stages identified by various authors (Caplan, 1964; James & Gilliland, 2001; Okun, 2002).

EP 2.1.10d

Stage 1: The initial tension is accompanied by shock and perhaps even denial of the crisis-provoking event.

Stage 2: To reduce the tension, the individual attempts to utilize his or her usual emergency problem-solving skills. If these skills fail to result

in the lessening of their tension, the stress level will become heightened.

Stage 3: The individual experiences severe tension, feels confused, overwhelmed, helpless, angry, or perhaps acutely depressed. The length of this phase varies according to the nature of the hazardous event, the strengths and coping capacities of the person, and the degree of responsiveness from social support systems.

EP 2.1.10d

Patterns of behavior associated with the stages may be characterized as disorganization, recovery, and reorganization (Lum, 2004; Parad & Parad, 1990, 2006; Roberts, 1990, 2005). Of course, people's reactions and their progression can vary. Variations can depend on the point in which you have contact. In reacting to a crisis, the potential exists for people to cope in ways that are either adaptive or maladaptive. You should be aware, however, that prolonged stress may have exceeded their coping capacity and usual problem solving, so much so that they are unable to effectively handle the stressors. Achieving equilibrium for some may depend on the extent to which their strengths, resilience, and social supports are mobilized. In these instances, the individual can perhaps achieve a higher level of functioning. As suggested by James (2008), the crisis may evoke a positive change opportunity. Specifically, an individual's reaction to a crisis may be to seek help and be motivated to succeed, thereby using the opportunity for his or her benefit (James, 2008). For others, the level of tension and feelings of being overwhelmed can escalate and his or her coping patterns may reach a level of *danger*. Danger is evident when restoring equilibrium is not immediately possible because the individual is unable to function, in which case additional assistance is required (James, 2008).

Duration of Contact

Typically, crisis work is limited in its duration, occurring within a time period spanning 4 to 8 weeks, although some clients or situations may require a longer time period. It is expected that active and intensely focused work in a brief time period will assist people to achieve a degree of pre-crisis functioning. The duration of contact may depend on the type of services offered by your agency and the crisis situation. Ultimately, the time required to resolve a crisis depends on the stress level; the individual's ego strengths, social supports, and resources; and whether the crisis is acute or chronic.

EP 2.1.10j

Your contact with clients may be daily, in an office, at a shelter, in a hospital or in the home, especially during the acute crisis period. Interventions range from a single-session, telephone intervention to comprehensive services with groups, families, and entire communities (Fast, 2003; Gibar, 1992; James & Gilliland, 2001; West, Mercer, & Altheimer, 1993). Several factors guide the time- limited duration of contact:

- *The focus of crisis intervention is on the here-and-now. Hence, no attempt is made to deal with either pre-crisis personality dysfunction or intrapsychic conflict, although attention to these symptoms may be required.*
- *Goals are limited to alleviating distress and assisting clients to regain equilibrium.*
- *Tasks are identified and task performance is intended to help clients achieve a new state of equilibrium.*

In crisis situations, the level of incapacity presented by the client may require you to have a more active and directive role than you might have in other interventions. Even though you may direct and define tasks, you should encourage clients to participate to the extent that they are capable of doing so. Although an individual's ability to actively participate and perform tasks may be limited during periods of severe emotional distress, his or her capacity can increase as their distress level diminishes.

Intervening with Minors

EP 2.1.10j

Minors are more vulnerable and at risk to crisis or traumatic events (Halpern & Tramontin, 2007; James, 2008). Work by Terr (1995), as discussed by James (2008, p. 163), established *Type I* and *Type II* categories as related to a minor's reaction to a crisis. Type I involves a single and distinct crisis experience, the big event, in which symptoms and signs are manifested. For example, with Type I trauma, the minor can display "fully detailed etched-in memories, misperceptions, cognitive reappraisals and reasons of the event." Type II, in contrast, is the result of longstanding and repeated trauma, and can have a cumulative effect, in which the minor's psyche develops defensive and coping strategies, anxiety, depression, or acting our behavior (James, 2008; Voisin 2007, Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006; James, 2008; Maschi, 2006; Zeira, Astor & Benbenishty, 2003).

For minors, a crisis event has the potential to disrupt biological, social, and cognitive development and age can make a significant difference in how minors respond. The Type I category seems to fit best with the basic equilibrium crisis intervention approach, in which the focus is on restoring the pre-crisis state of their caregivers in order to help the minor.

To direct the intervention, Korol, Green, and Grace (1999) emphasize a developmental ecological framework. The premise of this framework is that the developmental stage and the environment within which the minor operates are interrelated (James, 2008). Within this framework, four attributes are identified and are intended to guide the crisis intervention with minors (Korol, et al, 1999). The four attributes, based on research findings, are summarized by Halpern & Tramontin (2007, pp. 149–150).

- Characteristics of the stressors, *including the perception of threat related to the event, physical proximity to the event, duration, and intensity.*
- Characteristics of the minor. *Developmental stage, gender, and vulnerability play a significant role in how a minor experiences a threat, as well as psychological or behavioral problems that existed prior to the threat.*
- The minor's efforts to cope. *Generally, a minor with good communications skills, a sense of self, internal locus of control, and average intelligence are indicators of a positive outcome.*
- Characteristics of the post-disaster environment. *The minor's reaction is strengthened by social supports from significant others and resources, which can reduce stress and act as protective factors.*

EP 2.1.10j

The Interactive Trauma/Grief-Focused Therapy (IT/G-FT) model is another approach to address the post-effects on minors following a crisis (Nader & Mello, 2008). Eclectic in nature, the model utilizes theories relevant to the situation, including psychodynamic and cognitive behavioral approaches. It relies on the narratives, emotions, cognitions, and memories of the minor and the aim is to assist them to recover and to regain the healthy aspects of pre-crisis functioning.

The stages of crisis and the reaction may differ with minors. They may, for example, need additional help in understanding their crisis reaction and in developing problem-solving skills. The Triage System assessment can be especially important in determining the cognition and behaviors of minors as a result of the crisis. Cognitively, a crisis event can increase minors' sense of vulnerability and their perceived lack of power. Behavioral interventions to a crisis event may involve the minor's coping by role-playing, for example, an all-powerful action figure of their choosing (Knox & Roberts, 2008).

The basic crisis intervention equilibrium model, consistent with generalist practice, is appropriate for minors who have experienced a Type I crisis event. Intervening should also include the developmental ecological framework, the attributes proposed by Korol and colleagues (1999) and Halpern and Tramontin (2007) and the behavioral approaches suggested by Nader and Mello (2008).

Benefits of a Crisis

EP 2.1.9a

Much of the literature has tended to focus on the adverse reactions or the effects that a crisis has on people. Not surprisingly, then, intervention strategies, while incorporating strengths, coping, and social support, have sought to restore functioning to the pre-crisis level. Some theorists and researchers suggest that negative events may actually promote growth in the aftermath of a crisis (Caplan, 1964; Halpern & Tramontin, 2007; James, 2008; McMillen & Fischer, 1998; McMillen, Zuravin, & Rideout, 1995; McMillen, Smith, & Fischer, 1997; Joseph, Williams, & Yule, 1993). Note however, that the findings are specific to adult populations.

EP 2.1.6b

Building on prior research and the notion of benefits advanced by Caplan (1964), McMillen and Fisher (1998) explored the perceived harm and benefits with individuals who have experienced a crisis event. Some people in the study reported experiencing benefits, in positive life changes, such as increased self-efficacy and spirituality, faith in people, and in community closeness.

The McMillen and Fisher study results are significant for two reasons:

- *The deficit approach to psychosocial consequences appears to influence how human services professionals view their clients and how clients view their experience. Specifically, professionals may tend to focus on the trauma alone, whereas clients may view the situation or event through multiple lenses.*
- *In understanding the positive benefits that accrue from crises, professionals are able to construct interventions that strengthen these factors and increase successful outcomes.*

These findings also emphasized the subjective nature of the crisis experience as a key element to be included in crisis intervention work. Understanding the

individual's reaction to a crisis, their perception of harm to or vulnerability, and their affective, emotional, and behavioral functioning will assist you to plan and intervene appropriately. Otherwise, your intervention strategy may have little or no value to the client's situation.

Theoretical Framework

EP 2.1.7a

Parad (1965), Caplan (1964), and Golan (1981) were early and significant contributors to basic crisis intervention theory, delineating the nature of crises, stages, and intervention strategies for crisis resolution. Lukton (1982) further developed a practice theory and skills for social workers. Early crisis intervention theory spanned the life course to include grief and loss reactions, role transitions, traumatic events, and maturational or biopsychosocial crisis at various developmental stages (Lindemann, 1944, 1956; Rapoport, 1967). Early theories of crisis intervention strategies tended to reflect the psychoanalytic paradigm. For example, in Erikson's (1957) psychosocial stages of human development, a crisis was thought to develop if the individual failed to master the requisite developmental tasks in each stage.

Over time, additional theories have emerged because the basic crisis theory as a single framework was thought of as incapable of fully explaining the human response to trauma (Knox & Roberts, 2008; James, 2008). A prominent issue is that this theory paid little or no attention to environmental and situational factors as contributors to crisis and crisis reactions. In consequence, other crisis theories have emerged, influenced by ego psychology, cognitive behavioral, chaos, and ecological systems theories. In expanding theories related to crisis intervention, Okun (2002) and James (2008) have more broadly defined the context in which a crisis may occur. In doing so, they extended the underlying contextual and theoretical framework of crisis work.[2]

Application with Diverse Groups

EP 2.1.7b

An advantage of crisis intervention strategies is their use with different populations (Knox & Roberts, 2008). Lum (2004) asserts that crisis intervention as a generalist practice approach has "universal application to people of color" (p. 272). His assertion is based on the fact that people of color "often experience personal and environmental crisis" and in many instances they have "exhausted community and family resources" prior to seeking professional help (p. 273). For some, patterns of help-seeking behavior and historically based anxieties about formal helping can delay contact (Green, 1999). In consequence, crisis situation can reach a chronic state. In addition, influenced by culture, different communities may respond and cope differently to a traumatic event (Halpern & Tramontin, 2007).

EP 2.1.4c

James (2008), a prominent author of crisis intervention work, acknowledges the assumption that crisis intervention strategies represent ideals that are specific to Western norms and are unfamiliar to the majority of the world. In crisis work, Chazin, Kaplan, and Terio (2000) note that emphasizing crisis related deficits, rather than strengths and resources, can be particularly counterproductive with diverse groups. In this regard, there is perhaps merit in the perspectives of social constructionist and feminists. Specifically, they believe that the traditional clinical-focused procedures tend to emphasize normalcy. As such, they omit such pertinent factors as culture and inequality, faith, or injustice (Freud, 1999; Silove, 2000). In the aftermath of Hurricane Katrina, unavoidable questions about inequality and justice were raised with respect to the crisis response to citizens of the 9th Ward in New Orleans. You might, however, question whether the response to this segment of the population was the result of systemic inequality and structural barriers or the shortcomings of the crisis model. In many respects, one might conclude that it was the unequal, pre-disaster quality of their lives, when combined with unrelenting post-events, that profoundly overwhelmed and affected the coping capacity of the residents of the 9th Ward.

EP 2.1.6b & 2.1.7b

Although research and literature related to crisis intervention strategies with regard to culture, gender, and racial groups is limited, there is work in this arena that has advanced our knowledge base. Examples include Congress (2000) and Potocki-Tripodi (2002), with a focus on culturally diverse and immigrant families, and Cornelius, Simpson, Ting, Wiggins, and Lipford (2003) and Ligon (1997) with African Americans. In their work, Halpern & Tramontin (2007) amplify how culturally based perceptions influence expectations in certain Asian communities. In particular, they stress that reactions to a crisis can differ from those in Western societies. In working with immigrants and refugees, Potocky-Tripodi (2002) suggests that, while crisis intervention strategies are appropriate, ideally they should be implemented as preventive measures prior to the resettlement stage. Congress (2002, 2000) identifies common precipitants of crisis among immigrants and refugees; namely, intergenerational conflicts, changes in roles, unemployment, and interactions with formal institutions in which crisis strategies are appropriate. Ligon (1997) departs somewhat from

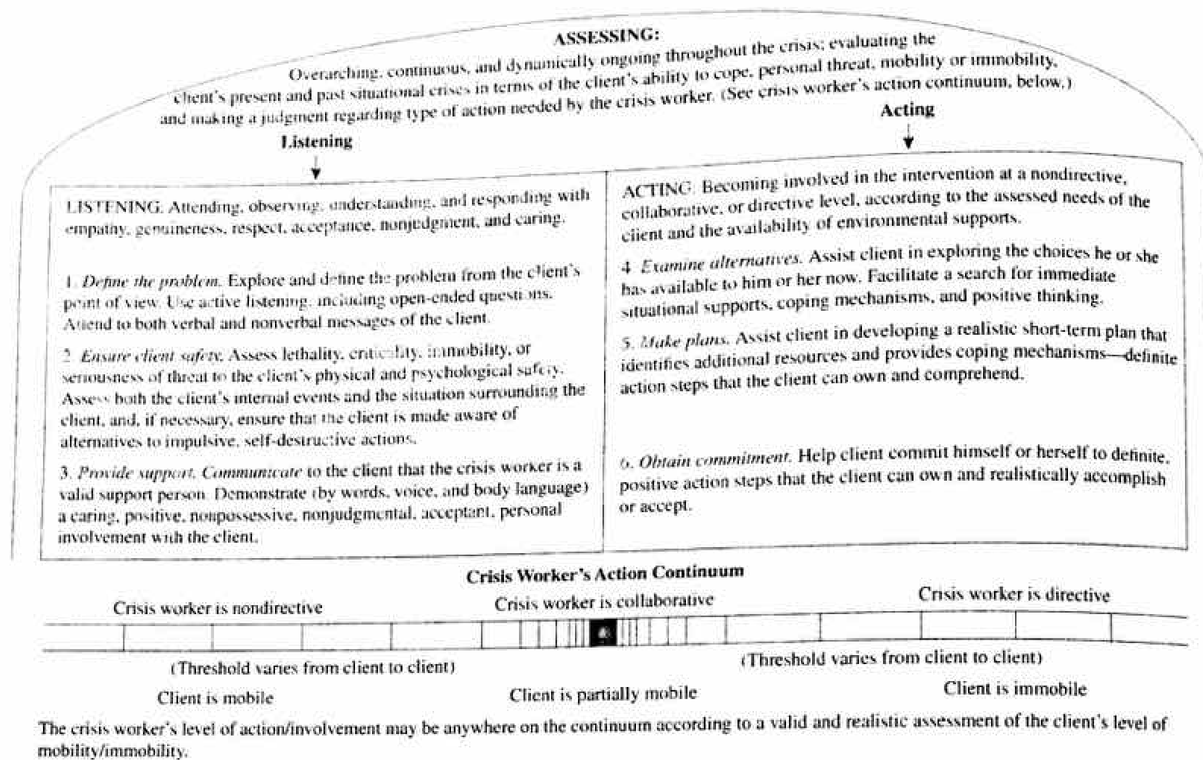


FIG-13-3 The Six-Step Model of Crisis Intervention

SOURCE: From JAMES, "Crisis Intervention Strategies", 6E. © 2008 Wadsworth, a part of Cengage Learning, Inc. Reproduced by permission. www.cengage.com/permissions.

the basic equilibrium crisis model, relying instead on cultural and ecological systems perspectives, integrated with empowerment. Using this framework Ligon demonstrated the merit of these perspectives with populations of color and individuals with serious health or mental health concerns. Poindexter (1997) makes the point that for HIV-infected individuals, the experience may involve a series of crises beginning with them learning of the disease as a precipitating event. As the condition progresses, multiple crises—social, situational, and developmental—can occur simultaneously. Poindexter's work, along with that of Ell (1995), Ligon (1997), and Potocky-Tripodi (2002), is significant in that it helps us to move beyond certain assumptions about the episodic nature of crises and to understand the evolving stages of certain crisis situations.

EP 2.1.4b

Crisis intervention, like other practice models, calls for multicultural helping that includes self-knowledge, awareness of bias, knowledge of the status and culture of diverse groups, and the willingness to use alternative strategies appropriate to the client's culture and situation (James, 2008; Sue, 2006; Sommers-Flanagan, 2007). Perhaps the most important factor for you to recognize is that crisis work, like any other problem-solving strategy, should include the world-view of the client, the meaning that he or she ascribes to the situation, and their patterns of coping and preferences for resolution.

Process and Procedures of Crisis Intervention

EP 2.1.10j

The processes and procedures of the six-step crisis intervention model, initially developed by Gilliland (1982) for systematically intervening in a crisis situation, are illustrated in Figure 13-3. These steps, which have continued to be the procedures of the basic crisis model, are consistent with the eclectic problem-solving approach. The figure outlines the fundamental skills and range of actions required for you to take in a crisis situation. Procedures for implementing the model are applied to the case of Lia, a pregnant teen. Cultural tensions related to her pregnancy are also discussed.

Step 1: Define the Problem

As a social worker in a crisis situation, you must determine the unique meaning of a crisis and the severity of the situation to the client. Having clients talk about the meaning and significance of the crisis can be a relieving cathartic process and thus, highly therapeutic for them. Gathering this information provides you with

IDEAS IN ACTION

The problem as presented by Lia, age 17 years, was that she was pregnant and unmarried. During the school year she participated in a school-based teen group for female students. On the day of the referral, Lia became so emotionally distraught that the group leader asked the group to take a break so that she could talk with her individually. Lia told the leader that she was pregnant and that she was in trouble with her family as a result. The group leader referred her to a social worker at the community based mental health center, located adjacent to the school. Lia calmed down after the group leader explained her reason for making the referral and the fact that the social worker was able to see her immediately. As she explained her situation to the social worker, however, she became highly distressed.

essential information about how the client defines their problem.

Cultural factors and status are equally essential in assessing clients' problem definitions and reactions to crisis situations. Situations deemed to be crises vary widely from one culture to another, as do the reactions to them. Interventions work best when they include cultural values, beliefs, and rituals (e.g., spiritual healing, circles of care) as critical reference points.

During the session with Lia in the Ideas in Action box, the social worker's initial tasks in this session were twofold:

- *Assess and alleviate Lia's emotional distress*
- *Elicit Lia's definition of the problem*

EP 2.1.10d

Assess and Alleviate Lia's emotional distress: *During the interview Lia cried, had trouble breathing, and expressed concern about whether the social worker could understand her situation. The social worker used a breathing technique to help her calm down. Listening, empathetic and nonjudgmental responses were also useful. Eventually the social worker was able to gain an understanding of the magnitude of her distress in relationship to her problem. During their conversation, Lia stated that she had thought about suicide. Furthermore, she had shared her thoughts in a conversation with her 12-year-old brother.*

EP 2.1.10b

By listening and responding empathically, the social worker encouraged Lia to talk about her feelings, which alleviated some of her emotional distress. When, however, the social worker learned that she had thought about hurting herself, this information prompted an immediate referral to the center's mental health services for an evaluation. As she questioned Lia further about the potential to harm herself, a hopeful sign was the fact that she expressed concern for the safety and well-being of her unborn child. In addition, she indicated that she wanted to continue her involvement with the teen group.

EP 2.1.10d & 2.1.7b

Eliciting the client's definition of the problem: *Lia's problem as she defined it was being pregnant and unmarried, which was further complicated by the cultural norms of her community. The severity of the situation became evident when Lia recounted her family's response to her pregnancy, specifically, her pregnancy without her being married, brought shame to the family. The crisis escalated when, upon learning that she was pregnant, her father had dismissed her from the family. He refused to talk to her or allow other family members to do so. The fact that Lia faced social ostracism, loss of face, and would be disconnected from her family and members of the clan added to her distress.*

Clearly, being pregnant and unmarried was worrisome to Lia, but she believed that she could manage her situation and had some ideas about how to do so. Her family's definition of the problem, however, was grounded in the context of cultural norms and expectations. Unwed pregnancy requires considerable adaptation in most cultures, but may pose an extreme threat for an individual who is a first-generation member immigrant family member. While her parents had made significant adjustments to their new culture, Lia's pregnancy was a situation for which the parents did not have a point of reference. Therefore, in this context, being unwed and pregnant as defined by Lia's family and community and their reactions became

a multiple-layered crisis, all of which contributed to the significance of the crisis and her level of distress.

Step 2: Ensure Client Safety

EP 2.1.10i

Ensuring client safety is the first and foremost concern in crisis intervention and an ongoing consideration (James, 2008; James & Gilliland, 2001). Safety involves deliberate steps to minimize the "physical and psychological" danger to the client or others (James, 2008). The social worker requested, and Lia agreed to complete, a depression scale. The results confirmed the necessity of making the referral to the center's mental health services for further evaluation.

Because Lia had considered self-harm, the social worker developed a safety plan contract with her, with each identifying resources, including a crisis hotline that Lia would call when her feelings reached a level in which she considered harming herself. As an additional precaution, the social worker reminded Lia of her desire to keep her unborn child safe.

EP 2.1.10d

In the assessment of her affective, cognitive, and behavioral domains, Lia's scores were moderate. Even so, the social worker made the referral for further evaluation. She also shared her observation of Lia's coping and resilient behaviors, namely that she often volunteered for the closing shift at work and afterwards walked to her sister's home to spend the night because she could not go home.

While she had missed several days of school, she continued to participate in the teen group. Furthermore, the fact that she was concerned about the well-being of her unborn child was an indication of her future-oriented thinking. But there was an additional concern for her safety related to Lia working late and walking alone to her sister's home, thus the she and the social worker explored other options.

In assessing the three domains, the social worker was able to evaluate the extent of Lia's adaptive and coping capacities. She also learned about family resources that could be tapped to alleviate some of her distress as well as options to ensure her safety.

Step 3: Provide Support

EP 2.1.10i

Within this step, the social worker's objective was to identify Lia's social support systems because mobilizing a helping network can be an essential aspect of intervening in a crisis situation. Social supports may include friends, relatives, and in some cases institutional programs that care about the client and can provide comfort and compassion (James & Gilliland, 2001).

As Lia and the social worker explored potential support resources, several were identified: her sister and an aunt and certain clan members who were sympathetic to her situation. These resources were individuals, including the social worker, with whom she would have daily contact, and they were also included in the safety plan. A school-based group for pregnant and parenting teens was identified as a new resource. In a supportive role, the social worker walked with her to her appointment for a mental status evaluation and also introduced her to the social worker and nurse practitioner in the healthy baby program at the center.

Step 4: Examine Alternatives

EP 2.1.10j

In this step, both the social worker and Lia explored courses of action appropriate to her situation. Of course, some choices that they considered were better and more realistic than others. Thus it was important for them to selectively prioritize available options. Ideally, alternatives are considered to the extent to which they are:

- *Situational supports, involve people who care about what happens to the individual*
- *Coping mechanisms that represent actions, behaviors, or environmental resources that may use to get past the crisis situation*
- *Positive and constructive thinking patterns that effectively alter how an individual views the problem, thereby lessening his or her level of stress and anxiety*

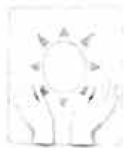
Lia had actually thought of alternatives, yet initially she was sufficiently immobilized emotionally and had not acted upon them. For example, in response to the threat from her father to change the locks on the doors, which forced her out of the home, she had considered moving in with her sister or aunt *(situational supports)* until after her child was born. Afterwards, she would be 18 years of age and able to live independently. Instead of acting on this option, however, she planned to wait until her parents were asleep or at work and appeal to her siblings *(coping mechanism)* to let her in the house. In the past, her siblings had opened the door for her when she had stayed out late with her boyfriend. Relying on this choice was a short-term solution at best, and posed a greater risk for both Lia and her siblings.

A more viable alternative suggested by the social worker involved Lia moving into a transitional housing complex for pregnant teens, located near her high school and job *(highlighting constructive thinking and action).*

Program services offered in the housing complex included transportation to prenatal visits, group counseling, independent living skills classes, and assistance in finding permanent housing. Although she was initially reluctant, Lia agreed to consider this option. Social workers who understand the client's point of view may be better able to plan alternatives and encourage clients to consider other options. For example, Lia's qualms about the pregnant teen housing program reflected her desire to remain with, or at least near, her family and community.

Of course there were additional alternatives to consider in stabilizing a crisis situation. You should, however, be aware that multiple options for can be overwhelming. Furthermore, the alternatives that you and the client consider should be "realistic" to the situation (James, 2008). In Lia's case, two options were discussed: moving in with her aunt on a short-term basis and a housing facility for pregnant teens. Lia chose the housing program because of the supportive services that were available. She and the social worker, however, also discussed ways in which she could have some contact with her family.

Step 5: Making Plans



EP 2.1.10f

Planning and contracting flow from the previous steps and involve the same planning and action steps that were discussed in Chapter 12. In this step, Lia and the social worker agreed on specific action steps or tasks. General and specific tasks, will, of course, vary according to the nature of the crisis situation and the unique characteristics of each person and/or family.

In developing and negotiating tasks, the social worker solicited Lia's views on what she believed would help her to function at a level of pre-crisis equilibrium. In their planning, they identified her safety as a priority and the relevant tasks were developed. Other tasks were created related to her eventual move to the pregnant teen housing facility.

Lia's estrangement from her parents was a central source of her distress. The social worker asked Lia to consider a task of writing a letter of apology to her parents and also whether such a gesture was culturally appropriate. Lia was unsure and she proposed an interim task of talking to her aunt about the letter.

EP 2.1.1c

There are times during this step when your interaction with a client requires you to be directive. For example, the idea of writing a letter to her family was the social worker's idea. James and Gilliand (2001), however, caution against "benevolently imposing" a plan on clients. Instead, you should strive to find a balance between being directive and respecting the individual's autonomy by encouraging and reinforcing feasible independent actions. As it turned out, Lia thought the idea was a good one, yet she was unsure about the impact that the letter might have, hence the decision to talk with her aunt before writing the letter.

Step 6: Obtaining Commitment

EP 2.1.10j

Completing tasks, which flow directly from the previous step, are considered to be essential to an individual's mastery of crisis situations. In the sixth and final step, Lia and the social worker committed to collaboratively engage in specific, intentional, and positive tasks designed to restore her to a level of pre-crisis functioning.

After a week, Lia informed the social worker that she was ready to move forward and develop tasks related to the plan to move into the housing facility for pregnant teens. In the meantime, she proposed living with her sister or her aunt, perhaps dividing her time between the two of them. A summary of the agreed-upon tasks involved the following:

Lia's Tasks

- *Call the 24-hour crisis line or other supports when she was feeling overwhelmed*
- *Talk to her sister or aunt about moving in with one of them*
- *Visit the pregnant teen housing facility*
- *Explore ways to have contact with family members*
- *Continue to attend the school-based teen group*

Social Worker

- *Provide Lia with information on the pregnant teen facility program prior to her visit*
- *Accompany Lia on her visit to the housing program*
- *Obtain information about financial support for Lia and her unborn child*

When Lia began her relationship with the social worker she was in a highly emotional state. In assessing the three domains, the social worker was able to evaluate the extent of Lia's adaptive and coping capacities. She also learned about family resources that could be tapped to alleviate some of her distress as well as options to ensure her safety. Subsequent tasks were developed that were intended to move Lia beyond the crisis of her pregnancy. You will note that not all of her concerns were resolved. Nonetheless, the tasks developed were instrumental in assisting her to gain a level of equilibrium.

Anticipatory Guidance

EP 2.1.10i

In addition to completing the six steps of the model, you may also find anticipatory guidance to be a complimentary technique. This technique involves assisting clients to anticipate future crisis situations and to plan coping strategies that will prepare them to face future stressors. Similar to identifying obstacles and barriers in the task-centered model, anticipatory guidance involves a discussion of scenarios of potential or future stressors. Used in Lia's case, the social worker and Lia discussed ways in which she could cope in the event that, despite her best efforts, she remained estranged from her family. They might also explore stressors related to the eventual but normative stress of the birth of her baby and living in a group setting with other pregnant teens. In their discussion, the social worker helped Lia to focus on her problem-solving, coping, and adaptation skills in her current situation. For example, Lia has proposed living with her aunt or sister as a temporary solution to her home situation, which showed her aptitude for problem-solving and adaptation capacities.

In using anticipatory guidance, it is important that you do not convey an expectation that people will always be able to independently manage future crisis situations. Even though you reassured them of their skills and helped them to anticipate future scenarios, you should clarify that you or other professionals are available if they need future help.

Strengths and Limitations

EP 2.1.10a

The crisis intervention equilibrium/disequilibrium model involves a structured, time-limited series of steps utilizing techniques that are guided by basic crisis theory. The initial intervention phase has three strategic objectives: (1) to relieve the individual's emotional distress, (2) to complete an assessment of their cognitive, behavioral, and emotional functioning, and (3) to plan the strategy of intervention, focusing on relevant tasks they are to perform.

Much of the theory upon which the equilibrium model is based assumes that people experience an event or situation that alters their usual patterns of living. Therefore, the goal of the intervention is to restore them to a pre-crisis level of functioning.

Over time, in recognition that no one theory is capable of defining or explaining a crisis, other theories and models have influenced an expanded classification for different kinds of crises and trauma and crisis responses. Models have also evolved that have emphasized the need to respond to crisis needs differently, in particular with minors, in consideration of their developmental age and stage. Promising research has demonstrated the effectiveness of crisis strategies with diverse populations by integrating aspects of other theories. These works represent significant contributions in that they advance our understanding and ability to differentiate crisis work.

While there is consensus about the definition of a crisis, it is also understood that what actually constitutes a crisis may be individually and culturally defined. Similarly, perceptions of a crisis vary based on associated threats, individual cognitions, and the significance of the situation, ego strengths, coping capacity, and problem-solving skills. In some instances, people can perceive and articulate positive benefits as a result of a negative experience. Of course, a perception of benefit may be limited by the nature and severity of the crisis.

The basic model retains the assumption of a crisis as an episodic, time-limited event. As such, crisis professionals aim to relieve emotional distress and develop a plan of action so that an individual or family's pre-crisis level of functioning is restored. Ell (1995) questions the assumption of time-limited crisis as well as the notion of homeostasis—specifically, whether the goal of restoring equilibrium is always possible. Ongoing difficulties in the daily lives of people who are exposed to the chronic and constant state of vulnerability in their environments can mean that the focus on time-limited crisis episodes is neither feasible nor realistic. The efficacy of crisis intervention strategies is not entirely diminished by Ell's observations. They do, however, suggest significant factors that can impact cognitive, affective, and behavioral functioning as a result of the cumulative effects of ongoing distress.

Understanding basic crisis theory provides you with a framework for working with both adults and minors. The model is consistent with generalist practice and utilizes the practice values, knowledge, and skills with which you are already familiar.

Cognitive Restructuring

EP 2.1.10a

Cognitive restructuring is a therapeutic process derived from cognitive-behavioral therapy (CBT). Also referred to as cognitive replacement, cognitive restructuring is "considered to be the cornerstone of cognitive behavioral

approaches" (Cormier & Nurius, 2003, p. 435). Intervention techniques in cognitive behavioral therapy are designed to help individuals modify their beliefs, faulty thought patterns or perceptions, and destructive verbalizations, thereby leading to changes in behavior. An assumption of cognitive restructuring is that people often manifest cognitive distortions which then affect a person's emotions and actions. Distortions are irrational thoughts derived from negative schemas that lead to unrealistic interpretations of people, events, or circumstances. Frequently, although an individual may be aware of his or her thinking, he or she may still lack the emotional strength to alter the schematic thought patterns.

Theoretical Framework

EP 2.1.7a

For you to fully appreciate the foundation of cognitive restructuring, it is important that you understand the theories upon which the procedures of the technique are based. Cognitive-behavior therapy attempts to alter the individual's interpretation of self and his or her environment and the manner in which he or she creates interpretations. The behavior of people is considered to originate from their processing of both internal and external information. According to cognitive theorists, most social and behavioral problems or dysfunctions are directly related to the misconceptions that people hold about themselves, other people, and various life situations (J. Beck, 1995; Dobson & Dozios, 2001). An understanding of the reciprocal relationship of cognition, affect, and behavior is considered to be central in using this approach.

The early and historic work of Ellis (1962), Beck (1976), and others in this arena led to cognitive theories and techniques that can be applied directly and systematically to problems of cognitive dysfunction. Ellis's (1962) seminal work, *Reason and Emotion in Psychotherapy*, explicated the theory underlying *Rational-Emotive Therapy* (RET). Perhaps the most significant is The *Cognitive Therapy of Depression*, which is widely recognized as the definitive work on treatment of depression (Beck, Rush, Shaw, & Emery, 1979).

The classical work of Pavlov (1927) related to conditioning and the operant conditioning studies of Skinner (1974) are prominent in the theoretical framework of cognitive behavioral therapy (Cobb, 2008). Learning as a primary focus is influenced by Bandura's (1986) social learning theory. According to social learning theory, thoughts and emotions are best understood in the context of behaviors associated with cognition or cognitive processes, as well as the extent to which individuals adapt and respond to different stimuli and make self-judgments. Increasingly, cognitive behavioral approaches include social constructionists' perspectives of the specific realities of different clients, and unique behaviors relative to their culture, beliefs, and worldview (Berlin, 2001; Cobb, 2008; Cormier & Nurius, 2003).

In the 1960s, behavioral theory and methods were introduced by Edwin Thomas at the University of Michigan (Gambrill, 1995). Berlin's (2001) *Clinical Social Work Practice: A Cognitive-Integrative Approach* is a significant contribution to adaptation of cognitive behavioral therapy to social work practice.[4]

Tenets of Cognitive Behavioral Therapy-Cognitive Restructuring

EP 2.1.10a & 2.1.1c & 2.1.7a

In general, the goal of cognitive behavioral intervention strategies is to increase the client's cognitive and behavioral skills so as to enhance his or her functioning. Restructuring is a cognitive procedural technique that aims to change a client's thoughts, feelings, or overt behaviors that contribute to and maintain problem behavior. To be effective in using cognitive restructuring as an intervention strategy you must be skilled in assessing cognitive functioning and in applying appropriate interventions.

Cognitive behavioral theory is based on the assumption that people construct their own reality. It is within the realm of processing information that people assess and make judgments that fit into their cognitive schema. The basic tenets of the cognitive-behavioral theory are:

- *Thinking* is a primary determinant of behavior and involves statements that people say to or about themselves. This inner dialogue, rather than unconscious forces, is critical to understanding behavior. To fully grasp this first tenet, you must clearly differentiate thinking from feeling, as confusing feelings with thoughts tend to create confusion in communication. This confusion can be observed in messages such as "I feel our relationship is on the rocks," or "I feel that the teacher does not like me." Here, the use of the word *feel* does not actually identify feelings, but rather it