embodies the individual's *thought* or *belief. Thoughts* per se are devoid of feelings, although they are often accompanied by and generate feelings or emotions. *Feelings* consist of emotions, such as sadness, joy, or disappointment.

- *Cognitions* affect behavior, which is manifested in behavioral responses. Behavioral responses are a function of the cognitive processes of attention, retention, production, and motivation, as well as of rewarding or unrewarding consequences (Bandura, 1986). Cognitions that lead to cognitive distortions or faulty thinking can be monitored and changed.
- *Behavioral change* involves assisting people to make constructive change by focusing on their misconceptions and the extent to which they produce or contribute to their problems. The thrust is that a change in behavior can be accomplished by changing the way in which people think.

In identifying distortions and faulty thoughts and behaviors, new patterns of thinking can be learned. You should, of course, temper the assumptions of these tenets in recognition of the fact that there are other factors that can influence the ways in which people see themselves, think and process information. Specifically, cognitions are not necessarily faulty given the realities of culture, unequal sociopolitical structures, and social interactions in which class, race, gender, or sexual orientation are major contextual life issues. The realities of people's lives and their beliefs have a significant impact on their thinking and cognitions, and therefore, the relationship between cognition, culture, and context should not be minimized or overlooked (Hays, 2009; Pollack, 2004; Berlin, 2001).

What Are Cognitive Distortions?

EP 2.1.7a

Beck (1967), in separating thinking from cognition, identified automatic thoughts and cognitive distortions as factors for which cognitive restructuring is indicated. The processing of information for most of us is automatic as our minds attempt to navigate and narrate our interactions and environment. Problems occur when thoughts are consistently distorted because of an individual's ingrained beliefs and faulty reasoning. While cognitive distortions are irrational, they make logical sense to the individual. Moreover, distortions maintain negative thinking and reinforce negative emotions. The most common types of distortions and negative thinking patterns conceptualized by Beck (1975) have been summarized in the literature (Leahy & Holland, 2000; Walsh, 2006) and are as follows:

- *All or Nothing Thinking* involves seeing things as all or nothing scenarios, and in most instances the glass is always half empty. *"I wanted to do well on the exam, and now that I didn't, I will never get into graduate school." "If I don't smoke stuff [dope] with my friends they won't ever hang with me." "Unless we know the background of these clients, we won't be able to help them."* In these statements, you may see the similarities between this thinking and catastrophizing and overgeneralizing
- *Blaming* occurs when an individual perceives others as the source of negative feelings or emotions, and can therefore avoid taking responsibility. *"I feel so stressed out because a driver cut in front of me on the way home." "Her snippy attitude about going shopping with me put me in a bad mood."*
- *Catastrophizing* is the belief that if a particular event or situation occurs, the results would be unbearable, effectively influencing your sense of self-worth. *"I need to study all the time, because if I don't get the highest grade possible on the exam, I will lose my financial aid and return home a failure."*
- *Discounting Positives* is the tendency to disqualify or minimize the good things that you or others do, and instead treats a positive as a negative. *"My friends said that I looked great in my dress I got at the secondhand store, but really, they were just being nice to me because they felt sorry for me because I don't have money."* Similarly, you are reviewing evaluations after making a presentation and you focus on that, *"Of the forty people at the presentation, two said that I was boring,"* instead of focusing on the 38 positive responses.
- *Emotional Reasoning* guides your interpretation based on how you feel, rather than reality. Interpretations and beliefs are facts bolstered by negative emotions, which are assumed to reflect reality. *"If I feel stuck [stupid] in social situations, then that's really who I am."*
- *Inability to Disconfirm* functions very much like a barricade in that you are unable to accept any information that is inconsistent with your beliefs or negative thoughts. For example, if your sister, with whom you frequently argue, says that she is willing to keep your kids any other night except tonight because she has an appointment, your mental response may be *"That's not the real reason. She has*

never liked me or my kids," which in effect, discounts the numerous other occasions that she has cared for your children.

- *Judgment Focus* leads to a perception of self and others or an assessment of events as good or bad, excellent or awful, rather than describing, accepting, or attempting to understand what is happening or considering alternatives. *"I know that when I go to a party people won't talk to me."* In some instances, you may establish arbitrary standards by which you measure yourself, only to find that you are unable to perform at this level, *"I won't do well in the class no matter how hard I try"* is an example of a self-defeating judgment statement, as is *"Everyone in the class gets good grades, but not me."* A judgment in contrast to one that is self-defeating is an assumption that a presentation was good because *"a lot of people came."*
- *Jumping to Conclusions* assumes a negative when there may be limited supporting evidence. Assumptions may also take the form of mind reading and fortune telling based on a prediction of a negative outcome. *"If I don't watch her children, she will be upset with me, a risk that I am unwilling to take."*
- *Mind Reading* assumes that you know what people will think, do or respond. *"There's no point in my asking my daughter to visit me more often. She will just see it as my attempt to get attention or embarrass her. If I bring up the topic, she and I will end up in an argument; besides, she is busy with her own family."*
- *Negative (mental) Filtering* results in mentally singling out bad events and ignoring the positives. *"As I was standing in the hallway at work, this kid bumped into me, you know, they are all like that. I was so angry. Then he turned around and apologized, but I pretended not to hear him. He should have apologized sooner."* In some instances, negative filters are linked to thoughts that are overgeneralized to people or events.
- *Overgeneralizations*, or globalization, involve perceiving isolated events and using them to reach broad conclusions. *"Today, when I raised my hand in class, the instructor called on another student. He never calls on me."* Labeling is another form of overgeneralizing in which a negative label is attached to self or others based on a single incident. *"I am not a very good student, so he does not value my opinion." "He is a lousy instructor otherwise he would help everyone [me]."*
- *Personalizing* assumes that you had a role in or that you are responsible for a negative situation, assuming that the results were in your control. *"We were close friends and then she was called to active duty and we loss contact."* Personalizing, when applied to others, is very much like blaming. *"She could have written to me while she was away." "The party that I planned in the park was a failure because it rained and people left early."*
- *Regret Orientation* is generally focused on the past, *"If I had worked harder, I could have gotten a better grade." "I had a chance for a better job, if I had been willing to relocate to a different city."*
- *Should Statements* are about self-failure or judgments about others relative to how things should be. *"I should be able to take the bus on my own when I work late." "My sister ought to be willing to care for my child when I am working late."* Judging statements about others generally result in feelings of resentment and anger. *"My sister has a husband, so she doesn't really understand how hard it is for me to manage as a single parent."*
- *Unfair Comparisons* measure self with others who you believe have desirable attributes. *"She is prettier than I am." "Everybody in the class is smarter than me."* Unfair comparisons can also lead to should or shouldn't statements when comparing self to others; for example, *"Even if she is prettier than me, she shouldn't wear that color lip gloss." "My college roommate is a CEO already, I'm nothing compared to him."*
- *What Ifs* is the tendency for you to continually question yourself about the potential for events or the catastrophe that might happen. *"I would go to the doctor to have her look at the mole on my back, but what if she tells me that I am really sick?" "What if I tell my sister that I can't watch her kids tonight and she gets upset with me and she refuses to talk to me ever again?"*

EP 2.1.10j

In each of the previous categories you are able to see how distorted and negative thoughts fit within an individual's cognitive schema. Schemas, either positive or negative, are the memory patterns that an individual uses to organize information (Berlin, 2001; Cormier & Nurius, 2003; McQuaide & Ehrenreich, 1997). Nonetheless, whether they emanate from a strengths or deficit orientation, schemas are shortcuts in thinking. Rather than processing information, the individual quickly accesses

repeatable content in his or her mind set, without further evaluation. Because schemas represent engrained beliefs, it is often difficult for people to hear or process different information because doing so causes them to experience cognitive dissonance. Specifically, dissonance occurs when the individual is presented with new information or an alternative explanation that is inconsistent to his or her thoughts. When this happens, the individual can experience a high level of stress, so much so, that he or she may shut down.

The activation of a negative schema can result from external or internal events that are adaptive or maladaptive. It is the latter that is the focus of your work with clients. Consider the influence of the negative image when the youth bumped into the woman in the hallway. Her automatic thought was, "They are all like that." Even though he apologized, her memory pattern (her global thinking about "they") was already operating in full force. Consequently, she was unable to process the youth's apology as new information, and therefore, unable to alter her cognition of the event. Of course, this event could have been trigged by a negative past experience or simply be the result of her ingrained biased thinking. If we were to examine this same situation from an internal vantage point, context would involve assessing her mood at the time of the incident and the extent to which it influenced her cognition and behavior. In either case, it is important that you first determine the context and the type of situation that triggers and maintains problematic behavior (Cormier & Nurius, 2003; Berlin, 2001). Further, where negative filtering about self and others has emotional content, blaming statements may be related to the mood of the individual at a particular point in time. By the same token, negative thoughts may be grounded in the individual's reality, however irrational the thoughts may appear to be. Hence you would assess whether an external and internal stimuli led to cognitive errors is an actual distortions or an individual's misunderstanding of his or her experiences. Keep in mind that negative thoughts and schemas do not represent the whole person. People generally are able to go about their daily lives until such time that an external or internal event ignites a particular thought pattern, upon which their reality is constructed.

EP 2.1.7b

You should also be mindful of the fact that marginalized and oppressed people and involuntary clients are often perceived as negative thinkers with distorted realities. When faced with their narrative, we may tend to think of them as overgeneralizing, blaming others for their misfortune or jumping to conclusions. Yet, if their narrative is derived from their experience of continually encountering adverse events or inequality, can we conclude, without further examination that their thoughts are actually distortions or discrepancies? A different culture than your own may also be challenging, especially if cultural practices and traditions are inconsistent with what you believe to be truth. As difficult as it may be for us to acknowledge truths that may be different from our own, ultimately, we must focus on what is meaningful to the client, rather than what we might consider to be an acceptable pattern of thinking and behaving.

EP 2.1.4b

Empirical Evidence and Uses of Cognitive Restructuring

EP 2.1.6b

Cognitive restructuring procedures are particularly relevant for treating problems associated with low self-esteem, distorted perceptions in interpersonal relations, unrealistic expectations of self, others, and life in general, irrational fears, panic, anxiety, and depression; control of anger and other impulses, and lack of assertiveness (Cormier & Nurius, 2003; Walsh, 2006). Selected studies have demonstrated the range of cognitive restructuring components in treating anger (Dahlen & Deffenbacher, 2000), impulse control associated with child abuse and gambling (Sharpe & Tarrier, 1992), and substance abuse and relapse (Bakker, Ward, Cryer, & Hudson, 1997; Steigerwold & Stone, 1999). Results of studies have also shown cognitive restructuring to be effective in the treatment of social phobias and anxiety (Feeny, 2004), spousal care-giver support groups (Gendron, Poitras, Dastoor, & Perodeau, 1996), and in crisis or trauma situations (Glancy & Saini, 2005; Jaycox, Zoellner, & Foa, 2002). The procedures of the cognitive restructuring are often blended with other interventions (e.g., modeling, behavioral rehearsal, imagery, psychoeducation) because combinations of interventions are believed to be more potent than single interventions in producing change (Corcoran, 2002).

Utilization with Minors

EP 2.1.6b

In comparison to adult populations, there are fewer studies that show evidence of effectiveness and the use of cognitive restructuring with minors. When combined with other strategies, for

example, narrative and enactive performance-based procedures, cognitive restructuring can be effective with younger minors. The work of Graham (1998) found that distorted thinking can affect the social and interpersonal skills of minors. Studies conducted by Rheingold, Herbert, and Franklin (2003) and Guadiano and Herbert (2006) showed that cognitive restructuring can increase self-efficacy and reduce social anxiety in adolescents.

The works of Giacola, Mezzich, Clark, and Tarter (1999) Liau, Barriga, and Gibbs (1998), and Rudolph and Clark (2001) emphasize assessing the context in which the minor's behavior occurs. To this point, several studies found contextual variations among minors with respect to cognitive distortions. Young minors with depressive and aggressive symptoms, for example, may exaggerate accounts of true negatives, raising the question as to whether their cognitions were distorted or were expressions of their actual reality (Rudolph, & Clark, 2001). With older minors, in particular those who are engaged in antisocial behaviors, distorted thinking may be used as self-servicing explanations for their behavior (Liau, Barriga, and Gibbs, 1998). Giacola, Mezzich, Clark, and Tarter (1999) suggest that, unfortunately, the context of distortions and negative self-talk exhibited by minors may not be fully explored by professionals. Instead, their behavior is often interpreted or diagnosed as oppositional defiant behavior or attention deficit or conduct disorder. In their further exploration of context, however, the negative thought patterns and self-talk of minors in the Giacola and colleagues study were linked to harsh punishment and excessive criticism in their home life. Collectively, these studies highlight the need to assist minors to distinguish between feelings and cognitions, in view of their circumstances and symptoms.

Studies specific to anger control in minors include Seay, Fee, Holloway, and Giesen (2003), Sukhodolsky, Kassinore, and Gorman (2004), and Tate (2001). Tate, however, emphasized peer influence and positive cognitive restructuring in schools, instead of strategies that are intended to control and rehabilitate and maintain adult-imposed order. Sukhodolsky and colleagues (2004) found the procedure to be more effective with older adolescents than with younger children, especially when the former did not have a prior history of violent behavior. Seay, Fee, Holloway, and Giesen (2003) reported improvement in anger control when specific behavior was targeted, accompanied by practicing different responses. Bailey (2001) cites the importance of the involvement of family and the school and discussed cognitive restructuring as effective when age-appropriate strategies are used. Use of the technique as an intervention with minors includes the reduction of HIV risk behavior among African American adolescents (St. Lawrence, Brasfield, Jefferson, O'Bannon & Shirley, 1995). Another study provides evidence of effectiveness in changing the thought processes of African American adolescents who had been abused as children (Lesure-Lester, 2002).

Application of Cognitive Restructuring with Diverse Groups

EP 2.1.7b

The worldview and social psychological processes that shape minority perceptions and resulting thoughts or experiences are different from those of the majority culture. Because of the differences in reality, history and context can influence cognitive development and processes. For example, Shih & Sanchez (2005) examined the role of identity among youth who have multiple identities with respect to cognition. Multiple identities, they asserted, shaped how individuals view their world as well as how they adjust to the real world of rejection and discrimination. The findings reinforce the need to examine context distortions or negative thought patterns before concluding that an individual's cognitions and thought patterns are irrational.

At the practice level, cognitive restructuring is widely used in correctional institutions in which the majority of inmates are members of minority groups. Based on the belief that change is needed in the criminal mindset, cognitive procedures are intended to reduce recidivism. The assumption is that the inmates patterned way of thinking essentially short circuits their ability to think in a logical manner and to use reason to make decisions. As a therapeutic intervention, the goal is to alter criminal thought processes by restructuring or replacing them with more acceptable patterns of behavior. Pollack (2004), in critiquing cognitive procedures, explains that they tend to overlook or deemphasize the influence of environmental and structural inequities. Potocky-Tripodi (2002), however, suggests that under specific circumstances cognitive restructuring as "supportive" counseling may help immigrants and refugees with their maladaptive thoughts and increase their coping skills in intercultural situations.

EP 2.1.7b

Hays (1995), as cited in Cormier and Nurius (2003), critiques cognitive restructuring with multicultural groups and observes that this "approach supports the status quo of mainstream society" (p. 437). Cognitive models tend to presume that negative views of self and of the world represent cognitive distortions. But, standardized beliefs about how to perceive and react to the world suggest a monolithic worldview and experience. With this in mind, you should be aware that cognition and thoughts expressed by different individuals and groups can be considered highly irregular behavior when measured by majority culture. In using the technique, modifications may be required so that it is responsive and does not oppress or punish differences. As an example of understanding a different perspective, you are invited to return to the video segment with Kim and Yanping.

EP 2.1.6b & 2.1.9a

Culturally compatible adaptations and modifications of cognitive procedures are illustrated in studies with Chinese Americans (Chen & Davenport, 2005), Latino clients (Organista, Dwyer, & Azocar, 1993), Native Americans (Renfrey, 1992) and Muslims (Hodge & Nadir, 2008). Still, you should observe that preferences, such as spirituality, beliefs, and self-perceptions that give purpose and direction to what people think and feel, are constructed by culture and within the context of the environment (Bandura, 1988; Berlin, 2001; Bronfenbrenner, 1989). For example, Renfrey (1992) combined Native American religious ceremonies with cognitive procedures and Hodge and Nadir (2008) advocate for adaptations to achieve congruence between individual self-statements that are consistent with the beliefs of Muslims.

While there is a need to study different groups in their context and the influence on cognitive development and processes, there are research studies with respect to the efficacy of cognitive restructuring with different racial and cultural groups. Selected examples include interventions with African American women smokers (Ahijevych & Wewers, 1993), low-income African American woman in group treatment (Kohn, Oden, Munoz, Leavitt, & Robinson, 2002), and in addressing race-related stressors among Asian American Pacific Islanders in the military (Loo, Ueda, & Morton, 2007). Work by Kuehlwein (1992), Ussher (1990), and Wolfe (1992) reported positive results with gay and lesbian clients. The technique used as a component of treatment with women effectively helped them gain a sense of power in confronting cultural messages of ideal physical attributes (Srebnik & Saltzberg, 1994; Brown, 1994).

On the whole, research on the efficacy of cognitive restructuring with diverse groups is limited. The studies discussed here have demonstrated that adaptations in language, culture, and specific group circumstances can result in cognitive restructuring being an effective intervention strategy with diverse groups.

Procedures of Cognitive Restructuring

EP 2.1.10j

The primary goal of cognitive restructuring is to alter people's thoughts and feelings and the accompanying self-statements or behaviors. Cognitive restructuring is particularly useful in assisting individuals to gain awareness of self-defeating thoughts and misconceptions that impair their personal functioning and to replace them with beliefs and behaviors that are aligned with reality.

Several discrete procedural steps are involved in cognitive restructuring. Although different authors may vary slightly in how the steps are defined, the similarities between the various models are far greater than the differences. These steps, as summarized in Table 13-2, are adapted from the steps identified by Goldfried (1977) and Cormier and Nurius (2003).

The steps of cognitive restructuring are summarized in Table 13-3. Each of the steps and their elements are discussed. A case example is used to demonstrate the steps of cognitive restructuring.

1. Assist clients in accepting that their self-statements, assumptions, and beliefs largely mediate their emotional reactions to life's events. The power difference between you and a client is likely to become

TABLE-13-2 STEPS IN COGNITIVE RESTRUCTURING

1. Assist clients in accepting that their self-statements determine their emotional reactions to events. (Tool: explanation and treatment rationale)
2. Assist clients in identifying dysfunctional beliefs and thought patterns. (Tool: self-monitoring)
3. Assist clients in identifying situations involving dysfunctional cognitions.
4. Assist clients in replacing dysfunctional cognitions with functional self-statements.
5. Assist clients in identifying rewards and incentives for successful coping efforts.

CASE EXAMPLE

The goal of the adolescent in this case is to increase his comfort level in expressing himself in peer social situations at school. He reports that he experiences a high level of anxiety about joining a peer group at lunchtime because he believes that they see him as being stuck [stupid]. There have been times when he has at times joined a group, but he has not talked. When others in the group *haven't* talked to him, he *has* perceived their behavior as evidence of his being excluded. His goal is to join a peer group during the lunch period without feeling anxious, and eventually to participate in the group conversations.

heightened when you present a goal of changing how they perceive themselves or their world. Mistrust and suspicion may be particularly acute with minors, members of a racial or ethnic group, and individuals who are involuntary. Thus, in the first step it is important to provide clients with an explanation and your rationale for selecting cognitive restructuring as an intervention procedure.

EP 2.1.10f

Explanation of Cognitive Restructuring

Social worker: As I understand what you have said so far, you want to be a part of a group during the lunch period, but you are anxious about what others will think about you. But, you also stated that you want to be a part of the group and to talk. So that you may achieve this goal, we first need to determine what happens inside you that caused you to feel anxious. This will help you to become aware of the thoughts you experienced in the group. Specifically, we need to review what you say to yourself *before, during,* and *after* you join a group. Generally, our thoughts occur automatically, and often we aren't fully aware of many of them. Becoming aware of your self-defeating thoughts, assumptions, and beliefs is an important first step in replacing them with others that will help you achieve your goal.

Social Worker's Use of Self in Explaining Cognitive Restructuring

EP 2.1.10i

To guide you in assisting clients to understand cognitive restructuring, it may be advisable to use self as an example to explain the technique to the adolescent. As demonstrated in the following dialogue, the practitioner draws upon his own experience to show ways of thinking and responding to a situation. In doing so, the practitioner demonstrates to the adolescent how cognitions mediate emotions and thinking.

Social worker: What you think determines in large measure what you feel and do? For example, recently I bought a used car. My friend told me that I was stupid, or to use your word, stuck, to buy a used car instead of a new one. I could have made various meanings or self-statements related to this message, each of which would have resulted in different feelings and actions. Consider the potential responses that I might have made to my friend's comment:

Response 1: *He's probably right; he's a bright guy, and I respect his judgment. Why didn't I think of buying a new car? He thinks that I am stupid.*

If I think that he is right, then my feelings and statements are negative and I may not like my used car as much.

Response 2: *Who does he think he is, calling me stupid? He's the one who's stupid. What a jerk!*

If I think this way about my friend, I am likely to become angry and defensive, leading to an argument between the two of us about which one of us is right.

Response 3: *It's apparent that my friend and I have different ideas about cars. He's entitled to his opinion, although I don't agree with him and I feel good about buying a used new car. I don't like his referring to my choice as stupid, though. There's no point in getting bent out of shape over it, but I think I'll let him know how I feel about what he said to me.*

If I think the thoughts in the third example, I'm less likely to experience negative feelings about myself. I'll feel good about my decision despite the differences of opinion, and I won't be influenced by his lack of sensitivity.

In using a self example, the social worker pinpointed for the adolescent how thoughts and beliefs can cause difficulties as well as how cognitive restructuring facilitates working on developing other thoughts that are realistic and consistent with his goal. Further, he clarified that other responses could be made, but these three should suffice to make his point. The social worker then points out that the task at hand is to enable the adolescent to master his anxiety and for the two of them to explore how his self-statements have influenced his feelings and behavior.

EP 2.1.10f

The previous example showed how the rationale for cognitive restructuring can be presented in a simple, straightforward manner. A majority of clients given an explanation will agree to proceed. Their commitment to the procedure is also necessary because individuals tend to resist efforts to change their beliefs.

2. *Assist clients in identifying self-statements, beliefs, and patterns of thoughts that underlie his or her problem.* Once he or she accepts the fact that thoughts and beliefs mediate emotional reactions, your next task is to help the client to identify the thoughts and beliefs that pertain to his or her difficulties. This step requires a detailed exploration of events related to problematic situations and their antecedents, with particular emphasis on cognitions that accompany distressing emotions.

EP 2.1.10j

To begin the process, you would focus on problematic events that occurred during the preceding week or on events surrounding a problem the individual has targeted for change. As you and the individual recalls these events, you are listening for specific details regarding overt behaviors, cognitions (i.e., self-statements and images), and emotional reactions. Focusing on the cognitive and emotional aspects related to the event clarifies the connection between what an individual perceives and his or her emotions and thoughts. From this point on, the aim is to identify his or her self-statements and beliefs related to the event, and to help him or her to become aware of the way in which him or her automatic thoughts and beliefs act as powerful determinants of their behavior.

EP 2.1.10d & 2.1.10f

As you and the individual continue to explore his or her thought patterns, you will be able to *identify thoughts and feelings that occur before, during, and after events.* To elicit self-statements, ask the individual to recreate the situation as it unfolded, recalling exactly what he or she thought, felt, and did. For example, with the adolescent, the practitioner asked him to describe his thoughts and feelings when he joined the lunch group. If this reflection had proven to be too difficult, as an alternative, the practitioner could have asked him to close his eyes and run a movie of his thoughts and feelings prior to, during, and after the problematic event.

By listening to the adolescent as he described his thoughts, the social worker was able to pinpoint the cognitive sets that predisposed him to experience certain emotions and to behave in predictable ways. To illustrate, consider the adolescent's inner dialogue of self-statements *prior* to his joining a group of peers in the lunchroom:

EP 2.1.10i

- *"I'm outey [out of here—disappear]. Straight up [the truth is], I'm not sure I want to join the others. If I do, I'll just cool [sit] there and feel that they be [are] hating on me [leaving me out]." Straight up, this is whacked."*
- *"If I show [join in], they'll dis me [disrespect me] about something."*
- *"I'd better show; otherwise, they'll be hating on me later [talking about me]. I'm outey, straight up." "I'm cool" [okay].*

Given these self-statements, the adolescent clearly experienced anxiety about joining the group, the content of which was also self-protective. His thought pattern and the accompanying self-statement predisposed him to enter the situation expecting defeat. In listening to his self debate as he recreated the event, the practitioner also observed his nonverbal cues. His physical posture, for example, spoke volumes. Not only did his self-defeating statements dominate his cognition of the group situation, it is likely that his nonverbal behavior also contributed to his self-presentation in the situation.

Exploration of self-statements during events often reveals that thoughts maintain self-defeating feelings and behaviors and drastically reduce personal effectiveness. For example, the adolescent tended to dwell on his fears and was vigilant to the possible negative reactions of others. As a result, he was unable to fully *tune in* to conversations or to verbally express himself in a way that created favorable impressions. In other words, he found it difficult to be fully present and involved because of his self-consciousness and anxiety about exposing his imagined personal inadequacies.

To illustrate the impact of his thoughts, let's again consider his self-statements *during* the time he joined a lunch group:

- *"Well, here I am, nothing is different. I am being dissed [disrespected, left out of the conversation]."*
- *"I wish I had the low, low [something interesting to say] but my life's ain't about doing anything [uninteresting]. What's up with this? They ain't interested in any low [ideas, information] that I might put out [say]."*
- *"Go figure, they're wondering why I even showed [joined them]. I don't add anything, but it's cool, I out of here [the group is not that important to me]."*

Because the group did not respond in the way that he had hoped, he continued to be preoccupied with self-defeating thoughts. He concludes that he has little or nothing to offer, and behaves accordingly, hence, his thoughts about being unwelcome and unworthy are reinforced. In turn, the potential of his engaging with his peers is blocked.

EP 2.1.10j

An individual's thoughts and feelings after an event can reveal the impact on their subsequent behaviors. In the telling of what had occurred, and the individual's conclusions, you are able to further highlight the mediating function of cognitions. Consider the adolescent's thoughts and feelings as he described his experience *after* he joined the group:

- *"I out man [blew it again]. I'm too threw [I'm finished; I might as well quit trying]. This ain't real for sure [no use kidding myself; I just can't talk with others]."*
- *"It ain't like that [they didn't really try to include me]. They be hating on me [it's obvious they could care less about me]. They'd probably be okay if I didn't show up tomorrow."*
- *"This is whack [uncomfortable; I won't try to eat lunch with them again]. I don't enjoy it, and I'm sure they don't either. Tomorrow I outey [eat by myself], for shiddley [for sure]."*

EP 2.1.10i

The following are general inquiries that can be developed into questions to help individuals to assess the rationality of beliefs and self-statements:

- *Ask how they reached certain conclusions*
- *Elicit evidence that supports their perception or beliefs*
- *Explore the logic of beliefs that have magnified their feared consequences of certain actions*

EP 2.1.10j

To assist the adolescent to assess the rationality of his conclusions, for example, the social worker asked him the following questions:

Social worker: So did someone "dis" you when you joined the group? What did they say that made you think that they were "hating" on you?

As illustrated in the following example, the individual may not be able to immediately acknowledge the irrationality of his or her beliefs:

Adolescent: Well, you see, this girl, I got the low [*perception, idea*], by the way she was looking at me, straight-up, this was whack [*not good*].

Individuals can tenaciously cling to their misconceptions and argue persuasively about their validity. For the adolescent, his perception of the way in which the girl looked at him confirmed that his thoughts about being in the group were valid. As the practitioner, you must therefore be prepared to challenge or "dispute" the validity of irrational beliefs, by emphasizing the costs or disadvantages associated with counterproductive beliefs. To illustrate how this works, the practitioner's response prompted the adolescent to consider the relationships between his thoughts and his goal.

Social worker: Okay, if you continue think that joining in with the group is "whack," and you continue to be "outey," how will this affect your goal of becoming comfortable about joining a lunch period group?

EP 2.1.7a

Clusters of misconceptions are commonly associated with problematic behavior, and they also tend to have a common theme. For the adolescent, the central theme or a slight derivative of his self-statements and expectations is that he is unwelcome and unworthy of becoming a participating member of a lunch group with peers. As a result, he is quick to reach conclusions that support his thoughts and beliefs, contributing to his expectations of self and unrealistic expectations of his peers. Often it is possible to observe such thought patterns by eliciting the accompanying thoughts in clusters, examples of which are illustrated in Table 13-3. By identifying clusters or patterns of misconceptions, you can direct your efforts to the theme common to all of them, rather than dealing with each misconception as a separate entity.

EP 2.1.10i

3. Assist clients in identifying situations that engender dysfunctional cognitions. Pinpointing the places where stressful events occur, the key persons involved, and situations that involved demeaning oneself, in the face of self-expectations enables you and the individual to develop tasks and coping strategies that are tailored to those specific situations.

EP 2.1.10j

TABLE-13-3 BELIEFS AND SELF-EXPECTATIONS

BELIEFS	SELF-EXPECTATIONS
Beliefs about oneself	I am usually not very good at anything that I do. My accomplishments aren't that significant, anyone could have done it.
Beliefs about others' perceptions and expectations of oneself	My partner dismisses my opinion, because I am not very smart. When I compare myself with others, I never quite measure up.
Expectations of oneself	At work, I feel I must perform better than others in my unit. I should be able to do lots of things and perform at a high level.
Expectations of others	My daughter should understand how I feel without my having to tell her. She should want to visit me.

EP 2.1.10m

Self-monitoring between sessions is a concrete way for individuals to measure and recognize cognitions related to their difficulties around problematic events. In doing so, they are able to increase their awareness of the pervasive nature of their thoughts and the need to actively cope with them. Self-monitoring thus expands self-awareness and paves the way for later change efforts.

To facilitate self-monitoring with the adolescent, the practitioner asked him to keep daily logs to record information, as illustrated in Figure 13-4. In the log, the adolescent recorded the situation, his feelings, beliefs, and self-statements. The daily log may also reveal other factors that influence his feelings about joining the lunch group, such as his comfort level with the composition of the group.

Daily self-monitoring is a valuable tool because it can focus a client's efforts between sessions, clarify the connections between cognitions and feelings, and provide information about the prevalence and intensity of thoughts, images, and feelings. In this case, keeping a daily log stimulated the adolescent to logically examine his thoughts.

Social Worker: *"After completing a week of logs, did you find anything out about yourself and the way that you think and behaved when you are with a group?"*

Adolescent Client: *"Yeah, I could see that I was whacked [out of bounds], and when I was scared I acted stuck. Then I wanted to be out of there before they dissed me."*

To prevent a person from becoming overwhelmed by the task of keeping a log, you might suggest that a client initially limit his or her recording to events related to those identified during the session and restrict recordings to no more than three each day. As an alternative, or in addition to, self-monitoring can also include the use of images drawn by the individual. As other counterproductive thought patterns emerge during sessions, the focus of self-monitoring can be shifted as necessary.

As you and the individual review completed log sheets and identify problematic feelings and cognitions, it is important to note recurring situations or themes. A recurring theme for the adolescent, for example, was his fear about not being included if he joined a peer group during the lunch period.

4. *Assist clients in substituting functional self-statements for self-defeating cognitions.* As a person expands his or her awareness of their dysfunctional thoughts, beliefs, and images, your goal is to help them recognize how they result in negative emotional reactions. Having done so, the goal is to help them cope as they begin to learn new patterns. Coping strategies typically consist of self-statements that are both realistic and effective in diminishing or eliminating

Date: Tuesday, September 6, 2008

Situation or Event	Feelings (Rate rationality from 1 to 10)	Beliefs or Self-Statements (Rate intensity from 1 to 10)
1. Joined group at lunch time	Scared (7) Stuck (7)	They will dis me, this is whack (6)
2. No one said anything to me; I didn't say anything	I'm outey (4); afraid to join in (8); disgusted with self (7)	I should speak up (9); they will ignore me and I'd be embarrassed (2); it is not worth the hassle (3)

FIG-13-4 Daily Log for Adolescent


EP 2.1.10j

negative emotional reactions and self-defeating behaviors. Although functional self-statements are intended to foster courage and facilitate active coping efforts, you should not ignore the individual's struggle in shifting from habitual, ingrained patterns of thinking, to adopting new behavioral patterns. In recognition of the difficulty and anxiety that an individual may experience, coping self-statements support the transition as he or she risks new behavior.

First, to introduce the adolescent to positive self-statements, the practitioner explained the rationale for new self-statements:

Social worker's explanation: *"Now that you've identified key self-defeating beliefs and thoughts, we're going to focus on how you can replace them with positive statements. It will take a lot of hard work on your part, but as you practice, you'll find that they will become more and more natural allowing you to rely less on old ways of thinking."*


EP 2.1.10i

Because mastery is unlikely to be immediate, after the practitioner's explanation, he modeled coping self-statements that the adolescent could use as substitutes for his thoughts and beliefs. In the exercise, the social worker assumed the role of the adolescent, using his words and thoughts as he coped with the target situation.

Social Worker as Adolescent client: *"I know a part of me wants to avoid being dissed [the discomfort of socializing]. I feel whack [scared], but it's not going to get any better by being outey [withdrawing]. "I don't have to low [talk] a lot to be part of the group. If I tune [listen] to the others and get my mind off myself, I can be cool [involve myself more]."*


EP 2.1.10i

Notice how the social worker modeled the adolescent's struggle and the idea of coping rather than mastery of new self-statements. Modeling coping self-statements should reflect the individual's actual experience, whereas mastery self-statements do not. Moreover, the former convey empathy for and understanding of the individual's struggle, which in turn inspires greater confidence in the process. As an alternative coping self-statement, the practitioner worker proposed the following:

Social worker: *"Yes, you might think: 'I can't expect them to include me in their conversations. It would be nice if they did, but if they're going to do so, I'll have to be responsible for including myself. It's better than withdrawing and feeling left out.' "*

After modeling coping self-statements, it is appropriate to ask whether the client feels ready to practice similar behavior. To enhance the effectiveness of guided practice, you could suggest that the person close their eyes and picture themselves in the exact situation they will be in *before* engaging in the targeted behavior. When they report they have succeeded in capturing the situation, ask them to think aloud the thoughts they typically experience when contemplating the targeted behavior. Then ask them to substitute coping thoughts, coaching them as needed. Give positive feedback and encouragement when they produce reinforcing self-statements independently, even though they may continue to struggle with conflicting thoughts. You may also expect the person to express doubt and uncertainty about their ability to eventually master new patterns of thinking. If they do, explain that it is natural for people to experience misgivings as they experiment with new ways of thinking. Continue to practice and coach them until they feel relatively comfortable in their ability to develop new self-statements.

When the individual has demonstrated his or her confidence in using coping self-statements before entering a targeted situation, you can shift to a strategy of self-statements *during* the time the client is actually in the target situation. As done with the adolescent, the practitioner models coping self-statements:


EP 2.1.10j

Social Worker as Adolescent: *"Okay, I'm feeling anxious. That's to be expected. I can still pay attention and show interest in the group. I can tune [communicate] by nodding my head, laughing when someone says something funny and not feeling that this is whack. As I feel more comfortable, I can join in by asking for questions if I want to know more. This is another way to show interest, especially if I have some take on the subject they're discussing. I think that my opinions are worth as much as theirs. Go ahead, take a chance and express them, but look at others as I talk."*

Following the modeling exercise, the social worker asked the youth to describe his feelings about what had happened so far. Inquiring about feelings was important; for example, had the modeling resulted in the youth becoming anxious, uncomfortable, or skeptical. These feeling should be dealt with before proceeding further.

Again, it may be worthwhile for you to model and eventually have the individual rehearse reinforcing statements. Here are some examples:

EP 2.1.10i ***Social Worker as Adolescent:*** *"Well, I did it. I stuck it out and even said a couple of things. That's a step in the right direction."*

- ***Adolescent Statement:*** *"No one played me [ignored me] when I sat down with the group. Man, it was hot [good] maybe I'm not stuck [stupid] so bad after all. Even though I was on ten [anxious] it was 100 percent real [good], it was so fire that it snuck upon me [even better than I expected]. It's a rap, [accomplishment]."*

EP 2.1.10j

To further assist clients in utilizing positive statements, it is beneficial to negotiate them as tasks between sessions. Between-session tasks foster autonomy and independent action by clients. But don't rush them, because undue pressure may be perceived as threatening or discouraging. You may use the readiness scale (discussed earlier in this chapter) as a gauge.

EP 2.1.10m

Continued self-monitoring is essential as clients implement Step 4 of the cognitive restructuring process, using the format suggested in Figure 13-4 as a tool. As the adolescent progresses, a fourth column could be added entitled, for example, *"Rational or Positive Coping Self-Statements."* By having an individual fill in a column such as this, the exercise can facilitate the development of reinforcing statements and eventually replace self-defeating ones.

EP 2.1.10i

Another technique that can help a person to replace their automatic problematic self-statements includes encouraging them, upon their first awareness of such thoughts, to nip them in the bud. For example, you might use the image of a flashing yellow signal, which indicates caution and their need to replace problematic thoughts. Substituting positive self-statements for self-defeating ones is the heart of cognitive restructuring. Because thoughts tend to be automatic and deeply embedded and persistent, it is important to explain that Step 4 may span over a time period in which a satisfactory degree of mastery is gradual, however, it is possible to achieve over time.

5. *Assist clients in rewarding themselves for successful coping efforts.* For people who dwell on their failures and shortcomings, and rarely, if ever, give themselves positive feedback, Step 5 in cognitive restructuring is especially important. When a person has mastered new statements and behaviors, you should reinforce their accomplishment by coaching them in giving themselves credit.

EP 2.1.10j

Social worker: *"So you joined the group. That's exciting, given where you started. What are your thoughts on how you would like to celebrate?"*

Adolescent: *"Well, it's a done deal as far as I am concerned. I even sent a text to a girl in the group, and she wrote back "r u ok, SPK."*

Social Worker: *"Well, that is a good thing! I also want you to think about rewarding statements that you can make to yourself. I'm going to pretend that I am you. I'll say aloud self-statements you might think about."*

- *"I wasn't sure that I was up to it but I did it!"*
- *"I backed off. I replaced my negative thoughts and stayed in the game!"*

Social Worker: *"Now what would you say to yourself?"*

Adolescent: *"Like I told you man, it's a rap, it's all the way live, you feel me [understand]! Everything is cool, maybe I'll go to a movie."*

For some people, rewarding themselves using self-statements can be difficult and they may feel awkward or self-conscious. Adults may be more readily able to think about rewards than minors. When a person is hesitant, empathic understanding and encouragement on your part will usually prompt them to try this exercise. Some individuals, like the adolescent, may focus only on the overall outcome. For example, his goal of joining a lunchroom group had been achieved, plus a bonus of a text message exchange with a female in the group. In any case, it is important that you review and credit an individual's progress with him or her so that

the techniques learned can be used in the future in other situations.

Strengths, Limitations, and Cautions

EP 2.1.10a

Cognitive restructuring is an effective procedure that is intended to address a range of problems related to an individual's cognitions and thought patterns. Research studies have shown the procedure to be particularly useful in altering perceptions, distorted beliefs, and thought patterns that result in negative or self-defeating behaviors. As a systematic process and problem-solving procedure, cognitive restructuring is compatible with crisis intervention, the task-centered system, and solution-focused treatment. The "miracle question," a solution-focused technique, may indeed motivate people to address problematic behavior and encourage them to formulate specific change goals. For the adolescent in the case situations, for example, the miracle question may have helped him to imagine being accepted by the peer group.

In assisting people to change, however, social workers must not mistakenly assume that a person will be able to perform new behaviors solely as a result of changes in their cognitions or beliefs. In reality, they may lack cognitive and social skills and require instruction and practice before they can effectively perform new behaviors. Cognitive restructuring is intended to remove cognitive barriers to change and foster a willingness to risk new behaviors, but it does not always equip clients with the skills required to perform those new behaviors.

Attempts to reshape thought patterns and perceptions to reflect a different pattern—in contrast to their actual experience—may be perceived as a threat, especially with diverse and involuntary clients. Furthermore, as noted by Vodde and Gallant (2002), simply changing one's story does not ensure a certain outcome, given the presence of very real external factors such as oppression or rejection. Thus, without an acknowledgment of these factors, diverse clients may perceive cognitive restructuring as blaming or just another form of social control and ideological domination. Of course, some minority group members have mastered a dual frame of reference that is selectively congruent with dominant views and beliefs. Thus, for these individuals, cognitive restructuring can be a useful intervention procedure.

Finally, although cognitive theorists attribute most dysfunctional emotional and behavioral patterns to mistaken beliefs, these are by no means the only causes. Dysfunctions may be produced by numerous biophysical problems, including brain injury, neurological disorders, thyroid imbalance, blood sugar imbalance, circulatory disorders associated with aging, ingestion of toxic substances, malnutrition, and other forms of chemical imbalance. Consequently, these possibilities should be considered before undertaking cognitive restructuring.

Solution-Focused Brief Treatment

EP 2.1.10a

Solution-focused brief treatment is a postmodern, constructivist approach with a unique focus on resolving client's concerns (De Jong & Berg, 2008; Murray & Murray, 2004). The approach was developed by Steve de Shazer and Insoo Kim Berg and their associates' work at the Brief Family Therapy Center in Milwaukee, Wisconsin (Nichols & Schwartz, 2004; Trepper, Dolan, McCollum, & Nelson, 2006). Influenced by the views of Milton Erickson, de Shazer and Berg embraced his assumption that people were constrained by the social construction of their problems. Thus, a goal of the approach is to release their unconscious resources, thereby shifting from a problem-oriented perspective to one that is more solution-based. In this regard, the approach integrates aspects of cognitive restructuring. As the professional, you have an active role in first "helping clients to question self-defeating constructions," and then assisting them to construct "new and more productive perspectives" (Nichols & Schwartz, 2004, p. 101). Work with clients is facilitated by having them identify and prioritize solutions. Like the task-centered system, the solution-focused approach is based on the premise that change can occur over a brief period of time.[5]

Tenets of Solution-Focused

EP 2.1.10a

The solution-focused approach emerged over the past 20 years as a strategy for working with adults, minors, and families, including clients who are involuntary. The approach emphasizes the identification of solution, rather than resolving problems. A series of interview questions are used during the phases of the approach and are instrumental to the development of solutions (De Jong & Berg, 1998; 2008). The solution-focused approach draws on

people's strengths and capacities, with the intent of empowering them to create solutions. Although clients may begin with a problem statement, a key belief of the approach is that the analysis of a problem does not necessarily predict a client's ability to problem solve (Corcoran, 2008). Furthermore, solutions and problems are not necessarily connected. Therefore, the thrust of your work with individuals encourages solution talk, rather than assessing how problems developed or are perpetuated (Koob, 2003; Nichols & Schwartz, 2004).

Oriented toward the future, rather than the past, the solution-focused treatment approach asserts that clients have a right to determine their desired outcomes. Change is believed to occur in a relatively brief time period, especially when people are empowered as experts and are encouraged to use their expertise to construct solutions. As the practitioner, your role is to listen, to absorb information that a person provides, and subsequently guide them toward solutions utilizing the "language of change" (DeJong & Berg, 2002, p. 49). Lee (2003) believes that these principles are motivating factors that strengthen the efficacy of the solution-focused approach in cross-cultural practice.

The manner in which clients are categorized is unique to solution-focused. The three types of individuals are identified as *customers, complainants,* or *visitors* (Corcoran, 2008; De Jong & Berg, 2008; Jordan & Franklin, 2003). *Customers* are individuals who willingly make a commitment to change. Therefore, the series of questions and the tasks to be completed are directed to them. Those individuals who identify a concern but do not see themselves as part of the problem or solution are referred to as *complainants.* A person who is willing to be minimally or peripherally involved but is not invested in the change effort is designated a *visitor.* These distinctions allow you to identify where potential clients stand relative to their commitment to change and their ownership of concerns. In distinguishing the various types, you are able to focus the concern and solution identified by the customer. There may be instances however, when it is advisable to engage the complainant or visitor, if only to ensure that he or she does not interfere with the customer's change efforts.

Theoretical Framework

EP 2.1.7a

The solution-focused approach borrows from the social constructivists' perspective belief that people use language to create their reality (deShazer & Berg, 1993). In the solution-focused approach, reality is constructed by culture and context, as well as perceptions and life experiences, thus an absolute truth does not exist (Murray & Murray, 2004). For example, truths about normative functioning or development have tended to be imposed by professionals, which may have little relationship to the reality of an individual's situation (Freud, 1999; Nichols & Schwartz, 2004). Therefore, it is more important for you to understand the way in which a person constructs the meaning of his or her experiences and relationships. The approach also draws from assumptions of cognitive-behavioral theory, specifically that cognitions influence a person's language and behavior.

Empirical Evidence and Uses of Solution-Focused Strategies

EP 2.1.6b

Empirical evidence was at one point in time considered to be less than robust. There is, however, substantial evidence of the effectiveness of the approach in practice settings and with different populations (Corcoran, 2008; Corcoran & Pillai, 2009; Kim, 2008). Solution-focused brief treatment has been utilized in a variety of settings and with diverse populations, including persons with mental illness and involuntary clients (Berg & Kelly, 2000; Corcoran, 2008; DeJong & Berg, 2001; Greene, Kondraft, Lee, Clement, Siebert, Mentzer, & Pinnell, 2006; Hopson & Kim 2005; Hsu, 2009; Tohn & Oshlag, 1996; Trepper, et al, 2006). Ingersoll-Dayton, Schroepfer, and Pryce (1999) found that a focus on positive attributes of nursing home residents with dementia, rather than their behavioral problems, changed interactions between the residents and the staff. The efficacy of the approach has also been demonstrated in couple's therapy and premarital counseling (McCollum & Trepper, 2001; Murray & Murray, 2004; Nelson & Kelly, 2001). Research on specific strategies of the model, for example using exception-based solutions, found strategies of the model were successful in changing domestic violence behavior (Corcoran & Franklin, 1998; Lee, Greene, & Rheinscheld, 1999; McQuaide, 1999).

Utilization with Minors

EP 2.1.6b

There is increasing evidence in the effectiveness and utilization of solution-focused strategies with minors (Kelly, Kim, & Franklin, 2008). In public school settings, study results show the successful specific solution-focused explore feelings, develop behavioral goals, and encourage positive

behaviors (Corcoran & Stephenson, 2000; Franklin & Hopson, 2009; Franklin & Streeter, 2004; Newsome, 2004; Springer, Lynch, & Rubin, 2000; Teal, 2000). Similarly, positive outcomes were reported for improving individual social skills and to manage school related behavioral problems (Cook & Kaffenberger, 2003; Gingerich & Eisengard, 2000; Gingerich & Wabeke, 2001). Multiple studies involving adolescents have shown positive results. These studies include high risk juvenile offenders, students referred for academic and behavioral problems or drug use, and pregnant and parenting teens (Corcoran, 1997, 1998; Froeschle, Smith, & Ricard, 2007; Harris & Franklin, 2003; Kelly, Kim & Franklin, 2008; Selekman, 2005).

Application with Diverse Groups

EP 2.1.7b

Critiques of the solution-focused approach point to a lack of attention on the diversity of clients (Corcoran, 2008). Demer, Hemesath, and Russell (1998) praised the approach for its explicit attention to competence and strengths, but they believe that it fails to address gender-related power differences. For example, they might argue that despite a change in the narrative of men and women in abusive relationships, the change lacked sufficient attention to the narrative of actual power differences. Proponents of the approach, however, assert that the solution-focused approach is responsive to diverse groups because its basic thrust recognizes the expertness of the narrative and language of the individual. Further, they assert that because professionals respect and honor the distinct cultural background of individuals, the basic tenets of the approach are consistent with competent multicultural practice with individuals in social service agencies (De Jong & Berg, 2002; Pichot & Dolan, 2003; Trepper, et al., 2006). The results of previously cited research studies with adolescents, the majority of which were members of diverse groups and also involuntary clients, are promising.

Solution-Focused Procedures and Techniques

EP 2.1.10j

The stages of "*solution building*" as outlined by De Jong and Berg (2003, p. 17) proceed as follows:

- *Description of the Problem.* Individuals are invited to give an account of his or her concern or problem, however, as the practitioner, you refrain from eliciting details about antecedents, severity or the cause of their concern. While listening to their description of the problem, you are looking for ways in which you can guide them toward a solution.

EP 2.1.10d

- *Developing Well-Formed Goals.* In this stage, your work involves encouraging the individual to think about what will be different once the problem no longer exists. Individuals are asked to describe what he or she wishes to be different, and this information is used to develop their goal.

EP 2.1.10f

- *Exploring Exceptions.* Questions asked of the individual in this stage are focused on those times in his or her life when the problem was not an issue or was less of a concern. These questions are followed by who did what and what could happen that would decrease the concern and make more exceptions possible.

EP 2.1.10j

- *End-of Session Feedback.* The aim of the stage is to compliment and reinforce what an individual has already done to solve the problem. Feedback is also based on the information that the individual has provided about his or her goals and exceptions. Also, clients are asked what he or she should do more or less of toward accomplishing their goal.

EP 2.1.10i

- *Evaluating Progress.* Monitoring progress is ongoing and is specific to evaluating the individual's level of satisfaction with reaching a solution. The scaling question facilitates this process. After the individual has rated his or her satisfaction level, you work with him or her to identify what needs to occur so that the problem is resolved. In later sessions, a central question posed to the individual is: "*What's better?*" When the individual's primary concern has been resolved in a satisfactory manner, contact with you is terminated.

EP 2.1.10m

Throughout your work with individuals, you make use of a series of questions that follow the phases of helping, specifically, engagement, assessment, goal setting, intervention, and termination. Four questions

TABLE-13-4 SOLUTION-FOCUSED QUESTIONS

Scaling
Coping
Exceptions
Miracle

EP 2.1.10j

typically guide the engagement, the formation of goals, and the solution-building process. The various types of interview questions are summarized in Table 13-4; they are intended to move clients toward goals and to think of solutions.

Scaling questions, using a scale of 1 to 10, solicit a person's level of willingness and confidence in moving toward the development of a well-formed goal and also encourages them to observe their progress. These questions may also be instrumental in preventing the client from returning to describing problematic behaviors and in developing specific behavioral indicators along a continuum of change (Corcoran, 2008; Trepper, et al., 2006).

Coping questions are intended to highlight and reinforce a client's resources and strengths. For example, how has he or she managed their current difficulty or the resources he or she has used previously when dealing with an issue? Coping questions credit the individual's prior efforts to manage a difficulty, and reenergize his or her strengths and capacities. A message for instance is: "In view of the chaos that you described in the transitional housing facility, please tell me how you were able to find the time to be actively involved with your children?"

Exception questions are considered to be the core of the intervention (Corcoran, 2008). Designed to diminish the problem focus, these questions assist a person to describe life when his or her current difficulty did not exist (Bertolino & O'Hanlon, 2002: DeJong & Berg, 2002, 2008; Trepper, et al., 2006; Shoham, Rorhbaugh, & Patterson, 1995). For example, "What was it like when you owned your home and lived in a neighborhood of your own choosing?" The exception question also advances the individual's ability to externalize or separate from the problem by building upon strengths and resources (Corcoran, 2008). In a segment of the Corning family video, Irwin asserted that "A man should provide for his family." To separate his sense of self from his job loss and highlight his strengths, you would emphasize that he had done so up until the time he had lost his job due to circumstances beyond his control. In essence, you are *reframing*, which allows you to address his cognition that contributed to his negative self-talk statement.

Miracle questions draws the individual's attention to what would be different if he or she reached the desired outcome (Corcoran, 2008; Koob, 2003; Lipchik, 2002). For example, "How do you imagine that you will feel when your family moves into your own apartment?"

EP 2.1.10j

Typical interview questions that facilitate an individual's capacity to think about the future and to identify solutions include the following queries adapted from De Jong and Berg (2008), Lipchik (2002), and de Shazer and Berg (1993).

- *How can I help?*
- *What's better?*
- *How will you know when your problem is solved?*
- *What will be different when the problem is solved?*
- *What signs will indicate to you that you don't have to see me any longer?*
- *Can you describe what will be different in terms of your behavior, thoughts, or feelings?*
- *What signs will indicate to you that others involved in this situation are behaving, thinking, or feeling differently?*

EP 2.1.10j

Questions will of course vary depending on the stage of the intervention, which is highlighted in the following examples adapted from De Jong and Berg (2008):

"How can I help?" is typically asked in the engagement session.

"What do you want to be different?" is intended to facilitate the development of a well-formed goal. Goals sought by the individual are framed on the basis of exceptions; specifically, individuals are asked about the absence of the problem (the exception) and it is on this basis that the work toward a solutions is formed.

For individuals who are involuntary situation, De Jong and Berg (2008, p. 372) recommend beginning the interview with questions that encourage the individual's participation by allowing the client to provide his or her view of the situation. Examples are:

"Whose idea was it that you needed to come here?"

"What is your understanding of why you are here?"

"What makes the _____ (pressuring person or mandating authority) believe that you needed to see me?"

"What is the difference between your point of view and that of the person who required that you come here?"

These questions are followed by, for example "what could be different?" and, as appropriate, coping or scaling questions and the miracle question.

In subsequent sessions, from one session to the next, interview questions are focused on:

What is better?

What could the individual continue to do more or less of?

Again, the flow of your questions will vary, influenced by the content of the conversation with each individual. For example, if the individual reports that little or no change has occurred, you would inquire about how he or she is coping. If indicated, you might ask a scaling question to gauge the level of stress. For instance, you would have the individual rate his or her current level of concern, and also what would be different or better at the next level. "*Would you rate what will be different in terms of your behavior, thoughts, or feelings when you move to the next level?*"

In the termination stage, the focus of your questions would emphasize signs of what is different. Specifically, you would ask, "*What signs will indicate to you that others involved in this situation are behaving, thinking, or feeling differently?*"

Compliments, bridging, amplification and *tasks* are techniques that are integrated with the process of asking questions. Compliments, for example, provide feedback about an individual's effort, as well as what he or she has accomplished. They are used as a means to reinforce their strengths and successes. Bridging is also a part of the feedback, the content of which clarifies goals, exceptions, or strengths. The technique of amplification encourages an individual to elaborate on the "What's different?" question. It may also be used as a link to a compliment and to link tasks to the miracle question. Used in another way, amplification can inform goals and tasks related to the miracle question. Tasks suggested by you can be either *formula* or *predictive* in nature, and they may be completed during or after a session. For instance, a post-session formula task for a couple who is experiencing conflict in their relationship would be to imagine how their relationship would be if the miracle occurred. In using a prediction task, you would direct the couple to predict the status of their conflict, for better or for worse, tomorrow (de Shazer, 1988). In essence, the predictive task invites them to think about what would be different.

EP 2.1.10i

To illustrate the procedures and some of the techniques of the approach, the case situation highlighted in the Ideas in Action box is used. The session is the third of the eight planned between the youth and the social worker.

EP 2.1.10j

IDEAS IN ACTION

Antonio, age 16, is a resident in a treatment center for juvenile offenders. Since the previous session with the social worker, he has transitioned from the lockdown area in the center to a less restrictive area of the center, referred to by the other residents as the "freedom house." Case notes indicate that Antonio had made significant changes in his aggressive, antisocial behavior, hence, the move to another level in the facility. Prior to his admission to the facility, Antonio lived with his mother, stepfather, and siblings. The parents are now divorced. For the most part, he has had a good relationship with his family, especially with his mother. This is the third session with the social worker. As he entered the room, he takes a seat on the couch and leans back. In previous meetings, he and the social worker engaged in small talk, but today he is unusually quiet. The session begins with the social worker asking him "What has happened that's better?" In reply, he informs her that he is moving to "freedom house" after his meeting with her. Afterwards, he becomes silent and slumps down on the couch. The social worker waits for him to speak. After about 5 minutes of silence, he presents a new concern.

Social Worker: Wow, Antonio, you are moving to "freedom house." [*reinforce/compliment*]

Antonio: Yep, now I can wear my own clothes, be in a room by myself, and go home on weekends. Soon, I will be able to get out of this place!

Social Worker: How did this happen? [*amplify*]

Antonio: Well, I stopped messing up, you know, acting all bad and stuff and fighting. You helped me a lot with my attitude.

Social Worker: Thank you. But you did the work on your own and now you are moving to another level. That's great! [*complimenting/bridging*] Now you've reached this level, what will it take for you to remain in freedom house, eventually be able to go home? [*do more of*]

Antonio: Like I said, I keep a check on my attitude. Right now, everything here is going okay. But I am not talking to my mother right now!

Social Worker: You and your mother usually talk everyday. What's different?

Antonio: Well, you see, whenever my mom has a new boyfriend or dude whatever, me and my brothers and sisters make up a name for him as a joke-and my mother always laughs too you know. This new dude is Clarence, so I called Claudius, and she got all bent; told me that I needed to respect him and some s...., whatever!

Social Worker: Is this a different reaction from your mother? [*What's different?*]

Antonio: Yeah, like she was really mad. I was surprised.

Social Worker: You said that there were times when your mother laughed when you joked about Clarence. What was different about this time? [*exception*]

Antonio: Well at other times, it was just me and my sister and brothers, no one else was around.

Social Worker: Sometimes, what else was different?

Antonio: I didn't change my voice and mimic the way he talks.

Social Worker: So you noticed that your mother did not get mad at you when you did not mimic Clarence? [*amplify*] Could you do this more often?

Antonio: Yeah, I guess so.

Social Worker: Is it possible that she's more serious with this guy than with some of the past ones? [*amplify, to encourage evaluation of his perception*]

Antonio: Nooo ... Man, she told me that she met this dude and then she brought him here two days later she to meet me when she visited. After two days! So she told me to say hello, so I said Hola, which is hello, and then I called him Claudius and she said that I was being disrespectful, and they left. The next day she called wanted us to do something together, and I'm like, ...

Social Worker: So you have used funny names to deal with the men your mother has been involved with since she and your stepfather divorced. Using funny names and joking around worked for you until now, and your mother also laughed with you [*coping*]

Antonio: Pretty much. But the way they acted, I think that they really like each other.

Social Worker: So, you think that this relationship is different. What will it take for you to talk to your mother? [*encouraging a solution*]

Antonio: Mmm, I don't know, I don't really care that much right now. I kind of need a break from her anyway. I feeling super stressed out right now.

Social Worker: You are feeling super stressed, okay. Have there been other times when you felt this way which caused you to want to take a break from your mother? [*exception*]

Antonio: Yeah, when she was late for my birthday party that the staff had for me.

Social Worker: What did you do?

Antonio: Nothing, cause when she arrived, we were okay.

Social Worker: Can I ask you a 1–10 question? Would you compare the two situations; you rate your level of stress with your mother, then and now? [scaling question]

Antonio: Yeeaahh. (said sarcastically)

Social Worker: That wasn't super convincing Antonio, thaaanks (laughs) I asked because it's a good way to let me know where you're at since, unfortunately, I'm not a mind reader.

Antonio: [Laughs] Alright go ahead then ...

Social Worker: Where is your stress level about the party and now: If you tell me a 10, this means that your stress is very high, and a 1 means that you are being calm as a cucumber [*scaling question*].

Antonio: Ahh, like a 3 for the party, because I got over it as soon as she arrived. Now, maybe a 5.

Social Worker: Okay, so like right in the middle? You're not super stressed about your mom, but she is still on your mind.

Antonio: Yeah, for now anyway.

Social Worker: What would it take for you to feel less stressed about your relationship with your mother? [*bridging, encouraging his ideas about a solution*]

(At this point, the social worker noted that Antonio seemed bored with the conversation, so she shifted to a miracle question).

Social Worker: Antonio, I sense that you are ready to move on, am I correct?

Antonio: Sort of. I'm not sure what to do. I want to get along with my mother, but just not right now!

Social Worker: I understand because the two of you have worked hard to have a good relationship, but right now things aren't going well. During this stressful time, you have not returned to some of your old behavior. This is good. Also, your mother, despite her frustration, has continued to visit you [*complementing, acknowledging individual and relationship strengths*].

Social Worker: Let's try something different.

Antonio: Like what?

Social Worker: I am going to ask you a question. It's called the miracle question.

Antonio: The what (rolling his eyes)?

Social Worker: The question is: What if you imagined being less stressed out with your mother? [*moving toward a goal*]

Antonio: Oh, I can answer that! She would dump this new dude, but I don't really have a say in this, do I?

Social Worker: That's a good point. Let me ask the question a different way. What if tomorrow, you woke up and were talking to your mother, what would be different?

Antonio: Wow, you're asking a lot, but I give it a shot. I think that if I didn't joke about him, she and I would get along better. I could have a conversation with her without her getting all bent.

Social Worker: Okay, well that sounds like good insight, which I know you are pretty good at. Is this something that you would like to work on in our next session? [*goal formulation*]

Antonio: Yeah, okay.

Social Worker: Next time, we can work on signs that will tell you that things are better between you and your mother, and whether or not you are coping better with the situation. As we end the session, let's summarize what we accomplished today.

In the session with Antonio, you will have noticed that the social worker's use of various solution-focused questions and techniques flowed from the information that Antonio provided. In critiquing the overall session, the social worker pointed out that she moved too quickly to encourage a solution. For example, she asked, "What's your plan?" Antonio seemed to become bored, or perhaps discouraged. But, at the point in which Antonio provided concrete, specific, and behavioral actions that he could do to make the miracle happen, he and the social worker were able to move toward developing a well-formed goal (De Jong & Berg, 2008).

Strengths & Limitations

EP 2.1.10a

The solution-focused approach involves practical procedures and techniques that can be readily learned and applied by you in many practice situations. For example, a miracle question can amplify an individual's goals and encourage a person to become invested in a future vision. The particular emphasis on clients' strengths and attributes is also a significant contribution in that this focus promotes a positive image of clients and their capacities. The strategic focus on change affirms that gains, albeit small, can occur over a brief period of time.

As the approach has matured, a promising body of empirical evidence has shown its efficacy with diverse populations and with the variety of problems presented by clients (Corcoran, 2008; Corcoran & Pillai, 2009; Corcoran & Vijayan, 2009; Kim, 2007; Trepper, et al., 2006). Previously discussed studies have also demonstrated the effectiveness of using certain questions with specific populations, especially minors (Corcoran & Stephenson, 2000; Franklin & Streeter, 2004; Springer, Lynch, & Rubin, 2000).

Particular aspects of the procedures and techniques of the approach have been criticized. Both critics and proponents of the solution-focused approach have questioned whether the approach is, in fact, collaborative. In particular, the practitioner assigns tasks that are intended to help the client to focus on solutions (O'Hanlon, 1996; Lipchik, 1997; Wylie, 1990), To the latter point, research conducted with solution-focused family therapists revealed discrepancies between clients' experiences and the observations made by their therapists related to outcomes (Metcalf, Thomas,

Duncan, Miller, & Hubble, 1996). Storm (1991) and Lipchik (1997) concluded that the primary focus on solutions was disconcerting for some clients. Specifically, clients reported that the positive thrust of the approach prevented them from discussing their real concerns, and instead they felt persuaded to explore solutions. Further, the avoidance of talking about their problem was perceived to have limited value for them (Efran & Schenker, 1993). Similarly, the limited attention to behaviors instead of feelings ignores the connection between feelings and cognitions (Lipchick, 2002). These critiques, in many respects, ignore the fact that when people seek help, they have been socialized to talk about and describe their problems in great detail in exchange for services.

Other critics have suggested that the simplicity and practicality of some of the solution-focused questions and techniques may lead in some cases to a "cookbook" that ignores the relational dynamics between the professional and the individual. As noted by Lipchik (1997), collaboration that keeps the "axles turning" as well as the "speed and success of solution construction depend on the therapist's ability to stay connected with the client's reality throughout the course of therapy" (p. 329). Critiques related to the client-professional relationship are not specific to the solution-focused approach. Such discussions about whether or not a relationship with clients can be fully developed have been ongoing since the emergence of brief treatment approaches.

Professionals who work in environments that are frequently, if not always, problem or pathology focused may experience limited support for using the solution-focused approach (Trotter, 1999). For example, individuals who are involved in the legal system are typically required to demonstrate that problems have been resolved or that assessed dangers have been reduced. Of course, the same can be true for any problem-solving approach in these systems, as strengths and empowerment often tend to be ignored. Nonetheless, some professionals suggest encouraging solutions, rather than focusing on the problem, results in an attempt to remedy a situation that may not be fully understood.

The research and literature regarding involuntary clients have shown success of the approach with this often-neglected and marginalized client group (Berg & Kelly, 2000; Corcoran, 1997; DeJong & Berg, 1998; Corcoran, 1998; De Jong, & Berg, 2001; Tohn & Oshlag, 1996). Work with this population is believed to be enhanced by combining solution-focused procedures with other techniques such as motivational interviewing (DeJong & Berg, 2001; Lewis & Osborn, 2004; Miller & Rollnick, 2002; Tohn & Oshlag, 1999).

The approach supports the construction of the client's reality and it is considered to be essential to interactions with diverse groups. In this regard, the expertise of the professional is minimized, as is the opportunity to rely on basic stereotypes and generalizations. On this basis, well-informed goals are more likely to be relevant to the client. Even so, the assignment of tasks by the professional would appear to be more directive than collaborative.

Aspects to the approach, in particular the commitment to empowerment, a focus on individuals' competence, strengths, and capacities are values that are consistent with social work's commitment to self-determination. However, having faith in and wishing to support individual capacities should not lead us to assume that people have within them the solutions to all of their difficulties. In fact, some individuals may lack sufficient cognitive skills and resources or face sociopolitical barriers that impact their ability to actually achieve their miracle. As Chapters 8 and 9 attest, practice need not focus exclusively on either problems and deficits or strengths and resources. Rather, in helping clients, an appraisal of each, including risks and protective factors, is important in developing a realistic view of their situation and systems involved (McMillen, Morris, & Sherraden, 2004).

Case Management

EP 2.1.10a

Case management entails work that interfaces between the client and his or her environment. As a method, case management has moved to the forefront of direct social work practice in recognition of the fact that people with unmet needs were often unable to negotiate the complex and often uncoordinated health and human services delivery systems.

As defined by Rothman, "Case management is designed to coordinate the provision of services from multiple sources for the benefit of the individual client" (2002, p. 267).

Although the profession of social work does not have an exclusive claim to case management, the method's facilitative and coordinating functions can be traced to the Charity Organization Societies. At that point in time, the intent of coordinating services was

two fold: to address the multiple problems that individuals and families experienced and to preserve public resources (National Association of Social Workers, 1992). Over time, the momentum for case management has grown, beginning in the 1960's with deinstitutionalization initiatives to relocate and maintain people in their community. To a large extent, the growth of case management has been driven by federal and state funded programs, the majority of which mandate the coordination and integration of services. Medicaid, for example, requires case management to help beneficiaries gain access to needed medical, social, and educational services and other services. Most recently, *Targeted Case Management*, an amendment to the Budget Reduction Act of 2005, was added as a provision of Medicaid case management services. Under this provision, certain beneficiary groups, such as individuals with an identified chronic health, mental health problems, or who have a developmental disabilities and minors in foster care, are considered to be primary recipients of targeted case management services. Also included in the Medicaid provisions are individuals or groups who reside in a particular geographical region and individuals whose needs have been identified by their health and human services organization in their respective states (Binder, 2008). In the current human services state and federal reimbursement environment, case management (and therefore case managers) is integral to services in health and mental health settings, long-term care facilities, homeless shelters, schools, adult and juvenile probation, and child welfare.

Tenets of Case Management

EP 2.1.10a

As a direct practice method, case management is not in and of itself a change-oriented intervention strategy. The method does, however, involve the procedural elements of the approaches discussed earlier in this chapter. Referred to in health or institutional settings as *care planning*, *care coordination*, or *patient-centered care*, case management is viable and often times vital to persons in need of comprehensive services. A critical function of the method is linking individuals or families to a range of services based on their assessed needs. In essence, people are able to gain access to health, mental health and social welfare service providers that otherwise might be difficult for them to navigate on their own. The coordination of services by the case manager is intended to reduce duplication, fragmentation, and ultimately the frustration of the individual. In some settings, evaluating the costs of services is a critical component of case management.

As a problem-solving method, case management is theoretically open (Epstein & Brown, 2002). As such, the method can make use of theories and intervention tactics or techniques that are appropriate to individuals' situations. For example, the protocols of the task-centered model have been integrated with case management services in addressing the needs of elderly persons in long-term care (Naleppa & Reid, 2003), youth in residential treatment centers (Pazartz, 2006), and in improving school performance (Colvin, Lee, Maganano, & Smith, 2008). Solution-focused techniques were central to case management services for persons with mental disabilities (Greene, Kondraft, Lee, Clement, Siebert, Mentzer, & Pinnell, 2006; Hagen & Mitchell, 2001; Rapp, 2002) and in the treatment of drug use and abuse (Hall, Carswell, Walsh, Huber, & Jampler, 2002). Intensive case management that made use of cognitive behavioral treatment methods was effective in assisting women to move from welfare-to-work (Lee, 2005) and assisting low-income depressed older adults (Arean, Alexopoulos, & Chu, 2008). Similar results were observed when case managers used cognitive behavioral intervention techniques to reduce risky behaviors among HIV drug injectors (Robles, Reyes Colon, Sahai, Marrero, Matos, Calderon, & Shepard, 2004). The *Social Work Desk Reference* (2009) consists of a number of chapters on case management in regard to specific populations, including immigrant and refugee children and families. With respect to the latter, case management in particular is recommended for immigrant children and families (Fong, Amour, Busch-Arendariz, & Heffron, 2008; Potoky-Tripodi, 2002).

Standards of Case Management Practice

Both the National Association of Social Workers (NASW) (1992) and the Case Management Society of America (CMSA) (2010) have developed practice standards to include the educational and licensing requirements for case managers. In 2008, the two organizations joined together to develop advisory standards for case managers' case loads.

Core elements of the standards for practice of NASW (1992) and the CMSA (2010) are based on a set of beliefs and professional values considered to be essential to case management practice.

EP 2.1.10a

- *Utilizing a comprehensive assessment to determine the biopsychosocial functioning and care needs of individuals, including their strengths and resources.*
- *A client-centric, shared decision- making collaborative relationship between the individual and the case manager, in which the person and, where appropriate, family members are involved in all phases of the case management process.*
- *Planning and implementing services which address and are responsive to the unique needs of the individual or family.*
- *Adhering to professional values and principles, including self-determination, privacy, confidentiality, informed consent, and empowerment.*
- *The primacy of the obligation to the individual, which may involve advocacy, mediation, and negotiation to ensure access to services.*
- *Monitoring progress and the evaluation of the achievement of targeted outcomes.*
- *Utilizing the best evidence available to inform case management practice with specific populations, conditions, and needs.*

In promoting these standards, the aim of both organizations was to establish uniformity in case management functions and practices across disciplines and organizational settings.

EP 2.1.7b

The Case Management Society of America articulates an explicit standard with regard to cultural competence. Within these standards, there is an expectation that the case manager is informed, utilizes relevant client cultural information, and is sensitive to cultural contexts, including verbal and nonverbal communication styles. An expectation of culturally competent practice is similarly set forth in the National Association of Social Workers practice and policy statements (2007; 2009) and also in the federal guidelines of the U.S. Department of Health and Human Services, Office of Minority Health (2001).

Empirical Evidence of Case Management

EP 2.1.6b

Although case management is a widely used practice method, some researchers assert that evidence of its effectiveness cannot be generalized (DePalma, 2001; Major, 2004; Simons, Shepherd, & Murro, 2008; Orwin, Sonneffeld, Garvin-Morgan, & Gray-Smith, 1994). There are studies, nevertheless, in which the findings support the method's efficacy with individuals and families and for specific conditions or problems. In health, substance abuse, and mental health settings, case management significantly improved the outcomes for HIV-infected individuals, the retention of substance abuse users in treatment, as well as a prevention and intervention strategy for homeless youth, adults, and families (Chennon, Rosenbeck, & Lam, 2008; Gardner, et al., 2004; Mercier & Racine, 2005; Havens, Cornelius, Ricketts, Latkin, Bishai, Lloyd, Huettner, & Strathdee, 2007; Young & Grella, 1998; Susser, Valencia, Conover, Felix, & Tsas & Wyatt, 1997; Herman, Conover, Felix, Nakagawa, & Mills, 2007; Kasprow & Rosenbeck, 2007; Helvic & Alexey, 1992). Clinically oriented studies summarized by Hoagwood, Burns, Kiser, Ringeisen, and Schoenwald (2001) show that case management was effective in reducing the number of inpatient psychiatric hospitalizations for young children, the length of stay for youths in substance abuse treatment programs, and the number of placement disruptions for youths in foster care.

The method is also reported to have advanced the effectiveness of a school-based approach to minimize the impact of a chronic illness on school performance, social skills, and quality of life (Keehner, Gutter, & Warren, 2008). As an innovative approach that combines specific social work practice methods, case management is cited as an effective method in the treatment of substance abuse with individuals who lived in rural communities (Hall, Carswell, Walsh, Huber, & Jampler, 2002).

The integration of the strengths perspective was advised by Rapp (1993) as critical to case management practice. Implementing strengths-based case management calls for a focus on people's assets, resilience, and their capacity for self-direction (Brun & Rapp, 2001). Several strengths-based case management studies have demonstrated promising results. Positive outcomes were reported for people in substance abuse treatment, including their retention and their relationship with their case managers (Brun & Rapp, 2001; Rapp, 2002; Siegal, Rapp, Li, Saha, & Kirk, 1998; Siegal, Fischer, Rapp, Killiher, Wagner, O'Brien, & Cole, 1996; Siegal, Rapp, Kelliher, Fisher, Wagner, & Cole, 1995).

Case Management Functions

Although case management processes may vary with respect to settings and organizational priorities and goals, there is a consensus that case management always includes the functions or phases summarized in Table 13-5

EP 2.1.10j

TABLE-13-5 CASE MANAGEMENT FUNCTIONS

PHASES	TASKS
Access & Outreach	Outreach or case finding identifies people who are likely to need case management services.
Intake & Screening	Preliminary to an assessment, screening is an initial step in determining eligibility for services. A preliminary plan may be developed at this stage.
Multidimensional Assessment	Information is collected about the individuals' physical, mental social, and psychological functioning, the physical environment, including strengths and resources. The multidimensional assessment guides the development of the case plan.
Goal Setting	Goals and objectives are developed based on assessed need, in collaboration with the individual. The goal plan and objectives are based on the individual's perception of needs, and may be structured as long or short term.
Planning Interventions & Linking to Resources	Planning the intervention and linking individuals to resources are interdependent functions. Both formal and informal resources and the appropriate service providers are identified. The specific services, as well as the frequency and duration of contact with the service provider are specified.
Monitoring the Progress & Adequacy of Services	Monitoring progress and the extent to which service providers continue to meet the needs identified in the case plan is a vital and ongoing process. Three sources of information are indicated: Regular contact with service providers to determine if services are responsive, monitoring progress toward the stated goals, and the individual's observations regarding the level of progress and satisfaction with the providers.
Reassessment at Fixed Intervals	It is particularly important to be sensitive to changes in clients' needs and to adjust or modify the plan as indicated. Reassessments can be formal or informal and are completed at fixed intervals. The information gathered can also determine the level of change since the initial assessment.
Outcome Evaluation/ Termination	Outcome evaluation, in brief situations in which goals have been achieved, leads to termination. In longer term, reassessment and evaluation of outcomes is ongoing.

(Case Management Society of America, 2010; Holt, 2002; Rothman, 2002; National Association of Social Workers, 1992).

EP 2.1.10g

While the phases and tasks of case management are for the most part self-explanatory, for some, elaboration and a brief rationale is indicated. Outreach and case finding, for example, may be particularly important for vulnerable populations such as homeless, frail elderly, and disabled persons, many of whom are likely to be eligible for health and supportive social services, but who may be reluctant to seek formal help. While the phases are procedural in nature, the practice standards are consistent with the ethical principles of social work practice, in particular, the emphasis on self-determination and collaboration with service recipients as key informants in the assessment and goal setting process and the implementation of the case plan. Although the case manager is ultimately responsible for overseeing the implemented plan, the individual or family is also involved in the evaluation of the adequacy of the service. You will also note that monitoring progress and reassessment depends on the goals and time frame of the case plan. For example, long-term case plans may require an infinite amount of services, in which case the reassessment intervals are ongoing. In these instances, reassessment is critical and assessing progress may require the use of pre/post baseline or standardized instruments. In contrast, with brief case management services (e.g., locating housing, securing medical care, attaining the capacity to live independently), satisfactory progress and goal attainment should lead to termination.

Case Managers

EP 2.1.1c

Case managers are fundamental to the case management tasks. Whether your title in an organization is case manager, plan coordinator, or care coordinator, you are the human interaction between individuals and various systems. You may work as a part of a team in some settings, and, in others, you can be solely responsible for providing case management services. The type of setting will also determine whether your involvement as a case manager is brief or time-limited, targeted, ongoing, or open-ended.

In practice, your role and your responsibilities relative to the phases and tasks can be as varied as the settings in which you are employed. For example, with a patient due to be discharged from a hospital, your contact with the individual would most likely occur at the assessment phase and proceed forward from this point. Similarly, screening and intake can be abbreviated when a targeted population has been designated in a Purchase of Service Agreement (POS). Conversely, as a case manager in a shelter for homeless youth, outreach or case finding would be a first step. In yet another scenario, you are the authorized professional who is solely responsible for completing the comprehensive assessment, developing an individualized service plan, and for negotiating and coordinating services.

EP 2.1.10f

The phases of case management and the point of contact notwithstanding, irrespective of your case manager role, it is important to keep in mind that case management begins with an assessed *need* rather than a *service*. No two individuals will have or express their needs, problems, or goal preferences in the same way. For this reason, the implemented case or care plan is tailored to the unique needs of the people involved. Specifically, each person or family should be able to expect that their case plan is responsive to their specific needs, rather than the priorities of an agency.

Name:	Angela and Irwin Corning			
Children:	Agnes, age 10 Henri, age 8 Katrina, age 18 months			
Case Manager	Ali Smith			
SUMMARY OF ASSESSED NEEDS				
Housing √	Health care √	Debt Counseling √	Tutors √	Employment √
Financial Assistance √	Preschool √			
COORDINATED REFERRALS				
Goals	Providers	Sessions/Duration	Monitoring	Reassessment
Obtain affordable Housing	Clarion Housing Program	1–3 months	Weekly	Every month
Permanent Full-time Employment (Irwin)	Employment Resource Center	8 weeks	Weekly	Monthly
Credit card debt reduction	Consumer Credit Counseling	4 Weeks	On going	1 month
Obtain rental deposit and 1 month's rental	County Temporary Housing Assistance Office	1–2 Sessions	2–3 days	N/A
Family Physicals Childhood Inoculations	Community Health Center	1 year	Ongoing	
Grade Level Assistance (Agnes & Henri)	After School Tutorial Program	1 year	Ongoing	Monthly
Social and Educational Activities	Head Start	1 year	Ongoing	Monthly
Outcome Evaluation & Reassessment:	**Monthly**			

FIG-13-5 Case Management Plan

Case Manager Responsibility and Roles

EP 2.1.10j

The case of the Corning family is used to illustrate a case management plan. In reviewing the case plan, you are able to observe that its implementation required the case manager to be both facilitative and active, both of which are illustrated in this case. Effectively responding to the goals of the plan required that she facilitate the concurrent efforts of public and private organizations and other disciplines. In collaboration with Angela and Irwin, decisions were made about the number of sessions with each provider. For example, the couple anticipated that applying for and obtaining approval for temporary rental assistance would require no more than two to three appointments. Conversely, their access and utilization of health care providers was established over a longer period of time.

In linking the Corning family with the mix of providers, the case manager had to be actively involved. Specifically, it would have not been sufficient for her to simply identify and refer them to the providers, and subsequently expect them to follow through. Making the connections to service is a central task. Afterwards, it was the case manager's responsibility to oversee the plan on an ongoing basis. Implementing a case plan also requires a great deal of up front work. Essential activities include determining the eligibility criteria of each provider, their ability to meet the plan's goals, and their case review and monitoring process. Once you are satisfied that there is a *fit* between the individual's needs and the service provisions of each provider, service agreements are developed with each. Similar to the service agreement or contract with clients (refer to Chapter 12) the case management plan specifies the work to be completed.

As a case manager, the *broker* role is vital to facilitating interagency coordination and cooperation. In this capacity, you need to have a working knowledge of, and an effective relationship with, a range of service providers, including available informal resources. The broker role, specifically connecting to critical resources, is evident in the response to the array of needs in the Corning family case. As a case manager, helping people gain access to available resources may require *negotiating* with the various service providers. Where indicated, *advocacy* at the systems level may be necessary to ensure that individuals have access to resources to which they are entitled. In addition to the broker role, in any one case, mediating between an individual and various systems is required. For instance, the role of a *mediator* role between the school and the Corning parents would have been indicated, had the school been reluctant to support the goal of enhancing the performance of Agnes and Henri by providing tutorial assistance. Furthermore, had the school lacked this resource, it would have been important to explore an alternative or develop a resource.

Strengths and Limitations

EP 2.1.10a

Case management is a problem-solving practice method that is designed to link the needs of individuals to a range of service providers. Based on assessed needs, services are individualized in recognition of the unique capabilities, goals, and circumstances of each service recipient. Although, the assessment is integral to case management, it is only one part of the core functions that make up the entire process. Other core tasks involve developing and implementing the case plan and monitoring progress. Hence, it is important that a case manager is skilled in all aspects of the problem-solving process. In completing this work, acting as a broker is a key role of the case manager. There are instances that necessitate the case manager to negotiate, mediate, or advocate on behalf of individuals to ensure that they have access to needed services.

The method has grown over time, in part, as a response to federal funding requirements which emphasize improved access to services and the coordination and integration of the services that they received. The growth of the method can also be attributed to a desire for greater continuity in care by reducing the fragmentation and duplication in service delivery systems as a result of a lack of coordination. Standards and principles of case management developed by the National Association of Social Workers and the Case Management Society of America have contributed to the uniformity of case management functions and the role of the case manager across settings.

As evidenced by the summarized results of research studies, case management, either as a stand alone practice method or when integrated with another treatment approach, has demonstrated its effectiveness in addressing a range of needs or problems with specific populations. Several of the summarized studies demonstrated the benefit of this integration.

An assumption of case management is that the resources or service providers that an individual

needs are always available both in adequate quality and quantity. In reality, gaps in services exist, in particular, disparities between assessed needs and available services. In some instances, the service can be available, but the provider may be overwhelmed with demands. Herein lies a challenge for the case manager, particularly in an age in which funding for services are reduced.

On the whole, case management is intended to meet the multiple needs of an individual in a coordinated, comprehensive manner. The phases and associated tasks allow for the development of a case plan unique to the individual. The greater benefit of case management is the fact that services are identified based on assessed needs, which eliminates an individual having to navigate complex helping systems on their own.

Summary

The task-centered and crisis intervention models and cognitive restructuring and case management approaches are focused on problem solving. As the name implies, the solution-focused approach is designed to deemphasize a problem focus and deliberately emphasize solutions.

The approaches are similar in that their focus is primarily on the present, they are time-limited, and they emphasize clients' capacity to change and grow through autonomous independent action. Research studies have shown brief, time-limited approaches to be as effective as those that require a longer time period (Reid & Shyne, 1969; Wells, 1994; Wells & Gianetti, 1990; Corwin, 2002). The efficacy of brief, time-limited approaches is that their scope is on a specific target problem or behavior and a specificity of goals or solutions. The conscious use of time is considered to be productive in that specific goals or solutions make the best use of brief contact (Corwin, 2002; Hoyt, 2000; Reid, 1996).

Increasing the power of people to participate in and influence change in their lives is a salient characteristic of each of the approaches. Whereas task-centered practice, crisis intervention, and cognitive restructuring seek to empower clients through systematic and collaborative problem solving, the solution-focused approach aims is to empower individuals through their construction of solutions. Even so, empowerment is evident in the other approaches as they too emphasize accepting individuals' identification of their target concern and their participation in developing goals. Inherent in each approach is the assumption that people know what they want and have a right to and that they have the capacity to solve their own problems (DeJong & Berg, 2002; Reid & Epstein, 1972).

A deliberate emphasis on clients' strengths, in recognition of the critical social work principle that "people have the capacity to change and grow," is also prominent in each approach. Strengths and resilience are foremost in the exploration of prior coping and adaptations, resources, and emotional stability in the crisis intervention and task-centered approaches. The recognition of how clients have coped and what they have done in the past effectively builds on his or her skills and resources. In solution-focused practice, a person is encouraged to reflect on exceptions to their problem and further problems are defined in a situational rather than an individual context. The latter of which may ignore strengths. Cognitive restructuring recognizes the strength of the individual's capacity for self-direction and to gain skills in managing his or her beliefs through the development of self-talk, coping statements, and self-reliance. Strengths are equally important in case management. Needs do not necessarily define the whole person, therefore, a focus on people's assets, resilience, and their capacity for self-direction is emphasized (Brun & Rapp, 2001; Case Management Society of America, 2010).

There is significant overlap in the theoretical perspectives and strategies of four of the approaches. For example, cognitive-behavioral and social learning theories influence the task-centered system, crisis intervention, and the solution-focused approaches. Cognitive restructuring is a technique utilized in task-centered practice to address client's beliefs and in crisis intervention, depending on the nature of the crisis (Reid, 1992; James & Gilliland, 2001). These overlapping strategies and perspectives of each approach provides the flexibility of being able to draw upon and adapt the change process to various theories of human behavior, needs, environment, and lifestyles. Because case management is theoretically open, the method can make use of different theoretical frameworks. Of course, each approach has limitations, and, for certain populations, an adaptation or modification may be required. Nevertheless, each has merit in that these interventions are brief, are action-oriented, and focus on specific goals for change.

Empirical support exists for each of the approaches, including their use with diverse populations, age groups, and in diverse settings was summarized in the section in which the approach

was discussed. But, in selecting the most suitable strategy, you must consider the problem and goals, developmental stages, racial, or cultural beliefs, customs and values, and environmental factors germane to the case. Most of all you should be able to assess the extent that an approach has demonstrated its effectiveness with whom, under what circumstances, and with which kinds of problems.

Competency Notes

EP 2.1.1c Attend to professional roles and boundaries. Selecting and utilizing an intervention strategy requires that social workers have the requisite knowledge and skills. Role behavior assumes that they are practicing within their scope as well as understanding their role and responsibilities in different practice settings (pp. 384–85, 407, 409, 431).

EP 2.1.1f Use supervision and consultation. In instances where the appropriate course of action may lack clarity, utilizing supervision is important to help social workers make decisions that inform their development (p. 385).

EP 2.1.2b Make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics and, if applicable, the International Federation of Social Workers/International Associations of Schools of Social Work Ethics in Social Work Statement of Principles. Implementing an intervention strategy should be guided by the ethical practice standards of the profession of social work (pp. 382–384).

EP 2.1.2d Apply strategies of ethical reasoning skills to arrive at principled decisions. Different settings in which social workers are employed may use practices or intervention strategies that are counter to the ethical standards of the profession of social work. In these situations, social workers rely on the ethical standards of the profession to guide their work with clients (p. 383).

EP 2.1.3b Analyze models of assessment, prevention, intervention, and evaluation. In preparation for selecting an intervention strategy, social workers should understand the tenets of the strategy to ensure that it is consistent with the client's problem and goals. They should also evaluate whether they have the knowledge and skills to successfully implement the strategy (pp. 380–81, 383).

EP 2.1.4b Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups. Planning and implementing change strategies with persons whose backgrounds are different, honors their values, beliefs, and preferences. Understanding self means that the social workers strive to avoid the potential that their values, beliefs, and preferences overshadow those of the client (pp. 404, 412).

EP 2.1.4c Recognize and communicate an understanding of the importance of differences in shaping life experiences. Social workers understand that the context of people's lives are different based on the perceptions, experiences, abilities, and cultural frame of reference (pp. 381, 383, 403).

EP 2.1.4d View themselves as learners and engage those with whom they work as key informants. Learning about different people and cultures requires that social workers recognize what they do not know, and further that they are willing to expand their ways of knowing and to use acquired knowledge to guide practice competence with diverse groups (p. 382).

EP 2.1.6b Use of research evidence to inform practice. Selecting and planning intervention strategy requires that social workers have knowledge of a strategy's utilization and evidence of effectiveness with the problems and goals of different clients and in different settings (pp. 382, 386, 402–403, 412, 414, 422, 430).

EP 2.1.7a Utilize conceptual framework to guide the process of assessment, intervention, and evaluation. Understanding the conceptual and theoretical framework upon which an intervention strategy is based is essential to the effective implementation of the strategy (pp. 380, 386, 403, 409–410, 417, 422).

EP 2.1.7b Apply knowledge of human behavior in the social environment. People interact and react within an environmental context. Social environments shape people's perceptions, cognitions, and experiences and their sense of self (pp. 382, 400, 403, 405, 412–414, 423, 430).

EP 2.1.9a Continuously discover, appraise, and attend to changing locales, populations, scientific and technological developments, and emerging societal trends to provide relevant services. Planning and implementing an intervention strategy requires social workers to understand and appraise different circumstances and to determine if a particular strategy has certain limitations that should be modified so that it fits with the needs of a particular group (pp. 400, 402, 414).

EP 2.1.10a Substantively and affectively prepare for action with individuals, families, groups, and communities. Selecting, planning, and implementing an intervention strategy requires that social workers understand the basic tenets of a strategy and its approach to solving problems (pp. 380, 385, 398–400, 408–409, 421, 427–429, 433).

EP 2.1.10b Use empathy and other interpersonal skills. Attending to client's emotions and responding with empathy can facilitate problem solving (p. 405).

EP 2.1.10d Collect, organize, and interpret client data. In implementing an intervention strategy, it is essential that social workers continuously appraise relevant information regarding client's functioning, problems, and goals (pp. 399–401, 405–406, 416).

EP 2.1.10f Develop mutually agreed-on intervention goals and objectives. An agreement between the client and the social worker is an essential step to implementing an intervention strategy. The agreement includes identifying the goals, action steps, or objectives that will be used to achieve the desired outcome (pp. 383, 387, 393, 395, 407, 415–416, 432).

EP 2.1.10g Select appropriate intervention strategies. Questions should be asked about an intervention approach so that the social worker and the client are assured that the strategy is a match with the client's needs, problems, and goals (pp. 380, 381, 384, 385, 431).

EP 2.1.10i Implement prevention interventions that enhance client capacities. In the best of circumstances, clients may need help so that they can move forward toward problem solving. Social workers can provide help by using techniques such as role-play, brainstorming, and modeling to prepare clients so that they feel more competent to take action (pp. 388–395, 406, 408, 415–417, 419–420, 423, 425).

EP 2.1.10j Help clients solve problems. Intervention approaches have procedures and techniques that are used in a systematic manner to assist clients to resolve their problems (pp. 387–389, 391–393, 395, 401–402, 404, 406–407, 411, 414, 416–417, 419–420, 423–425, 430, 433).

EP 2.1.10m Critically analyze, monitor, and evaluate interventions. Social workers and clients should engage in an ongoing evaluation process that will allow them to monitor and measure progress relative to the client's goals, the effectiveness of the intervention approach, and to evaluate outcomes (pp. 396, 398, 418, 420, 423).

Skill Development Exercises

1. Using the Corning case, select both a task-centered and a solution-focused approach as a change-oriented strategy and assess the merits of each approach in this case. In what way could you combine aspects of both approaches in this case?
2. A mother, who has been sanctioned for failing to comply with the welfare-to-work rule, tells you that her caseworker is "out to get her." What additional information or factors would you need to determine how you would respond to the client's statement?
3. You are the social worker for a minor in a residential treatment program. How would you determine if the minor is able to give consent for his treatment plan?
4. Review Lipchik's (2002) solution-focused questions and answer the questions based on a current concern that you have. Also, indicate how you would use scaling, coping, exceptions, and the miracle question.
5. Using the same situation that you have identified, develop a goal and general and specific tasks in the task-centered approach. Indicate how you would measure goal attainment.
6. Choose one of the cognitive distortion statements that apply to you. What strategies would you use to modify your thinking?

Notes

1. For additional information on brief treatment models, see Corwin (2002), Roberts & Greene (2002), and Walsh (2006).
2. Potocky-Tripodi (2002) has written an informative text on "best practices" for social work with immigrants and refugees.
3. For additional information on models and crisis intervention practice, see Parad & Parad (1990, 2006), Roberts (2000), Roberts (2005) the *Crisis Intervention Handbook: Assessment, Treatment and Intervention* (3rd ed.) and Okun (2002). Suggested resources for crisis strategies with minors include the *Journal of Traumatic, Violence and Abuse*, and the *Journal of Aggression Maltreatment and Trauma*. For more extensive information on the early definitions, developments, and critiques of crisis intervention strategies, see Aguilera & Messick (1982), Golan (1978), Puryear (1979), Caplan (1964), and Lukton (1982). For

evidence-based approaches to trauma intervention, see Cohen (2003).

4. Cormier, Nurius, and Osborne (2009) is highly recommended as a resource for more comprehensive information on change strategies and skills in cognitive-behavioral therapy and cognitive restructuring. Another resource includes Bergin and Garfield (2004), *Handbook of Psychotherapy and Behavioral Change.* See also Beck's *Handbook of Cognitive-Behavioral Therapies* (2005) for a review of the current state of cognitive therapy. For cognitive therapy specific to children, Reinecke, Dattilio, and Freeman (2003) is an excellent resource. Walen, DiGuiseppe, and Wessler (1980) present and illustrate earlier comprehensive strategies for disputing beliefs.
5. Chapin, R., Nelson-Becker, H., & MacMillan, K. (2006). Strengths-based and solution-focused approaches to practice. In Berkman, B. & D'Ambruson, S. (Eds.) *Handbook of Social Work in Health and Aging.* New York: Oxford University Press; B. O'Connell & S. Palmer, *Handbook of Solution-focused Therapy* (2nd ed.), Sage Publications; A. J. Mcdonald, *Solution-Focused Therapy, Research and Practice,* Sage Publications and M.S. Kelly, J. Kim, & C. Franklin, *Solution-focused Brief Therapy in Schools: A 360 degree View of Research and Practice.* Oxford University Press, Inc.

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