CHAPTER 13

Planning and Implementing Change-Oriented Strategies

Chapter Overview

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

After reading this chapter, you will be able to:

- Select a change strategy to facilitate goal attainment.
- Explain the importance of matching the strategy to the problem, utilizing a person-in-situation and person-in-environment framework.
- Utilize empirically supported change strategies with clients, including with diverse groups and minors.
- Describe the major tenets and procedures of four change-oriented strategies and the functions of case management.
- Understand the principles of trauma-informed care.

EPAS Competencies in Chapter 13

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

- Competency 1: Demonstrate Ethical and Professional Behavior
- Competency 2: Engage Diversity and Difference in Practice
- Competency 4: Engage in Practice-Informed Research and Research-Informed Practice
- Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities
- Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities

CHANGE-ORIENTED APPROACHES

The change-oriented approaches presented in this chapter may be used in your work with individuals, families, and groups. Their aim is to facilitate the attainment of goals or respond to a mandate in the case of involuntary clients. Each of the approaches is supported by research and uses empirically grounded techniques or procedures that have demonstrated their effectiveness with clients of different ages, backgrounds,

and needs. The approaches are organized around the systematic interpersonal and structural elements of the helping process and follow the distinct phases of engagement, assessment, goal planning, intervention, and termination. They adhere to the principles of social work practice, which emphasize mobilizing individuals, families, and groups toward positive action. Each supports collaboration with clients, utilizing their strengths and increasing self-efficacy, all of which are critical aspects of empowerment. The approaches are:

- The task-centered model
- The crisis intervention model
- The cognitive restructuring technique
- The solution-focused brief treatment model
- Case management practice

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

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

PLANNING GOAL ATTAINMENT STRATEGIES

EP 7

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

- Is the approach appropriate for addressing the problem and the service goals?
- What empirical or conceptual evidence supports the effectiveness of the approach?
- Is the approach compatible with the basic values and ethics of social work?
- Am I sufficiently knowledgeable and skilled enough in this approach to use it with others?

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

During Phase I, you collected information that provided a picture of the client as a person and his or her problem, situation, strengths, and goals. The method selected to address these, however, requires an understanding of context, circumstances, and the nature of the problem and timing. The essential questions to be answered are: *What is the problem?* and *What are the client's goals and values?* To achieve a desired goal, the change strategy must be directed to the problem specified by the client or a mandate, as well as to the systems or environmental issues that are implicated in the problem. A school truancy problem, for example, will, by necessity, involve the family, the educational system, and perhaps the juvenile justice system.

Other factors that guide your consideration include developmental age and stage and the family life cycle, the latter of which can become exaggerated as a result of stressful transitions (Carter & McGoldrick, 2005; Halpern & Tramontin, 2007; James, 2008; Spoth et al., 2003). With respect to life cycle and human development, culture and race are requisite factors to be considered. For instance, not all cultural or racial groups mark life cycle or human development according to the normative Western expectations (Garcia Coll, Akerman, & Cicchetti, 2000; Garcia Coll et al., 1996; Ogbu, 1997, 1994). The following questions can help guide you in planning and eventually deciding on an approach:

- Does the approach acknowledge and allow for the integration of environmental factors—for example, the experience of minority or socioeconomic status and oppression—as contributing to a problem, so as not to add a sense of being marginalized?
- Are modifications to the approach indicated so that it is responsive to diverse individuals, families, and minors?
- Is the approach flexible enough that it respects and can be adapted to specific cultural beliefs, values, and a different worldview?

- Does the approach address the sociopolitical climate as a factor in creating and sustaining the client's problem?

These questions are, of course, by no means exhaustive. The intent is to prompt you to critically examine the appropriateness of a particular approach. In addition, in considering the third question, Green (1999, pp. 50–51) reminds us that "help-seeking behavior" is embedded in a cultural context as well as the experience of minority status. Exploring the client's cultural context can include attention to gender relations and position in the family and in the community. In some ethnic cultural and racial communities, the act of asking for help, whether formally or informally, can be frowned upon. Narratives or suspicions about change strategies, real or imagined, may be well formed in diverse communities, some of which may be based on historical and sometimes oppressive experiences. These dynamics can be so prominent that problems or feelings may be minimized or ignored for fear of being perceived as vulnerable or giving the appearance of a cultural anomaly (Kung, 2003; Mau & Jepsen, 1990; Nadler, 1996; Potocky-Tripodi, 2002; Sue, 2006).

EP 2

As you plan and select a change strategy, we encourage you to allow diverse clients to consider the cost–benefit tradeoff of seeking help, essentially determining the extent to which the approach allows the client to retain a sense of self or cultural identity and/or poses a threat to the client's cultural values and beliefs (Potocky-Tripodi, 2002; Sue, 2006; Williams, 2006). As Potocky-Tripodi (2002) explains, for example, immigrants or refugees with little or no prior experience with formal helping systems may perceive a change approach as a threat, especially if past experiences involved forceful or repressive tactics. Some clients may experience tensions with change strategies that require them to move from the familiar to the unfamiliar in such matters as child rearing and customs such as arranged marriages.

At this point, you may wonder how to go about selecting a change strategy that is consistent with the needs and interests of diverse clients. *Discovery* and *cultural humility* are two concepts that will help you understand clients and ultimately select a change strategy that is in harmony with those clients' values and beliefs. The spirit of discovery guides you to elicit clients' view of the problem at hand; the related symbolic, cultural, and social nuances of their concerns; and their ideas about an approach as a remedy to their difficulties (Green, 1999). Cultural humility encourages you to place yourself in a student role in which you are open to the clients as a teacher. Together, you and the clients are partners in understanding and clarifying the relevance of the change effort to their problem (Tervalon & Murray-Garcia, 1998).

Regarding whether the approach addresses the sociopolitical climate as a factor in creating and sustaining the client's problem, social workers must keep in mind that minority and poor families, many of whose contact with professional helpers is involuntary, often face insurmountable odds in their everyday lives, some of which are the results of limited resources, pressures to conform to dominant societal norms, marginalized status, inequity, and constrained self-determination. Societal presumptions about people, their competence, or their lifestyles are oppressive forces that create toxic environments for persons who are different, and which they contend with on a daily basis.

In most instances, overt acts of discrimination and bigotry have diminished as a result of laws. Laws, however, cannot command positive interpersonal and social behavior, especially covert interactions. **Covert interactions** are those subtle acts characterized as **microaggressions**, in which people are treated differently based on their race, ethnicity, sexual orientation, ability, or socioeconomic status (Sue et al., 2007). Conditions and circumstances that affect cognitive, physical, and psychological functioning are extraordinary stressors; therefore, a change strategy should acknowledge the existence of such ever-present stressors. At the same time, it is important to recognize that despite the circumstances, diverse individuals, families, and groups have strengths and resilience, including the fact that over time, they have coped with adversity (Connolly, 2006; Guadalupe & Lum, 2005; Sousa, Ribeiro, & Rodrigues, 2006).

Finally, note that in some instances, the approach that you use may be determined by your practice setting. In either case, in planning and selecting an approach, when you are uncertain, supervisory consultation can be useful to help you clarify or affirm your decision.

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

EP 4

An effective intervention approach is one that has the most promise for achieving goals identified by the client or the mandate. In evaluating an approach, you are looking for evidence of its effectiveness: with whom

did it work, under what circumstances, and what were the results? Furthermore, the evidence should specify the approach's effectiveness with respect to client problem or status, developmental stage, and cognitive ability, as well as its compatibility with diverse cultural values and beliefs.

As you are exposed to novel or emerging strategies, it is important that you evaluate the evidence of the effectiveness of each approach. Ethical standards require social workers to use approaches with clients that respect their dignity and rights and that do not cause harm. Therefore, untested interventions, as well as those that are coercive, confrontational, or dangerous, should not be utilized.

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

EP 1

Professional social work ethics and values provide a foundation upon which knowledge and skills are used. Two specific ethical standards are applicable in your decision making related to planning and selecting an intervention approach: safeguarding the client's right to self-determination and informed consent.

Does the Approach Safeguard the Client's Right to Self-Determination?

Promoting self-determination upholds a client's right to make decisions about his or her life. In essence, in your work with clients, they should feel empowered to fully participate in decisions that will resolve or change their situation. You might ask, *"What if the client has limitations—for example, in language, cognitive, mental, or physical capacity—that can hamper his or her ability to make decisions?"* Multiple factors are involved in this question, including the nature of the decision, age and stage of development, and the capacity to understand the consequences of a decision (Strom-Gottfried, 2007). Although some clients have limitations and may be unable to make decisions about certain aspects of their lives, the clients' limitations are not the sum total of who they are, nor does this mean that they lack the ability to process task-specific information. For example, you may recommend a change approach, followed by an explanation: *"If we select this approach to resolve your concern, it would mean that together we take steps that we believe would best change your situation."* In essence, the focus should be on the client's capacity rather than limitations. Above all, you are cautioned to refrain from acting in a paternalistic or beneficent manner in order to achieve *your* perception of the client's best interest.

Your ethical obligation to respect a client's right to be self-directed may be a challenge with certain client populations. For example, some involuntary clients and clients who have experienced a situation in which they were victimized may be reluctant to accept the notion of self-determination, believing instead that they lack influence, knowledge, or power to effect change. In a crisis situation, respecting self-determination can become overshadowed by a strong desire to help, so much so that the client's rights and the outcome sought may be unintentionally overlooked (Fullerton & Ursano, 2005; Sommers-Flanagan, 2007). In either scenario, actively encouraging self-direction with such clients and emphasizing the ways in which they can exercise their rights and regain control over their situation should be discussed.

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

We acknowledge that the work setting in which you are employed may determine the approach utilized with a certain client population and therefore may limit decision making about an intervention approach. In other settings, professionals acting as proxies can presume that a particular client or client population lacks the capacity for self-direction. Best interest, in many instances, has become a means to sacrifice self-determination, in which social workers act in a paternalistic manner. Fostering self-determination in such settings may present a challenge for you as a social worker. Whatever the circumstances might be, the defining question for which you may need to seek supervision is, *What is the justification for ignoring a client's rights in making decisions about an intervention strategy?*

Self-Determination and Minors. When it comes to minors, the right to self-determination is complicated. In most states, minors are presumed to have limited

decision-making capacity; therefore, parents or legal guardians act as their proxies (Strom-Gottfried, 2008). Developmental stage, reasoning, and cognitive capacity are also significant factors that influence a minor's capacity for decision making and self-direction. Minors who are immigrants may be unfamiliar with the ideals of self-determination, and being asked to make a decision may be outside of their realm of cultural expectations (Congress & Lynn, 1994). Nonetheless, you should not assume that a minor is unable to make choices. In general, most minors are able to express how they feel and what they want. Your task is to provide the opportunity for them to participate in intervention planning, which includes your explaining the benefits and potential risks using words that they understand (Green et al., 2003; Strom-Gottfried, 2008).

Does the Approach Safeguard the Client's Right to Informed Consent?

Ensuring that clients understand and consent to an approach is essential to ethical and collaborative practice and is supportive of the principle of self-determination. So that clients are fully informed, you should explain the approach in language that is easily understood, presenting information about the benefits, risks, and evidence of the approach's effectiveness with their problem. This same information should be provided to involuntary clients, even though they may lack the freedom to withhold consent or to refuse a goal or service plan. They can, however, be given information about their options and the consequences of their choices.

Following the conversation in which you explain the suitability of an approach for addressing the problem or service goals, you should be guided by the client's responses to the following questions:

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

A client's responses to these questions provide assurance that the client understands, is able to make an informed decision, and is subsequently able to give or withhold consent.

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

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

EP 1

First and foremost, you are ethically obligated to have the requisite knowledge, skills, training, and competence to use an approach to resolve a particular client problem (NASW, 1999, 1.04b). The complexities of clients' problems often necessitate having the knowledge and competence to blend strategies and techniques of multiple approaches. In many respects, techniques can transcend models. An addendum to the question of sufficient knowledge and skills in an approach is, *Are you competent enough to make use of the techniques of another approach with the one that you have selected?* For example, let's assume that the intervention approach that you are using is the task-centered model. You might blend the strategic solution-focused miracle or scaling questions to clarify a goal. Posing the miracle question in the initial crisis stage would, however, be ill advised because a solution would have precedence over attending to the client's emotional state (James, 2008). Nor is it advisable to use the miracle question solely as an intervention strategy. Coady and Lehmann (2008) refer to this type of blending generalist practice as **technical eclecticism**. In sum, in deciding to blend tactics or techniques, an essential question is whether you have

the requisite knowledge, skills, and level of competence to engage in eclectic practice.

In working with minors, you may find that blending tactics is advisable. Very young children, for example, typically lack the cognitive capacity to think abstractly. Therefore, it can be useful if you are skilled in techniques such as play imagery or storytelling (Morgan, 2000; Nader & Mello, 2008). School-age minors, especially those in middle childhood, are influenced by self-evaluation, the evaluation of others, and their own sense of mastery (Hutchison, 2008). Hence, the use of tasks consistent with the task-centered or the solution-focused questions can be combined to support and reinforce their sense of self-efficacy.

A word of caution is in order. Eclectic practice does not mean that you select a little bit of this and that from various intervention approaches irrespective of your skill level. Ethically, in combining one approach with techniques from another, you must consider whether this is appropriate for the problem or situation at the time. In specific circumstances and with specific populations, selecting and utilizing an approach may in fact require that you have knowledge of and integrate non-Western traditional healing systems (Al-Krenawi & Graham, 2000; Hodge & Nadir, 2008; Sue, 2006). This knowledge can inform you as to whether adaptations or modifications of an approach are needed.

In general, it is advisable to use only those approaches in which you have the requisite knowledge and skills to implement them in a manner that is appropriate to the client situation and is consistent with ethical standards (NASW, 1999, 1.04a). In instances where you lack the requisite skills or competence, you should seek ongoing supervision or consultation or refer the client to a professional with the applicable skills (Strom-Gottfried, 2007).

MODELS AND TECHNIQUES OF PRACTICE

EP 8

Having described guidelines for planning and selecting a change approach, we now turn our attention to the major tenets and theoretical frameworks of the task-centered model, the basic model of crisis intervention, the cognitive behavioral technique of cognitive restructuring, the solution-focused brief treatment, and case management.[1]

THE TASK-CENTERED MODEL

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

Tenets of the Task-Centered Approach

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

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

Theoretical Framework of the Task-Centered Model

EP 4

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

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

The task-centered system is designed to be eclectic. Reid (1992) emphasizes, however, that combining the procedures of the model with another (technical eclecticism) requires utilizing compatible research-based theories and intervention techniques. With this in mind, you can make use of various theories that are relevant to the client situation (Ramos & Tolson, 2008; Reid, 1992). For example, cognitive restructuring can inform task strategies when feelings, anxieties, and fears are influenced by beliefs or irrational thought patterns (Reid, 1992). Still, Reid (1992) and Berlin (2001) caution that you should first determine that the client's emotional state is consistent with cognitive theory rather than stressors caused by environmental factors, conditions, or a crisis situation. The task-centered model, however, allows for the advent of a crisis, in which techniques from the crisis intervention approach may be used.

Evidence Base and Use of the Task-Centered Model

EP 4

The task-centered model has been adapted to various settings in which social workers practice, and its use has been empirically established with different client populations, including families, organizations, and communities (Parihar, 1984; Pomeroy, Rubin, & Walker, 1995; Ramarkrishnan, Balgopal, & Pettys, 1994, 2008; Reid, 1987, 1997; Reid & Fortune, 2002; Tolson, Reid, & Garvin, 1994). Adaptations of the task-centered approach have been tested in most settings where social workers practice, including mental health, health care, and family practice (Alley & Brown, 2002; Epstein & Brown, 2002; Fortune, 1985; Fortune, McCallion, & Briar-Larson, 2010; Reid, 1987, 1992, 1997, 2000). Additional evidence of the model's utilization and effectiveness include case management with minors and families, with elderly individuals in long-term care (Lee, Magnanano, & Smith, 2008; Naleppa & Reid, 2000, 2003; Pazaratz, 2000; Tolson, Reid, & Garvin, 1994), in supervision and staff development (Caspi & Reid, 2002), and with groups (Garvin, 1987; Larsen & Mitchell, 1980; Lo, 2005; Pomeroy, Rubin, & Walker, 1995). Building on the basic thrust of the model—specifically, eliciting the clients' view of the mandated problem and involving the client in task development and implementation strategies—R. H. Rooney (2009) and Trotter (2006) demonstrated the model's applicability and effectiveness with involuntary clients. Both Rooney and Trotter found that the approach, when combined with other strategies, reduced reactance and engaged the client.

Utilization of the Task-Centered Model with Minors

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

Application of the Task-Centered Model with Diverse Groups

According to Ramos and Tolson, the task-centered model has been used in agencies in which the client base consists of clients who are from "poor, racial and ethnocultural minority groups" (2008, p. 286). The model is thought to be sensitive to the experience of diverse individuals and families because of the emphasis on the right of clients to identify concerns, including clients who are involuntary. The use of tasks is believed to empower clients who are marginalized, lack power, and are oppressed (Boyd-Franklin, 1989; Ramos & Garvin, 2003). The model also responds to issues considered by Sue (2006) to be barriers to multicultural clinical practice because of its explicit acceptance of the client's view of the problem and a here-and-now action orientation rather than insightful talking. In their evaluation of various models

of practice, Devore and Schlesinger (1999) concluded that the basic principles of the task-centered system are a "major thrust" in ethnically sensitive practice (p. 121). Because the model accommodates different worldviews, it has been translated into several languages in different practice settings (Ramos & Tolson, 2008; Rooney, 2010; Chou & Rooney, 2010).

PROCEDURES OF THE TASK-CENTERED MODEL

EP 8

Figure 13-1 presents an overview of the procedures of the task-centered model. The initial phase begins with the client identifying and prioritizing a target problem. It is recommended that priority concerns and goals be limited to a maximum of three. Goals are agreed upon, and general and specific tasks to achieve goal attainment are developed. In keeping with the model's action orientation and brevity, termination begins with the first session. Specifically, you and the client agree to work together for a particular number of sessions (e.g., 6 to 8 weeks), although there is potential for you and the client to extend contact or negotiate a new contract for a different problem. During the period of contact, progress toward the identified goal is monitored and reviewed in each session as the client moves toward termination. Let's explore aspects of developing general and specific tasks and monitoring progress in more detail.

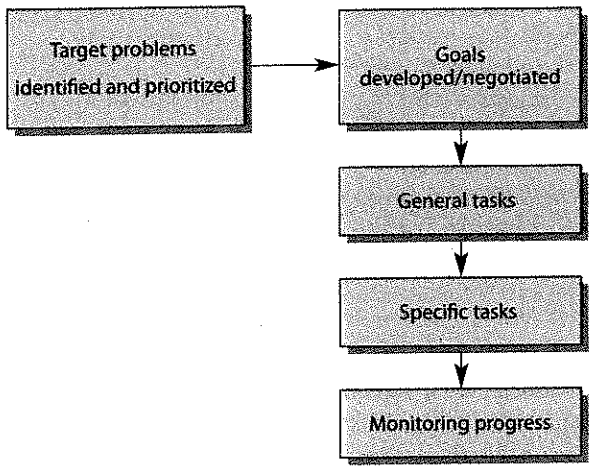

FIG 13-1 Overview of the Task-Centered Model

Developing General Tasks

As illustrated in Figure 13-1, when you and the client have identified a target problem and related goals, you are ready to develop general tasks. General tasks consist of discrete actions to be undertaken by the client and, in some instances, by you the social worker. Each general task has specific tasks that direct the incremental action steps to achieve goals.

VIDEO CASE EXAMPLE

The video "Problem Solving with the Corning Family" illustrates how goals and related general and specific tasks are developed. At this point, you will want to review all of the five video segments. A review of the family's situation is summarized here.

Target Problem

Angela and Irwin Corning, an interracial couple and their three children, are living in a transitional housing facility. Irwin lost his job 8 months ago when the county agency where he worked as a maintenance specialist hired a private contractor to reduce its labor costs. The couple's preference is to purchase another home, but their current financial situation does not permit them to do so. Consequently, the family will need to move into an apartment.

Goals

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

Irwin has found temporary employment that may lead to a permanent position. Now that he is employed, however, the family is no longer eligible to remain in transitional housing. They have 6 weeks to move from the facility; thus, the priority goal is finding an apartment, preferably one with three bedrooms. Irwin, in the meantime, will continue to look for more permanent employment.

To accomplish their goals, the following general tasks were developed:

General Tasks for the Couple

1. Meet with the transitional housing case manager to obtain information about affordable three-bedroom apartments.

2. Plan to visit apartments located in the general area where they want to live.
3. Identify schools in the area for the children.
4. Develop a budget.
5. Explore permanent employment for Irwin.

General Tasks for the Social Worker

In the examples provided, it is apparent that general tasks involve actions to be undertaken by one or both of the Corning spouses. In some situations, general tasks can also require actions by the social worker, either on the client's behalf or jointly with the client. In the Corning case, Ali, the social worker, agreed to a general task of providing resource information about employment opportunities as well. At the same, Irwin's general task involved pursuing employment opportunities on his own. Thus, both Ali's and Irwin's actions are jointly focused on tasks related to the job search.

Initially, general tasks may be disconnected and may not follow a logical sequence. Therefore, tasks will need to be prioritized by you and the client. For Angela and Irwin, it was important for the social worker to clarify which of the general tasks were the most significant. They agreed to the general task of moving from the transitional housing facility as a priority.

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

VIDEO CASE EXAMPLE

The following are specific tasks related to one of the Cornings' goals and previously outlined general tasks:

- **Goal:** Move from the transitional housing facility into an apartment within the next 6 weeks.
- **General Task:** Contact the transitional housing assistance coordinator to obtain information about available and affordable three-bedroom apartments.
- **Specific Tasks:**
  1. Schedule a meeting with the housing coordinator to learn about housing options within the next week.
  2. Plan to visit apartments located in the general area where they would like to live.

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

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

Developing Specific Tasks

General tasks can prove to be overwhelming for some clients. The key to the task-centered system is developing general *and specific* tasks. The latter direct the actions that the client or you as the social worker will attempt between one session and the next.

Although the Corning couple were ready to carryout identified tasks, sometimes preliminary steps may be required to help clients to move forward. The following three facilitative factors can be of assistance in this regard:

1. *Assessing client readiness to engage in an agreed-upon task.* A client's readiness to implement a

task can be gauged by asking the client to rate his or her readiness using a scale of 1 to 10, in which a rating of 1 represents a lack of readiness and 10 indicates that the client is ready to go (De Jong & Berg, 2001). Should clients indicate that their readiness is on the low end of the scale—for example, in the 1 to 3 range—you should explore the reason for the low rating, as doing so can uncover vital information concerning potential obstacles. However, even when clients have indicated a level of readiness to move ahead, implementing a task can cause a certain amount of tension and anxiety. It is neither realistic nor desirable to expect clients to be altogether comfortable with tasks, despite the fact that they were involved in them. Nonverbal behavior on the part of a client can also indicate a level of readiness in the lower range that can signal an obstacle or apprehension about undertaking a task. When you observe such behavior, you should explore the context and content so that the behavior does not become a barrier.

In those instances in which the client's level of readiness is low, you may be tempted to assign tasks. For the most part, however, individuals of all ages, irrespective of status, are unlikely to be motivated by and become reactive to assigned tasks (Brehm & Brehm, 1981; Miller & Rollnick, 2002). Reactance theory suggests that individuals are inclined to act to protect themselves, especially when a choice is imposed, and further when the choice is inconsistent with a desired direction.

VIDEO CASE EXAMPLE

Note that in the video "Problem Solving with the Corning Family," although Irwin expressed a high level of readiness, he was nonetheless apprehensive about his job search. Had his apprehension involved an inordinate level of anxiety, his feelings would need to be clarified, as anxiety can be a major deterrent to further action. Nonverbal behaviors are also visible in the video. For example, Irwin seemed uncomfortable, at times annoyed, and had very little to say unless prompted by Angela. He became animated, however, when Ali asked about his willingness to develop goal-related tasks, stating, "I am ready to do something. Instead of sitting here talking, I could be out looking for a job or a place for my family to live. So, let's get on with it."

2. *Brainstorming alternative tasks.* Essential tasks are often readily apparent; however, in instances in which tasks are less apparent, you and the client can brainstorm to identify a range of alternatives. Brainstorming alternative tasks involves a process in which you and the client mutually focus on generating a broad range of possible task options from which the individual, family, or group may choose. Note that when you suggest tasks during the brainstorming process, it is critical to check with the client to ensure that he or she agrees with and is committed to the tasks. Most clients will be generally receptive to your suggestions. Reid (1978, 2000) found that there was little difference in the rate at which clients accomplished tasks suggested by the social worker when compared to those they proposed themselves. Brainstorming can be particularly useful with minors to encourage their ownership of possible actions.
3. *Establishing a reward or an incentive.* Given the varied circumstances in which clients may be hesitant to engage in tasks, it may necessary to identify an immediate reward to support motivation. Rewards and incentives are particularly relevant when a change in behavior or cognition is associated with the choice of pain over pleasure, such as engaging in activities that may be perceived as unattractive (e.g., studying, cleaning house) instead of engaging in self-time. Possible rewards can be identified with the client; however, to be effective, the reward should be realistic. Rewards can be helpful in encouraging minors to complete tasks, in particular when doing something else is more attractive. An incentive can be especially beneficial for minors when the intent of a task is a behavioral change. You may also work with parents or other significant adults in the minor's life to establish a complementary reward.

When using an incentive or reward to motivate, it is important to observe and record incremental change, followed by an immediate reward; otherwise, the client may become discouraged or give up, believing instead that he or she is unable meet expectations. The following guidelines can help you best utilize incentives or rewards and encourage the completion of a task, especially among minors:

- Specify the time frame and the conditions under which the task is to be performed (e.g., every 2 hours, twice daily, each Wednesday, once a day

for 5 days), so that the client understands the specifics of what is being asked of him or her.
- In collaboration with the client, identify the reward to be earned as well as establish a method for tracking the progress of task completion.
- When possible, identify relationship rewards (for example, going to the mall or spending time with friends or other significant individuals).
- Provide a bonus for consistent achievements of tasks over an extended period of time.
- Encourage task completion by providing consistent and positive feedback. For minors, using visuals, such as graphs to record and track progress on tasks, can be a motivator.

Task Implementation Sequence

After agreeing on one or more tasks, the next step is to assist clients in planning and preparing to implement each task. When skillfully executed, these processes enhance client motivation for undertaking tasks and substantially increase the likelihood of a successful outcome. The **task implementation sequence (TIS)**, as described by Reid (1975, 2000), involves a sequence of discrete steps. The steps (summarized in Table 13-1) involve the major elements generally associated with successful change efforts. Research suggests that clients were more successful in accomplishing tasks when TIS was implemented than when it was not (Reid, 1975, 2000), even though being faithful to the sequence may initially seem tedious. Although Reid recommends that the TIS be applied systematically, the sequence is flexible and permits adaptations or modifications that are appropriate to the circumstances of each client situation.

Merely agreeing to carry out a task doesn't guarantee that a client has the knowledge, resources, courage, interpersonal skills, or emotional readiness to successfully implement a task. Consequently, each step in the TIS is intended to increase the potential for a successful outcome: obstacles are examined and resolved in advance, and behavior involved in the task is rehearsed. It may also be useful to revisit incentives or rewards associated with task completion.

In the following sections, we discuss the steps of the TIS in greater detail.

TABLE 13-1 Task Implementation Sequence (TIS)

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

Step 1: Enhance the Client's Commitment to Carry Out Tasks

Step 1 in the TIS is intended to ensure the client's commitment to carry out tasks. This step involves clarifying the significance of tasks for reaching the goal and identifying the potential benefits. To encourage follow-through with tasks, it is important that clients perceive that the gains of completing a task outweigh the costs (including anxiety and fear) associated with risking a new behavior or dealing with a changed problem or situation. Because change is difficult, exploring apprehension, discomfort, and uncertainty is especially critical when a client's motivation to carry out a given task is questionable.

It is advisable to begin implementing Step 1 of the TIS by asking clients to identify benefits they will gain by successfully accomplishing the task. In many instances, the potential gains and benefits of carrying out the task are obvious, and it would be pointless to dwell on this step.

VIDEO CASE EXAMPLE

Note that in the video "Problem Solving with the Corning Family," for Irwin Corning, the benefit and subsequent gain of completing the task of seeking permanent employment, the result of which is economic stability for the family, is clear. Ali, the social worker, therefore does not need to focus extensively on this step of the TIS.

Step 2: Plan the Details of Carrying Out Tasks

Step 2 of the TIS is intended to prepare clients for all of the actions involved in a task. When a task involves both cognitive and behavioral subtasks, it is beneficial to help the client to be psychologically prepared before carrying out an overt action. For example, you can coach clients to reflect on past successes or focus on their supportive resources such as spirituality or faith.

By including cognitive (covert) strategies in this step, you are assisting clients to cope with their ambivalence or apprehension with regard to implementing actions. Of course, planning behavioral tasks that involve overt actions requires considering real-life details as well, such as transportation, child care, access to technology, financial resources, and the like.

VIDEO CASE EXAMPLE

The video "Problem Solving with the Corning Family" touches on several factors related to Step 2 of the TIS. For example, in one of the sessions, Irwin talked about himself as a low-skilled laborer, which he believed meant that he had fewer opportunities. Although the details of the job search had been discussed, addressing Irwin's cognitive appraisal of his situation would be important. In addition, the Corning couple discussed practical details about carrying out tasks, such as whether to take their three children as they looked for an apartment. If visits occurred early in the day, the two older children would be at school. In the evenings, unless the couple could arrange for child care, all three children would accompany them. Because the couple relied on public transportation, they would need bus fare for a family of five, and multiple bus rides might be required. Angela identified her sister as a child care resource. Discussing the details and discrete actions associated with completing tasks, and planning for the inevitable in advance, effectively increased the opportunity for the couple to be successful.

The Practitioner's Role in Task Planning. The details of a task may involve certain actions for which the social worker assumes responsibility. Clients may wonder about your role. (Angela Corning, for example, asked Ali, the social worker, "What kinds of things can you do for us? I'm not clear about how you can help us.") In planning the details of tasks, a social worker's tasks can be developed when he or she has ready access to resources or information that will facilitate client work. In the Corning case, for example, Ali agreed to obtain information about the couple's eligibility for temporary financial assistance to help with their move from the transitional housing facility. On the other hand, when it is advantageous for a client to complete a task on his or her own, a review of the actions involved would be helpful.

During the performance of tasks, there may be occasions on which it will be useful for you to accompany the client or make use of his or her support system. For example, if the task involved applying for financial assistance, which for some people can be intimidating, supporting task performance can involve assisting the client in completing the application or having a support person to talk to while they are waiting to be interviewed.

Conditions for Task Completion. When the time frame for completing tasks lacks specificity or is vague or abstract, clients and social workers can procrastinate, leaving little time to effectively implement the planned action. Think about a group project assignment in which your classmates agree to meet within the next week. Without specifying when and where the meeting is to take place, each person can have a different idea about what next week means. Therefore, for the sake of clarity, the details of tasks should specify when, as well as the conditions or circumstances of the action that is to occur.

For example, consider a scenario in which an elementary school student constantly disturbs his peers and speaks out in class without raising his hand. The condition for the task behavior is attentive listening (condition) while the teacher is speaking during the 1-hour math class (circumstance) for a certain time period. Although problematic behavior occurs in other classes, the task is focused in the math class within a specified time period. Of course, the overall task is movement toward the eventual change behavior in all classes. Focusing on the behavior in the math class, however, partializes the task behavior, as it would be unrealistic to expect an immediate behavior change.

Because tasks connected to *ongoing* goals are incremental, it is important that you and the client begin with a structured first task that is easy and within the individual's capacity to achieve. In the classroom situation, for example, the student's task of raising his hand for 5 straight days may be difficult to achieve. Alternatively, raising his hand in math class for 2 out of 5 days may, with positive feedback from the teacher, increase the likelihood of eventually engaging in the task directed toward the goal of behavioral change.

Step 3: Analyze and Resolve Barriers and Obstacles

In Step 3 of the TIS, you and the client deliberately anticipate and subsequently prepare for obstacles that can

affect or stall task accomplishment. Returning to the student's classroom behavior as an example, as the social worker involved, it would be useful for you and the student to discuss obstacles to goal completion, such as social, physical, or psychological barriers. For the student, his behavior was reinforced because of the attention he gained from his peers and social standing within the peer group. Therefore, change for the student involved not only mastery of a new behavior but also a loss of his esteemed position within his peer group.

It is also prudent to inquire about the practical and economic resources needed for completing the tasks (Eamon & Zhang, 2006). A caveat should be observed, however: A simple action of making a phone call may prove difficult for a client, depending on his or her on level of confidence, cognitive capacity, or social ability. Fears and cognitions can be a formidable barrier to accomplishing a task.

VIDEO CASE EXAMPLE

For Irwin Corning, telephone calls to inquire about available jobs or looking online for job postings seem to be relatively easy and simple tasks. However, his fears and cognitions were a more difficult obstacle. For example, although Irwin was eager to find employment, he felt vulnerable because "being laid off' amounted to a failure, based on his belief that "a man ought to provide for his family."

When tasks are complex, obstacles likewise tend to be complex, and clients may have difficulty identifying obstacles. Tasks that involve changes in patterns of interpersonal relationships tend to be multifaceted and require developing subtasks as a prerequisite. For example, many intrapersonal tasks require the mastery of certain interpersonal skills.

Clients' capacity to resolve barriers and obstacles varies depending on the nature and complexity of the task. Some clients overlook or underestimate potential barriers and obstacles, resulting in a delay to take on tasks, needless difficulties, and in certain cases outright failure in accomplishing a task. In such instances, explaining that obstacles and barriers are common is helpful. You might take the lead in brainstorming with clients to identify and resolve obstacles that can influence the planned course of action. Returning to the example of the elementary school student, the student and social worker would brainstorm different *what if* scenarios that could hinder the student's ability to raise his hand before speaking in class, thereby resulting in his becoming frustrated and returning to his old behavior. For example, what if he raised his hand and the teacher did not call on him? What would he do if he became discouraged? Discussing different scenarios with the student can identify potential obstacles and responses in advance (for example, "I would wait my turn," or "I could keep my hand up, even if the teacher called on another student first," or "If I felt discouraged, I might talk to the teacher after class"). Equipping the student with possible responses reinforces his motivation to engage in task behavior.

Psychological barriers to task performance leading to goal attainment are often encountered regardless of the nature of the task. Think of your cognitive appraisal of a situation in which you experienced intense emotions—for example, when you applied for a job, were required to appear in court, or had to express your feelings in a difficult situation. Now think about how the experience was intimidating or caused you anxiety. How did your appraisal of the situation affect the quality and intensity of your emotions and influence you thoughts and feeling in the situation?

VIDEO CASE EXAMPLE

Whether real or perceived, thoughts, feelings, and beliefs about self or stereotypic perceptions of others can become major obstacles to task completion. In the video "Problem Solving with the Corning Family," Irwin Corning's discomfort about losing his job dominates his thinking and self-perception—in particular, his belief about his role as the head of the household. At one point he asserts, "Nothing is comfortable about this situation." In examining the cognitive content of his message, there are several layers in his reasoning. Understandably, he is experiencing intense emotions as a displaced worker. His appraisal of the economic climate is realistic, as is his belief about the available employment opportunities for an African American male. But Irwin's perception that the company prefers hiring undocumented workers as a reason for his becoming unemployed lacks concrete evidence.

What can you do when you encounter situations in which cognitions and intense emotions have the potential to derail a client's plan of action? To begin, you and the client can develop a subsidiary task of neutralizing his or her emotions by exploring and clarifying the emotional content and empathizing with the client's apprehension. It may also be important to examine the problematic emotions, helping the client to identify the cognitive source and to align his or her thoughts and feelings with reality.

In general, the time and effort invested in overcoming and resolving barriers and obstacles are likely to pay dividends, resulting in a higher rate of success in accomplishing tasks. Consider the economy of this process, as failure to complete tasks can have an effect on an individual's sense of self-efficacy and can extend the time involved in successful problem solving.

Step 4: Rehearse or Practice Behaviors Involved in Tasks

Certain tasks involve skills that people may lack or behaviors with which they have had little or no experience. Step 4 of the TIS is aimed at assisting such clients to gain experience and mastery in performing skills or behaviors essential to task accomplishment. Bandura (1977) builds a strong case for mastery. Specifically, he emphasizes that the degree of an individual's positive expectation of his or her ability to perform will determine how much effort will be expended and the length of time an individual will persist when faced with obstacles or aversive circumstances. It follows, then, that a major goal in the TIS is to enhance clients' sense of self-efficacy so as to increase their potential for successful task completion. Successful experience, even in simulated situations, encourages a client's belief that he or she has the ability to be successful in performing a task.

Confirming research studies indicate that a sense of self-efficacy can be transferred to other situations, including those that a client previously avoided (Bandura, 1977). According to Bandura, people receive information about self-efficacy from four sources:

- **Performance accomplishments:** Major methods of increasing self-efficacy through performance accomplishment include assisting people to master essential behaviors through modeling, behavior rehearsal, and guided practice (discussed later in this chapter).
- **Vicarious experience:** Insight may be gained by observing others demonstrate certain behaviors or observing the performance of a behavior without experiencing adverse consequences. Efficacy expectations can be bolstered by a client's observing you, the social worker, or others who model the desired behaviors. Observing others, however, is clearly not as powerful as the sense of self-efficacy that results when the client successfully engages in a behavior on his or her own.
- **Verbal persuasion:** Talking to clients about their capacity to perform can be somewhat effective and also raise outcome expectations. But talking to clients about expectations or attempting to persuade them about their competence does not in fact enhance self-efficacy. To be effective, the appraisal of a client's capabilities has to be based on his or her perceptions and assumptions about competence and sense of self.
- **Emotional arousal:** Self-efficacy can be influenced by emotions, which in turn affect how people perform. Individuals who are extremely anxious or fearful about performing a new behavior are unlikely to have sufficient confidence to do so. In such instances, verbal persuasion directed toward reducing anxieties or fears is generally ineffective. Specifically, emotions such as fear are undependable source of self-efficacy in that they can overshadow the actual evidence of an individual's capacity. Perceived self-competence, however, can reduce emotional arousal rather than the converse.

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

Increasing Self-Efficacy Using Behavioral Rehearsal, Modeling, and Role-Play. **Behavioral rehearsal** used in an actual session is intended to reduce anxieties and help clients practice new behaviors or coping patterns. Indications for using this technique include situations in which a client feels threatened, feels inadequately prepared to face a situation, or is anxious or overwhelmed by the prospects of engaging in a given task.

Role-playing is the most common form of behavioral rehearsal to encourage mastery because the client is able to rehearse a desired behavior or outcome. In a simulated situation, a client can build on his or her existing skills, as well as identify potential barriers or obstacles. Modeling behavior through role-play, in effect, allows for the vicarious learning of a behavior before actually having to do so in a real-life, potentially difficult situation. The advantage of role-play is illustrated in the following video case.

VIDEO CASE EXAMPLE

In the video "Working with Yanping," Yanping, a student from China, has decided to change her major from business to history. Her parents have expressed their displeasure with her decision, indicating that they consider the status of a history degree as low and the financial rewards of the degree as limited. Yanping's decision is further complicated by her parents' expectation that she will return to China prepared to eventually take over the family business. Therefore, a history degree has little value to the family. At the point of contact with Kim, the social worker, Yanping's anxiety is due to her parents' disappointment and distress regarding her study decision. As the time for her return to China draws near, Yanping's anxiety has increased in anticipation of having further conversations with her parents.

In the first segment of the video, observe that Kim, the social worker, attempts to understand the cultural meaning and implications of Yanping's decision, her parents' reaction, as well her prior coping efforts. Kim also inquires whether Yanping has talked with or observed others in a similar situation (*vicarious experience*). Together, they brainstorm options regarding possible ways that Yanping can have a conversation with her parents. This case is difficult for Kim as a social worker because she is versed in the individual autonomy norms of Western society and the guiding principle of self-determination. Consequently, Kim feels that she is not sufficiently prepared to understand and be sensitive to the serious consequences for Yanping should she disregard cultural expectations.

In the second segment of the video, Kim refers Yanping to Jilan, a colleague from China, in the hopes that Jilan can help Yanping navigate the cultural expectations and perhaps resolve her dilemma. In the following session, Jilan and Yanping role-play a scenario between Yanping and her father in preparation for an eventual face-to-face conversation (*behavioral rehearsal*). As the two take turns, either as Yanping or her father, Yanping has the opportunity to rehearse responses to anticipated questions from her father and to observe Jilan's responses to her father's questions (*behavioral modeling*). Note that during the role-play, Yanping is more relaxed and more willing to approach her father. In fact, during the course of the role-play, a new idea occurs to her: she will also study business history, which she believes will appeal to her father as being advantageous to the family business.

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

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

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

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

Step 5: Summarize the Task Plan

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

Social worker: I have agreed to contact the employment information specialist by our meeting next week.
Client: I will make three phone calls to potential employers who have posted job listing online.

Alternatively, the client would be asked to review and summarize his or her plans:

Social worker: What are your plans for searching for a job by our next session?

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

Failure to Complete Tasks

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

Reasons Related to the Specific Task

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

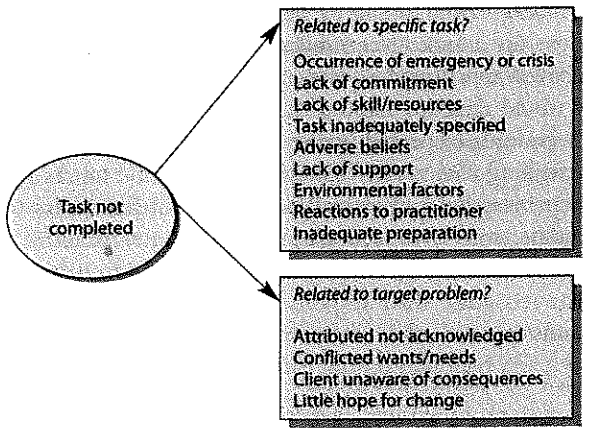

FIG 13-2 Reasons for Low Task Performance

Occurrence of an Emergency or Crisis. Certain overwhelming situations may dictate taking a brief detour from set tasks. Consequently, a client's forward momentum can be slowed, making it difficult for him or her to complete a task. Should this prove to be the case, it is appropriate for you to empathetically respond to the emotional state of the client. It may also be necessary to focus on the more urgent difficulty and to develop a goal and tasks related to the unexpected situation. If possible, an agreement should be reached about the timing for resuming work on tasks that were designated for completion prior to the crisis. If in the course of your work with the client you observe that his or her life appears to reverberate from crisis to crisis, the two of you can discuss whether it would be beneficial to remain focused on the initial tasks and see them through to completion.

Lack of Commitment. Lack of commitment has been documented as a statistically significant predictor of whether a client will engage in task performance (Reid, 1977, 1997, 2000). However, hesitation or a lack of commitment should not be confused with a lack of readiness. In the former, the willingness to change is absent. In the latter, the client is willing but

is blocked from acting by other barriers. One frequent cause for a lack of commitment to undertake tasks is a covert unwillingness to own one's part of a problem. "I would raise my hand if the teacher called on me," is an example of paying lip service to carrying out a task. Unwilling clients may use excuses to blame others for their behavior and instead passively wait for others to initiate corrective actions. The technique of ethical confrontation (see Chapter 17) can be used to help clients recognize their responsibility for maintaining the status quo.

Lack of Skills/Resources. In planning tasks, it is important to ensure that clients have the necessary resources and skill for completing the agreed-upon action. For example, if the task is obtaining a job, it would be prudent to assess whether the client has adequate interviewing skills. It would be equally important to determine, for example, whether the client has the funds for transportation to the interview.

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

Adverse Beliefs. A client may agree to a task but may not fully disclose information about conflicting values or beliefs. For example, a parent who believes that children are to obey is likely to be hesitant to utilize reward systems, believing instead that parents should not bargain with their children. Being sensitive to and respecting different beliefs is important. By listening to the parent, the two of you could renegotiate a task that is consistent with the parent's belief as a solution.

Lack of Support. When a problem involves others or another system, the relevant individuals should be involved in supporting task accomplishment. For example, a teacher should be encouraged to call on the student we described earlier when he raises his hand or give him an indication that she will do so in time.

Environmental Factors. Support for completing tasks can also be related to family or environmental factors. For example, finding a subsidized apartment can depend on the availability of such housing. These are difficult situations in which a ready a solution may not be apparent, and you and the client will need to explore interim options. It can also be useful for you and the client to look for others in his or her network to provide support.

Reactions to the Practitioner. Negative reactions to the social worker, both verbal and nonverbal, can affect a client's ability to complete tasks. The range of possible reactions may be difficult to anticipate in a given situation. For example, clients may react to what they perceive as the social worker's arbitrary assignment of tasks. Another situation that can cause a client to react is highlighted in the following example: "She keeps telling me that she is going to make a referral to the child care resource center, but week after week, she has failed to so." Without the social worker's completing a task on behalf of the client, the client was unable to complete her work.

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

Reasons Related to the Target Problem

Attributed Not Acknowledged Problems. Low task performance can occur when a client has not accepted that a problem exists and therefore is unlikely to engage in a change action. For example, "I don't have a drug problem. Sometimes I do a little meth [methamphetamine] with my buds [buddies], but that don't mean that I'm a drug head" (attributed problem). In these instances, you can begin by acknowledging this view of the situation, respecting the client's reactions, and exploring incentives that might encourage him or her to complete tasks. Persistent inaction certainly speaks louder than words, and the benefits of continuing to work with the client should be carefully weighed.

Conflicting Wants/Needs. Certainly, what can initially appear to be a lack of commitment may actually be that a client is faced with a competing or a more pressing concern. The initial task remains important; however, another issue, either new or existing,

demands the client's attention. The situation need not be a crisis. It may simply mean that even though a client had prioritized a goal and developed a related task, there are other issues competing for his or her attention. Flexibility is called for in such instances until the competing concern is resolved.

Client Unaware of Consequences. A failure to perform a task may stem from a lack of understanding about the consequences of failure. For example, the consequences of failing to complete a chemical dependency treatment program and providing clean urinalysis samples should be explained.

Little Hope for Change. In spite of the fact that a client has agreed to undertake a certain task, he or she may feel that completing the task may have little or no impact on a problem or situation. This is an opportunity for you to help the client by calling attention to his or her past successes. For example, addressing these issues with Irwin Corning, you might say to him, "I understand that you are feeling some anxiety about getting a job, and I can't guarantee that you will. But remember how you felt about talking to the housing authority about rental assistance. You were able to do so, and you obtained a housing voucher." Crediting clients with past successes is particularly useful to boost confidence when a client's perception of his or her ability to effect change is uncertain.

Even when preparation has been adequate and potential obstacles and barriers have been reviewed, the successful outcomes of task efforts are not guaranteed. The preceding discussion highlighted valid reasons for low task performance. The intended message of the discussion was simple: The majority of clients with whom you work want relief from their difficulties and are motivated to take action. Nonetheless, their ability to do so can be hampered by their beliefs and other factors. To avoid or minimize the potential of a client's becoming discouraged, you should not interpret low task performance as a failure but rather as an indication of the need for additional exploration or task planning.

Monitoring Progress

EP 9

In the task-centered model, tasks are the instrumental action steps taken by the client and in some instances the social worker. Tasks are intended to alter or remediate the target concern and achieve a desired outcome. The continuous review of tasks maintains continuity and focus and monitors progress. The following procedures for the systematic review of progress are specific to the task-centered approach:

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

In reviewing task accomplishments, it is critical to discuss with the client details about the conditions, actions, or behaviors that facilitated completion of the task. Even when tasks have been only partially completed, it is important to connect the progress made to the client's efforts. In doing so, you are highlighting and reinforcing the client's strengths and sense of competence.

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

Strengths and Limitations of the Task-Centered Model

The task-centered model is the first empirically based social work model of a planned, short-term, problem-solving approach based on the principles and values of the social work profession (Kelly, 2008; Reid & Epstein, 1972). The model honors self-determination, strengths, and empowerment by allowing clients to define the problem, develop goals and tasks, and participate in monitoring progress. To increase clients' self-efficacy and opportunity for mastery, obstacles to task completion and goal attainment are identified and resolved. The review of obstacles and barriers is a distinct strength of the approach. Similarly, when tasks are not completed, the reasons for low task performance are reviewed and new tasks, if indicated, are developed.

As noted earlier, the efficacy of the model has been supported by empirical evidence in multiple settings and for a range of voluntary and involuntary client problems, including minors (Ramos & Tolson, 2008; Reid, 1992; Tolson, Reid, & Garvin, 1994). The model's effectiveness has also been demonstrated in worldwide practice settings (Ramos & Garvin, 2003; Ramos & Tolson, 2008; Reid, 1996, 1997, 2000). The emphasis on taking action on problems acknowledged by clients is believed to be appealing to racial and ethnic minorities (Boyd-Franklin, 1989; Devore & Schlesinger, 1999; Lum, 2004; Sue, 2006). Key aspects of the model, namely the use of tasks, have become foundational elements of a number of other intervention approaches (Hoyt, 2000; Ramos & Tolson, 2008).

Opinions are mixed about the efficacy of the model with certain populations and in certain situations. Critiques of the central tenets of the model—in particular, time limits and the systematic structure—have led some observers to conclude that a sustained therapeutic relationship with clients is unlikely to evolve (Ramos & Tolson, 2008). Given the utilization and effectiveness of the model with a range of client problems and settings, there is limited evidence to support this claim.

THE CRISIS INTERVENTION MODEL

EP 8

The crisis intervention model discussed in this text is the **equilibrium model**, which is based on basic crisis theory. Knowledge of how to intervene with clients who are experiencing a crisis is considered essential for skilled practice (Knox & Roberts, 2008; Walsh, 2010). Depending on the nature of the crisis and the systems involved, it may be necessary for you to intervene at the micro, mezzo, and macro levels (Gelman & Mirabito, 2005). While multiple disciplines including social work have played an important role in developing crisis theory, social workers have been responsible for advancing practice methods and skills and for formulating strategies for responding to crises (Bell, 1995; Fast, 2003; Komar, 1994; Lukton, 1982; Parad & Parad, 1990).

Tenets of the Crisis Intervention Equilibrium Model

The equilibrium model is a basic approach to crisis intervention. The model is action oriented, with the central intent being to reduce the intensity of a client's emotional, mental, physical, and behavioral reactions to a crisis and to restore client functioning to the precrisis state. Promptness of response, a key aspect of the model, is considered critical to prevent deterioration in functioning. It is during the acute period that people are most likely to be receptive to an intervention. The procedures of the model involve assessing the nature of the crisis, identifying priority concerns, and developing limited goals.

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

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

James (2008; James & Gilliland, 2013) and Roberts (2005) cite the **triage assessment system** developed by Meyer, Williams, Ottens, and Schmidt (1991) as a "fast" and efficient way to assess and "obtain a real time estimate of what is occurring with a client" in a crisis situation (pp. 43–48). This assessment system provides a framework for social workers to assess the client's affective, behavioral, and emotional functioning; assess the severity of the situation; and plan the appropriate intervention strategy. Where possible, you use the three domains to establish a baseline that can subsequently be compared to the triage assessment system results to determine the functioning level prior to and after the crisis (James, 2008).

Definition of Crisis

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

In your work with clients, you have no doubt assisted them to deal with crisis situations. These situations may have ranged from job loss to death, a medical diagnosis, eviction, divorce, domestic violence, child abuse or neglect, crime, relocation, or even a natural disaster. Similarly, revealing one's sexual orientation to an unsupportive family (often a high-anxiety event) can result in an unmanageable crisis, accompanied by additional stressors for which relief is uncertain.

Uncertainty can also become a stressor for refugees, immigrants, and migrants, who may simultaneously experience demands related to their transition and the related sense of loss as a result of leaving their homeland, familiar networks, and culture. (However, note that despite the stress of having to adjust to the norms, values, and language of another country, migrants tend to perceive their relocation as an opportunity, unless the transition was not of their choosing.)

It is important to note that segments of the population experience cumulative events or circumstances that result in a perpetual state of crisis (Ell, 1995). Consider, for example, the hypervigilance of unauthorized immigrants related to fear of deportation and family disruption, or the very real threats experienced by gay and lesbian individuals as a result of hate crimes, brutal beatings, and even murder. Intense anxiety related to threats and potential harm is pervasive in many among minorities who live in impoverished urban communities. Residents in these communities face ongoing violence, including institutionalized violence such as negative encounters with the police, poverty-related stressors, and inadequate services or resources, resulting in perpetual disequilibrium. Studies have shown that the continuous exposure to violence can also have an enduring effect on minors, resulting in depression, delinquency, or acting-out behavior (Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006; Maschi, 2006; Maschi, Perez, & Tyson, 2010; Voisin, 2007; Zeira, Astor, & Benbenishty, 2003). Emotional and psychosocial crises resulting from the experience of combat by military personnel, specifically posttraumatic stress disorder (PTSD), can pose a lifetime risk for these individuals (Halpern & Tramontin, 2007; James, 2008). Stress-related symptoms may also be observed in professionals who work in highly stressful, emotionally charged situations (Bell, 2003; Curry, 2007; Knight, 2006). In addition, crises can occur in the lives of some people on a regular basis.

VIDEO CASE EXAMPLE

In the video "Working with the Cornings," Irwin Corning's job loss set in motion a series of stressful events that were significant threats to the family's stability. While the family was experiencing a situational crisis, the continuation of stressful events could eventually reach a level of emotional and behavioral distress that exceeded the family's coping capacity.

Crisis Reactions and Stages

A **crisis reaction** is described as any event or situation that upsets the client's normal psychic balance to the extent that his or her sense of equilibrium is severely diminished (James, 2008; Roberts, 2005). Crisis intervention theory posits that people's crisis reactions typically go through several stages, although theorists differ as to whether three or four stages are involved. The following description is a synthesis of models and stages identified by various authors (Caplan, 1964; James & Gilliland, 2001, 2013; Okun, 2002; Roberts, 2005):

- **Stage 1:** The initial tension is accompanied by shock and perhaps even denial of the crisis-provoking event.
- **Stage 2:** To reduce the tension, the client attempts to utilize his or her usual emergency problem-solving skills. If these skills fail to result in a lessening of tension, the stress level will become heightened.
- **Stage 3:** The client experiences severe tension, feels confused, overwhelmed, helpless, angry, or perhaps acutely depressed. The length of this phase varies according to the nature of the hazardous event, the strengths and coping capacities of the client, and the degree of responsiveness from social support systems.

Patterns of behavior associated with these stages may be characterized as disorganization, recovery, and reorganization (Lum, 2004; Parad & Parad, 1990, 2006; Roberts, 1990, 2005).

Crisis situations inevitably have a subjective element because people's perceptions and coping capacities vary widely. Keep in mind, therefore, that a crisis that is severely stressful and overwhelming for some people may be manageable for others. Variations in reaction can depend in part on the point at which the social worker has contact with the client.

In reacting to a crisis, the potential exists for clients to cope in ways that are either adaptive or maladaptive. You should be aware, however, that prolonged stress may have exceeded clients' coping capacity and usual problem solving to such an extent that they are unable to effectively handle the stressors. Achieving equilibrium for some clients may depend on the extent to which their strengths, resilience, and social supports are mobilized. In some instances, the crisis may even evoke a positive change opportunity. Specifically, a client's reaction may be to seek help

and succeed, thereby using the opportunity for his or her benefit (James, 2008). For others, the level of tension can become elevated, in which case the client's coping patterns reach a level of danger. Danger is evident when restoring equilibrium is not immediately possible because the client is unable to function.

Duration of Contact and Focus

Typically, crisis work is time limited, spanning 4 to 8 weeks, although some clients or situations may require prolonged contact. Your contact with a client during the acute crisis period may be daily for a period of time, and may take place in an office, a shelter, a hospital, or in the home. Interventions range from a single-session telephone intervention to comprehensive services with an individual, group, family, or an entire community (Fast, 2003; Gibar, 1992; James & Gilliland, 2001; West, Mercer, & Altheimer, 1993). The active, intense, time-limited, focused, and action-oriented nature of the crisis intervention approach is believed to help people return to a level of precrisis functioning (James & Gilliland, 2013; Roberts, 2005; Walsh, 2010). Ultimately, the level of distress, whether the crisis is acute or chronic, and client characteristics (perception of the crisis, ego strengths, and situation-specific resources such as social supports) will dictate the time required. Follow-up as an additional contact—included as a step in the Seven-Step Crisis Intervention Model (Roberts, 2005; Roberts & Ottens, 2006) and the Hybrid Model (James & Gilliland, 2013)—may be incorporated in the basic equilibrium model discussed in this chapter.

The guiding principles of time-limited crisis intervention are as follows:

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

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

Intervening with Minors

Minors are more vulnerable and at greater risk when a crisis or traumatic event occurs (Halpern & Tramontin, 2007; James, 2008). Understanding the nature of the crisis and the minor's response to it is the first intervention step (Terr, 1991). Two distinct crisis categories can be used to distinguish the minor's reaction to a crisis (James, 2008, p. 163): **Type I** involves a single, distinct crisis experience in which symptoms and signs are manifested; for example, the minor can display fully detailed etched-in memories, misperceptions, cognitive reappraisals, and reasons for the crisis event (James, 2008). **Type II,** in contrast, is the result of longstanding, repeated trauma whose cumulative effects result in the minor's psyche developing defensive coping strategies, anxiety, depression, or acting-out behavior (James, 2008; Lindsey et al., 2006; Maschi, 2006; Voisin, 2007).

For minors, a crisis event has the potential to disrupt biological, social, and cognitive development, and age can make a significant difference in how minors respond. The Type I category seems to fit best with the basic equilibrium crisis intervention approach, in which the focus is on restoring the precrisis state of their caregivers in order to help minors. The stages of crisis and the reaction may differ with minors. They may, for example, need additional help in understanding their reaction to the crisis and in developing problem-solving skills. The **triage system** assessment can be especially important in determining the minor's cognitions and behaviors as a result of the crisis. Cognitively, a crisis event can increase minors' sense of vulnerability and their perceived lack of power. Behavioral interventions to a crisis event may involve the minor's coping by role-playing, for example, an all-powerful action figure of their choosing (Knox & Roberts, 2008).

Korol, Green, and Grace (1999) developed the **Interactive Trauma/Grief-Focused Model (IT-GFT),** which emphasizes a developmental ecological framework as another approach to crisis work with minors. The premise of this framework is that the developmental stage and the environment within which the minor operates are interrelated. Four attributes based on

research address the effects of a crisis experienced by a minor and guide the intervention (Halpern & Tramontin, 2007; Nader & Mello, 2008):

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

Eclectic in nature, the model utilizes theories relevant to the situation, including psychodynamic and cognitive behavioral approaches, as well as a minor's narrative, emotions, cognitions, and memories, to aid in recovery and precrisis functioning.

The basic crisis intervention equilibrium model, consistent with generalist practice, is appropriate for minors who have experienced a Type I crisis event. Adaptations from the IT/G-FT, in particular the developmental ecological framework emphasis and the attribute proposed by Korol and colleagues (1999), can be useful in intervening with minors.

Benefits of a Crisis

Much of the literature has tended to focus on the adverse reactions or effects that a crisis has on people. Not surprisingly, then, intervention strategies, while incorporating strengths, coping, and social support, have sought to restore functioning to the precrisis level. However, some theorists and researchers suggest that negative events may actually promote growth in the aftermath of a crisis (Caplan, 1964; Dziegielewski & Powers, 2005; Halpern & Tramontin, 2007; James, 2008; Joseph, Williams, & Yule, 1993; McMillen & Fisher, 1998; McMillen, Smith, & Fisher, 1997; McMillen, Zuravin, & Rideout, 1995). Note, however, that these findings are specific to adult populations.

Building on prior research and the notion of benefits advanced by Caplan (1964), McMillen and Fisher (1998) explored the perceived harm and benefit to individuals who have experienced a crisis event. People involved in the study reported experiencing benefits such as increased self-efficacy, spirituality, faith in people, and community closeness. The McMillen and Fisher study results are significant for two reasons:

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

These findings emphasize the subjective nature of the crisis experience as a key element to be included in crisis intervention work. Understanding clients' reactions to a crisis, their perception of harm or vulnerability, and their affective, emotional, and behavioral functioning will help you plan and intervene appropriately. Otherwise, your intervention strategy may have little or no value to the client's situation.

Theoretical Framework of Crisis Intervention

EP 4

Caplan (1964), Parad (1965), and Golan (1981) were early and significant contributors to basic crisis intervention theory, delineating the nature of crises, stages, and intervention strategies for crisis resolution within a brief time period. Parad and Caplan (1960) and Lukton (1982) further developed a practice theory and practice skills for social workers. Early crisis intervention theory spanned the life course to include grief and loss reactions, role transitions, traumatic events, and maturational or biopsychosocial crisis at various developmental stages (Lindemann, 1944, 1956; Rapoport, 1967). Early theories of crisis intervention strategies tended to reflect the psychoanalytic paradigm. For example, in Erikson's (1963) psychosocial stages of human development, a crisis was thought to develop if the individual failed to master the requisite developmental tasks in each stage.

Over time, additional theories have emerged based on a belief that basic crisis theory as a single framework was incapable of fully explaining the human response

to trauma (James, 2008; Knox & Roberts, 2008). A prominent issue is that the theory paid little or no attention to environmental and situational crises and subsequent reactions. Consequently, other crisis theories have emerged—in particular, ego psychology, cognitive behavioral, chaos, ecological systems, and life cycle theories—which distinguish the types of crises and define an underlying contextual theoretical framework in which a crisis can occur (James, 2008; Lantz & Walsh, 2007; Okun, 2002; Potocky-Tripodi, 2002; Walsh, 2010).

Evidence Base and Use of Crisis Intervention

EP 4

Crisis intervention as a systemic strategy is recognized and widely used throughout the world in response to a range of client, professional, and community crisis situations and in a variety of settings, including schools, hospitals, and residential treatment facilities (James & Gilliland, 2013; Roberts, 2005; Roberts & Ottens, 2005).

The prevalence of crises has resulted in teams of professionals being trained to respond to crisis situations and events. In addition, beginning with the Memphis Police Department in 1988, municipal and state police departments have established **Crisis Intervention Teams (CITs).** Published reviews of CITs emphasize the effectiveness of the approach in improving interactions between police and persons who are mentally ill, reducing the use of force (Compton, Bahora, Watson, & Oliva, 2008; Compton et al., 2011) and in response to domestic violence (Corcoran, Stephenson, Perryman, & Allen, 2001)

Research has demonstrated the effectiveness of the crisis intervention approach in reducing disruptive classroom behavior (Gibson & Holden, 2008; Grskovic & Goetze, 2005) and as an alternative to seclusion, punishment, and restraints in residential treatment facilities (Colton, 2008; Day, 2002; Day, Bullard, & Nunno, 2008). Positive results were confirmed in studies in which the approach was used in intensive in-home family-based services, the results of which were reductions in child abuse and neglect and out-of-home placements (Corcoran, 2000; Roberts & Everly, 2006), as well as in stabilizing persons with mental illness and medication adherence (Everly, Lating, & Mitchell, 2005; Haynes et al., 2008; Joy, Adams, & Rice, 2006). Informal evidence and anecdotal case information also indicate client satisfaction with the efficacy of the approach; however, the longevity of resulting change has not been established (Dziegielewski & Powers, 2005; Roberts & Everly, 2006; Walsh, 2010).

Application of Crisis Intervention with Diverse Groups

An advantage of crisis intervention is that the strategy is believed to be applicable to different populations (Knox & Roberts, 2008). Lum (2004), in addressing the multicultural sensitivity of the approach, asserts that crisis intervention as a generalist practice approach has "universal application to people of color" (p. 272) because people of color "often experience personal and environmental crisis" and in many instances have "exhausted community and family resources" prior to seeking professional help (p. 273). In some communities of color, patterns of help-seeking behavior and historically based anxieties can result in delayed contact, and as a result a crisis situation can reach a chronic state prior to contact. Also, influenced by culture, different communities may respond and cope differently to a traumatic event (Halpern & Tramontin, 2007).

However, note that crisis intervention embodies ideals specific to Western norms and that are unfamiliar to the majority of the world (James, 2008). Crisis intervention, like other practice models, calls for multicultural helping that includes the social worker's sensitivity to differences and worldviews, self-knowledge, and awareness of his or her bias. A crisis can be culturally universal or culture specific. In this regard, it is important to understand the meaning of the crisis to the client and his or her preference for resolution (James, 2008; Roberts, 2005; Sommers-Flanagan, 2007; Stone & Conley, 2004; Sue, 2006). Chazin, Kaplan, and Terio (2000) further note that crisis-related deficits, rather than strengths and resources, can be particularly counterproductive with diverse groups. Also, in crisis situations with diverse clients, attention should be given to such pertinent issues as inequality, faith, and social justice (Freud, 1999; Silove, 2000; Stone & Conley, 2004; Walsh, 2010).

Although research and literature related to the crisis intervention modality with regard to culture, gender, and racial groups is limited, practice literature and research have advanced the knowledge base. Examples include Congress (2000) and Potocky-Tripodi (2002), with a focus on culturally diverse and immigrant families, and Cornelius et al. (2003) and Ligon (1997) with a focus on African Americans. Halpern and Tramontin (2007) amplify how culturally based perceptions

influence expectations in certain Asian communities—in particular, crisis reactions—that can differ from those in Western societies. In working with immigrants and refugees, Potocky-Tripodi (2002) suggests that, while crisis intervention strategies are appropriate, ideally the approach should be implemented as a preventive measure prior to the resettlement stage. Congress (2000, 2002) identifies common precipitants of crisis among immigrants and refugees—namely, intergenerational conflicts, changes in roles, unemployment, and interactions with formal institutions—for which crisis strategies are appropriate.

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

Procedures of Crisis Intervention

EP 8

The procedures of the six-step basic crisis intervention model, initially developed by Gilliland (1982), provide a framework for systematically intervening in a crisis situation. These steps, illustrated in Figure 13-3, guide the application of the approach and are consistent with the eclectic problem-solving approach. Figure 13-3 also specifies the fundamental skills needed and the actions required of you in a crisis situation. In the following sections, we apply the steps of the approach to a case example involving Lia, a pregnant teen.

Step 1: Define the Problem

The first step in the six-step model of crisis intervention is to define the problem.

As a social worker in a crisis situation, you must determine the unique meaning of the crisis and the

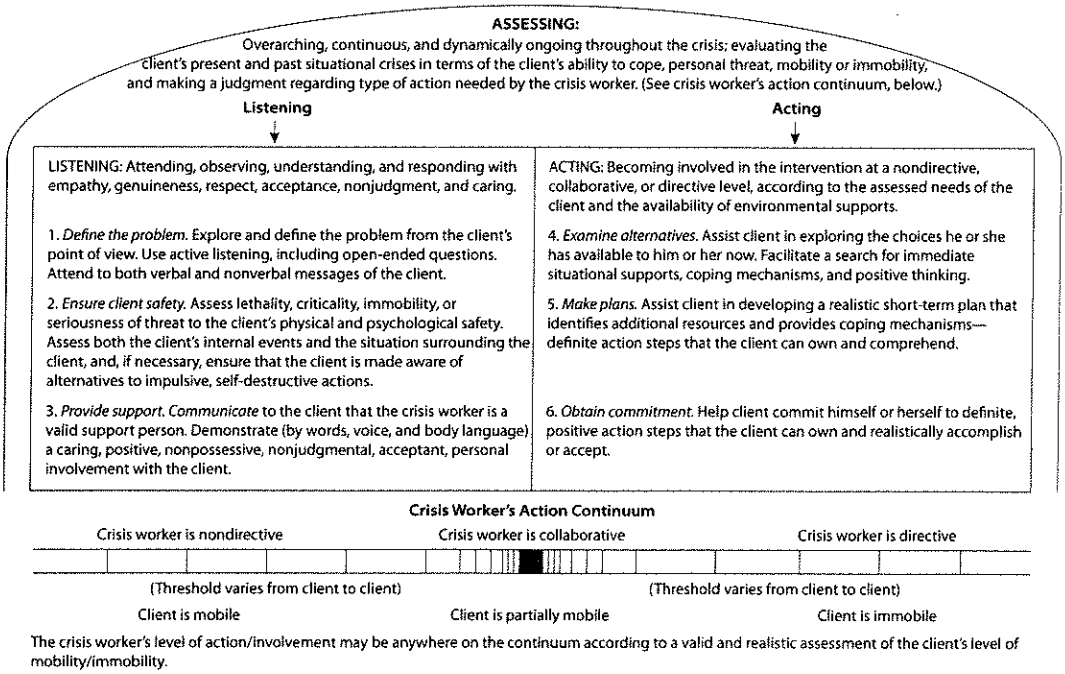

FIG 13-3 The Six-Step Model of Crisis Intervention

Source: From James, "Crisis Intervention Strategies," 6e. © 2008 Wadsworth, a part of Cengage Learning, Inc. Reproduced by permission, www.cengage.com.

CASE EXAMPLE

For Lia, age 17, the problem was being unmarried and pregnant. During the school year, she participated in a school-based teen social group for female students. On the day of the referral, Lia became so emotionally distraught that the group leader asked the group to take a break so that she and Lia could talk. During the conversation, Lia told the leader that she was pregnant and that she was in trouble with her family as a result. The group leader referred her to a social worker at the community-based health and mental health center, located within walking distance of the school. Lia calmed down after the group leader explained that the social worker would be able to see Lia immediately. As Lia explained her situation to the social worker, she again became emotional and distressed.

severity of the situation to the client. Having clients talk about the meaning and significance of the crisis provides you with essential information about how clients define their problem and can be a cathartic process for clients as well. In the case of Lia, culturally held beliefs and expectations were critical reference points in the social worker's understanding of Lia's reaction. The social worker's initial tasks in this session were twofold:

1. **Assess and alleviate Lia's emotional distress:** During the interview, Lia cried, had trouble breathing, and expressed concern about whether the social worker could understand her situation. The social worker used a breathing technique to help her calm down. By listening and responding empathically, the social worker encouraged Lia to talk about her feelings to reduce her emotional distress. Eventually, the social worker was able to gain an understanding of the magnitude of Lia's distress in relationship to her problem within her culture. During the conversation, Lia stated that she had thought about suicide. Furthermore, she had shared her thoughts in a conversation with her 12-year-old brother. The social worker therefore made an immediate referral to the center's mental health services for further evaluation. As the social worker questioned Lia further about her potential for self-harm, Lia's responses revealed two hopeful signs: her concern for the safety of her unborn child and her desire to continue her involvement with the teen group.
2. **Elicit the client's definition of the problem:** According to Lia, the problem began when her family became aware of her pregnancy, which was further complicated by the fact that she had ignored the cultural norms of her community and was told by her family that in being pregnant and unmarried, she had brought shame to the family. The crisis escalated when, upon learning that Lia was pregnant, her father dismissed her from the family, refused to talk to her, and forbade other family members from doing so. The fact that Lia faced social ostracism and loss of face and would be disconnected from her family and members of the clan increased her distress.

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

Step 2: Ensure Client Safety

Ensuring client safety is the first and foremost concern in crisis intervention and an ongoing consideration (James, 2008; James & Gilliland, 2001; Roberts, 2005). Safety involves deliberate steps to minimize the physical and psychological danger to the client or others. The social worker requested, and Lia agreed to complete, a depression scale. The results confirmed the necessity of making the referral to the center's mental health services for further evaluation.

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

The results of the assessment of Lia's affective, cognitive, and behavioral domains were in the moderate range, which also confirmed the need for Lia to be seen by a mental health professional. In focusing on Lia's strengths, the social worker shared her observation of Lia's coping and resilient behaviors—namely, that she often volunteered for the closing shift at work and afterward walked to her sister's home to spend the night because she was unable to go home. Also, Lia's concern for her unborn child and desire to continue with the group were indications of her future-oriented thinking. An additional safety concern related to Lia's working late and walking alone to her sister's home, so she and the social worker explored other options.

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

Step 3: Provide Support

In this step, the social worker's objective was to identify and mobilize Lia's social support systems network, which is essential for intervening in a crisis situation. Social supports may include friends, relatives, and in some cases institutional programs that care about the client and can provide comfort and compassion (James & Gilliland, 2001).

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

Step 4: Examine Alternatives

In this step, both the social worker and Lia explored courses of action appropriate to her situation. Of course, some choices that they considered were better and more realistic than others, so together Lia and the social worker selected and prioritized available options. Ideally, alternatives are considered to the extent to which they are:

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

Lia had actually thought of alternatives, yet initially she was too immobilized emotionally to act on them. For example, in response to the threat from her father to change the locks on the doors, forcing her out of the home, she had considered moving in with her sister or an aunt (*situational supports*) until her child was born. Afterward, she would be 18 years of age and able to live independently. Instead of acting on this option, however, she planned to wait until her parents were asleep or at work and appeal to her siblings (*coping mechanism*) to let her in the house. In the past, her siblings had opened the door for her when she had stayed out late with her boyfriend. Relying on this choice was a short-term solution at best and posed a greater risk for both Lia and her siblings.

A more viable option suggested by the social worker involved Lia's moving into a housing complex for pregnant teens, located near the high school and her job (*highlighting constructive thinking and action*). Program services offered in the housing complex included transportation to prenatal visits, group counseling, independent living skills classes, and assistance in finding permanent housing. Although she was initially reluctant, Lia agreed to consider this option. Social workers who understand the client's point of view may be better able to plan alternatives and encourage clients to consider other options. For example, Lia's qualms about the pregnant teen housing program reflected her desire to remain with, or at least near, her family and community.

Of course, there were additional alternatives to consider in stabilizing this crisis situation. You should be aware, however, that multiple options can be overwhelming for clients. Furthermore, the alternatives that you and the client consider should be realistic for the

situation (James, 2008). In Lia's case, two options were discussed: moving in with her aunt on a short-term basis and moving to a housing facility for pregnant teens. Lia chose the housing program because of the supportive services that were available. She and the social worker, however, also discussed ways in which she could have some contact with her family.

Step 5: Make Plans

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

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

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

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

Step 6: Obtain Commitment

In the sixth and final step, Lia and the social worker committed to collaboratively engage in specific, intentional, and positive tasks designed to restore her to a level of precrisis functioning.

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

Lia's Tasks

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

Social Worker's Tasks

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

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

Anticipatory Guidance

In addition to completing the six steps of the model, you may also find anticipatory guidance to be a complementary technique. This technique involves assisting clients to anticipate future crisis situations and to plan coping strategies that will prepare them to face future stressors. Similar to identifying obstacles and barriers in the task-centered model, anticipatory guidance involves a discussion of scenarios of potential or future stressors. Used in Lia's case, the social worker and Lia discussed ways in which she could cope in the event that, despite her best efforts, she remained estranged from her family. They might also explore stressors

related to the eventual but normative stress of the birth of her baby and living in a group setting with other pregnant teens. In their discussion, the social worker helped Lia to focus on her problem-solving, coping, and adaptation skills (strengths) in her current situation. For example, Lia had proposed living with her aunt or sister as a temporary solution to her home situation, which showed her aptitude for problem solving and adaptation capacities.

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

Strengths and Limitations of the Strategy

The crisis intervention equilibrium/disequilibrium model is a structured, time-limited model consisting of a series of steps informed by basic crisis theory. As noted, the initial intervention phase has three strategic objectives: (1) relieve the client's emotional distress; (2) complete an assessment of the client's cognitive, behavioral, and emotional functioning; and (3) plan the strategy of intervention, focusing on relevant tasks the client is able to perform. The goal of the intervention is to restore the client to a precrisis level of functioning. Promising research and practice have demonstrated the effectiveness of crisis strategies with diverse populations to include an understanding that the definition of a crisis is influenced by culture. Strengths of the model are that perceptions of a crisis vary based on associated threats, client cognitions, ego strengths, coping capacity, and problem-solving skills.

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

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

COGNITIVE RESTRUCTURING

Cognitive restructuring is a therapeutic process derived from cognitive behavioral therapy (CBT). Also referred to as *cognitive replacement*, cognitive restructuring is "considered to be the cornerstone of cognitive behavioral approaches" (Cormier & Nurius, 2003, p. 435). Intervention techniques in CBT are designed to help clients modify their beliefs, faulty thought patterns or perceptions, and destructive verbalizations, thereby leading to changes in behavior. An assumption of cognitive restructuring is that people often manifest cognitive distortions, which in turn affects their emotions and actions. Distortions are irrational thoughts derived from negative schemas that lead to unrealistic interpretations of people, events, or circumstances. Frequently, although a client may be aware of his or her thinking, he or she may still lack the emotional strength to alter the schematic thought patterns.

Theoretical Framework

EP 4

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

The early and historic work of Ellis (1962), Beck (1976), and others led to cognitive theories and

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

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

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

Tenets of Cognitive Behavioral Therapy and Cognitive Restructuring

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

CBT is based on the assumption that people construct their own reality. It is within the realm of processing information that people assess and make judgments that fit into their cognitive schemas. The basic tenets of CBT are as follows:

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

In identifying distortions and faulty thoughts and behaviors, a basic assumption is that the client can learn new patterns of thinking. You should, of course, temper this assumption by recognizing that other factors influence a client's self-perception and the manner in which the client thinks 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, and sexual orientation are major contextual life issues. The realities of people's lives and beliefs have a significant impact on thinking and cognitions; therefore, the relationship between cognition, culture, and context should not be minimized or overlooked (Berlin, 2001; Hays, 2009; Pollack, 2004).

Cognitive Distortions

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 a client's ingrained beliefs and faulty reasoning. While cognitive distortions are irrational, they make logical sense to the client. Moreover, distortions maintain negative thinking and reinforce negative emotions. The most common types of distortions and negative thinking patterns conceptualized by Beck (1976) have been summarized in the literature (Cormier, Nurius, & Osborn, 2009; 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 seeing the glass as 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 a client 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 treat a positive as a negative. *"My friends said that I looked great in an outfit from the secondhand store, but really, they were just being nice and feel sorry for me because I don't have money."* Similarly, say you are reviewing evaluations after making a presentation and you focus on the following, *"Of the 40 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 on 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 a relative with whom you frequently argue is unwilling to keep your kids because of an appointment, your mental response may be *"That's not the real reason; the relative never liked me or my kids,"* in effect discounting the numerous other occasions on which the relative did care 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 the 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 the 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 the instructor 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 lost contact. I wonder if I did something that caused her to forget about me."* 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 against others believed to have desirable attributes. *"She is prettier than I am." "Everybody in the class is smarter than me." "My college roommate is a CEO already; I'm nothing compared to him."* Unfair comparisons can also lead to "I could or should be" or "I shouldn't be" statements when comparing self to others; for example, *"My college roommate is a CEO already; I could have a job like that."*
- **What ifs** refer to the tendency for people to continually question themselves about the potential for events or the catastrophe that might happen. *"I would go to the doctor to examine the mole on my back, but what if I am really sick?" "What if I tell my relative that I can't watch the kids tonight and she gets upset with me and she refuses to talk to me ever again?"*

Cognitive Schemas

In each of the examples above, you are able to see how distorted and negative thoughts fit within a client's cognitive schemas. **Cognitive schemas**, either positive or negative, are the memory patterns that a client uses to organize information (Berlin, 2001; Cormier & Nurius, 2003; Cormier, Nurius, & Osborne, 2009; McQuaide & Ehrenreich, 1997). Whether they originate from a strengths or deficit orientation, cognitive schemas are shortcuts in thinking. Because such schemas are ingrained beliefs, it is often difficult for people to hear or process new or different information or an alternative explanation, the result of which is cognitive dissonance. When cognitive dissonance occurs, clients can experience a high level of stress, so much so that they may completely shut down.

The activation of a negative cognitive 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're all like that." Even though the youth apologized, the woman's 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 unable to alter her cognition of the event. Of course, this event could have been trigged by a negative past experience or could 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 (Berlin, 2001; Cormier & Nurius, 2003). Further, where negative filtering about self and others has emotional content, blaming statements may be related to the mood of the client at a particular point in time. By the same token, negative thoughts may be grounded in the client's reality, however irrational the thoughts may appear to be. Hence you would assess whether external and internal stimuli that led to cognitive errors, are actual distortions or a client'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

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

Empirical Evidence and Uses of Cognitive Restructuring


EP 4

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 et al., 1997; Steigerwald & Stone, 1999). Results of studies have also shown cognitive restructuring to be effective in the treatment of posttraumatic stress disorder (Foa et al., 2005), social phobias and anxiety (Feeny, 2004), spousal caregiver support groups (Gendron et al., 1996), and in crisis or trauma situations (Glancy & Saini, 2005; Jaycox, Zoellner, & Foa, 2002). The procedures of cognitive restructuring are often blended with other interventions (e.g., modeling, behavioral rehearsal, imagery, and psychoeducation) because combinations of interventions are believed to be more potent than single interventions in producing change (Corcoran, 2002).

Using Cognitive Restructuring with Minors

In comparison to adult populations, there are fewer studies that show evidence of the effectiveness of cognitive restructuring with minors. However, 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. Findings of a pilot study highlighted the feasibility of cognitive restructuring in reducing the symptoms of posttraumatic stress disorder in minors (Rosenberg et al., 2011).

Giacola et al. (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 exhibiting depressive and aggressive symptoms, for example, may exaggerate accounts of true negatives, raising the question as to whether cognitions were distorted or were expressions of the minor's actual reality (Rudolph & Clark, 2001). With older minors, in particular those who are engaged in antisocial behaviors, distorted thinking may be used as self-serving explanations for behavior (Liau, Barriga, & Gibbs, 1998). Giacola et al. (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, Giacola and colleagues found that the negative thought patterns and self-talk of minors were linked to harsh punishment and excessive criticism in their home life. Collectively, these studies highlight the need to help minors distinguish between feelings and cognitions in view of their circumstances and symptoms.

Studies specific to anger control in minors include Seay et al. (2003), Sukhodolsky, Kassinore, and Gorman (2004), and Tate (2001). Tate, however, emphasized peer influence and positive cognitive restructuring in schools rather than strategies to control and rehabilitate and maintain adult-imposed order.

Sukhodolsky and colleagues 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 et al. reported improvement in anger control when specific behavior was targeted, accompanied by practicing different responses. Bailey (2001) cited the importance of family and school involvement and discussed cognitive restructuring as effective when age-appropriate strategies were used. Use of the technique as an intervention with minors included the reduction of HIV risk behavior among African American adolescents (St. Lawrence et al., 1995). Another study provided evidence of effectiveness in changing the thought processes of African American adolescents who had been abused as children (Lesure-Lester, 2002).

Applying Cognitive Restructuring with Diverse Groups

The worldview and social psychological processes that shape minority perceptions and resulting thoughts or experiences may be different from those of the majority culture. Specifically, differences in reality, history, and context can influence cognitive development and processes. For example, Shih and Sanchez (2005) examined the role of identity among youth who have multiple identities with respect to cognition that shaped how the youth viewed the world and the extent in which they adjusted to the reality of rejection and discrimination. In sum, the findings of multiple studies reinforce the importance of examining the context of distortions or negative thought patterns before concluding that a client'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 logically and 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, stresses that the procedures 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.

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). 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.

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.

Although there is a need for further study of the cognitive development and processes of diverse groups, there are studies that demonstrate the efficacy of cognitive restructuring with different racial and cultural groups. Selected examples include interventions with African American women smokers (Ahijevych & Wewers, 1993) and low-income African American woman in group treatment (Kohn et al., 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 (Brown, 1994; Srebnik & Saltzberg, 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 8

The primary goal of cognitive restructuring is to alter clients' thoughts and feelings and their accompanying self-statements or behaviors. Cognitive restructuring is particularly useful in assisting clients 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 vary slightly in how the steps are defined, the similarities between the various models are far greater than the differences. These steps, summarized in Table 13-2, are adapted from the steps identified by Goldfried (1977) and Cormier and Nurius (2003). In this section, we illustrate each step through a case example of a military veteran who has returned home after serving two tours of duty in Iraq.

1. Assist Clients in Accepting That Their Self-Statements, Assumptions, and Beliefs Largely Determine Their Emotional Reactions to Life's Events

The power difference between you and clients is likely to become 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 minority, and clients 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, as illustrated in the following dialogue:

Social worker: I understand from what you have said so far that you want to be with friends in social situations, but you become anxious before and during the times you are actually with friends. So that you may achieve your goal, we first need to determine what happens that causes you to feel anxious. This will help you become aware of the thoughts you experience in the situation. Specifically, we need to review what you say to yourself *before, during,* and *after* you are with your friends, because thoughts occur automatically, and often we may not be fully aware of them. Becoming aware of your thoughts, assumptions, and beliefs is an important first step in replacing them with others that will help you achieve your goal.

To guide you in assisting clients to understand cognitive restructuring, it may be advisable to use self as an example to explain the technique, as demonstrated in the following dialogue. The social worker draws upon his own experience to show how ways of thinking and responding mediate cognitions, emotions, and thoughts:

Social worker: What you think determines in large measure what you feel and do. For example, I'm planning a trip to a country, despite the fact that my knowledge of that country and its language and culture is limited. When I shared my plan with a friend, he told me that my idea was stupid and questioned whether my decision was wise. Instead, the friend thought that I should travel to a more familiar place. I could have made various meanings or self-statements related to my friend's 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 taking a trip to a place where I would be more comfortable? He thinks that I am stupid.*

TABLE 13-2 Steps in Cognitive Restructuring

1. Assist clients in accepting that their self-statements, assumptions, and beliefs determine their emotional reactions to life's events. (Tool: explanation and treatment rationale)
2. Assist clients in identifying dysfunctional self-statements, beliefs, and thought patterns that underlie their problem. (Tool: self-monitoring)
3. Assist clients in identifying situations that engender 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

Erik is a military veteran whose goal is to reduce his anxiety so that he is comfortable in social situations. Having completed two tours of duty in Iraq, he is grateful to have returned home without a serious physical injury. Erik explained that "trouble" began shortly after he returned home, when friends invited him to social gatherings. Urged by his family, he initially accepted the invitations and looked forward to the various events. Eventually, however, his doing so caused him to become anxious, which intensified between the time he accepted an invitation and when he actually went. Erik described himself as never being much of a talker. When people talked to him, they mostly wanted him to describe his tours of duty, and he generally declined to do so, preferring instead to have a normal conversation. Because of his anxiety, Erik declined future invitations, believing that he did not fit in, even though he wanted the social contact. Erik's future goal is to return to school to obtain a degree, but his anxiety level has prevented him from moving forward.

If I think that my friend is right, then my feelings and statements are negative and I consider changing my plan.

- 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 travel. He's entitled to his opinion, although I don't agree with him and I feel good about my plan. 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'll ignore my friend's insensitive remarks.

In using a self example, the social worker highlights for his client, Erik, how thoughts® and beliefs can cause difficulties and the manner in which cognitive restructuring facilitates the development of other thoughts that are realistic and consistent with his goal. Further, the social worker suggests that other responses could be appropriate, but the three examples suffice to make his point. The social worker then points out that the task at hand is to help Erik to master his anxiety and to understand how his self-statement of not fitting in influences his feelings and behavior.

This example shows how the rationale for cognitive restructuring can be presented to a client in a simple, straightforward manner. A majority of clients, given an explanation, will agree to proceed. However, a client's commitment to the procedure is necessary because beliefs are not easily changed.

2. Assist Clients in Identifying Dysfunctional Self-Statements, Beliefs, and Patterns of Thoughts That Underlie Their Problem

Once the client accepts that thoughts and beliefs mediate emotional reactions, your next task is to help the client identify the associated thoughts and beliefs relevant to his or her difficulties. This step requires a detailed exploration of events related to problematic situations and antecedents, with particular emphasis on cognitions pertinent to the distressing emotions.

To begin the process, you would focus on problematic events that occurred during the preceding week or on events surrounding a problem the client has targeted for change. For example, for Erik, the targeted change is increasing his comfort level in social situations. As the client recalls 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 a client perceives and his or her emotions and thoughts. From this point on, the aim is to identify self-statements and beliefs related to an event and to increase the client's awareness of the way in which automatic thoughts and beliefs are powerful determinants of behavior.

As the client continues 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 client to recreate the situation as it unfolded, recalling exactly what he or she thought, felt, and did. For example, the social worker asked Erik to describe his thoughts and feelings when he was in a social situation. Should the reflection prove to be too difficult, as an alternative, the social worker could ask Erik to close his eyes and run a movie of his thoughts and feelings prior to, during, and after he accepted an invitation.

As the social worker listened to Erik describe his thoughts, the cognitive sets that predisposed him to experience anxiety and to behave in predictable ways were identified. To illustrate, consider Erik's inner dialogue or self-statements *prior* to going to a social event:

- "If I go, I'll be unsure of what to say because I don't talk much."
- "When people talk to me about Iraq, I feel uncomfortable, and they probably think that something is wrong with me. So it's better to not go."

Erik's self-statements increased his anxiety and influenced his expectation that he did not fit in. As the social worker listened to Erik's self-debate as he recreated the social situation, he also made note of his nonverbal behavior. His physical posture, for example, spoke volumes. Previously, Erik sat tall and erect, but as he talked he begin to slouch in the chair. So in addition to his self-defeating thoughts, which dominated his cognition, it would be useful to explore whether his nonverbal behavior also contributed to his presentation of self 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, Erik tended to dwell on the perceived 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 consider his self-statements *during* the time he attended a social event:

- "Well, here I am, nothing is different. I'm not talking and people are not talking to me and I feel left out of conversations."
- "I wish I had something interesting to say. But they aren't interested in me. I'm just the boy who went off to war, and I don't want to talk about my experience. Right now my life is not about much and not very interesting."
- "Even if I talked more or people talked to me, I don't add anything to the conversation, so going to events has become unimportant to me."

Because Erik's interactions with people were not what he had hoped for, he continued to be preoccupied with self-defeating thoughts. If he doesn't talk about his military experience, for instance, he concludes that he has little or nothing to offer and behaves accordingly; therefore, his thoughts about not fitting in and being unworthy are reinforced. In consequence, the potential of having a positive experience of engaging with others is blocked.

A client's thoughts and feelings after an event can have an impact on his or her subsequent behaviors. In listening to clients tell what occurred and their conclusions, you can further highlight the mediating function of cognitions. Consider Erik's thoughts and feelings as he described his experience *after* he attended a social event:

- "I'm finished; I might as well quit trying. I just can't talk to people, no use in kidding myself."
- "People didn't really try to include me. It's clear that they aren't interested in me. If I don't go to the next party, I'm sure that no one would notice or care."
- "This situation is so uncomfortable. I won't go to future parties. I don't enjoy myself, and I'm sure they don't enjoy being around me."

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

- Ask how a client has reached certain conclusions.
- Elicit evidence that supports the client's perceptions or beliefs.
- Explore the logic of beliefs that have magnified the feared consequences of certain actions.

To assist Erik in assessing the rationality of his conclusions, for example, the social worker asked him the following question:

Social worker: So when you went to the party, what happened that made you think that people were not interested in you and didn't want you around?

As illustrated in the following example, a client may be unable to immediately acknowledge irrational beliefs:

Erik: Well, there was a girl there I've known most of my life, but by the way she looked at me I could tell she didn't want to talk to me.

Clients can tenaciously cling to misconceptions and argue persuasively about the validity of a belief to prove a point. For example, Erik's perception about the young woman's behavior was a confirmation that he did not fit in. As the social worker, 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 disputing or challenging an irrational belief works, the social worker's response prompted Erik to consider the association between his thoughts and his goal:

Social worker: Okay, if you continue to think that you don't fit in and you continue to decline invitations, how will achieve your goal of becoming comfortable in social situations?

Clusters of misconceptions are commonly associated with problematic behavior, and they also tend to have a common theme. For Erik, a central theme or a slight derivative of his self-statements and expectations was that he is unwelcome and unworthy in social situations. Consequently, Erik's thoughts and beliefs automatically supported his conclusions, contributing to his expectations of self and unrealistic expectations of others. It is possible to observe such thought patterns by exploring accompanying thought 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 separately.

3. Assist Clients in Identifying Situations That Engender Dysfunctional Cognitions

Identifying the places where cognitions cause stress, the key persons involved, and situations in which the client feels demeaned helps you and the client to develop and tailor tasks and coping strategies to specific situations.

Self-monitoring between sessions is a concrete way for a client to monitor and recognize cognitions related to difficulties around problematic events. Such recognition increases self-awareness of the pervasive nature of thoughts and the need to actively cope. Self-monitoring thus expands self-awareness and paves the way for later change efforts.

To facilitate self-monitoring, the social worker asked Erik to keep daily logs to record information, as illustrated in Figure 13-4. In the log, Erik recorded his feelings, beliefs, and self-statements in a social situation. The log may also reveal other factors that influence his feelings about social situations—for example, his comfort level in instances in which he is the only person with military experience.

Daily self-monitoring is a valuable tool because it focuses a client's efforts between sessions, clarifies the connections between cognitions and feelings, and appraises information regarding the prevalence and intensity of thoughts, images, and feelings. In Erik's case, keeping a daily log helped him to logically examine his thoughts. The social worker then discussed the log with Erik in their next session:

Social worker *[to Erik]:* After completing a week of logs, did you discover anything about yourself

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.

Date: Tuesday, September 6, 2015		
Situation or Event	**Feelings** (Rate intensity from 1 to 10)	**Beliefs or Self-Statements** (Rate rationality from 1 to 10)
1. I went to a party.	I'm feeling uncomfortable (7)	No one will talk to me (6)
2. No one said anything to me; I didn't say anything.	I'm anxious (7); reluctant to join in (8); I don't fit in (7)	I should talk (9); but people will ignore me and I'm embarrassed (2); it's not worth the hassle (3)

FIG 13-4 Daily Log for Erik

and the way that you think and behave when you go to a party?

Erik: Yeah, I could see the times when I felt uncomfortable and most anxious.

To prevent a person from becoming overwhelmed by the task of keeping a log, you might suggest that recordings be limited to no more than three. As an alternative, or in addition, self-monitoring can also include images drawn by the client. As other counterproductive thought patterns emerge during sessions, the focus of self-monitoring can be shifted as necessary.

As you and the client review completed log sheets and identify problematic feelings and cognitions, it is important to note recurring situations or themes. A recurring theme for Erik, for example, was his concern about a lack of fit between himself and others at the social events.

4. Assist Clients in Replacing Dysfunctional Cognitions with Functional Self-Statements

As clients become aware of their dysfunctional thoughts, beliefs, and images, the goal is to help them recognize the connection to negative emotional reactions. Having done so, an additional goal is to help them cope as an intermediary step to learning new behavioral responses. Coping strategies typically involve self-statements that are both realistic and instrumental in diminishing or eliminating negative emotional reactions and self-defeating behaviors. Although functional self-statements are intended to foster courage and facilitate active coping efforts, it is important to not ignore the struggle as a client shifts from habitual and ingrained patterns of thinking to adopting new behavioral patterns. In recognition of the difficulty and anxiety that a client may experience, coping self-statements are intended to support the transition to risking new behavior.

First, to introduce Erik to positive self-statements, the social worker explains the rationale for developing new self-statements:

Social worker: Now that you've identified key self-defeating beliefs and thoughts, let's 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.

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

Social worker as Erik: "I know a part of me wants to avoid social situations because I feel anxious about fitting in, but it's not going to get any better if I continue to decline invitations. I don't have to talk a lot. If I listen to the others and get my mind off myself, I could become more involved in conversations."

Notice how the social worker modeled Erik's struggle and the idea of coping rather than mastery of new self-statements. Modeling coping self-statements should reflect the client's actual experience, whereas mastery of self-statements does not. Moreover, the former conveys empathy for and understanding of a client's struggle, which can inspire greater confidence in the process. As an alternative coping self-statement, the social worker proposed the following:

Social worker: "Yes, you might think, 'I can't expect them to include me in their conversations. It would be great if this happened, but if not, I'll be responsible for including myself, because doing so is better than withdrawing and feeling left out.'"

After modeling coping self-statements, it is appropriate to encourage the client to practice the behavior.

To enhance the effectiveness of guided practice, you could suggest that clients 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 clients 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 clients to express doubt and uncertainly 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 client has demonstrated his or her confidence in using coping self-statements before entering a targeted situation, you can shift to self-statements *during* the time the client is actually in the target situation, as demonstrated by the social worker's modeling coping self-statements:

Social worker as Erik: "Okay, I'm feeling anxious. That's to be expected. I can still pay attention and show interest in the conversation. I communicate by nodding my head, laughing if someone tells a funny story. As I begin to feel more comfortable, I can join in by asking questions if I want to know more. This is another way to show interest, especially if I have some take on the subject people are discussing. I think that my opinions are worth as much as others. Go ahead, take a chance and join in the conversation and maybe look at people as I talk."

Following the modeling exercise, the social worker asked Erik to describe his feelings about what had happened so far. Inquiring about Erik's feelings is important; if the modeling results in his becoming anxious, uncomfortable, or skeptical, the social worker should deal with these feeling before proceeding further. Again, it may be worthwhile for you to model and eventually have the client rehearse reinforcing statements. Here are some examples:

Social worker as Erik: "Well, I did it. I stuck it out and even said a couple of things. That's a step in the right direction." "No one ignored me when I joined the conversation. It wasn't so bad after all, even though I was a little nervous at first."

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

Continued self-monitoring is essential as clients implement Step 4 of the cognitive restructuring process, using the daily log format illustrated in Figure 13-4 as a tool. As Erik makes progress, for example, a fourth column could be added titled "Rational or Positive Coping Self-Statements." By having clients fill in a column such as this, the exercise can facilitate the development of reinforcing statements, eventually replacing self-defeating ones.

Another technique that can help clients replace their automatic problematic self-statements is 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 traffic signal, alerting clients of the 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, deeply embedded, and persistent, it is important to explain that Step 4 may extend over a time span in which a satisfactory degree of mastery is gradual; however, it is possible to achieve over time.

5. Assist Clients in Identifying Rewards and Incentives for Successful Coping Efforts

For clients who dwell on their failures and shortcomings and rarely, if ever, give themselves positive feedback, Step 5 in cognitive restructuring is especially important. When clients have mastered new statements and behaviors, you should reinforce their accomplishment by coaching to observe and credit success, as indicated in the following dialogue:

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

Erik: Well, actually it was okay. I made an effort to talk with the girl I knew, and we had a brief conversation.

Social worker: That's 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 a self-statement you might think about: "I wasn't sure that I was up to it but I did it!" Now what would you do for yourself?

For some people, rewarding self-statements can be difficult and feel awkward or self-conscious. When a person is hesitant, empathic understanding and encouragement on your part will usually prompt them to try this exercise. Some clients, like Erik, may tend to focus on the overall outcome. For example, the conversation with the young woman was positive, and he felt less anxious as a result. In any case, it is important that you review and credit a client's progress so that the learned behavior can be attempted in other or future situations.

Strengths, Limitations, and Cautions of the Approach

Cognitive restructuring is an effective procedure that is intended to address a range of problems related to a client'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. In assisting clients to change, however, social workers must not mistakenly assume that clients 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 clients, cognitive restructuring can be a useful intervention procedure.

Finally, although cognitive theorists attribute most dysfunctional emotional and behavioral patterns to mistaken beliefs, dysfunctional emotions and beliefs 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 MODEL

EP 8

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 at the Brief Family Therapy Center in Milwaukee, Wisconsin (Nichols & Schwartz, 2004; Trepper et al., 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 a client's 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 social worker, 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.

Tenets of the Solution-Focused Brief Treatment Model

The solution-focused approach has emerged over the past 20 years as a strategy for working with adults,

minors, and families, including clients who are involuntary. The approach emphasizes identifying solutions rather than resolving problems. A series of interview questions used during the phases of the approach are instrumental in 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 clients 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 social worker, your role is to listen, absorb information that a person provides, and subsequently guide them toward solutions utilizing the "language of change" (De Jong & 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 treatment. Three types of individuals are identified: *customers*, *complainants*, and *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. Distinguishing the various types enables you to focus on 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 4

The solution-focused approach borrows from the social constructivists' perspective that people use language to create their reality (de Shazer & 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, professionals have tended to impose truths about normative functioning or development that may have little relation to the reality of a client's situation (Freud, 1999; Nichols & Schwartz, 2004). Therefore, it is more important for you to understand the way in which a client constructs the meaning of his or her experiences and relationships. The approach also draws from assumptions of CBT—specifically, that cognitions influence a person's language and behavior.

Empirical Evidence and Uses of Solution-Focused Strategies

EP 4

Empirical evidence was at one point 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; De Jong & Berg, 2001; Greene et al., 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 on their behavioral problems, changed interactions between the residents and the staff. The efficacy of the approach has also been demonstrated in couples' therapy and premarital counseling (McCollum & Trepper, 2001; Murray & Murray, 2004; Nelson & Kelley, 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

There is increasing evidence on the utilization and effectiveness of solution-focused strategies with minors (Kelly, Kim, & Franklin, 2008). In public school settings,

study results show that successful, specific solution-focused therapy explores feelings, develops behavioral goals, and encourages positive behaviors (Corcoran & Stephenson, 2000; Franklin & Streeter, 2004; Kim & Franklin, 2009; Newsome, 2004; Springer, Lynch, & Rubin, 2000; Teall, 2000). Similarly, positive outcomes were reported for improving client social skills and managing 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 of Solution-Focused Approach with Diverse Groups

Critiques of the solution-focused approach point to a lack of attention to the diversity of clients (Corcoran, 2008). Demer, Hemesath, and Russell (1998) praise 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 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 client. Further, they assert that because professionals respect and honor the distinct cultural background of clients, the basic tenets of the approach are consistent with competent multicultural practice with clients 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 whom were members of diverse groups and also involuntary clients, are promising.

Solution-Focused Procedures and Techniques

EP 8

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

- **Description of the problem:** Clients are invited to give an account of their concern or problem. However, as a practitioner, you refrain from eliciting details about antecedents, severity, or the cause of their concern. While listening to clients' description of the problem, you are looking for ways in which you can guide them toward a solution.
- **Developing well-formed goals:** In this stage, your work involves encouraging the client to think about what will be different once the problem no longer exists. This information facilitates the development of a client's goal.
- **Exploring exceptions:** Questions asked of the client 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 questions relating to what could happen that would decrease the concern and make exceptions possible.
- **End-of-session feedback:** The aim of this stage is to compliment and reinforce what a client has already done to solve the problem. Feedback is based on the information that the client provided about goals and exceptions. Also, clients are asked what they should do more or less of in order to accomplish a goal.
- **Evaluating progress:** Monitoring progress is ongoing and is specific to evaluating the client's level of satisfaction with reaching a solution. The scaling question facilitates this process. After a client 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 client is: "What's better?" When the client's primary concern is resolved in a satisfactory manner, contact with you is terminated.

Throughout your work with clients, you make use of a series of questions that follow the phases of helping—specifically, engagement, assessment, goal setting, intervention, and termination. Four questions typically guide the engagement, the formation of goals, and the solution-building process. The various types of interview questions are listed 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 client's level of willingness and confidence in moving toward developing a solution and are subsequently used to observe progress. These questions may also be instrumental in preventing the client from returning to describing problematic behaviors and in developing

TABLE 13-4 Types of Solution-Focused Questions

Scaling Questions
Coping Questions
Exception Questions
Miracle Questions

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 the client managed the current difficulty, or what resources has he or she used previously when dealing with the issue? Coping questions credit the client's prior efforts to manage a difficulty and reenergize his or her strengths and capacities.

Exception questions are considered the core of the intervention (Corcoran, 2008). Designed to diminish the problem focus, these questions assist a client to describe life when the current difficulty did not exist (Bertolino & O'Hanlon, 2002; De Jong & Berg, 2002, 2008; Shoham, Rorhbaugh, & Patterson, 1995; Trepper et al., 2006). The exception question also advances the client's ability to externalize or separate self from the problem by highlighting strengths and resources (Corcoran, 2008).

Miracle questions draw the client's attention to what would be different once a desired outcome is achieved (Corcoran, 2008; Koob, 2003; Lipchik, 2002).

VIDEO CASE EXAMPLE

In the video "Working with the Cornings," a *coping question* to Irwin and Angela Corning might be: "In view of the chaos that you described in the transitional housing facility, how were you able to find the time to be actively involved with your children?" An example of an *exception question* to the couple might be: "What was it like when you owned your home and lived in a neighborhood of your own choosing?" At one point in the video, Irwin declares, "A man should provide for his family." To separate his sense of self from his job loss and highlight his strengths, you could emphasize that he had done so previously before he lost his job due to circumstances beyond his control. In essence, you would be helping Irwin to *reframe* and address his negative self-talk.

An example of a *miracle question* to the couple might be: "How do you imagine that you will feel when the family moves from the housing facility to an apartment?"

Typical interview questions that facilitate a client's capacity to think about the future and to identify solutions include the following questions 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?

Questions will vary, of course, depending on the stage of the intervention, as 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 client are framed on the basis of exceptions; specifically, clients are asked about the absence of the problem (the exception), and it is on this basis that the work toward a solution is formed.

For clients who are involuntary, De Jong and Berg (2008, p. 372) recommend beginning the interview with questions that encourage the client'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 client continue to do more or less of?

Again, the flow and sequence of the questions will vary, influenced by the content of the conversation with each client. For example, if a client 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 client 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?"

Before and during the termination phase, the focus of your questions would emphasize signs of what can be and 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 into the process of asking questions. **Compliments** provide feedback about a client's efforts and reinforce strengths and successes. **Bridging** is also a part of the feedback, clarifying goals, exceptions, or strengths. **Amplification** questions encourage clients to elaborate on the "What's different?" question. The question may also be used as a link to a compliment or to link tasks to the miracle question. Used in another way, amplification can inform goals and tasks related to the miracle question. Tasks that you suggest can be either *formula* or *predictive* in nature, and they may be completed during or after a session. For example, a postsession formula task for a couple experiencing relationship conflict 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 the couple to think about what would be different in their relationship.

The following case example demonstrates the procedures and techniques of the solution-focused approach.

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, when she asked, "What's would it take ...?," Antonio seemed to become bored or perhaps discouraged. But at the point in which Antonio provided concrete, specific 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 and Limitations of the Approach

The solution-focused approach involves practical procedures and questions that can be readily learned and applied in many practice situations. For example, a miracle question can amplify a client's goal and encourage an investment 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; Kim, 2008; 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 of the solution-focused approach have been criticized. Both critics and proponents have questioned whether the approach is, in fact, collaborative—in particular, the assignment of tasks by the practitioner based on the assumption that assigned tasks help the client to focus on solutions (Lipchik, 1997; O'Hanlon, 1996; Wylie, 1990). To the latter point, research conducted with solution-focused family therapists revealed discrepancies between clients'

CASE EXAMPLE

Antonio, age 16, is a resident in a treatment facility for juvenile offenders. Since the previous session with the social worker, he has transitioned from the lockdown area in the facility to a less restrictive area, referred to 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 of eight sessions with the social worker. As Antonio enters 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, Antonio informs the social worker that he is moving to freedom house after the session. 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 that you've reached this level, what will it take for you to remain in freedom house and eventually go home? *[do more of]*

Antonio: Like I said, I can 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 every day. 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 him 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: 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 others? *[amplify, to encourage evaluation of his perception]*

Antonio: Nooo ... Man, she told me that she met this dude a month ago and then she brought him here to meet me when she visited. After a month! So she told me to say hello, so I said hello, and then I called him Claudius and she said that I was being disrespectful, and they left. The next day she called wanting us to do something together, and I'm like ... whatever.

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'm feeling super stressed out.

Social worker: You are feeling super stressed, okay. Have there been other times when you felt this way that 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-to-10 question? Would you compare the two situations and 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, thanks (laughs). I asked because it's a good way to let me know where you're at now, since, unfortunately, I'm not a mind reader.

Antonio: (Laughs) Alright, go ahead . . .

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 acting-out behavior. This is good. Also, your mother, despite her frustration, has continued to visit you. *[complementing, acknowledging client 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'll 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 you are coping better with the situation. As we end the session, let's summarize what we accomplished today.

experiences and the observations made by therapists related to outcomes (Metcalf et al., 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 real concerns, and instead they felt persuaded to explore solutions. Further, they perceived the avoidance of talking

about a problem to have limited value (Efran & Schenker, 1993). Similarly, the limited attention to behaviors instead of feelings ignores the connection between feelings and cognitions (Lipchik, 2002). These critiques, in many respects, ignore the fact that when clients seek help, they have been socialized to talk about and describe problems in great detail in exchange for services. For this reason, it is important that you explain the basic intent of the process and procedures of solution-focused approach, and perhaps give clients time to talk about their concerns.

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 social worker and the client. In particular, Lipchik (1997) emphasizes collaboration between the professional and the client as a key factor that keeps the "axles turning" and also influences the "speed and success of solution construction, which 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–social worker relationship are not specific to the solution-focused approach. Such discussions about whether 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, clients 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 that encouraging solutions, rather than focusing on the problem, results in an attempt to remedy a situation that may not be fully understood.

The research literature regarding involuntary clients has shown success in using the solution-focused approach with this often neglected and marginalized client group (Berg & Kelly, 2000; Corcoran, 1997, 1998; De Jong & Berg, 1998, 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 (De Jong & Berg, 2001; Lewis & Osborn, 2004; Miller & Rollnick, 2002; Tohn & Oshlag, 1996).

The solution-focused approach supports the construction of the client's reality and is considered to be essential to interactions with diverse groups. In this regard, the expertise of the social worker 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 social worker would appear to be more directive than collaborative.

Aspects of this approach—in particular, the commitment to empowerment and a focus on clients' 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 client capacities should not lead us to assume that clients have within them the solutions to all difficulties. In fact, some clients may lack sufficient cognitive skills and resources or face sociopolitical barriers that affect their ability to actually achieve their miracle. As Chapters 8 and 9 discussed, practice need not focus exclusively on either problems and deficits or strengths and resources. Rather, an appraisal of each, including risks and protective factors, is important in developing a realistic view of a situation and the systems involved (McMillen, Morris, & Sherraden, 2004).

CASE MANAGEMENT

EP 8

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 are 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 charity organization societies. The intent of coordinating services was twofold: 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 1960s 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, educational, 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 clients with an identified chronic health or mental health problem or 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 geographic region and clients whose needs have been identified by the health and human services organization in their respective states (Binder, 2008). In the current human services state and federal reimbursement environment, case management is integral to services in health and mental health settings, long-term care facilities, homeless shelters, schools, adult and juvenile probation situations, and child welfare.

Tenets of Case Management

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 similar to the intervention 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 vital to persons in need of comprehensive services.

A critical function of case management 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 client. In some settings, evaluating the costs of services is a critical component of case management. The Affordable Care Act (ACA) and the resulting expansion of Medicaid provide greater opportunities in this regard. Specifically, the care coordination and integration goals of the Act are consistent with the overall intent and function of case management (Andrews et al., 2013; Darnell, 2013).

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 clients' situations. For example, the protocols of the task-centered model have been integrated with case management services in addressing the needs of older persons in long-term care (Naleppa & Reid, 2003), youth in residential treatment centers (Pazaratz, 2006), and in improving school performance (Colvin et al., 2008). Solution-focused techniques have been central to case management services for persons with mental disabilities (Greene et al., 2006; Hagen & Mitchell, 2001; Rapp, 2002) and in the treatment of drug use and abuse (Hall et al., 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 in 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-positive drug injectors (Robles et al., 2004). The *Social Work Desk Reference* (Roberts, 2009) contains 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 et al., 2008; Potocky-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' caseloads.

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:

- Utilizing a comprehensive assessment to determine the biopsychosocial functioning and care needs of clients, including their strengths and resources
- A client-centric, shared decision-making collaborative relationship between the client and the case

manager, in which the client and, where appropriate, family members are involved in all phases of the case management process
- Planning and implementing services that address and are responsive to the unique needs of the client or family
- Adhering to professional values and principles, including self-determination, privacy, confidentiality, informed consent, and empowerment
- The primacy of the obligation to the client, 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.

The CMSA 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 NASW practice and policy statements (2007, 2009a) 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 4

Although case management is a widely used practice method, some researchers assert that evidence of its effectiveness cannot be generalized (DePalma, 2001; Major, 2004; Orwin et al., 1994; Simons, Shepherd, & Murro, 2008). There are studies, nevertheless, whose findings support the method's efficacy with clients 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 clients, improved the retention of substance abuse users in treatment, and served as a prevention and intervention strategy for homeless youth, adults, and families (Chinman, Rosenheck, & Lam, 2000; Gardner et al., 2005; Havens et al., 2007; Helvic & Alexey, 1992; Herman et al., 2007; Kasprow & Rosenheck, 2007; Mercier & Racine, 2005; Susser et al., 1997; Young & Grella, 1998). Clinically oriented studies summarized by Hoagwood and colleagues (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.

Case management 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 Engelke, Guttu, Warren, & Swanson, 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 lived in rural communities (Hall et al., 2002).

The integration of the strengths perspective was cited by Rapp (1993) as critical to case management practice. Implementing strengths-based case management calls for a focus on people's assets, resilience, and 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 et al., 1995, 1996, 1998).

Case Management Functions

EP 8

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.

Although the phases and tasks of case management are for the most part self-explanatory, for some, elaboration and a brief rationale are 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. Although the phases are procedural in nature, the practice standards are consistent with the ethical principles of social work practice—in particular, the

TABLE 13-5 Case Management Functions

PHASES	TASKS
Access and Outreach	Outreach or case finding identifies people who are likely to need case management services.
Intake and 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 client's physical, mental, social, and psychological functioning and the physical environment, including strengths and resources. This multidimensional assessment guides the development of the case plan.
Goal Setting	Goals and objectives are developed based on assessed needs, in collaboration with the client. The goal plan and objectives are based on the client's perception of needs and may be structured as long or short term.
Planning Interventions and Linking to Resources	Planning the intervention and linking clients 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 and 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 client'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 situations, reassessment and evaluation of outcomes are ongoing.

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

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 depend on the goals and time frame of the case plan. For example, long-term 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

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 clients and various systems. You may work as part of a team in some settings; in others, you may 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 client 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 (POS) agreement. 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 negotiating and coordinating services.

The phases of case management and the point of contact notwithstanding, and 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 clients will have or express 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 his or her case plan is responsive to a specific identified need, rather than the service priorities of an agency. Figure 13-5

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

shows a sample case management plan. The video case involving the Corning family is used to illustrate a case management plan.

VIDEO CASE EXAMPLE

In the video "Working with the Cornings," implementation of Angela and Irwin Corning's case plan required that Ali, the social work case manager, be both facilitative and active. Effectively responding to the goals of the plan required that Ali facilitate the concurrent efforts of public and private organizations and other professional 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, the family's access to and utilization of health care providers were established over a longer period of time. In linking the Corning family with the mix of providers, Ali, as case manager, was actively involved; it would have been insufficient for her to simply identify and refer Angela and Irwin to providers and subsequently expect them to follow through. Making the connections to service is a central task. Afterwards, it was Ali's responsibility to oversee the plan on an ongoing basis.

Clearly, implementing a case plan requires a great deal of up-front work. Essential activities include determining the eligibility criteria of each provider, the provider's ability to meet the plan's goals, and the case review and monitoring process. Once you are satisfied that there is a *fit* between the client'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 clients have access to resources to which they are entitled. In addition to the broker role, in any one case, mediating between a client and various systems is required. For instance, the role of *mediator* 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 the Corning children by providing tutorial assistance. Furthermore, had the school lacked this resource, it would have been important for Ali to explore or develop an alternative resource.

Strengths and Limitations

Case management is a problem-solving practice method that is designed to link the needs of clients 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 be skilled in all aspects of the problem-solving process.

The utilization of case management has grown over time, in part as a response to federal funding requirements that emphasize improved access to services and the coordination and integration of the services that clients receive. Utilization of this method can also be attributed to goals of the Affordable Care Act—specifically, greater continuity and coordination in care and a reduction of duplication in service delivery systems. Standards and principles of case management developed by the NASW and the CMSA have contributed to the uniformity of case management functions and the role of the case manager across settings.

As evidenced by the previous discussion which 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 and 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 a client needs are always available in adequate quality and quantity. In reality, gaps in services exist. In some instances, the service may 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 a client in a coordinated, comprehensive manner. The phases and associated tasks allow for the development of a case plan unique to the client. The greater benefit of case management is the fact that services are identified based on assessed needs, which eliminates clients' having to navigate complex helping systems on their own.

TRAUMA-INFORMED CARE: AN OVERVIEW OF CONCEPTS, PRINCIPLES, AND RESOURCES

This final section of Chapter 13 is intended to increase your understanding of trauma and to acquaint you with the core principles and elements of trauma-informed care and services.

Defining Trauma

While trauma is broadly defined, we have chosen the definition articulated by the Substance Abuse Mental Health Services Administration (SAMHSA), which refers to **trauma** as a "single event, multiple events or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's social, emotional and spiritual well-being" (SAMHSA, 2012, p. 2).

There are three main types of trauma. Type I refers to trauma in which the individual retains complete memory of the experience. Type II trauma involves repetitive and prolonged exposure to a traumatic event or experience, resulting in intense psychological and physical reactions. Type III trauma involves multiple pervasive violent events, often taking place in childhood and continuing into adulthood (Solomon & Heide, 1999). Clients who experience Type III trauma often suffer severe, persistent psychological effects requiring different treatment strategies.

Trauma in clients with a diagnosis of serious and persistent mental health problems (Felitti et al., 1998):

- Is interpersonal and intentional in nature: prolonged, repeated, and serious
- Involves emotional, sexual, or physical abuse, serious neglect, witnessing violence, repeated abandonment, or a sudden and traumatic event
- Occurs in childhood or adolescence and may extend over a client's life span

The Effects of Trauma

The effects of trauma over the life span are biological, psychological, social, and spiritual in nature. Their impact is associated with changes in brain neurobiology; social, emotional, and cognitive impairment; and the adoption of health risk behaviors as coping mechanisms (Mueser et al., 1998; Mueser & Taub, 2008).

An individual's response to trauma depends on his or her age and stage of development at the time of the traumatic event, the severity of the traumatic event, the violence and level of force involved, and whether the event occurred multiple times. The nature of the relationship to the person who caused the traumatic event also has consequences for the survivor. A survivor's response can also depend on whether he or she is believed when the trauma experience is disclosed, as well as the help that is received.

Gender differences are observed in the rates, impact, and response to trauma. Adult and adolescent females, for example, experience more trauma in the form of sexual or physical abuse and psychological distress when compared to males (Shin Tang & Freyd, 2012; Tolin & Foa, 2006). Sexual abuse is associated with posttraumatic stress disorder (PTSD) and self-harm, health risks behaviors, and depression and anxiety (Chamberlain & Moore, 2002; Mueser & Taub, 2008; Smith, Chamberlain, & Leve, 2006). The trauma experience of males is more often related to being involved in or a witness to violence, resulting in antisocial behaviors and posttraumatic stress.

Posttraumatic stress disorders were also found to be higher among racial and ethnic minorities, and these groups also had a higher lifetime risk of developing PTSD. Participants in the study reported a prevalence of high exposure to or the experience of trauma; however, they were less likely to seek or receive treatment for PTSD (Roberts et al., 2011).

The Adverse Childhood Exposure (ACE) study advanced our knowledge of the longevity of exposure or the experience of trauma by identifying adverse childhood experiences and exposure (Felitti et al., 1998). Results of this study confirmed that 60% of

Americans ages 18 to 50 had experienced at least one type of trauma, and more that 20% had experienced three or more traumatic events in their lifetime. This study was the first and largest investigation that linked the physical effects of trauma and identified the association between childhood maltreatment and household dysfunction and later-life health and well-being. Certain experiences were linked to major risks factors—for example, smoking, suicide attempts, alcoholism, substance use and abuse, including illicit drug use, and chronic disease.

The psychological and emotional effects of trauma are spiritual and relational in nature, resulting in behavioral and relationship problems (Breslau et al., 2004; Thompson & Massat, 2005). Behavioral effects include reactions and symptoms that persist into adulthood, including a decreased ability to concentrate, disturbed sleep patterns, and disruptive behavior when an individual is in a situation that reminds him or her of the traumatic experience.

Childhood trauma is associated with changes in brain neurobiology; social, emotional, and cognitive impairment; and the adoption of health risk behaviors as a coping mechanism (National Childhood Trauma Network, 2004; Terr, 1991). In the aftermath of trauma exposure or experience, children and youth exhibit posttraumatic stress symptoms and behaviors, behavioral disorders, and a greater risk of engaging in antisocial and risky behaviors (Becker & McClosky, 2002; Chamberlain & Moore, 2002; Cicchetti & Rogosch, 2002; D'Andrea et al., 2012; Dube et al., 2001; Herrera & McClosky, 2001; Hillis et al., 2004; Kessler & Walters, 1998; Terr, 1991).

Prevalence of Trauma: What Is Known

Until recently, trauma and trauma symptoms and reactions were thought to be confined to combat exposure and the experience of a large-scale disaster (Bowman & Chu, 2000; Kessler et al., 1995). Counter to the earlier assumptions about the experience or exposure to trauma in specific populations, trauma literature and research studies have documented the high incidence and prevalence of trauma in the general population, including among youth and young adults (Dube et al., 2001; Finkelhor et al., 2009; Kessler et al., 1995; Kessler & Walters, 1998; Kim & Cicchetti, 2004). Trauma histories were observed among women in maternity care (Seng et al., 2009) and among urban and immigrant youth and minority child populations (Breslau et al., 2004; de Arellano et al., 2008; Jaycox et al., 2002). Trauma history has also been documented among females and males in prison populations (Grella, Lovinger, & Warda, 2013; Haugebrook et al., 2010; Maschi, Violn, & Morgen, 2013; Zgoba et al., 2012).

Trauma experience among children and youth has led to involvement in the juvenile justice system and residential treatment facilities (Brosky & Lolly, 2004; Ford & Blaustein, 2013; Ford, Chapman, & Cruise, 2012; Hummer, Robst, Dollard, & Armstrong, 2010; Kerig et al., 2009; Simpkins & Katz, 2004) and adolescent pregnancy (Hillis et al., 2004). Trauma or a trauma-causing event are linked to lower school achievement and to behavioral and relationship problems (Breslau et al., 2004; Dube et al., 2001; Keller-Dupree, 2013; Thompson & Massat, 2005).

Parental trauma or exposure to a trauma-causing event or condition has resulted in involvement with child protective services (Blakey & Hatcher, 2013; Marcenko, Lynn, & Courtney, 2011). While homelessness is a traumatic circumstance in and of itself, a history of trauma is evident among home less clients and families (Hooper, Bassuk, & Olivet, 2010).

Trauma-Informed Care

EP 7 and 8

Trauma-informed care refers to a person-centered and strengths-based service delivery approach in recognition of the prevalence of trauma among clients across settings and human services systems. Trauma-informed care understands and is responsive to the impact of trauma and emphasizes the "physical, psychological and emotional safety of providers and survivors, and creates opportunities to rebuild a sense of control and empowerment" in their lives (Hooper, Bassuk, & Olivet, 2010, p. 82). A trauma-informed system of care requires a significant shift in an organization's culture, structure, programs, policies, and practices. Particular attention is paid to practices that inadvertently cause distress for the trauma survivor. At the most basic level, helping should not cause harm.

In general, a **trauma-informed approach** refers to the delivery of services and includes an understanding and awareness of the impact and consequences of trauma exposure and of a history across settings and populations. Trauma is viewed through an ecological and cultural lens—specifically, the importance of context and the client perception and processing of traumatic events. Essential organizational and professional characteristics recognized by SAMHSA (2012, p. 4) as

integral to a trauma-informed approach and trauma-informed care are that the treatment:

- Realizes the prevalence of trauma and understands the potential for recovery
- Recognizes the signs and symptoms of trauma in clients and how trauma affects all clients involved with the service delivery system, including its own workforce
- Responds by integrating the knowledge about trauma into practice, policies, and procedures
- Actively avoids practice and polices that can result in retraumatization

It is the perspective of SAMHSA that in working with trauma survivors, it is critical to promote the linkage to recovery and resilience for those clients and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration. Trauma-specific interventions support and recognize:

- The survivors' need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

Six Key Principles of a Trauma-Informed Approach and Trauma-Informed Care

Although a trauma-informed approach can be initiated and implemented in a range of service delivery systems, SAMHSA (2014) has established six principles rather than a set of prescriptive practices and procedures for trauma-informed care because settings, client populations, and practices can vary. SAMHSA's perspective on a trauma-informed approach reflects adherence to the following key principles (SAMHSA, 2012):

- **Safety:** Trauma survivors and the staff involved in service delivery feel emotional, physical, and psychological safety; and interpersonal interactions promote a sense of safety.
- **Trustworthiness and transparency:** Organizational decisions and operations are clear to clients receiving services, the goal of which is to build and maintain trust among all involved. Trust and transparency are maximized through task clarity, consistency, and interpersonal boundaries.
- **Peer support and mutual help:** These are considered integral to the organizational and service delivery approach and are understood as vehicles for building trust, establishing safety, and empowerment.
- **Collaboration and mutuality:** There is a true partnership and leveling of power differences between staff and clients and among direct care staff and administration, as well as a recognition that healing happens in relationships and in the meaningful sharing of power and decision making rather than through exclusive reliance on the professional's specific skills or services.
- **Empowerment, voice, and choice:** Throughout the organization and among clients, resilience and strengths are recognized, built upon, and validated as new skills are developed. The organization allows clients, staff, and family members to experience choice and recognizes that every person's experience is unique and requires an individualized approach. There is a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma, building on what clients, staff, and communities have to offer rather than responding to perceived deficits.
- **Cultural, historical, and gender issues:** Cultural, historical, and gender issues are addressed in a manner that actively moves past cultural stereotypes and biases, offers gender-responsive services, leverages the healing value to traditional cultural connections, and recognizes and addresses historical trauma.

SAMHSA's principles of a trauma-informed approach and care are intended to specifically address the consequences of trauma in the client and to promote healing.

The Need for a Trauma-Informed Service Approach

The recognition and collective understanding of the prevalence and effects of trauma have resulted in a paradigm shift—in particular, the need for social services and mental behavioral and mental health providers and

professionals to be trauma informed. Although trauma is thought to be subjective and defined by the individual, sensitivity to the potential of a trauma history is encouraged regardless of the client's presenting problem (Huckshorn & Lebel, 2013). Even so, the treatment approach should be person centered; specifically, it cannot be assumed that a one-size-fits-all approach is appropriate.

In support of the development of trauma-informed service delivery across settings and systems, the National Center for Trauma-Informed Care (NCTIC) was created in 2005 and funded by SAMHSA. The NCTIC provides education, outreach, consultation, resources, and technical assistance to assist organizations to address and respond to the needs of clients with trauma histories (NCTIC/SAMHSA, 2014).

Implementing a trauma-informed approach consistent with the tenets of trauma-informed care and SAMHSA's principles is a conscious, intentional, and ongoing process. In the best circumstance of helping, trauma survivors can be problematic, but this is more so in settings that are non-trauma-informed—specifically, in instances in which the treatment provided does not address trauma nor respond adequately to the needs of trauma survivors.

Research studies point to the need for an approach beyond social services and mental health settings to include health, educational systems, and child welfare and juvenile systems (Ford & Blaustein, 2012; Keller-Dupree, 2013; Ko et al., 2008). Recommendations for and examples of implementing trauma-informed care include Ford and Blaustein (2012), Harris and Fallot (2001), Hooper, Bassuk, and Olivet (2010), and Hummer et al. (2010).

Evidence of the Approach

EP 4 and 8

Trauma-informed care is considered evidence-based practice particularly for clients who have histories of trauma. This is the gold standard of care. Policies and practice recognize and acknowledge the histories that shape clients lives. Trauma histories are recognized as part of the treatment process rather than denying they exist. In the absence of trauma-informed policies and practices, survivors of trauma are unlikely to heal and recover. In essence, the trauma-informed approach can:

- Validate a part of people and a history that often has been dismissed or denied
- Create a safe place where people come for help, restoration, and motivation to continue
- Increase the effectiveness of services designed to empower clients in transition periods
- Provide opportunity to plant seeds of hope, demonstrate that someone in this world cares about them, and show clients that they matter

At the very least, the services provided should not harm clients, and at best should leave survivors better off than when they first sought help.

Evidence-based studies that demonstrate the effectiveness of trauma-informed care continue to evolve. Presently, CBT and trauma-focused CBT (T-F-CBT) are the most widely used interventions and are regarded as the most promising (Beehler, Birman, & Campbell, 2012; Black et al., 2012; Brown, Pearlman, & Goodman, 2004; Dorsey, Briggs, & Woods, 2011; Getz, 2012; Hinton et al., 2011; Stambaugh et al., 2007) and include cultural adaptations (Bernal, 2006; Cohen et al., 2000; Jaycox et al., 2002; Katoaka et al., 2003; Lau, 2006).

Implications for Social Work Practice

In reality, social workers have always worked with vulnerable clients, many of whom have experienced trauma and who have conditions that meet criteria in the *Diagnostic and Statistical Manual for Mental Disorders* (2013). The growing knowledge about trauma effects leads the profession toward practice that is consistent with trauma-informed care despite the fact that the work setting may not be trauma informed. The consequences of trauma are complex, and as such, traditional treatment plans and goals are limited in their capacity to respond to the needs of trauma survivors. Trauma-informed practice is ideally individualized and flexible and validates the survivor's solution for recovery and healing.

The trauma assessment may be incorporated with the biopsychosocial as discussed in Chapters 8 and 9. Exploring whether a current difficulty is related to a traumatic event is an important part of the assessment process. For example, certain behaviors that are considered to be maladaptive may in fact be a means of coping. Various trauma screening tools exist that can confirm the presence of and extent of trauma. However, professionals are encouraged to avoid hiding behind a mound of papers in order to determine the problem rather than listening to the client and the meaning that their difficulties has for them.

In some instances, persons with a trauma history may be reluctant to disclose because of psychological barriers—for example, embarrassment, shame, or fear—focusing instead on more pressing needs or problems. The foundation of a trauma-informed assessment is "What happened to you?" rather than "What is wrong with you?" The former is facilitative and nonjudgmental, establishes rapport, and fosters trust by creating a safe environment.

Historically, social workers have worked in a range of settings, organizations, and systems, while engaging in practice that adheres to the values and principles of the profession. Concepts and principles associated with trauma-informed care—for example, client participation, empowerment, recognition and utilization of strengths, resilience, the capacity for change and growth, and respecting the dignity and worth of clients—are in harmony with the ethics and value base of the profession. For this reason, trauma-informed care is not a radical shift for social work practice.

Trauma-Informed Resources

The following is a brief list of trauma-informed resources:

- SAMHSA provides a range of resources that can be ordered or downloaded free of charge at www.samhsa.hhs.gov.
- Check out the following treatment improvement protocols:
  - *Trauma-Informed Care in Behavioral Health Services.* (TIP Series 57). HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
  - *Improving Cultural Competence.* (TIP Series 59). HHS Publication No. (SMA) 14-4845. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
- The National Center for Trauma Informed Care (NCTIC) offers trauma-informed care and alternatives to seclusion and restraint at www.samhas.gov/nctic.
- National Child Traumatic Stress Network (NCTSN): www.nctsn.com
- National Native Children's Trauma Center: http//iers.umt.edu/National_Native_ Children-Trauma Center
- Culturally Sensitive Trauma-Informed Care Health Care Toolbox: www.healthcaretoolbox.org/index.php/cultural-considerations
- Child Welfare Information Gateway: www.child-trauma.com

SUMMARY

This chapter discussed four intervention approaches, processes and procedures of cognitive restructuring, and case management practice. Examples of questions that may be used in the selection of an intervention strategy were presented, along with factors to be considered in the process, such as evaluating the extent to which an approach has demonstrated its effectiveness, with whom, under what circumstances, and with what types of problems. The theoretical framework and empirical support for each of the approaches was summarized, including its use with diverse populations, age groups, and settings. The final section of the chapter introduced the concepts and principles of trauma-informed care and their implications for social work practice.

COMPETENCY NOTES

EP 1 Demonstrate Ethical and Professional Behavior

- Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulation, models for ethical decision making, ethical conduct of research, and additional codes of ethics as appropriate to context.

Selecting and implementing an intervention strategy, social workers observe the principles, values and ethics of the profession.

In selecting a strategy, social workers are obligated to have the knowledge and skills necessary to implement the strategy.

EP 2 Engage Diversity and Difference in Practice

- Apply and communicate understanding of the importance of diversity and differences in shaping life experiences in practice at the micro, mezzo, and macro levels.

Selecting an intervention strategy understand and are guided by the context of people's lives, differences, perceptions, experiences,

abilities, and the client's cultural frame of reference.

Social workers understand and appraise difference and determine if a particular strategy has certain limitations with certain groups, and whether the approach should be modified so that it fits with the needs, values, and beliefs of a client.

People interact and react within the context of their environment. The social environment shapes their perceptions, cognitions, experiences, and sense of self.

EP 4 Engage in Practice-Informed Research and Research-Informed Practice

- Use and translate research evidence to inform and improve practice, policy, and service delivery.

Selecting and planning an intervention strategy requires that social workers have knowledge of the strategy utilization and evidence of effectiveness with the problems and goals of different clients and in different settings.

Understanding the conceptual and theoretical framework upon which an intervention is based is essential to the effective implementation of the strategy and ethical practice.

EP 7 Assess Individuals, Families, Groups, Organizations, and Communities

- Collect, organize, critically analyze, and interpret information from clients and constituencies.

Selecting and intervention strategy is guided by questions that clarify whether the strategy is appropriate to the presenting problem, meets the needs of diverse groups and is consistent with professional ethics.

- Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data for clients and constituencies.

Understand differences and use this knowledge to guide practice competence with in planning interventions with diverse clients.

- Select appropriate intervention strategies based on the assessment, research knowledge, and values and preferences of clients and constituencies.

Selecting an intervention strategy requires an understanding of the basic tenets of the strategy and its effectiveness to ensure that the strategy is capable of resolving the client's problem and achieves a desire goal.

Social worker's also evaluate also evaluate whether they have the requisite knowledge and skills to successfully implement the strategy.

EP 8 Intervene with Individuals, Families, Groups, Organizations, and Communities

- Implement interventions to achieve practice goals and enhance capacities of clients and constituencies.

Intervention approaches have procedures and techniques that are implemented in a systematic manners to enhance client's capacity, and to assist them to resolve problems and achieve goals.

An approach should have demonstrated evidence of effectiveness with a client's problem.

SKILL DEVELOPMENT EXERCISES

in Planning and Implementing Change-Oriented Strategies

1. Using the Corning case, select the task-centered and 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 consider to determine how to 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 you may have used. What strategies would you use to modify your thinking?
7. Review what you have learned about trauma and the principles of trauma-informed care. Reflect on how you might change the way in which you complete an assessment of clients.

NOTE

1. For additional information on brief treatment models, see Corwin (2002), Roberts and Greene (2002), and Walsh (2006, 2010).