Direct Practice Skills for Evidence-Based Social Work
A Strengths-Based Text and Workbook
Elizabeth C. Pomeroy, PhD, LCSW
Renée Bradford Garcia, MSW, LCSW

Featuring an evidence- and strengths-based approach to practice methods, this new text teaches students how to apply social work skills in a variety of settings. Designed to enhance self-awareness, professionalism, ethical reasoning, cultural sensitivity, and an appreciation for social justice issues, this text introduces readers to social work’s core values and practice methods to help them assimilate the skills needed for working in the field. Cases and skills-based exercises demonstrate how to make accurate assessments and design effective intervention plans. After laying the groundwork in theory, values, and ethics, the authors review methods for working with individuals, children, and families from an individual and environmental strengths-based perspective. Client engagement, assessment, intervention, evaluation, and termination, and documentation are then reviewed. Readers are introduced to the foundational concepts of social work practice and through application learn to successfully work with clients.

Highlights include:
- Integrates the Council on Social Work Education’s EPAS standards and core competencies throughout, including engagement, assessment, intervention, evaluation, social justice, ethics, critical thinking, professional conduct and decision making, and cultural competency and diversity.
- Case scenarios in client interview format that closely resemble actual interactions, followed by questions, test readers’ understanding of the practice skills needed to work in the field.
- Skill-building exercises including individual and group activities, role plays, simulations, and discussion questions that provide an opportunity to apply one’s knowledge and skill sets.
- Personal reflections that encourage students to examine their own beliefs to help them assimilate social work ethics and values into their professional demeanor.
- Icons throughout the text that draw attention to useful tips for developing direct practice skills.
- A strengths-based approach that heightens understanding and results in a higher level of proficiency in the change process.
- Introduces challenging situations often encountered in practice to help readers acquire the more advanced practice skills necessary for assessment and intervention.
- Resources including PowerPoints, test questions, sample syllabi, and suggested answers to text exercises and discussion questions.
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DIRECT PRACTICE SKILLS FOR EVIDENCE-BASED SOCIAL WORK

A STRENGTHS-BASED TEXT AND WORKBOOK

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PREFACE

Preparing for a career in social work is an exciting endeavor that demands a lot of effort from future practitioners. Based on years of experience in teaching and practice, the authors developed this text/workbook to provide students with a practical application of the information that accompanies beginning and advanced methods and practice classes. It focuses on evidence-based research and the strengths-based approach as it applies to practice methods. Students will not only gain a working knowledge of practice methods but also learn how and when to apply these skills to specific clients in a variety of settings.

The text/workbook outlines the value base of the profession, theoretical approaches, and cultural, ethical, and social justice issues that social workers will encounter in their work. In addition, it provides detailed instructions on building rapport and engaging with clients, conducting assessments, formulating goals with clients, using evidence-based interventions, evaluating progress, and terminating the helping relationship. Throughout the book, attention is given to the important qualities that an ethical professional must possess, such as self-awareness and a nonjudgmental attitude. Unlike other texts of this nature, particular attention is given to a strengths-based perspective on direct practice social work. To this end, the authors developed the strengths-based direct practice (SBDP) framework, which is explained thoroughly in Chapter 3 and subsequently woven into the rest of the text.

INTENDED AUDIENCE

Designed for use in introductory direct or generalist social work practice, practice I, or practice with individuals and families (micro practice) required for all BSW and MSW students, this engaging text prepares readers to work with clients in the helping relationship. Social work methods and practice courses for which this text/workbook is intended are taught throughout the academic year at the undergraduate and master’s levels. Regardless of the setting/agency in which students find positions, these basic skills will lay the foundation for further growth in their skill repertoire. These practice courses are at the core of their professional work as social work practitioners. Students understand the need to be well versed in direct practice skills and interventions to be effective change agents in the community. Although students have little difficulty understanding the foundational concepts of social work practice, they often have less opportunity to apply some of the necessary skills needed to effectively assist clients with the issues they encounter in their lives. Hence, this text/workbook specifically addresses these issues and provides cases and activities with which students can practice these skills. From these
authors’ experience in teaching these courses numerous times at the undergraduate and graduate levels as well as counseling clients in practice, examining case examples gives students the context by which they can further their understanding of the issues confronting clients, and know how to assess the individual and how to successfully intervene with clients who are in distress. Case examples and professional growth activities also allow for richer learning experiences that foster critical thinking, growth, and maturity.

LEARNING TOOLS

This text/workbook integrates the Council on Social Work Education’s Educational Policy and Accreditation Standards (EPAS) and core competencies throughout, including engagement, assessment, intervention, evaluation, termination, social justice, ethics, critical thinking, professional conduct and decision making, and cultural competency and diversity.

Each chapter contains case scenarios developed in client interview format so that they closely resemble actual interactions between workers and clients. A series of questions follow each case so that students can apply their understanding of the chapter content. The authors relied heavily on their clinical experiences in devising case scenarios for this workbook. However, any resemblance between actual clients and those presented herein is completely coincidental. Chapters also include individual and group activities, role-plays, and simulations that can be used for in-class instruction or as homework assignments. The close of each chapter contains personal reflections designed to encourage students to examine their own beliefs, values, and emotions regarding the subject matter. This helps students more solidly integrate and assimilate social work ethics and values into their professional demeanor.

Furthermore, icons are used throughout the textbook to draw attention to specific pieces of information that are useful to direct practice at a glance. An overview of the icons, their chapter placement, and meaning follows:

<table>
<thead>
<tr>
<th>ICON</th>
<th>CHAPTER</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chapter 1</td>
<td>The <strong>Roles</strong> icon alerts readers to the professional services and functions that social workers can provide.</td>
</tr>
<tr>
<td></td>
<td>Chapters 4, 5, and 6</td>
<td>The <strong>Cultural Context</strong> icon alerts readers that culturally specific direct practice skills will be presented.</td>
</tr>
<tr>
<td></td>
<td>All chapters (1 to 10)</td>
<td>The <strong>Case Study</strong> icon alerts readers that they will be presented with an example to teach essential skills discussed in that chapter.</td>
</tr>
</tbody>
</table>

Of note, the authors recognize that all the examples and cases in this workbook could apply to persons of any gender, race, or ethnicity. As social workers, we value inclusivity and embrace all genders, sexual orientations, races, ethnicities, and cultures. Currently, this text/workbook uses traditional gendered pronouns (she or he, her or him, etc.), until a more gender-neutral pronoun emerges and becomes integrated into the social lexicon. The authors alternate the use of pronouns between chapters, with an understanding that it could
be any gender in the examples given. We have a deep and abiding respect for persons of all genders and sexual orientations and have a strong commitment to diversity and social justice issues among all who live in our society.

It is our hope that students will gain a better knowledge of the practical application of direct practice social work from a strengths-based perspective. We are extremely honored to have had the opportunity to contribute to the development of competent and confident social workers for the future.

CONTENTS

Chapter 1 introduces the student to direct practice social work and defines the roles of the social worker engaged in direct practice. Various direct practice work settings are delineated as examples of the types of agencies where many social workers are employed. The qualities of the professional social worker conclude this chapter followed by a case example of both a professional and an unprofessional social worker. Chapter 2 explains the value base of the social work profession and describes the National Association of Social Workers’ Code of Ethics, which provides the framework for conduct in direct practice settings. In addition, this chapter discusses ethical dilemmas and outlines a method for resolving such dilemmas. This chapter provides multiple scenarios to illustrate the ethical principles explained in the text. The SBDP and other direct practice theories and approaches are explained thoroughly in Chapter 3 and subsequently woven into the rest of the text. The SBDP has 13 guiding tenets that inform practice. Chapters 4 through 7 form the core of the skill building methods for social work students. Each of these chapters contains an overview of the tenets and their application to each chapter’s subject material. The overview and application of the tenets are presented in table form at the beginning of Chapters 4 through 7. Chapter 4 discusses the process of engaging clients in the helping relationship, including the tasks of building rapport and communicating empathy. The text distinguishes differing levels of empathy with an added emphasis on highlighting client strengths. It also provides an examination of cultural variations within the context of rapport building with clients. Chapter 5 provides a detailed discussion of the strengths-based assessment process; its characteristics and guidelines for conducting an assessment are at the core of this chapter. A detailed psychosocial assessment outline is provided as well as information and scripts that cover the kinds of questions to use when performing assessments. In addition, this chapter delineates the Stages of Change approach and its use in the assessment process. It also outlines how to formulate goals with clients so that students are prepared upon entering a work setting. Skills for assessing clients of various cultural backgrounds are also discussed. Chapter 6 focuses on hands-on skills that beginning social workers can use to intervene with clients. It provides an overview of the importance of using evidence-based practice methods as well as guidelines for discerning which interventions meet these criteria. This is followed by explanations of current evidence-based practice methods that are appropriate for beginning-level direct practice social workers, including task-centered approach, case management, psychoeducation, crisis intervention, cognitive restructuring, and prevention. In addition, this chapter examines modifications of existing interventions that can be utilized with culturally diverse clients. This chapter is rich in case examples and scenarios that illustrate the use
of the intervention with clients. Chapter 7 covers important information about evaluation and termination with clients. This chapter includes the importance of evaluation and quantitative and qualitative methods for determining client progress toward goals. Termination issues and methods comprise the second half of the chapter and include typical challenges and reactions to the termination process for both the client and the practitioner. The conclusion of this chapter contains case scenarios in which students can learn how to terminate with clients effectively and ethically. Chapter 8 focuses on the importance of documentation of client interviews and best methods for documenting client encounters. It also instructs students on how to produce a written assessment, summarize goals, formulate treatment plans, and evaluate and document client progress, interventions used, and outcomes.

Chapter 9 covers issues that merit special concern among practitioners, including boundaries and transference, working with clients who are angry or violent, working with clients who are suicidal, and providing services in a client’s home. The chapter also contains discussion about working with children and adolescents, survivors of abuse, clients who abuse substances, and the jail and prison populations.

In Chapter 10, we focus on the practitioner and the connection between managing oneself and ethical behavior. The importance of self-awareness is emphasized and the need for personal and professional self-care is highlighted. Given the fact that personal and professional growth requires a deep understanding of the ethical dilemmas facing practitioners, the influence of the practitioner’s values is also examined. Compassion fatigue, burnout, and professional impairment are also prominent in the helping professions and, therefore, these issues are addressed along with guidelines for prevention. Finally, the growth of the professional is graphically depicted so that students gain an understanding of how the various components of their personal and professional lives work together to transform students into effective change agents.

**INSTRUCTORS’ RESOURCES**

The authors provide online resources that include sample syllabi, PowerPoint slides based on each chapter, test questions, and suggested answers to the case scenario questions. This is in addition to the class activities and possible homework assignments that are relevant to the content of each chapter. **Qualified instructors can request these ancillaries by email: textbook@springerpub.com.**
ACKNOWLEDGMENTS

As with any large project, the authors are indebted to a number of others for their assistance and support in the process. We are indebted to our colleague, Kathleen Hill, for her assistance with some of the research, editing, and formatting of the material. Her technical support was invaluable in the final stages of this production. We would like to thank Stephanie Drew, Debra Riegert, and Mindy Chen. We extend our gratitude to the entire production staff of Springer Publishing.

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Direct Practice Skills for Evidence-Based Social Work: A Strengths-Based Text and Workbook
CHAPTER 4

THE ENGAGEMENT PROCESS

In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?

— Carl Rogers, On Becoming a Person: A Therapist’s View of Psychotherapy (1989, p. 32)

The engagement process refers to the initial interactions between the social worker and the client. A successful engagement process sets in place a strong foundation for the work that the client and social worker will do together. The social worker’s most fundamental goal at this stage is to establish a relationship with the client in which the client feels respected and secure in discussing personal matters. This is achieved by developing rapport with the client, demonstrating empathy, and clarifying expectations of the helping process. This chapter outlines skills needed to accomplish these goals.

THE STRENGTHS-BASED DIRECT PRACTICE FRAMEWORK IN THE ENGAGEMENT PROCESS

From the initial encounter with the client, the social worker emphasizes client strengths and strives to create an atmosphere in which these strengths are highlighted and utilized. The basic tenets of the strengths-based direct practice (SBDP) framework can be integrated into the engagement process by building rapport and communicating empathy (see Table 4.1). By conveying respect and a nonjudgmental attitude toward the client from the beginning of the relationship, the social worker puts emphasis on uncovering the client’s strengths over his weaknesses and limitations. This creates an environment in which clients can more comfortably and easily activate their capacity for change. In contrast, focusing only on the client’s problems can unintentionally stigmatize the client and leave him feeling disempowered.

A professional attitude combined with genuine warmth that is communicated through body language, tone of voice, eye contact, and active listening engenders trust from the client, which improves the effectiveness of interventions for change. Furthermore, discovering the client’s hopes and desires for positive results, rather than imposing the worker’s own agenda, can lead to productive and achievable outcomes. The engagement process, as discussed in this chapter, is a collaborative one that emphasizes the strengths-based perspective outlined in Chapter 3.
### TABLE 4.1 Strengths-Based Direct Practice (SBDP) in the Engagement Process

<table>
<thead>
<tr>
<th>SBDP TENET</th>
<th>SBDP TENET OVERVIEW</th>
<th>PRACTITIONER APPLICATION OF TENET</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Given the appropriate support and guidance, all persons have the capacity to improve their lives. Clients benefit by knowing that respectful and nonjudgmental support is available to them as they work to achieve their goals.</td>
<td>Practitioner’s body language, tone of voice, word choice, and application of empathic listening is a way to demonstrate respect and support to clients and should begin with the very first interaction.</td>
</tr>
<tr>
<td>2</td>
<td>All persons have individual and environmental strengths that can assist them throughout the helping process. Clients benefit from the reinforcement of those strengths and the encouragement to consciously employ them during the helping process.</td>
<td>Beginning with the initial encounter, skilled practitioners converse with clients in a manner that affirms their challenges and accentuates their strengths including the client’s abilities, efforts, and characteristics.</td>
</tr>
<tr>
<td>3</td>
<td>The helping process is fertile ground for personal growth and the development or enhancement of the clients’ strengths.</td>
<td>Providing information and explaining what clients can expect from the helping process is a critical step in creating a safe space for clients to develop and build on their strengths.</td>
</tr>
<tr>
<td>4</td>
<td>Improving one’s life is a gradual process that takes varying amounts of time and effort. Experiences of discomfort and resistance to change are expected reactions in the helping process and are not inherently pathological or indicative of weakness.</td>
<td>Initial suspicion or distrust of the practitioner or the helping process is an expected reaction from some clients. Practitioners must understand that they are responsible for earning the client’s trust by using rapport-building skills and communicating empathy.</td>
</tr>
<tr>
<td>5</td>
<td>The quality of the helping relationship can either help or hinder clients’ capacities to make improvements in their lives.</td>
<td>Practitioners create an atmosphere conducive to change by using unconditional positive regard, empathy, and an open, nonjudgmental demeanor.</td>
</tr>
<tr>
<td>6</td>
<td>Interactions with clients should aim to support clients’ aspirations, competencies, confidence, and individual and environmental strengths.</td>
<td>Practitioners should strive to maintain a positive and hopeful attitude with clients and communicate belief in their capacity to change.</td>
</tr>
<tr>
<td>7</td>
<td>Consideration of a client’s cultural background aids in the understanding of the client’s circumstances and life experiences, and thus enhances the helping process.</td>
<td>Rapport building and empathic communication are most effective when sensitive to and respectful of the cultural context in which the client lives.</td>
</tr>
</tbody>
</table>

(continued)
### TABLE 4.1 Strengths-Based Direct Practice (SBDP) in the Engagement Process (continued)

<table>
<thead>
<tr>
<th>SBDP TENET</th>
<th>SBDP TENET OVERVIEW</th>
<th>PRACTITIONER APPLICATION OF TENET</th>
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<tr>
<td>8</td>
<td>All persons are impacted to varying degrees by the interactions they have with other people. Maintaining awareness of how interactions are being received by clients is essential to a productive helping relationship.</td>
<td>Practitioners must be mindful that even subtle behaviors send messages to clients. It is essential that practitioners actively monitor and reach for feedback from clients and be willing to adjust their style of relating as appropriate.</td>
</tr>
<tr>
<td>9</td>
<td>When communicating with clients, the worker should use verbal statements, listening styles, and body language that honor the value and dignity of clients.</td>
<td>Practitioners should utilize advanced listening skills that allow them to be truly present with clients. Practitioners need to also maintain awareness of implicit biases they may carry that could affect their understanding of the client.</td>
</tr>
<tr>
<td>10</td>
<td>Clients are more receptive to opportunities when interactions contain elements of unconditional and genuine positive regard and an emphasis on their individual and environmental strengths.</td>
<td>When practitioners maintain strengths-based interactions with clients, the clients are more likely to be receptive to engage in the helping process.</td>
</tr>
<tr>
<td>11</td>
<td>All interactions are an opportunity for both the worker and client to learn and grow. Rather than an authoritarian relationship, the practitioner collaborates in an egalitarian manner.</td>
<td>Practitioners should conduct themselves in a manner that regards clients as the experts on their experience. Skillfully using tone of voice, word choice, body language, and empathic listening establishes the practitioner as a collaborative partner.</td>
</tr>
<tr>
<td>12</td>
<td>Practitioners should remain mindful of how social and economic disparities may impact their clients. The practitioner’s belief in social justice leads to action-oriented responses when confronted with societal inequities, injustices, and discrimination.</td>
<td>It is important that practitioners be aware that a social history of oppression, inequality, and discrimination may play a role in the client’s perception of the practitioner and the helping relationship and look for opportunities to recognize and communicate his or her understanding of these injustices.</td>
</tr>
<tr>
<td>13</td>
<td>Making changes often requires clients to acquire different thoughts, feelings, and behaviors that increase feelings of fear and vulnerability. Adherence to ethical principles of practice provides the necessary safety for these changes to occur and protects clients from unnecessary harm while pursuing their goals.</td>
<td>Maintaining professional integrity while clients move through the helping process diminishes the fear and vulnerability that clients inevitably experience at various times.</td>
</tr>
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</table>
BUILDING RAPPORT

Rapport refers to “the nature of the contact between the social worker and the client—how you engage with each other” (Knapp, 2010, p. 45). Tickle-Degnen and Rosenthal (1990) note that “the presence of a high degree of rapport between individuals has been thought to create powerful interpersonal influence and responsiveness” (p. 285). A positive rapport between the social worker and client exists when the client feels at ease with the social worker, safe disclosing personal information, and regards the social worker as authentic and trustworthy. In addition, communicating unconditional positive regard, being appreciative of cultural beliefs and attitudes and being open to learning from the client as the expert on his situation conveys genuine interest in the client as a person. These elements are the building blocks for the client and social worker to productively work together.

UNCONDITIONAL POSITIVE REGARD

Carl Rogers was one of the most influential psychologists in American history. His approach, “client-centered therapy,” proposed that certain conditions in the therapeutic relationship facilitate a client’s motivation to grow, explore self and his situation more fully, and accept self more completely. This culminates in clients choosing goals and behaviors that will enhance psychological and social well-being. Rogers believed that these “growth forces” will be activated by the client if certain principles are present in the helping relationship (C. R. Rogers, 1946).

In summary, these elements include the following:

- The practitioner believes in the importance of individual responsibility.
- The practitioner believes the client has an inherent motivation and internal capacity for improving the quality of his life.
- The practitioner understands that the client has free will to choose what he will disclose, while also establishing a safe and nonjudgmental environment for the client to express thoughts and emotions.
- Boundaries are established around behaviors but not around thoughts or emotions. For example, violence will not be tolerated during an interaction.
- These techniques lead to positive acceptance of the client that is free of prejudice and judgment.

Underlying these conditions, is Rogers’s notion of unconditional positive regard, which may be defined as full and complete acceptance of a person regardless of the person’s opinions or behavior. Unconditional positive regard is different from liking someone, agreeing with them, or approving of their actions. It means that respect and value of the client are always present, and not dependent on the client’s thoughts, feelings, or actions. It is grounded in the assumption that the individual is functioning to the best of his capacity and has the right to

(continued)
Building rapport with clients is the social worker’s responsibility. It begins with the very first interaction and continues throughout the helping relationship. It includes common social courtesies such as smiling, introducing oneself, making eye contact and shaking hands (if culturally appropriate), making the client comfortable by the use of initial casual conversation, showing the client where to sit, offering a glass of water, and other gestures that allay any uncertainty or awkwardness the client might be experiencing. The specific behaviors that will effectively establish rapport will depend on the context of the interaction (Tickle-Degen & Rosenthal, 1990). For example, a social worker accompanying police to a scene of domestic violence will use different mannerisms from a social worker who is meeting with a client to help him or her cope with a chronic illness.

Establishing rapport in the engagement phase of the helping relationship also includes providing the client with information about confidentiality, the scope, and conditions for receiving services and fees that may be charged. Providing this information communicates respect to the client and can ease any anxiety the client may have about seeking assistance. The social worker should explain these details early in the engagement process and encourage clients to ask questions so that they have an accurate understanding of the client/worker relationship and the services available. In addition, any paperwork that needs to be completed by the client will be done during this phase of the helping process. Finally, addressing any ethical issues that may hinder the relationship can eliminate future misunderstandings.

Social workers often work with persons who are receiving interventions involuntarily, such as those required to receive services by the legal system or minors whose parents have requested assistance. When working with involuntary clients, building rapport can be more challenging. However, many of the same skills are utilized to establish a trusting relationship. The difference in approach may be that the client may initially be less willing or cooperative to openly engage with the social worker. Therefore, it may take more than one session to establish rapport and gather meaningful information from the client. Despite these challenges, the social worker assumes a nonjudgmental attitude and an appreciation for the client’s circumstances and viewpoint, and continues efforts to build a productive working relationship with the client.

RAPPORT BUILDING IN A CULTURAL CONTEXT

Culture, according to Ani (1994; as cited by Gallardo, Yeh, Trimble, & Parham, 2012), is a way in which groups organize their perceptions of the world, their experiences, and explanations of reality. Culture provides groups with their identity based on historical background, icons, and shared meanings that legitimize the culture’s values, customs, and beliefs. Thus, it is crucial that social workers
continually strive to deliver services that are culturally relevant to clients. This includes adopting interpersonal skills that communicate respect for cultural differences as well as a willingness to learn about how a client’s cultural identity and cultural context influences his circumstances, barriers to success, and strengths. Gallardo et al. (2012) assert that culturally competent practices are an integral component of clinical competencies and are necessary to the delivery of ethically sound services. The vast number of variables that constitute a person’s cultural identity include race, ethnicity, gender, sexual orientation, religion and spirituality, disability, age, socioeconomic status, geographic context, migration patterns, level of assimilation and acculturation, and experience of oppression and discrimination, in addition to individual and family differences. Even within one broadly described group such as Hispanics, there are numerous nationalities and cultural variations that require astute differentiation by the helping professional. For this reason, practitioners need to understand the importance of accumulating knowledge about different cultures while also being mindful not to make assumptions about a client based on his culture. There are numerous resources available to help practitioners remain culturally competent to work with clients that can provide more in-depth coverage of this topic than this text can offer. Therefore, we offer an overview of salient mindsets and skills that social worker students can begin to practice.

Self-awareness is an essential component of one’s ability to be a culturally competent practitioner. This includes awareness of one’s own prejudices, biases, and lack of knowledge about a client’s culture. This is enhanced by a willingness to be self-reflective, honest, curious, and open to learning from the client and acknowledging that mistakes will be made as the practitioner refines his skills. For more in-depth study, see Gallardo et al. (2012) and Paniagua (2005).

The following is a brief summary of factors of which social workers will want to be mindful when building rapport with cultural minorities. Practitioners are encouraged to be perpetual students of different cultures, which can be accomplished by increased exposure to and interaction with the cultural group as well as academic study.

**African Americans**

- Clients respond best to an authentic and collaborative therapeutic relationship (Westbrooks & Starks, 2001).
- Rather than being fearful of a client’s demonstration of anger, permit and support appropriate demonstrations of anger (Westbrooks & Starks, 2001).
- Recognize that even if the worker believes he does not have an issue with race, the client’s perception may differ (Westbrooks & Starks, 2001).
- Recognize that the history of racism and experiences of systemic oppression may make it more difficult to engage with the client (Substance Abuse and Mental Health Services Administration, 2014).
- Avoid behaviors that reflect the desire to prove to clients that you are “with them” and focus on ways you can be helpful (Westbrooks & Starks, 2001).
- Be aware that clients may have preconceived ideas of the worker that could inhibit the establishment of trust (Westbrooks & Starks 2001).
Hispanics

- Use the client’s preferred language.
- Avoid personalismo in the first session with a client and instead emphasize formality (Gallardo, 2012).
- Engage in small talk and developing the relationship between worker and client (Gallardo, 2012).
- Graciously receive hospitality including small gifts and advice (Machucha, 2014; Negroni-Rodriguez & Morales, 2001).
- Be aware of the great diversity within this group that includes Cubans, Mexicans, Puerto Ricans, South Americans, Central Americans, and other Spanish cultures.
- Respect the familial roles that exist in the family. For some families, it may be advisable to interview the father separately in the first session (Paniagua, 2005).

Asians and Pacific Islander Americans

- Recognize the immense diversity within this group that encompasses a multitude of nationalities and ethnic groups from East Asia (China, Japan, Korea, the Philippines), South Asia (Pakistan, India, Sri Lanka, Bangladesh, Nepal, Bhutan), Southeast Asia (Burma/Myanmar, Singapore, Thailand, Laos, Cambodia, Vietnam, Indonesia, East Timor, and Brunei), and the Pacific Islands (Polynesia, Micronesia, and Melanesia). Within each of these subgroups is further differentiation (Vakalahi & Fong, 2015).
- Understand that there may be a high value on self-reliance and emotional self-restraint, making these clients more likely to try to solve their difficulties on their own rather than seeking help (Leong, Chang, & Lee, 2006).
- Regard the first session as a potential crisis point for the client (Paniagua, 2005).
- Recognize that there may be the expectation that the worker will function as an expert helper (Leong et al., 2006).
- Realize that there may be discomfort in discussing emotions in great detail (Leong et al., 2006).

Native Americans

- Understand that there is greater emphasis placed on nonverbal communication (Paniagua, 2005).
- Be aware that active listening is valued over talking and seen as a respectful gesture (Paniagua, 2005).
- Exercise patience and allow for silence as clients may need time to reflect on their thoughts and choose their words (Brave Heart, 2001).
- Avoid taking many notes, which can be interpreted as not listening (Paniagua, 2005).
• Understand that the client’s avoidance of direct eye contact is a sign of respect and should not be interpreted as avoidance. (Brave Heart, 2001; Paniagua, 2005).

• Accept the presence of others brought to the session (Paniagua, 2005).

• Recognize that due to a social history of genocide and continual oppression, establishing trust will be a slower and more difficult process (Brave Heart, 2001).

ENGAGING WITH CLIENTS VIA TELEPHONE

Social workers are increasingly called upon to provide services to clients over the phone. While it is always preferable to work with clients in person, providing services over the phone can be a convenience for clients who would face hardship in coming to the office. It is also a way for financially strapped agencies to provide care in a more cost-efficient manner. Phone services are a common method of service delivery when providing case management with rural populations, homebound individuals, and in health care settings. Even though the client and social worker may never meet face to face, professional social work skills along with practiced telephone skills can be used to establish trusting and productive helping relationships with clients. The following suggestions can help you effectively service clients through the telephone:

• Smile. Even though the client can’t see this, your warmth will be communicated through the phone.

• Maintain a professional demeanor just as you would in a face to face meeting.

• Explain who you are, the agency from which you are calling, and the purpose of your call.

• Adhere to the same processes of building rapport, assessment, goal formulation, intervention, evaluation, and termination.

• Remain mindful that your perceptions about a client may be incorrect due to missing information that cannot be obtained via telephone.

• Give your full attention to the conversation at hand. It can easily be detected if your attention is split by doing an additional activity while talking.

• Enunciate your words clearly and avoid speaking too quickly.

• Communicate about communicating to supplement for the absence of visual cues. For example, if there is silence, you might politely ask, “Are you there?” or “Did I lose you?”. To explain your silences, you might say something like, “I’m thinking about what you’ve said.” To get more feedback from the client, you could prompt them by saying, “Tell me about your reaction to what I’ve said.”

• In the absence of nodding your head in understanding, use small utterances that don’t interrupt the speaker to let them know you are listening. For example, “hm” and “okay.”

(continued)
DEMONSTRATING EMPATHY

There are several skills and behaviors that help social workers build rapport with their clients. Paramount among these relates to the social worker’s ability to communicate empathy. Empathy refers to “the act of perceiving, understanding, experiencing, and responding to the emotional state and ideas of another person” (Barker, 2003, p. 141). Empathy involves putting oneself in the other’s shoes and conveying an understanding of the client’s emotions and perceived reality. Through empathic understanding of the client’s internal and external experiences, the social worker develops rapport and a basic framework for a positive and constructive relationship. Research indicates that the use of empathy corresponds to beneficial results (Bohart & Greenburg, 1997; Eisenberg, Spinard, & Sadovsky, 2005; Forrester, Kershaw, Moss, & Hughes, 2008; Hoffman, 2000; Jensen, Weersing, Hoagwood, & Goldman, 2005; Watson, 2002). Social workers communicate empathy with their clients via statements, facial expressions, physical gestures, tone of voice, actions, and a sense of being present for the client.

The ability to empathize with others involves several core competencies some of which are largely automatic and others that require enhanced consciousness combined with deliberate practice. Humans have an innate tendency to imitate others due to “mirror neurons” that exist in the human brain. These neurons account for our tendency to mimic the behavior of another and feel as though we are sharing in the experience of the person we are observing (Gerdes & Segal, 2009). Decety, along with others (Decety & Jackson, 2004; Decety & Lamm, 2006; Decety & Moriguchi, 2007), call this phenomenon “affective sharing,” and consider it to be one of four essential components needed for a complete and in-depth experience of empathy. They conceptualized that empathy also involves “self-awareness, mental flexibility, and emotion regulation” (Decety & Moriguchi, 2007, p. 4). In this view, self-awareness refers to the ability to distinguish between oneself and another even when sharing the same feelings (Decety & Moriguchi, 2007). Mental flexibility, also referred to as “perspective taking,” occurs in the thinking part of the brain (executive functioning) and facilitates a rational understanding of the other’s
experience, while also maintaining awareness of what the self is experiencing (Gerdes & Segal, 2011). Emotion regulation refers to the ability to manage one’s emotional responses. For example, when a client describes discriminatory practices in his workplace, the practitioner contains the outrage she feels because failure to do so would draw attention away from the client’s needs. All of these components are essential for social workers to be empathic but also to avoid overburdening themselves with their clients’ problems, which can lead to compassion fatigue and burnout (Gerdes & Segal, 2011). An extensive discussion about compassion fatigue and burnout can be found in Chapter 10.

In addition, the concerned and sincere identification with the client, coupled with emotional and mental detachment, enables the worker to provide a more objective perspective in order to be helpful to the client (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2013).

Gerdes and Segal (2009) suggest that for social workers, empathy must include the additional step of “conscious decision making to take empathic action” (p. 120) with and on behalf of the client. Doing so, they propose, aligns with the social worker’s person-in-environment perspective and commitment to social justice. For example, Lydia, a social worker, is seeing Jeff who is on parole for assaulting a woman on the street. In the course of their work together, Lydia learns that Jeff was abused as a child. Lydia’s disdain for Jeff’s criminal behavior initially made it difficult for her to feel any connection with him. However, she found that she could empathize with his plight as an abused child. This allowed her to be more helpful to Jeff and also prompted her to become an advocate for abused children.

Being able to effectively respond with empathy requires that practitioners be astute observers of their clients’ words, stories, tone of voice, cultural context, and body language. Such concentrated attention requires that social workers learn to manage both external and internal distractions that keep them from being attentive observers and listeners. Internal distractions include mental activities of theorizing, categorizing, and formulating how one will respond (Gerdes & Segal, 2011) as well as personal distractions such as whom the worker will be seeing later in the day or after work activities.

A practitioner’s emotional reactions may also become a distraction and produce barriers to being attentive and present with a client, which is why the ability of workers to regulate their emotions is so important. At times, emotional regulation takes the form of judgment and negatively impacts the ability to feel empathy (Gerdes & Segal, 2009). When practitioners believe that clients should experience negative emotions as a result of their behavior, the worker’s degree of empathy is likely to be diminished (Davis, 1996). Judgment and its resulting interference with empathy can occur anytime a worker makes a determination about whom she considers deserving of care (Gerdes & Segal, 2009). For example, in the case of Lydia’s work with Jeff in the earlier example, her initial judgmental response to Jeff’s behavior hindered her ability to feel empathy toward him. Because biases, assumptions, and value judgments are ingrained, subtle, and hidden, even from one’s self, it is imperative that social workers challenge themselves to think critically, question their assumptions, and not be afraid to admit shortcomings in this area. Mindfulness practices are tremendously beneficial to help social workers achieve the ability to have affective sharing, self-awareness, mental flexibility, and emotion regulation thus enabling them to experience greater empathy with their clients (Gerdes & Segal, 2011).
THE MECHANICS OF EMPATHY

Understanding and refining one’s capacity to employ the core competencies of empathy stated earlier enable beginning social workers to more effectively learn the concrete skills associated with empathic communication. These skills include the ability to recognize stated and unstated feelings expressed by clients, reflect those feelings back to clients in an accepting and nonjudgmental manner, and help clients access underlying feelings and motivations (Hepworth et al., 2013). Empathic responses can range from mildly empathic to highly empathic and various scales exist that delineate these different levels. The following levels of empathic responding are adapted from Hepworth et al. (2013) with the added lens of the SBDP approach. The responses range from minimal to full appreciation for the client and convey varying degrees of respect and understanding. The SBDP approach to empathic communication is outlined as follows:

SBDP APPROACH TO EMPATHIC COMMUNICATION

Level 1: Minimal Appreciation for Client

This type of interaction fails to communicate empathy to the client. Responses in this category are not attuned to the client’s feelings, circumstances, or cultural background as evidenced by changing the subject, minimizing, moralizing, giving advice, or other responses that shut down communication. A minimal appreciation level of responding includes no mention of the client’s feelings, strengths, and resiliencies and makes no attempt to gauge the impact of the worker’s statements on the client. Coping capacities are overlooked or regarded negatively rather than viewed and accepted as strengths upon which to build. This level of responding may also involve use of body language or tone of voice that conveys disinterest or negative judgment. These types of responses often cause clients to become confused, defensive, argumentative, or withdrawn, thus impeding the worker–client relationship.

Client Statement: “Out of everything, my biggest worry is housing. I’ve put in applications, but they all tell me the waiting list is really long.”

Level 1 Responses:

a. “I told you that would happen, remember? You should have applied sooner. Since you’re low income, you’ve just got to be patient” (ignores feelings, judgmental, condescending).

b. “Have you considered getting a roommate? That would help you save money” (gives advice and does not acknowledge feelings).

c. “You know, there are lots of people trying to get subsidized housing. The city budget cuts haven’t helped and the local homeless population has grown” (moves the conversation away from the client and fails to acknowledge the client’s feelings).

Level 2: Partial Appreciation for Client

This level of responding includes some but not all of the components that express Accurate Appreciation (see Level 3 in this section) or Full Appreciation.
(see Level 4 in this section) of the client. The client’s situation may be acknowledged, but there is only vague or superficial reference to feelings, strengths, or cultural background. Partial appreciation may also manifest in judgmental interpretation, or inappropriate reassurance. Efforts to check for accurate understanding between worker and client are absent or inadequate and client strengths are not mentioned. Responses at this level may also include body language and tone of voice that is negative and/or inconsistent with the verbal statements being made. An extensive vocabulary related to emotions in addition to familiarity with words that convey strengths is one way to help workers move beyond partial appreciation responses.

Client Statement: “Out of everything, my biggest worry is housing. I’ve put in applications, but they all tell me the waiting list is really long.”

Level 2 Responses:

a. “So, housing is one thing you are working on. Did they tell you how long the wait could be?” (ignores feelings).

b. “You are concerned about securing housing with the long wait lists. That’s why you can’t procrastinate on getting your application in” (reflects feelings only superficially, implies judgment).

c. “Housing is your biggest worry. I’m sure something will open up for you. You also need to work on finding a job” (vague reference to feelings, inappropriate reassurance, changes the subject).

Level 3: Accurate Appreciation for Client

Responses in this category communicate empathy by demonstrating appreciation and accurate understanding of both the information and the emotions the client is communicating. Practitioners do not merely parrot what the client says, but provide responses in their own words to avoid appearing stiff and disingenuous. Body language, word choice, and tone of voice are congruent with the worker’s authentic concern. This level of responding includes active checking for understanding and an appreciation of the client’s culture, resources, and coping skills. It paves the way for elaboration, exploration, and productive collaboration in the relationship. While client strengths may or may not be verbalized at this level, the demeanor and phrasing used by the practitioner do not imply any negativity, judgment, or disinterest. Beginning practitioners should strive to master communicating empathy at this level.

Client Statement: “Out of everything, my biggest worry is housing. I’ve put in applications, but they all tell me the waiting list is really long.”

Level 3 Responses:

a. “If I’m hearing you correctly, you’re feeling pretty anxious about where you will live and you’re concerned that the subsidized housing you’ve applied for won’t be available when you need it” (checks for accurate understanding, acknowledges feelings and circumstances).

b. “Despite your determination, you’ve applied for housing but nothing has come open which makes you very worried” (shows appreciation for coping skills, acknowledges feelings and circumstances).

c. “Although you’re juggling a lot of things right now, you’re especially nervous about finding a place to live because of the long waiting lists” (acknowledges coping skills, feelings, and circumstances).
Level 4: Full Appreciation for Client

Responses at this level go beyond Level 3 by including statements that reflect clients’ strengths. This level of responding can also help clients get in touch with both expressed and unexpressed feelings and encourage them to consider problems in greater depth and with new perspectives and insights. It is achieved by using rich vocabulary along with deliberate intonation and body language that reflect the subtleties of the client’s experience. Strengths-based empathy at this level often helps to illuminate goals and solutions for the client. It includes an understanding of the client’s cultural identities and backgrounds. This depth of connection occurs more organically when there is an established and trusted relationship between the social worker and client. Thus, with the exception of highlighting strengths, it should not be used extensively in the beginning phases of the helping process so that the client can first develop trust in the worker.

Client Statement: “Out of everything, my biggest worry is housing. I’ve put in applications, but they all tell me the waiting list is really long.”

Level 4 Responses:

a. “You’ve been working hard to get your housing situation settled but you’re beginning to feel frantic since the waiting lists are so long and you haven’t seen results yet. I imagine you must be worried you will end up on the streets again if you can’t find anything and that thought really scares you. Have I got that right? (Client nods in agreement.) Would you like to explore other housing options besides government subsidized housing?” (acknowledges circumstances, expressed and unexpressed feelings, the depth of the problem, and points toward a solution).

b. “It must be very upsetting to hear such discouraging news about getting housing, especially after your experience of being temporarily homeless. I admire that you are working so hard to prevent that from happening again. How about we work together to see if we can find some other options for you?” (acknowledges client feelings, circumstances, strengths, and cultural identity, and offers a solution).

The most basic formula for composing empathic responses is one that reflects the client’s feelings and the content of the client’s message. As stated earlier, social workers are advised to familiarize themselves with a wide vocabulary of feeling words to use when paraphrasing clients’ expressions. This allows clients (who often do not have an extensive emotional vocabulary) to feel that the social worker genuinely understands them while also encouraging deeper exploration of feelings. In addition, it is beneficial for beginning social workers to practice using different lead phrases that can check for accurate understanding and make the response seem less mechanical and check for accurate understanding. Examples of such phrases include: “I wonder if ...,” “If I’m hearing you correctly ...,” “You must have felt ...,” “It sounds as though you are feeling ...,” “Have I got that right?” “Am I understanding you correctly?” (Hepworth et al., 2013, p. 107). In addition to word selection, intonation and body language are essential elements of empathic communication, often overriding the impact of verbal expressions. Therefore, workers will want to strive for an open posture, affirming gestures, and minimal fidgeting.
ENGAGING INVOLUNTARY CLIENTS

When working with involuntary clients, communicating empathically is a greater challenge as such clients are typically unwilling to be vulnerable by exposing their thoughts and feelings. In such circumstances, social workers can empathize with what is immediately apparent by the client’s statements and behavior. For example, social workers can express empathy with having to participate in activities that are not of their choosing, being made to feel inadequate or inferior, being expected to share personal information with persons they do not know or trust or feeling that they are not in control of their lives. Once clients feel that the social worker wants to understand them and sincerely cares for them as persons, they often feel secure enough to engage with the worker at a deeper level. Consider the following examples of empathic responding with involuntary clients:

A teenager is mandated to attend drug and alcohol counseling by the juvenile court. She sits in her chair, arms crossed, looking at the floor, and not responding to the social worker’s questions.

Worker: “I imagine you might be feeling pretty ticked off at having to come here. You probably have other things that you’d like to be doing.”

A parent is mandated to attend parenting classes by child protective services.

Parent: (in an angry tone of voice) “They told me I had to do this so I can get my kid back.”

Worker: “It sounds like you feel really resentful at having others tell you how to raise your child.”

As in the earlier examples, when a client does not directly state her feelings, the social worker tries to intuit how the client is feeling and verbalize this to the client. If the social worker incorrectly guesses the client’s emotional response, the client will usually correct the worker, as in the following example:

Worker: “It sounds like you are feeling really angry at having to spend time in these classes. Have I got that right?”

Client: “I don’t mind the classes. I’m just angry that I can’t see my kid and in the meantime, she is having to stay with someone she doesn’t even know!”

Despite the social worker’s initial inaccuracy, this is still regarded as successful engagement of the client because it prompted the client to open up about thoughts and feelings.

Empathic communication from a strengths-based approach involves the added step of observing client strengths and verbalizing those strengths to the client. At the beginning of the relationship, it may be difficult to identify specific strengths, but general statements that acknowledge a client’s courage to seek help, openness to change, and tenacity and desire for improvement can build rapport and communicate empathy. Social workers will want to pay particular attention to strengths inherent in a client’s cultural identity and background. The following case scenario utilizes the SBDP framework in the initial encounter with a client.

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CASE SCENARIOS

CASE 4.1

Identifying Information:
Client Name: Anthony
Age: 14 years old
Relationship Status: Single
Race/Ethnicity: African American
Educational Level: High school
Members of Household: Foster parents Mr. and Mrs. Jones; parents incarcerated
Setting: Greater Balcones foster care program
Social Worker: Anne

Anne works as a caseworker in the Greater Balcones foster care program. Her new client is Anthony, a 14-year-old African American male who was recently removed from his home. Anthony’s file states that his parents were incarcerated for child abuse and selling drugs. He has been living with his foster family, the Joneses, for 2 weeks. Mr. and Mrs. Jones report that Anthony has often been unwilling to cooperate with their house rules, including going to school.

Anne goes to the waiting room and calls Anthony’s name. No one responds. She sees a young teenager in the corner, slouched in his chair, eyes closed as if asleep. Anne walks to him, bends down so she is eye level with him and gently calls, “Anthony? Anthony?” The young man stirs and awakes from his nap. “Hi. Are you Anthony?” Anne asks.

“Uh, yeah,” he says.

“Hi Anthony, I’m Anne. I’m your caseworker,” she says while extending her hand. Anthony keeps his hands in the pockets of his jacket and looks at Anne as if sizing her up. “I’m here to talk with you about how things are going for you with your foster family. Will you come back to my office with me?”

Anthony sighs heavily but stands and follows Anne to her office. “Looks like you were taking a nap,” Anne says cheerfully. “Are you sleepy today?”

“Yeah,” Anthony says rubbing his eyes.


“Nah,” Anthony shakes his head as he plops himself on the couch. He takes in Anne’s office and notices that it is organized, neat, and has a comfortable feel about it. He reaches for one of the couch pillows and holds it to his chest. He thinks to himself that he might be able to relax a little in here if he decides he can trust Anne.

“Are you sure?” Anne asks. Anthony shakes his head. “OK, well, let me know if you change your mind.” She pauses, “So let me explain who I am and how we’ll be working together. I know you’ve been through a lot lately and are having to live in a strange situation with people you don’t really know. That’s a big adjustment and not an easy one.” Anne pauses to see if Anthony wants to respond to what she has said. When he remains silent, she continues, “Part of my job is to make sure you are being treated well in your foster home, that you are safe and have what you need. I’ll do my best to answer any questions you have about your family and how foster
care works. Also, I really hope that with time you will feel comfortable talking with me about any difficulties you are having, be it in school, with friends, at home, or with thoughts and feelings you have. Does this make sense to you, so far?"

Anthony nods.

Anne then outlines when and how often she will see Anthony, how he can contact her if needed, and explains the limits of confidentiality. "Anthony, do you have any questions about what I've explained?"

"No," Anthony says.

"So, you have been with the Jones family for about 2 weeks now, is that right?"

Anthony nods. "Tell me about how things are going for you over there."

"Mmmm ... meh," Anthony responds and then is quiet.

Anne waits, hoping he will add more. When he doesn't she says, "So not so great, huh?" Anne asks. Anthony shakes his head. Anne ventures, "It must be really hard to be away from your home and then to be in a place where things aren't going well—that's like a double hit."

"Yeah," Anthony admits.

"Many kids are really surprised by being suddenly taken from their home and placed in a completely new situation. Was that how it felt for you?"

"Yeah," Anthony says nodding. "I never thought I would be in foster care." He raises his head and for the first time makes eye contact with Anne. "I knew my parents might go to jail someday because they were doing drugs and stuff, but I always figured I'd stay with my Grandma or my Auntie." Anthony returns his gaze to his shoes as tears well up in his eyes.

Anne leans forward and softly says, "I can see that this is really rough for you. You feel really hurt that you aren't able to stay with your family." Anthony nods as tears fall down his face. "What's your understanding of why that didn't happen?"

"I don't really know why. I guess it's too much of a burden for them. Or they just didn't want me ... But, geez, they're family! Now I've got to live with these ..." Anthony cuts himself off.

"Yeah, that must be really hard, Anthony. I imagine it feels as though you've lost your parents and your other family members all at once." Anthony nods. "That's a huge change. Your whole world has been turned upside down."

Anthony nods, "It really has."

"What's going on at the Joneses? What about being there is hard for you?" Anne asks.

"They're just so annoying. They're onto me about going to school and they've got all these rules," Anthony explains. "I don't like it there."

"Is that very different from what you are used to?" Anne asks.

"Yeah, for sure," Anthony responds. "I'm used to doing my own thing. I go to school when I want to. I go to bed when I'm ready. I don't need people telling me what to do!"

"So, you're a very independent person," Anne says.

"I am. I'm my own person. I don't even know these people and they want me to act like nothing happened, like it's no big deal. And they keep making these comments about how drugs are bad and I better not be doing any drugs because bad people do drugs."

"It's hard for you to hear them say those things. What about that bothers you?" Anne inquires.
“They’re basically saying my parents are bad people because they did drugs! And they’re not! They’re not bad people!” Anthony says with a raised voice and more tears.

“You’re loyal to your parents and it hurts you to hear someone put them down.” Anthony nods. Anne continues, “And on top of that, you’ve got all these new expectations that have been put on you by the Joneses, which makes you really angry,” Anne suggests.

“Yeah, it does make me angry!” Anthony says emphatically. “I can’t stand it!”

“I’m sorry you are having to go through all of this, Anthony. For someone who is so independent like you, it must feel like torture to have all these rules put on you,” Anne says.

“It sure is. I don’t think I can stay with this family, Miss. Do I have to stay with them?” Anthony pleads.

“You’re really not liking it at the Jones’s house and you’d rather stay with someone else,” Anne reflects.

“Yeah, I mean, maybe I can stay with my cousin. I don’t know. I just really don’t want to stay with these people. I don’t feel comfortable there. I’d rather be by myself than be with them.”

“It sounds like you are feeling so miserable with the Joneses that you’ll do just about anything to not be there. Is that accurate?” Anne confirms.

“That’s right. Can you help me with that?” Anthony asks.

“I know you are going through a lot and I want to do what I can to make things easier for you. I can’t make any promises, but we can certainly talk more about how to make your situation better. There may be things I can do; there may be things the Joneses can do; and there may be things you can do. Would you be willing to work with me and see what we can come up with?”

“Yeah, ok.”

“Thanks for agreeing to work with me, Anthony,” Anne says. “I know it’s hard to trust someone whom you’ve just met and I admire your courage for doing that.”

4.1-1. In what ways does Anne communicate respect and nonjudgmental support to Anthony?

4.1-2. Give two examples of how Anne attempts to engage Anthony in the helping relationship. Were these attempts successful? If so, how?

4.1-3. Identify a statement Anne made that is reflective of Anthony’s strengths.

4.1-4. Provide two examples of how Anne’s body language communicates her desire to engage with Anthony.

4.1-5. What does Anne say to Anthony that indicates her empathic understanding of his situation? Choose an empathic statement and indicate its level of empathy based on the strengths-based direct practice approach to empathic communication.

4.1-6. Why did Anthony move from being withdrawn to engaging with Anne?

4.1-7. Did Anne effectively execute Tenet 4 of the SBDP approach? Explain your answer.
CASE 4.2

Identifying Information:
Client Name: Anthony
Age: 14 years old
Relationship Status: Single
Race/Ethnicity: African American
Educational Level: High school
Members of Household: Foster parents Mr. and Mrs. Jones; parents incarcerated
Setting: Greater Balcones foster care program
Social Worker: Velma

Velma works as a caseworker in the Greater Balcones foster care program. Her new client is Anthony, a 14-year-old African American male who was recently removed from his home. Anthony's file states that his parents were incarcerated for child abuse and selling drugs. He has been living with his foster family, the Joneses, for 2 weeks. Mr. and Mrs. Jones report that Anthony has often been unwilling to cooperate with their house rules, including going to school.

Velma goes to the waiting room and calls Anthony's name. No one responds. She sees a young teenager in the corner, slouched in his chair, eyes closed as if asleep. Velma walks over and calls down to him, “Anthony?” When there is no response she repeats more loudly, “Anthony!” The young man stirs and awakes from his nap. “Are you Anthony?” Velma asks.

“Uh, yeah,” he says.

“I'm Velma. I'm your caseworker,” she says. Anthony looks at Velma as if sizing her up. “It's time for our appointment. Follow me, please.”

Anthony sighs heavily, stands, and follows Velma to her office. “You're tired, huh? Are you not getting enough sleep?” Velma asks. Anthony shrugs. Velma motions to the couch, “Have a seat.”

Anthony plops himself on the couch and takes in Velma's office. Her desk is in disarray, covered in papers and empty fast food containers. She spends a minute or so shuffling through the papers. “Now where did I put that file?” she says to herself but loud enough for Anthony to hear.

Velma begins, “As I said, I'm Velma, your caseworker. I'm here to help you and make sure things are going OK in your foster home.” Velma goes on to explain the limits of confidentiality and then begins asking questions about his school, grades, other children in the foster home while looking at her forms and making notes. Anthony answers with nods, shrugs, and one word answers and frequently glances at the door.

“So, you have been with the Jones's family for about 2 weeks now, is that right?” Anthony nods. “How are things going over there?”

Anthony shakes his head and says nothing.

Velma waits, hoping he will add more. When he doesn't she says, “I know it's hard to lose your parents, but I can't help you if you won't talk to me,” Velma says. Velma pauses. When Anthony doesn't respond, she tries again, “Are you getting along with everyone in the Jones's house?”

Anthony sighs heavily. “It's OK.”

“Do you understand why you are in foster care, Anthony?”
“Yeah,” Anthony says nodding. “My parents went to jail.” He pauses, "And my Grandma said she couldn’t take me.” Anthony gazes at his shoes as tears well up in his eyes.

“You miss your parents and wish you could be with your Grandma,” Velma says. "I’m sure you’ll get used to the Jones’s house with time," she adds. Anthony wipes his tears with his sleeve, sits back, and crosses his arms.

Velma says, "I know it’s a big adjustment, but the Joneses are there to help you. I think if you would cooperate with them and let them know you’re grateful to have a place to stay, it will be easier for you. Would you try to do that for me, please?"

"I guess," Anthony responds.

“Great!” Velma says. "We’ll meet again in a few weeks, OK? In the meantime, try to stay out of trouble and let me know if you need anything. I’m here for you, Anthony.”

4.2-1. Give two examples of how Velma attempts to engage Anthony in the helping relationship? Were these attempts successful? Why or why not?

4.2-2. What does Velma say to Anthony to communicate empathic understanding of his situation? Choose an empathic statement and indicate its level of empathy based on the strengths-based direct practice approach to empathic communication.

4.2-3. In your opinion, does Velma fulfill Tenet 1 of the SBDP approach? Explain your answer.

4.2-4. Give two examples of how Velma’s behavior hinders the engagement process with Anthony.

4.2-5. Evaluate Velma’s approach to Anthony from the SBDP perspective. In what ways is she aligned or misaligned with the SBDP framework?

4.2-6. Do you think Anthony trusts Velma? Why or why not?

CLASS ACTIVITIES

4.3 Plan a trip to a coffee shop for an hour. Your assignment is to observe personal interactions between two or more people. Pay particular attention to body language, tone of voice, proximity to each other, animation level, eye contact, physical touch, and other nonverbal cues. In addition, focus on the coffee shop environment. Note the noise level, the ambiance, the number of persons at the shop, and so on. How does the environment impact the manner in which people engage with each other and converse? Identify correlations between these communications and the level of engagement you observe between people. Provide a written summary of your observations and personal and professional insights gleaned from this activity.
4.4 Use the Internet to find vignettes from videos, movies, books, or other forms of social media that demonstrate varying degrees of empathy. Be prepared to make a short class presentation of two of these media representations and describe the level of empathy in each. If the level of empathy is at Level 1 or 2, provide responses that would increase the level to 3 or 4.

4.5 Make a communication and behavior handbook to increase your fluency in empathic communication. Include lists of feeling words, lead-in phrases, phrases for further questioning, and phrases to check for understanding. Also, include body language and behaviors that communicate empathy.

4.6 Respond empathically to the following client statements. Aim to respond at Level 3 empathy or higher.
   a. "Nothing works out for me. It doesn’t matter how hard I try."
   b. "My mom won’t listen to me. She thinks I’m still 10 years old."
   c. "My boss is driving me crazy. He just piles more work on me and expects me to have it done by tomorrow."
   d. "I don’t understand why I’m so upset. I know this problem shouldn’t be that important."
   e. "I bet you think I’m an idiot. I just can’t seem to figure out what to do next."

INDIVIDUAL ASSIGNMENTS AND PERSONAL REFLECTIONS

4.7 Complete the Empathy Scale for Social Workers by King and Holosko (2011). The scale can be found at the following website (www.academia.edu/23419591/Empathy_Scale_for_Social_Workers). Rate your findings and write one paragraph each on your strengths and areas for growth with regard to empathy.

4.8 Make a conscious decision to practice empathic responding to a friend. Write a reflection on this experience. Include the level of difficulty you experienced, how your friend reacted, how it made you feel, and what the outcomes were.

4.9 Use the Internet to find a simple mindfulness activity such as the “raisin meditation.” Complete the activity per the instructions provided and write a reflection on this experience. Note the level of ease or difficulty you experienced, the thoughts that arose, the emotional responses you encountered, and additional observations, thoughts, and insights. How might practicing mindfulness enhance your ability to work with clients?
REFERENCES


INTERVENTION

A fundamental concern for others in our individual and community lives would go a long way in making the world the better place we so passionately dreamt of.

— Nelson Mandela, Sixth Annual Lecture, July 12, 2008

Selecting and implementing interventions become the focus of the helping relationship after the social worker and client have completed the initial assessment and identified goals they will pursue. In choosing interventions, the strengths-based practitioner considers several factors to ensure that the intervention will be a good fit for the client. It should be noted that assessment is an ongoing process throughout the working relationship. As the client moves forward or is confronted with additional barriers toward achieving her goals, reassessing the client’s status is important and informs the client and social worker about any modifications to the initial intervention strategy. This chapter details the factors that must be considered when identifying interventions and outlines a few of the more prevalently used modalities. The practitioner develops the intervention plan utilizing the assessment outlined in Chapter 5, based on the context and needs of the client (Table 6.1).

CHOOSING INTERVENTIONS

When choosing the type of intervention to use with a particular client, many factors must be considered. The following questions can serve as a guide for choosing relevant interventions:

- If successful, will the intervention help the client achieve the stated goals?
- Does the practitioner possess the skill level necessary to competently guide the intervention?
- Can the intervention be successfully carried out given any time constraints that may be present?
- Is the intervention congruent with social work values of client self-determination and empowerment? (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2013)
- Does the intervention leverage the client’s strengths, or involve the development of new strengths?
- Is the intervention compatible with the unique attributes of this client, with regard to the client’s cultural identity and context?
### TABLE 6.1 Strengths-Based Direct Practice (SBDP) for Intervention

<table>
<thead>
<tr>
<th>SBDP TENET</th>
<th>SBDP TENET OVERVIEW</th>
<th>PRACTITIONER APPLICATION OF TENET</th>
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<tbody>
<tr>
<td>1</td>
<td>Given the appropriate support and guidance, all persons have the capacity to improve their lives. Clients benefit by knowing that respectful and nonjudgmental support is available to them as they work to achieve their goals.</td>
<td>Practitioners regard clients from a view of possibility and a belief in their capacity to grow. This is communicated to clients via encouragement and support for achieving goals.</td>
</tr>
<tr>
<td>2</td>
<td>All persons have individual and environmental strengths that can assist them throughout the helping process. Clients benefit from the reinforcement of those strengths and the encouragement to consciously employ them during the helping process.</td>
<td>The process of achieving goals should leverage the clients’ strengths. Practitioners recognize that a goal may be achieved in many different ways and consequently, support the execution of goals in a manner that is aligned with the clients’ strengths.</td>
</tr>
<tr>
<td>3</td>
<td>The helping process is fertile ground for personal growth and the development or enhancement of the clients’ strengths.</td>
<td>The effort involved in working toward goals gives clients the opportunity to discover and develop strengths that may have been outside their awareness as they stretch beyond their comfort zone and what they originally perceived as possible for themselves.</td>
</tr>
<tr>
<td>4</td>
<td>Improving one’s life is a gradual process that takes varying amounts of time and effort. Experiences of discomfort and resistance to change are expected reactions in the helping process and are not inherently pathological or indicative of weakness.</td>
<td>Resistance and noncompliance in working toward goals may be indicative of strengths that were beneficial to clients in other settings. Practitioners do not demonstrate disappointment or frustration with clients as they struggle to achieve their goals. Rather, they recognize the clients’ willingness to engage in the struggle as a strength.</td>
</tr>
<tr>
<td>5</td>
<td>The quality of the helping relationship can either help or hinder clients’ capacities to make improvements in their lives.</td>
<td>Practitioner’s earned trust, demeanor, and tactics have great influence on the client’s capacity to engage in the effort required to achieve goals. Unconditional positive regard plays a pivotal role in facilitating the client’s ability to take the risks often necessary for change.</td>
</tr>
<tr>
<td>6</td>
<td>Interactions with clients should aim to support clients’ aspirations, competencies, confidence, and individual and environmental strengths.</td>
<td>Practitioners look for possibility rather than problems and view obstacles as something that merely requires more effort or a different strategy. Interventions involve helping clients leverage strengths that are already developed and/or to develop strengths that would be useful to them in the change process.</td>
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(continued)
### TABLE 6.1 Strengths-Based Direct Practice (SBDP) for Intervention

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<tr>
<td>7</td>
<td>Consideration of a client’s cultural background aids in the understanding of the client’s circumstances and life experiences, and thus enhances the helping process.</td>
<td>Practitioners are cognizant of the fact that cultural background plays a role in what interventions will be helpful. Intervention methods chosen should be tailored to stay in alignment with the client’s cultural beliefs and values and build on the strengths inherent in the client’s cultural affiliation.</td>
</tr>
<tr>
<td>8</td>
<td>All persons are impacted to varying degrees by the interactions they have with other people. Maintaining awareness of how interactions are being received by clients is essential to a productive helping relationship.</td>
<td>Throughout the intervention phase of the helping relationship, practitioners are mindful of the client’s investment, level of comfort, and readiness for change. Practitioners address any deficits in these areas with compassion and awareness that they (the practitioner) may be part of the difficulty.</td>
</tr>
<tr>
<td>9</td>
<td>When communicating with clients, the worker should use verbal statements, listening styles, and body language that honor the value and dignity of clients.</td>
<td>The effectiveness of interventions is influenced by the manner in which they are delivered. Condescending, impatient, and authoritarian attitudes will impede the success of the intervention.</td>
</tr>
<tr>
<td>10</td>
<td>Clients are more receptive to opportunities when interactions contain elements of unconditional and genuine positive regard and an emphasis on their individual and environmental strengths.</td>
<td>Even when interventions do not produce the desired results, practitioners maintain a respectful attitude in their communication and interactions with the client. Recognizing that clients will confront obstacles in their progress allows practitioners to communicate an empathic understanding toward clients during these times, and is crucial to future change efforts.</td>
</tr>
<tr>
<td>11</td>
<td>All interactions are an opportunity for both the worker and client to learn and grow. Rather than an authoritarian relationship, the practitioner collaborates in an egalitarian manner.</td>
<td>Walking with clients through the intervention process reveals the complexity and uniqueness of the clients’ condition. Being a partner in, and witness to, the life changes clients make gives social workers an enhanced understanding of the human experience as well as providing opportunities for personal growth and insight.</td>
</tr>
<tr>
<td>12</td>
<td>Practitioners should remain mindful of how social and economic disparities may impact their clients. The practitioner’s belief in social justice leads to action-oriented responses when confronted with societal inequities, injustices, and discrimination.</td>
<td>Practitioners recognize that effective interventions may take place on the micro, mezzo, and macro levels. Advocacy on the client’s behalf, and/or to change oppressive societal structures, is essential to being effective.</td>
</tr>
</tbody>
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(continued)
13 Making changes often requires clients to acquire different thoughts, feelings, and behaviors that increase feelings of fear and vulnerability. Adherence to ethical principles of practice provides the necessary safety for these changes to occur and protects clients from unnecessary harm while pursuing their goals.

Practitioners understand that the client, not the practitioner, will be left with the results of the intervention. Therefore, client consent and agreement with the chosen actions is essential. Maintaining professional and ethical guidelines throughout the intervention process is of paramount importance.

TABLE 6.1 Strengths-Based Direct Practice (SBDP) for Intervention (continued)

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</tr>
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</table>

- Is the intervention deemed ethical, valid, and reliable for this specific type of client?
- Is the intervention sensitive to and compatible with the client’s broader environment (Allen-Meares & Garvin, 2000)?
- In addition to micro level client-centered interventions, does the situation call for additional interventions at the mezzo and/or macro level?
- Does the intervention allow for a collaborative approach between practitioner and client?
- Is there any harm that could possibly occur as a result of the intervention?

Practitioners should remain mindful that they may also play a role in implementing change beyond the coaching and instruction given to clients. Effective change may require that workers play some of the varying roles for which they are qualified such as advocate, broker, and facilitator (see Chapter 1). A multisystem approach that intervenes at the micro, mezzo, and macro levels of practice tends to have a greater impact on the sustainability of the changes made and the overall quality of the client’s life. Intervention may also include prevention strategies that mitigate the probability of future challenges.

EVIDENCE-BASED PRACTICE

In recent years, the social work profession has given increased attention to advancing the use of an evidence-based practice (EBP) framework. EBP is defined by Sackett, Rosenberg, Gray, Haynes, and Richardson (1996) as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (p. 71).

The move to EBP originated in the medical profession and was intended to aid doctors in the selection of efficacious treatments for their patients (Jenson & Howard, 2013). The emphasis on EBP has grown rapidly as patients are becoming more knowledgeable and involved in their health care decisions.
Choosing effective treatments as a way to bring down health care spending has also expanded the demand for EBP (Gray, 2001). With regard to social work, EBP attempts to give guidance on “who should deliver the intervention to whom, what intervention is the most effective with which clients, where and at what level should the intervention take place, when should the intervention occur, how long should the intervention continue, and how is behavior change maintained?” (Wodarski, 2004, p. 1).

The drive toward EBP has come to represent a profession’s allegiance to knowledge and practice decisions derived from research-based evidence (Rosen, 2003). EBP purports that interventions verified by scientific scrutiny lead to better outcomes than practice decisions based on authority, tradition, or common sense (Mullen, Bledsoe & Bellamy, 2007).

The EBP framework is characterized by the following steps developed by Sackett, Straus, Richardson, Rosenberg, and Haynes (2000): Identify information needed for practice and construct it into viable questions, find evidence that addresses the questions, determine how the evidence applies to practice methods and policy decisions, and evaluate the process (Sackett et al., 2000). These steps are intended to guide practitioners in the identification and use of EBP models when intervening with clients and evaluating the results of the intervention. Gibbs (2003) suggests that “placing the client’s benefits first, evidence-based practitioners adopt a process of lifelong learning that involves continually posing specific questions of direct and practical importance to clients, searching effectively for the current best evidence to each question, and taking appropriate action guided by evidence” (p. 6).

Encompassed within an EBP framework is the use of empirically supported interventions (ESIs). These are particular practice methods that have been investigated using empirically rigorous and systematic procedures by multiple researchers (Mullen et al., 2007). For example, Johnson, Velasquez, and von Sternberg (2015) developed and implemented an ESI to prevent alcohol-exposed pregnancies and fetal alcohol spectrum disorders (FASDs) for female inmates and evaluated the intervention using scientifically rigorous methods. The FASD prevention intervention was subsequently replicated with other populations and was found to be effective. After many studies had been conducted with positive outcomes, the intervention was deemed to be an EBP model that has been widely utilized by practitioners nationally and internationally.

Also, practice guidelines, sometimes called “best practices,” are available to guide assessment and intervention with clients. Proctor and Rosen (2003) define practice guidelines as “a set of systematically compiled and organized knowledge statements designed to enable practitioners to find, select, and use appropriately the interventions that are most effective for a given task” (p. 108). Practice guidelines are developed by professional and governmental organizations and focus on specific populations, such as depression in adolescents (Mullen et al., 2007). Practice guidelines may be based on research findings on professional consensus if research studies are unavailable or nonexistent (Mullen et al., 2007). Social workers should routinely consult the practice guidelines produced by relevant fields of psychology, psychiatry, and medicine in addition to the practice standards developed by National Association of Social Workers (NASW). Practice guidelines can be accessed through the professional organizations of social work and other pertinent professions as well as the National Guideline Clearinghouse sponsored by the U.S. Department of Health and Human Services (at the website www.guideline.gov).
CHALLENGES OF EBP

The move toward EBP in the profession of social work is not without criticisms and challenges. There are numerous factors that make the utilization of an EBP framework difficult for social workers. First, there is a dearth of research available that meets the criteria of EBP in comparison with the numerous problems clients present to social workers and the infinite factors involved in the human condition. Such research has not been undertaken or lacks the sample size to qualify as evidence-based research (Adams, Matto & LeCroy, 2009). Second, the ability of researchers to finance studies is influenced by numerous factors including the funders of the research, the current social and political climate, and the availability of limited resources. This means that when research on one intervention is funded, other interventions are not. The result is that data are available only for those interventions that were able to secure funding. Some practices that are widely regarded as successful do not have empirical research that supports them. For example, 12-step programs within the Alcoholics Anonymous organization forbid scientists from doing studies on the efficacy of their programs, but are anecdotally considered effective by participants. Third, even when research studies are available, translating those results and techniques to real-world practice can be difficult. Fourth, the pragmatic nature of social work must include the consideration that interventions used are not only effective but provide the greatest possible benefit at the least cost with efficient use of limited resources (Rosen, 2003). Fifth, in some cases, even though an intervention is considered to be EBP, it can have a built-in cultural bias. Thus, care must be taken when generalizing practice models that are effective with one population to all cultural groups (Marsiglia & Booth, 2014). Finally, many social workers lack the training required to locate and critically examine evidence-based research, and therefore, more education and training on this skill set needs to be provided to students and practitioners (Weissman & Sanderson, 2001).

INTERVENTION MODELS

Task-Centered Practice Approach

The task-centered practice (TCP) approach, developed by Reid and Epstein (1972), can be used with individuals, families, and groups and is designed to be delivered in 8 to 12 sessions. The primary elements of TCP have become so widely integrated into social work that many practitioners do not know it by name but simply consider it to be “good social work practice” (Kelly, 2013, p. 5). TCP consists of three phases that involve structured meetings with the client to help her successfully reach her goal. Those phases are discussed as follows:

TCP begins by identifying the target problem and the goal or goals that the client wants to achieve. It is recommended that no more than three goals be identified and then prioritized to determine which goal will be addressed first. In keeping with this approach to goals, TCP emphasizes the importance of the client’s preferences and strengths (Kelly, 2013). Once the goals have been identified and agreed upon, the practitioner and client work together to identify general tasks to be completed by both parties. These general tasks are then broken down into smaller, more specific tasks. The client and worker agree on who will complete each task and set deadlines for completion. For example,
Maria is a Hispanic single mother who does not speak English well. She would like to enroll in an English literacy program, locate childcare while attending classes, and ultimately be able to read to her children. She and her social worker determine that locating an English literacy program on the bus line and finding childcare are the first two tasks to accomplish. The social worker agrees to provide a list of potential programs near Maria’s neighborhood by the next session. Maria commits to asking her friends and family if they will keep her children during the classes.

The process of generating tasks is collaborative in nature and may require some brainstorming if they are not immediately evident (Hepworth et al., 2013). Brainstorming tasks allows for consideration of a wide variety of options and can direct the client’s focus toward possibilities, rather than obstacles. Ideally, clients participate in the process of generating ideas and choosing the path to be followed. This follows the strengths-based orientation by creating “buy-in” and motivation in/from the client and forming a collaborative relationship with the worker. Generally, tasks that are perceived as being chosen for the client are inconsistent with a strengths-based approach and far less effective. Practitioners will want to pay close attention to the client’s nonverbal communication to ensure the client is in agreement with the chosen task (Hepworth et al., 2013).

The following example exemplifies the TCP approach in action. Leticia is a 26-year-old mother of two young children aged 5 and 3 years. The social worker, Marsha, has been working with Leticia for the past 2 weeks on improving her parenting and coping skills. Leticia has made significant progress in this area and wants to obtain a job to supplement the family income. Leticia’s husband, Roy, works the night shift at a grocery store. Although Leticia has worked on and off between pregnancies as an on-call respiratory therapist, she now wants to obtain a full-time position. She tells Marsha she wants to get a job in the next 2 weeks. She and Marsha discuss the practicality of this given that it will take time to get applications submitted to potential employers, find affordable childcare, and interview for positions. Working collaboratively, Marsha and Leticia decide that the next task will be to submit applications and locate childcare near her home.

The next phase of TCP involves implementing the identified tasks and tracking the progression toward the goal. Frequently this involves both client and worker executing tasks between sessions and reporting back on progress made. In preparation for implementing tasks, the task implementation sequence (TIS) (Reid, 1975, 2000) is initiated in order to increase the likelihood that the tasks will be completed. The TIS involves the following steps:

1. **Strengthening commitment**: This can be achieved by engaging the client in a discussion about the potential benefits of achieving the task, clarifying how it fits into the larger goal, and pointing out ancillary benefits that may not be readily apparent. If the task feels especially challenging to the client, the worker may help the client identify a tangible reward the client can give to herself after completing the task. In the previous example with Leticia and Marsha, they discuss the benefits of submitting multiple applications and having more than one job offer in order to secure the best salary and benefit package.

2. **Strategizing task execution**: This step involves collaboratively discussing the practical logistics of conducting the task, including when, where, and the precise actions the client will take. The worker may help the client outline specific steps to take, make suggestions
for alternate approaches, and provide encouragement to the client. For example, Leticia and Marsha discuss optimal times for completing applications, given the schedule and needs of her children. Leticia concludes that she will need at least 2 weeks to complete these tasks. She decides she can be more focused if she uses the children’s nap time as her designated time for submitting applications.

3. **Assessing barriers:** This step involves both the client and the worker identifying in advance any obstacles that may make it difficult to accomplish the task. Such barriers may be found in the client’s environment, such as no access to the Internet, or internal to the client, such as anxiety about making phone calls. Both the client and the practitioner may have ideas about what stumbling blocks will be present. Once these barriers have been identified, strategies can be devised for overcoming them. For instance, Leticia expresses some anxiety about interviewing for jobs as she realizes she may try to oversell herself in an effort to get hired. She worries that her anxiety will come across as aggressive behavior and potential employers will be negatively impacted by her demeanor. She also worries about explaining why she has gaps in her work history. Once barriers have been identified, the worker and client can determine strategies for overcoming these obstacles. Marsha helps Leticia in this way by normalizing the anxiety that comes with doing job interviews. She also teaches Leticia some anxiety-reducing techniques and they identify helpful self-talk statements to use prior to and during the interview. In addition, Marsha provides Leticia with a list of popular interview questions and helps her script appropriate responses to the difficult ones. Marsha also talks with Leticia about her assumption that potential employers will look down on her for staying home with her children. She helps Leticia see this as something for which she can feel proud which will then help her feel more confident in the interview.

4. **Collaboratively rehearsing necessary skills:** These activities can be used to allow the client to practice completion of the task. Along with modeling by the worker and role-playing, the client can rehearse the necessary skills and behaviors and acquire a sense of competence in reaching her goals. In addition, it provides the opportunity to develop any skills that may be necessary for decreasing anxiety and enhancing the client’s confidence about executing the task. Marsha and Leticia engage in role-playing and interview preparation. In addition, Marsha provides Leticia with a list of popular interview questions and ways to answer them. She also suggests that Leticia seek support from Dress for Success so that she can obtain appropriate interview clothes and feel confident in her interview.

5. **Summarizing:** This final step of the TIS involves reviewing and clarifying the actions that each party has agreed to implement before the next meeting. To ensure accurate understanding, practitioners can ask clients to outline their plan. Throughout this process, Marsha and Leticia keep a written list of the tasks they have identified, who will do what, and the dates by when they want to achieve the tasks.
Progress on task completion is monitored throughout the process. Reasons for task incompletion are explored and adjustments are made accordingly. Successes are celebrated and the client is praised for her accomplishments. After 3 months, Leticia has been able to successfully obtain a full-time respiratory therapist job at a clinic near her home. With the help of Marsha’s referrals, she has also secured affordable childcare at a nearby church.

The final phase of TCP involves termination. During these last one to two sessions, client and worker evaluate the present state of the problem, determine what successful strategies were used by the client, and consider ways to sustain the achievements made (Fortune, Ramos, & Reid, 2015). It may be determined that additional sessions are necessary to complete the assigned tasks, that additional tasks require attention, or that the goal has been achieved and the relationship is ready for termination. Marsha and Leticia agree that Leticia’s goals have been accomplished and she feels more confident in both her parenting skills and her occupational abilities. As a result, they decide to discontinue the counseling sessions with the caveat that Leticia can make a follow-up appointment if needed.

Throughout this process, social workers can employ a strengths perspective by pointing out client strengths that can be utilized for the client’s success. Practitioners may suggest that the client use strengths employed in other areas of her life and apply them to the task at hand. For example, a client who works in customer service can be encouraged to transfer the skills she would use with a difficult customer and use them when managing conflict with a family member. The practitioner can also remind the client of past instances when she has overcome similar obstacles. The strengths-based social worker will also highlight the successful execution of skills as they were demonstrated in the session rehearsals and role-plays.

Case Management

Case management is a form of intervention that involves assisting clients in their interface with the environment by helping them navigate the often fragmented and bureaucratic health and human service system. Case management aims to link clients with resources that will meet their needs such as housing, medical care, counseling, employment, and education. Case management has its origins in social work with the Charity Organization Societies, but is now used by other disciplines including nursing and other medical professions. The increase in case management services is due in part to requirements by federal programs, such as Medicaid, that recipients receive case management services with the aim of reducing “duplication, fragmentation, and ultimately the frustration of the individual” (Hepworth et al., 2013, p. 429). Case managers (also referred to as “plan coordinators” or “care coordinators”) are employed in a variety of settings and are frequently used to address the needs of foster children, elderly persons, people with disabilities, people with chronic health problems, persons on probation, veterans, immigrant families, people recovering from substance abuse, and many more. They often serve as members of an interdisciplinary team alongside other professionals (Ruffolo, Perron, & Voshel, 2016). In addition, many social workers employ case management techniques as part of a more expansive position within an agency.

Practice standards for case management have been developed by both NASW and the Case Management Society of America (CMSA). These
standards designate the licensing requirements for case managers and highlight best practices and ethical expectations (see NASW’s practice standards for case managers at www.naswdc.org). Case management emphasizes client self-determination and strives to help clients live meaningful lives in the “least restrictive environments” (Moore, 1990, p. 446). For example, case managers who work with the elderly population are often able to prevent or delay their clients from entering a nursing home by arranging for meals to be delivered, transportation to medical appointments, and assistance with household duties. Numerous studies have shown positive benefits for clients who received case management services (de Vet et al., 2013; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). Rapp (1998) was the first to integrate the strengths perspective into case management and advocated that the modality include consideration of a client’s resources, capabilities, and self-efficacy.

Though job specifics may vary, case managers implement the following tasks to assist their clients:

1. **Cultivate a network of resources**: This involves developing knowledge and relationships with other agencies and service providers in the community that can benefit the client. In addition, case managers are familiar with the informal supports that are available to clients such as families, friends, and self-help groups.

2. **Make contact with clients**: Some case managers are involved in outreach to the community in order to identify clients who are in need of services. When clients are put on a waiting list for services, case managers are involved in communicating eligibility requirements and providing information about resources that can help clients in the interim.

3. **Evaluate the strengths and challenges of the client**: Case managers work together with clients to identify the clients’ needs and if necessary help prioritize these needs. Effective case managers also give particular emphasis to the clients’ strengths and how those can be used for the clients’ benefit.

4. **Create a service plan**: Case managers work with clients to identify goals, outline the necessary tasks that will lead to goal achievement, and identify who will complete what tasks. Case managers are careful to honor the clients’ right to self-determination, allowing clients to choose their own goals.

5. **Assemble the resource system**: This involves choosing which services and resources will be used to help the client achieve her goals. Case managers consider which services will be most effective, what forms of advocacy the client may need in order to receive fair and equitable services, as well as how the services will fit with the unique values and characteristics of the client.

6. **Generate documented agreements**: The care plan is then formalized in writing between the social worker and the client. A separate contract is also created with third-party providers. These contracts specify the goals of the care plan, who will do what tasks, time limits, and repercussions if services are not delivered.

7. **Execute the service plan**: Case managers assist clients to engage with the plan and receive the services. This could involve providing
encouragement, identifying sources of client motivation, or addressing more practical needs such as arranging for transportation to third-party providers.

8. **Oversee the service plan**: This task involves maintaining communication with formal and informal service providers, monitoring timelines, and assuring that quality services are being delivered.

9. **Assess the process**: Case managers work with the client, their family, and other providers to determine the effectiveness of the care plan. This information is used to determine if additional services need to be provided.

10. **Terminate the case**: The case manager uses the client’s input to facilitate the process of termination. This is made easier when the parameters of the service (e.g., time limits and eligibility requirements) have been clearly explained in the beginning of the helping relationship. The case manager also provides appropriate information to third-party providers about the status of the client’s case.

11. **Monitoring, feedback, and follow-up**: Case managers arrange for additional contact with the client after termination to determine how the client is managing and if new needs have emerged. This information can be used to determine the effectiveness of the interventions (Roberts-DeGennaro, 2008).

Effective case management requires that practitioners have knowledge of community resources and be familiar with the inner workings of complex agencies. This allows workers to efficiently determine if a client is eligible for services, advocate for services on behalf of the client, and coordinate eligible services over time (Ruffolo et al., 2016). Case management goes beyond simply providing clients with a phone number to call and often includes “active outreach” and “follow-up” to ensure that contact was made and services were delivered satisfactorily (Ruffolo et al., 2016).

Example: Ben works in the Leplin County Social Services Department and provides case management services to 4-year-old Adam who has autism spectrum disorder (ASD). Ben meets regularly with Monica, Adam’s mother, to make sure that Adam has access to all the services for which he is eligible. Their work together began when Monica called the department because she was concerned about Adam’s behavior and development. Ben was instrumental in helping Monica arrange to have Adam evaluated. After Adam was diagnosed with ASD, Ben gave her emotional support as well as information about ASD. He connected her to a support group/play group with other parents and discussed various treatment options that have been reported to be helpful for children with this diagnosis. Ben told Monica about medical professionals in her community who specialize in working with children with ASD. He also helped Monica enroll Adam in an early intervention program to meet his preschool needs. When it came time for Adam to start school, Ben walked Monica through the process of getting special education accommodations for Adam. He kept in touch with school personnel who agreed to send Adam to a school with a special program for children with Adam’s challenges. Upon getting Adam enrolled, Ben advocated that Monica’s house be included on a special bus route to get him to this school. Ben also helped Monica register for parenting education classes specific to the needs of children with ASD and
also connected her to a therapist who could support her in meeting the unique challenges that came with parenting a child with ASD. In summary, without Ben’s assistance, Monica may have missed numerous opportunities for Adam to receive the early interventions that are crucial to the emotional, social, and intellectual development of children with ASD. In addition, case management enabled Monica to receive supportive services and become empowered to be an advocate for her child.

Bachelor of Social Work (BSW)–level social workers and other helping professionals with undergraduate degrees are often employed in case management positions under agency supervisors who can provide additional mentorship and training. Case managers play an important role in helping clients who would otherwise not receive needed services. It is a fundamental role of social work that every practitioner should be able to deliver.

Psychoeducation

Psychoeducation is a form of intervention that combines educational approaches with therapeutic techniques to resolve clients’ problems. Psychoeducation is informed by several theoretical orientations and practice models including ecological systems theory, cognitive behavioral theory, learning theory, group practice models, stress and coping models, social support models, and narrative approaches (Anderson, Reiss, & Hogarty, 1986; Griffiths, 2006; Lukens & McFarlane, 2004, 2006; Lukens, Thornig, & Herman, 1999; McFarlane, Dixon, Lukens, & Lucksted, 2003). It can be used alone or in conjunction with other interventions. It is commonly used with groups, but can also be employed with individuals and families. Psychoeducation focuses on the client’s present-day difficulties and assumes that accurate information about her challenges increases her capacity for overcoming them. Psychoeducation has been effectively used to assist patients with an illness, such as cancer, and their caregivers, the bereaved, victims of relationship abuse, persons with addictions, persons with psychiatric disabilities as well as their family members. For example, psychoeducation interventions have documented benefits for individuals with schizophrenia including “improved compliance with the medication regimen, lower relapse rate, longer participation in aftercare programs, improved social functioning and quality of life, decreased negative symptoms, improved insight into illness, improved skills acquisition, improved attitudes toward medication intake, and a better understanding of mental illness” (Ascher-Svanum & Whitesel, 1999, p. 297).

Psychoeducation is strengths-based in nature. By bolstering the client’s internal resources, it cultivates heightened feelings of dignity and self-esteem (Hayes & Gantt, 1992). Psychoeducation fosters increased resiliency, healthy coping mechanisms, and an amplified sense of empowerment as participants master the challenges they face (Hayes & Gantt, 1992; Landsverk & Kane, 1998).

Psychoeducation involves the following components:

1. Delivering information specific to the problems the client is facing
2. Teaching and guiding the client in developing skills and coping strategies
3. Creating an atmosphere conducive to mutual support and problem solving
Effective delivery of this intervention requires that practitioners be knowledgeable and skillful in teaching methods that will resonate with the population they are serving. Using methods that require participants to actively engage with each other, rather than relying solely on didactic methods, for example, have been found to be more effective (Emer, McLarney, Goodwin, & Keller, 2002). Practitioners also need to provide “elements of practicality, concrete problem solving for everyday challenges, incremental shaping of social and independent living skills, and specific and attainable goals” (Kopelowicz & Liberman, 2003, p. 1495). A psychoeducational group for weight management, for example, may teach participants to recognize personal triggers that will cause them to overeat, and then develop an action plan, or alternative behaviors, to respond to these triggers. In addition, it is essential that practitioners develop a collaborative relationship with clients that is “infused with hope, optimism, and mutual respect” (Kopelowicz & Liberman, 2003, p. 1495) and be able to facilitate an environment of reciprocity and support among members.

One significant benefit of providing psychoeducation in a group setting relates to the impact of the members’ interactions with each other. Participants indicate that by sharing with others, who experience the same challenges, they benefit from the interpersonal support and validation they receive, an increased incentive to participate, a forum for expressing their feelings and concerns, interactions with peer role models, affiliation with a connected group of people, and recognition that they are not alone in their experience (Ascher-Svanum & Whitesel, 1999). For this reason, the criteria for membership in the group deserve special attention to ensure that members are able to empathize with each other and form a cohesive group.

Many psychoeducational interventions make effective use of members of the lay community who have had personal experience with the challenge the group is facing. These people are often referred to as “peer advocates” (Ruffolo et al., 2016). Due to their lived experience, peer advocates can easily relate to group participants and are able to credibly offer guidance in a way that differs from how members experience counsel provided by professional leaders. One study, for example, trained persons with schizophrenia or schizoaffective disorder to provide psychoeducation to their peers and found the results comparable to psychoeducation led by professionals (Rummel, Hansen, Helbig, Pitschel-Walz, & Kissling, 2005). By serving as role models, peer advocates provide powerful messages of hope and possibility to group participants.

Crisis Intervention

Crisis intervention is based on Crisis Theory (see Chapter 3) and aims to help clients who are facing a situation in which their coping capacities have become overwhelmed and inadequate. Families of the 2016 Orlando nightclub shooting who suddenly lost their loved ones, refugees forced from their home countries due to war and terrorism, the victims of intimate partner abuse and violence, suicidal individuals, and the 2016 police killings in Dallas, are all examples of the need for crisis intervention by first responders and practitioners. Crisis intervention can be conducted with individuals, families, and communities. It is designed to quickly provide relief to persons in distress and typically lasts between 1 and 6 weeks (Teater, 2014). Due to the wide prevalence of critical events, proficiency in crisis intervention strategies is an essential skill for all social workers (Roberts & Ottens, 2005).
The prevailing model of crisis intervention is Roberts’s (1991) Seven-Stage Crisis Intervention Model (R-SSCIM) outlined in the next sections. The stages are executed in order, although they can overlap and occur congruently.

**Stage 1: Assess the client’s physical, psychological, and social states, with priority emphasis on life-threatening circumstances.** Assessment in crisis situations must be done rapidly. At minimum, the practitioner will want to obtain information about the client’s support system and stress reactions to the event(s), any needs for medical attention or medications, recent consumption of alcohol or other drugs, and life-enhancing and life-depleting coping strategies and resources (Eaton & Ertl, 2000; Pomeroy & Garcia, 2009). Determining the presence of a life-threatening situation is crucial at this stage and involves assessing for risks of suicide attempts and/or imminent danger from another person. Practitioners will first want to determine if a suicide attempt has been initiated, such as overdosing on medication. If no attempt has been made, the worker should inquire about the potential that the client will engage in self-harm. More information about this is provided in Chapter 9. Workers should also ascertain if the client is in a dangerous situation as may be the case with intimate partner violence or a serious stalking situation. If a suicide attempt is in progress or there is imminent danger for the client, practitioners will want to immediately alert emergency workers while keeping the client engaged in conversation. “Rather than grilling the client for assessment information, the sensitive clinician or counselor uses an artful interviewing style that allows this information to emerge as the client’s story” (Roberts & Ottens, 2005, p. 334). Successful execution of this stage occurs when the practitioner has a sufficient and informed grasp of the situation and the client simultaneously feels heard and understood (Roberts & Ottens, 2005).

**Stage 2: Create rapport and quickly build a collaborative relationship.** This stage is done simultaneously with and is vital to the success of stage one. The practitioner’s goal of developing trust with the client can be accomplished through a variety of skills including using eye contact, expressing unconditional positive regard, thinking innovatively and flexibly, reinforcing positivity, validating progress, and encouraging resiliency.

**Stage 3: Determine significance of the primary challenges as well as the immediate events triggering the crisis.** This stage is focused on understanding, from the client’s perspective, the dilemma that led to the current crisis. Particular attention is given to the event that immediately provoked the crisis, determining which concerns to address first, and getting a sense for the client’s way of coping.

**Stage 4: Use active listening skills to explore the client’s feelings.** This stage has two components. One involves the use of active listening skills to facilitate the venting, emotional expression, and the client’s telling of her situation. The second component involves carefully inserting challenging responses into the conversation with the client in an attempt to weaken her hold on unhelpful ways of thinking and be open to alternative behaviors.

**Stage 5: Brainstorm and consider alternate options, including internal and external resources and strengths that have not been utilized.** During this stage, the practitioner leads the client in a collaborative discussion about possible solutions to the current problem. This is most likely to be effective if the client was able to process some of her feelings in Stage 4, which would enable her to see things from a broader vantage point.

**Stage 6: Create and prepare a plan for action.** At this stage, specific actions are chosen with agreement from the client and a plan for implementation is
put in place. In addition to the tangible tasks that are executed, clients can be guided to consider the significance of the event, including how it came to be, what behaviors or thoughts exacerbated the event, and how the events diverged from the clients’ expectations. These thoughts facilitate learning that can then be applied to future situations.

Stage 7: Secure agreement with the plan for action, arrange and execute a follow-up plan. After the imminent crisis has been resolved, practitioners should schedule a follow-up meeting with the client to confirm that resolution is underway and to assess the client’s condition. In particular, considerations should be given to the client’s physical, cognitive, emotional status; her overall ability to function; current stressors; and the need for additional resources. Additional meetings with clients can be scheduled about a month after the event as well as on anniversary dates of significant events, such as the death of a loved one (Worden, 2001).

There are opportunities for practitioners to highlight, build on, and leverage client strengths throughout the implementation of the R-SSCIM and doing so enhances its effectiveness. R-SSCIM has been widely used and researched in a variety of crisis situations and has been shown to be effective in assisting clients to overcome the psychological toll that a crisis can engender. Students and practitioners can find numerous articles and books that delineate how crisis intervention techniques can be used in practice with different populations. The following describes an example of crisis intervention:

Stages 1 and 2: Social worker Rhonda meets Joshua and his wife Cassandra at a Red Cross station set up after their community flooded due to a hurricane. Rhonda notices that Josh appears agitated as evidenced by pacing and wringing his baseball cap in his hands. Nearby, Cassandra appears to be very lethargic while she is trying to keep an eye on her three young children. Upon offering to help the couple, Joshua speaks rapidly as he explains that their home was completely destroyed and they were able to save nothing. Rhonda uses an attentive and empathic demeanor to assure Joshua that she wants to help him and begins to gather more details about their situation. She inquires if all of the family is now safe, if anyone is injured or needs immediate medical attention, how long since they arrived at the station, and when did they last eat. She tries to determine the family’s immediate concerns. Rhonda learns that, with the exception of a beloved pet, the family is all together at the station and they recently ate food provided by relief workers. She also learned that Cassandra is without her thyroid medication. Joshua expresses devastation at losing everything and feels overwhelmed with the task of trying to rebuild his life. He continually repeats, “I don’t know what to do.” Rhonda escorts the family to the medical unit and arranges for Cassandra to be seen.

Stage 3: Rhonda then gives the kids crayons and coloring books to keep them occupied while she continues conversing with Joshua. She asks about the events leading up to their evacuation and listens empathically as he tells about getting out of their rapidly flooding home in the nick of time. He then describes waiting on the rooftop of their house for over 5 hours before being rescued by helicopter.

Stage 4: Rhonda listens and encourages Joshua to express his feelings. He says the family is very worried about their pet dog that they were unable to find at the moment of evacuation. He worries that he doesn’t know where they will stay or where the next meal will come from and indicates feeling inadequate because he can’t take care of his family. Rhonda validates these feelings,
commends him on getting his family to safety, and affirms his desire to meet his family’s needs.

Stage 5: “Joshua,” Rhonda suggests, “I think we should work on two different plans. One to figure out how to get you what you need for the next 2 to 3 days and another plan to help you get back into a home, a job, and a stable life. How does that sound to you?” Joshua’s shoulders relax a bit and he seems to feel relief with the direction Rhonda has provided. Rhonda asks about social support and financial resources. Joshua says he doubts his friends will be able to help because the entire community has been hit hard by the hurricane. He heard that his place of employment was also destroyed so he ruled out being able to get support from his boss. He has been unable to reach family members who reside in another state because his cell phone died. He indicates that they are a low-income family with no savings.

Stage 6: Rhonda finds a charger that Joshua can use for his phone and consults the list of emergency shelters nearby that have openings. They agree that once his phone is charged, he will call his family to see if they are able to provide support. She also gives him paperwork to complete that will help him qualify for financial assistance. She gets a description of their dog and agrees to call the animal shelter to see if the dog is there.

Stage 7: They agree to meet in a couple of hours to follow up on what they have learned and make decisions about the next steps.

In summary, crisis intervention is an EBP model that has been shown to be highly effective in assisting persons to move forward from a crisis to gaining control of their lives again. As demonstrated in the previous case, the seven stages of crisis intervention (Roberts, 1991) can be used in a wide variety of settings. It is a natural complement to the strengths-based direct practice framework. Clients like Joshua are often “frozen” in terms of their ability to cope with the situation with which they are confronted. Crisis intervention methods can provide them with the skills needed to navigate through the present crisis and toward a resolution of the problem. It is not designed to resolve all the issues that a client might possess but rather to serve as a method for remediating the immediate emergency. Follow-up assistance is an important component of crisis intervention in order to further address other issues that may ensue as a result of the crisis.

**Cognitive Restructuring**

Cognitive restructuring is a fundamental element of cognitive behavioral therapy and operates on the presumption that feelings, and the resulting behaviors, are influenced by thoughts. The use of cognitive restructuring as an intervention involves pointing out ways that the client’s thoughts are irrational and suggesting ways of thinking that are logical and functional. When clients are willing to consider alternative and more rational thoughts, they then possess the ability to change their feelings and behaviors.

Cognitive restructuring is most effective when the practitioner can artfully challenge the client’s thinking while also communicating respect and understanding. Practitioners of cognitive restructuring will want to be familiar with the thinking mistakes that are prevalent in humans. In addition to reflecting more logical thoughts into the dialogue with the client, the client can benefit from a psychoeducational approach to cognitive restructuring so that clients can learn the techniques independently of the practitioner.
In cognitive restructuring, “automatic thoughts” (A. T. Beck, 1979) refer to persons’ internal dialogue about themselves and their interactions with the environment. Though these thoughts have often become background noise and may be hidden from a client’s awareness, they exert a powerful influence on the client’s perspectives of the world, feelings, and behaviors. Difficulties appear when a person’s cognitions contain flawed reasoning but seem sensible to her. Many automatic thoughts reflect strongly held beliefs which contradict logic when further appraised. When left unexamined, this discrepancy can create friction as the individual engages with her environment (J. S. Beck, 2011). For example, the belief that one must always work hard can become problematic if a person is working so hard that she develops health problems due to stress and lack of rest. A more logical belief, such as it is important to balance work and rest, is more realistic and adaptive to the realities of life. Commonly held cognitive distortions are outlined as follows:

- **All or nothing thinking**: Seeing things only in extremes
  - After eating a cookie, Carl concludes he has ruined his diet so he then eats five more cookies.

- **Overgeneralizing**: Making conclusions based on little evidence; using terms such as “always” or “never.”
  - Stacey dates a guy who treats her badly and then concludes that “all guys are jerks.”

- **Mental filter**: Considering only some aspects of a situation while discarding other aspects.
  - After successfully giving a presentation to his class, Dan berates himself for one point he forgot to make.

- **Disqualifying the positive**: Dismissing the good aspects of a situation or accomplishment.
  - Mona makes an A on a test and concludes that she was just lucky and isn’t a competent student.

- **Jumping to conclusions**: Predicting negative things will happen in the future or assuming that you know how others think and feel.
  - Fred is dreading dinner with his family because he has convinced himself that his parents will chastise him.
  - While giving a presentation, Debra notices that a member of the audience leaves the room. Debra concludes “He left because he thinks this presentation is horrible.”

- **Magnification and minimization**: Inflating things to seem bigger than they are, or inappropriately diminishing things to make them seem less significant.
  - Gus was 2 minutes late to a meeting at work. He apologized profusely and concluded that his job was in jeopardy.
  - Sonia disregarded her 12-year-old son’s drug use, telling herself that it’s “what kids do.”

- **Emotional reasoning**: Drawing conclusions based on one’s feelings about something rather than facts.
  - Juan feels overwhelmed with all the homework he has and concludes that it will be impossible to get it done.
• **Critical words such as “should” or “must”**: Using these words puts one in conflict with reality and promotes feelings of guilt and inadequacy. When applied to others, it frequently produces frustration.
  - “I must make an A on every test; otherwise I’m a failure.”
  - “He should have been more respectful to me.”

• **Labeling**: Using categories or designations to identify ourselves or others.
  - Felicia made a low grade on a test and concluded that she is “stupid.”

• **Personalization**: Taking full blame or responsibility for something that you did not cause or blaming others for something they did not cause.
  - “If I had cleaned the house before he came home, my husband wouldn’t have been so grumpy.”
  - Marcus concludes that his failing grade is because the teacher doesn’t like him.

Using cognitive restructuring with clients involves the following steps:

1. Educate clients about the impact of thoughts on feelings and behaviors.
2. Assist the client to identify the automatic thoughts she has about a situation.
3. Encourage the client to identify the distortions in her cognitions.
4. Support the client in identifying alternative and more rational thoughts about the situation.
5. Encourage the client to notice and reflect on any shifts in her feelings about the situation once she has changed the cognition.
6. Help the client identify ways to adjust her behavior so that it better reflects her new cognitions.

One way to conceptualize Cognitive Restructuring is the A + B = C model with Albert Ellis (1973) being a chief proponent. In this model, A represents an action, event, or antecedent; the precipitating event of an emotional reaction. B signifies a person’s beliefs or thoughts about the event. C refers to the consequence of the belief which may be a feeling, state of being, or behavior. Cognitive restructuring focuses on helping people change unhelpful beliefs (B) which then leads to more favorable results (C). The following diagram provides an example (see Figure 6.1).

**Cultural Considerations With Cognitive Restructuring**

When practicing cognitive restructuring with clients, practitioners must remain cognizant of the fact that the thoughts and perceptions of members of oppressed and culturally diverse populations are influenced by their history and experiences in the broader societal context (Hepworth et al., 2013). Practitioners must be cautious when comparing the beliefs and worldviews
of minorities with the dominant culture so that they do not automatically assume their thoughts as being problematic. Critiques of cognitive restructuring suggest that it overlooks the influence of environmental and structural inequalities (Pollack, 2004). Others point out that cognitive restructuring with multicultural groups helps to maintain the status quo of the dominant society (Hays, 1995). Therefore, it is important to adapt and modify cognitive techniques when appropriate. Such adaptations have been demonstrated in studies with Chinese Americans (Chen & Davenport, 2005), Latinas/os (Organista, Muñoz, & González, 1994), Native Americans (Renfrey, 1992), and Muslims (Hodge & Nadir, 2008).

Since the early 1970s, cognitive restructuring has garnered the attention of social scientists and practitioners throughout the world. It has been widely researched and proven to have scientific merit. It is considered to be one of the primary EBPs and is used by helping professionals to assist with health, mental health, and other life challenges. A variety of techniques have been developed to enhance the effectiveness of this approach. As an outgrowth of cognitive restructuring, cognitive behavioral therapy is perhaps the most widely used therapeutic modality and has been shown to be effective for depression, anxiety, pain management, addictions, and interpersonal problems, among others. There are numerous articles and books available for both professionals and laypersons that demonstrate the application of this model to practice situations and diverse populations.
Interventions in a Cultural Context

Given the diverse racial, ethnic, and cultural groups residing in the United States, it is beyond the scope of this textbook to address all of the assessment and intervention issues that would need to be discussed to ensure quality service provision. Expansive categories exist for all cultural groups reported in the U.S. Census including African American, Hispanic, Asian Pacific, and American Indian. Indeed, for the first time in over 75 years of publication, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) provides a cultural assessment instrument that examines a person’s history and current experience. Therefore, the authors provide a brief overview of the importance of being culturally knowledgeable, aware, and responsive to clients’ cultural backgrounds.

There is considerably less research on EBP as it relates to various racial and ethnic groups when compared with Anglo populations. The lack of sufficient evidence to establish an intervention as effective has commonly led to the use of methods shown to be useful and adapting them in ways that will work for non-Anglo clients. There are, however, some established guidelines for intervening in ways that are culturally sensitive. Practitioners should familiarize themselves with their client’s culture, be aware of their own biases, and be able to communicate in a culturally responsive manner.

Interventions should be based on a thorough assessment of the individual client’s cultural background and current cultural values as well as experiences of discrimination and social injustice. The impact of culture on the primary challenges facing the client will affect the best choice of intervention. The following intervention techniques have been introduced for consideration in the literature.

**African Americans**

- Utilize strategies aimed at helping clients feel empowered (Harvey, 2001).
- Group interventions can help foster a sense of community in relationships with others (Harvey, 2001).
- Use of metaphors and analogies can be helpful (Harvey, 2001).
- Allow clients to tell their story and appreciate their efforts at coping and surviving (Harvey, 2001).
- Including elements of spirituality in the intervention may be beneficial (Harvey, 2001).
- Validate emotional responses regarding experiences of social injustice and allow for appropriate expression (Harvey, 2001).
- Use an Afrocentric approach that “encourages African Americans to rely on the cultural thought and behaviors of their Ancestors and apply it to their daily lives” (Harvey, 2001, p. 238).
- It may be appropriate to involve the family and extended support systems (Logan, 2015; Paniagua, 2005).
- Solution-focused brief interventions, psychoeducational approaches, family interventions, task-centered practice, and cognitive behavioral interventions may be beneficial (Walsh, 2009).
Hispanics

- Use cognitive methods and include the client’s unique personal experience (Galan, 2001).
- Facilitate communication between family members who may have different levels of acculturation to clarify the meanings and symbolism of behaviors and emotional responses (Galan, 2001).
- Encourage critical thinking and cognitive methods to intervene in the sources of discomfort (Galan, 2001).
- “Employ the techniques of clarification, interpretation, and confrontation in order to help the client with problem solving” (Galan, 2001, p. 266).
- Help clients navigate any tension between current beliefs and culturally traditional beliefs (Galan, 2001).
- “To better serve undocumented immigrants, social workers should strive to understand the laws that govern their work and constantly seek alternative resources” (Marsiglia, Booth, & Baldwin, 2013, p. 18).
- When working with undocumented immigrants, it can be helpful to determine and address “internalized messages of oppression” (Marsiglia et al., 2013, p. 19).
- Support “healthy acculturation practices that incorporate both cultures [and] can help buffer the impact of psychosocial stressors” (Marsiglia et al., 2013, p. 19).
- Facilitating bicultural or multicultural identity formation can be beneficial to the client (Marsiglia et al., 2013).
- More information on working with undocumented Latino immigrants can be found in Marsiglia et al. article titled, “Individual Practice with Undocumented Immigrants” (2013).

Asians and Pacific Islander Americans

- Practical solutions versus emotion-focused methods may be preferred (Paniagua, 2005).
- Incorporate belief systems that resonate with clients’ cultural background (Chua, 2003; Martin & Zweben, 1993).
- Investigate and utilize cultural healing practices such as Ho’oponopono (Hawaiian), Ifoga (Samoan), and Fakaleleli (Tongan) (Vakalahi & Fong, 2015).

Native Americans

- Interventions that include storytelling may be helpful (Brave Heart, 2001).
- Use an empowerment practice perspective (Brave Heart, 2001).
- Support clients in telling their personal story while using attentive listening skills (Brave Heart, 2001).
• Refer clients to experts in trauma interventions when indicated (Brave Heart, 2001).
• Native families can benefit from their rich cultural histories and resiliencies when using the strengths-based approach (Evans-Campbell & Limb, 2015).
• “When individuals are emotionally prepared and ready, social workers can assist in exploring historical losses and making links to current family functioning” (Evans-Campbell & Limb, 2015, p. 990).
• “Honor the client’s commitment to Native traditional spirituality and support her [sic] work with traditional practitioners in addition to, or in place of, social work interventions” (Evans-Campbell & Limb, 2015, p. 991).
• “Explore relevant treatment resources at tribal or Native agencies in the region” (Evans-Campbell & Limb, 2015, p. 991).

GROUP INTERVENTIONS

In addition to working one-on-one with individuals, social workers also deliver interventions to groups of people. Group practice is used to serve diverse populations and target a variety of goals. Groups with the purpose of meeting the needs of individual members are referred to as “treatment groups.” In contrast, “task groups” focus on achieving a goal that goes beyond the needs of the individual members, though the members may also benefit from the work accomplished by the group. While direct practice social workers commonly facilitate both types of groups, they are most often involved in treatment groups. The following examples demonstrate the wide array of ways that groups are used in social work practice:

• Inpatient clients in a treatment facility meet daily with other residents to talk about their interpersonal issues.
• Bereaved parents meet weekly to learn about grief and share their experiences.
• Survivors of a natural disaster meet to discuss and share information about the process of rebuilding their homes.
• A court-ordered group for perpetrators of intimate partner violence meets weekly to learn relationship skills and anger management.
• Senior citizens in an assisted living facility meet to get cognitive stimulation, socialize, and reminisce.
• Caregivers of patients with chronic illness meet every other week to learn about resources and stress management.
• Adolescents, who live in homes with alcoholic parents, meet weekly to learn healthy coping skills.
• A group of college students meets to discuss ways to promote diversity on campus.
• A group of citizens meets with a social worker to develop plans to lobby against a toxic factory plant designated for their neighborhood.
As is evident in the previous examples, treatment groups may focus on providing support, education, therapy, socialization, self-help, or to promote personal growth (Toseland and Rivas, 2016).

There are numerous advantages to delivering services in a group setting. Being with others who are in similar circumstances typically produces decreased feelings of shame and isolation. It also gives members the opportunity to practice new behaviors, perspectives, and attitudes with others in a safe, learning environment. In addition, groups are a more cost-effective way to provide services to a greater number of people (Garvin & Galinsky, 2013).

There are several structures, models, and theoretical approaches that can be used in groups (Garvin & Galinsky, 2013). Some groups are open ended and allow for new members to join at any time, while others are closed groups in which membership is fixed until the group’s termination. Some groups are time limited while others are ongoing. Groups may follow a curriculum or attend to whatever needs are presented by members at the time. Groups may incorporate psychoeducational, cognitive behavioral, or interpersonal strategies. The best approach for a particular group is determined by the goal of the group, the population it will serve, and the resources available to sponsor the group.

The requisite skills for facilitating groups include the ability to assess if clients are appropriate for group membership, structure the group’s content or curriculum, establish trust and cohesion among group members, effectively shepherd the group through its developmental phases, manage complex group interactions, and effectively terminate the group. Group leaders must be skilled in addressing the issues faced by individual group members while simultaneously managing the interactions between members and the needs of the group as a whole. For this reason, it can be helpful to have two facilitators who can share in the task of observing the multiple interactions of members and addressing the variety of needs.

While it is beyond the scope of this book, social workers will be expected to have the skills to effectively structure and facilitate groups for the populations they serve. Students can learn more about social work group practice in L. Shulman’s book, Empowerment Series: The Skills of Helping Individuals, Families, Groups, and Communities (2015).

**PREVENTION**

In addition to intervening with persons who are currently in need, social workers are also involved in prevention with the aim of administering services prior to the presence or full development of a problem. Prevention efforts are used to address a wide range of issues including physical disease such as diabetes, heart disease, and cancer as well as behavioral and mental health concerns such as child abuse, teen pregnancy, substance abuse, and mental illness. Epidemiological data are used to identify rates of prevalence, severity, and outcomes in populations or subgroups. This information leads to the identification of risk and protective factors (Woody, 2006). Effective prevention interventions are then structured on the basis of these findings.

One of the primary models for preventative services is the continuum of care model, which is used to address a complete range of health concerns including behavioral disorders. This is in slight contrast to the public health model, which focuses solely on physical disease. Under the continuum of care model,
prevention approaches may be universal, selective, or indicated. Universal efforts at prevention are aimed at the public at-large or at an entire population group. An educational program about the dangers of substance use in elementary schools is an example of universal prevention. Selective prevention strategies are directed at individuals or groups who are at greater risk for having the problem than the general population. A substance abuse prevention program aimed at children of drug-abusing parents is an example of selective prevention. Indicated prevention interventions target individuals or groups who are at high risk for developing the problem, or are already exhibiting initial signs and symptoms, but for whom the problem has not yet fully developed (Rishel, 2007). An example of an indicated prevention is an HIV education program for partners or friends of HIV-positive individuals who have been exposed to or have symptoms of HIV.

In addition to averting problems, efforts to promote health and increase protective factors are also part of prevention. For example, there has been a sweeping advertising campaign focused on healthy eating and exercise to promote a healthy heart or reduce a risk of diabetes. City-wide runs and walks often promote healthy habits and disease prevention.

Population-based prevention interventions often employ strategies targeted at the mezzo and macro levels of the environment such as lobbying the city council for an ordinance that bans texting while driving or using mass media to promote regular medical checkups. Health fairs are often held in communities at risk for this purpose. Direct practice social workers may become advocates for population-based prevention strategies based on their experience working with individuals and families. Clinical prevention focuses on services for individuals, such as developing a school-based health clinic for adolescents or providing preschool education to low-income children (Woody, 2006). Direct practice social workers may be employed in prevention programs to deliver services. In addition, direct practice social workers often use standard interventions in a preventative capacity in their regular work with clients. Teaching effective parenting skills to a stressed-out parent, for example, can be regarded as an intervention as well as a prevention of child abuse.

Prevention experts advocate for an approach that incorporates biological, psychological, social, and spiritual elements and targets the interaction between individuals and their environment (Beardslee, 1998; Coie et al., 1993; Kellam, Koretz, & Moscicki, 1999). The importance of the person-in-environment perspective makes social work well suited to lead prevention efforts and such strategies are a rich part of the profession’s historical legacy (McCave & Rishel, 2011; Ruth, Velasquez, Marshall, & Ziperstein, 2015). Many have critiqued the profession for not showing more leadership in promoting prevention and advocate that increased attention on prevention be incorporated into social work education (McCave & Rishel, 2011; Ruth et al., 2013; Woody, 2006).

Case management, task-centered approach, cognitive restructuring psychoeducation, crisis intervention, and group interventions and prevention are just a few of the numerous intervention approaches that social workers use with clients. Students are encouraged to also learn about solution-focused approach, mindfulness, motivational interviewing, and other methods specific to their client population. New approaches to help clients are continually being explored and developed as technology advances the knowledge of how the brain works and its effects on human behavior. Social workers are encouraged to be lifelong learners and to continually stay abreast of the latest information that will inform intervention approaches.
CASE 6.1

Identifying Information:
Client Name: Brenda
Age: 29 years old
Relationship Status: Married
Race/Ethnicity: Anglo American
Educational Level: High school
Members of Household: Husband and three young children
Setting: National Domestic Violence Hotline
Social Worker: Audrey

Audrey is a social worker who works the night shift on the National Domestic Violence Hotline. At 12:30 a.m., Audrey answers the hotline call, "This is the hotline. How can I help you?"

Amidst heavy crying, the voice on the line says, “Hello? Is someone there?”
“I’m here,” Audrey says. “Can you hear me?”
“Yes. Yes, I can.” Audrey hears sniffles and gets the sense that the person on the line is trying to control her emotions enough to speak.
“My name is Audrey and I’m here to help you. Can you tell me your name?”
“Brenda,” the caller manages.
“Hi Brenda. It sounds like you’re very upset. Can you tell me what’s going on?”
“I just … I just don’t think I can take it anymore. My husband won’t stop …” Brenda begins crying heavily again.
Audrey asks, “Is your husband there right now, Brenda?”
“No. No, he just left,” Brenda manages.
“OK, so it’s safe for you to talk right now?” Audrey checks.
“Yes. He went out drinking so I don’t think he’ll be back for a while.”
“I can tell you are really upset. What is going on with your husband, Brenda?”
Audrey spends several minutes using active listening and gathering information as Brenda explains, through many tears, that her husband regularly becomes drunk and enraged and takes it out on Brenda. When this happens, he physically abuses her by throwing her against the floor, choking her, and picking up any nearby object and hitting her. She has had multiple broken bones and bruises over the past year and a half. Although her family has urged her to leave, none of them live in town and she has three young children whom he has threatened to harm if she leaves. She also does not know any resources or services available to her as she has kept the abuse as private as possible.
“That sounds extremely stressful, Brenda. And very dangerous,” Audrey says.
“It is,” Brenda affirms. Audrey has the impression she is crying silently.
“What do you mean when you say 'I can't take it anymore'?" Audrey asks.
"I just … I'm just so tired of this. I can't live this way. I've got to get out!"
“Yes, it sounds really hard. Get out of what exactly, Brenda?” Audrey asks gently.
"Out of this house! Out of this marriage!"
"I think that makes a lot of sense, Brenda," Audrey responds. "I'm really glad you called. I'd like to help you get out of the marriage in a safe way."

Audrey makes more inquiries about the situation and learns that Brenda has been married for 6 years. She learns that the fights always happen at home and never in front of others. She also finds out that Brenda left the relationship once in the past but her husband then became even more violent and controlling. Brenda also imparts that this is the first time she has reached out for help with her situation.

“What happened that made you decide to call today, Brenda?”

“He … he raped me,” Brenda says, sobbing.

“Oh, that must have been very traumatic for you.” After letting Brenda cry for a moment, she asks “Has that ever happened before?”

“This is the second time,” Brenda explains. “But it was worse this time.”

“OK. Can you help me understand what was going on when that happened?” Audrey asks. Brenda tells Audrey that her husband had been tense for a couple of days so she knew he would probably rage soon. She had been trying to get the house really clean hoping to prevent him from exploding. When he got home, she was finishing up in the kitchen when her phone rang. He began accusing her of being with someone else and it escalated into sexual assault.

“Oh, Brenda. That sounds like torture. I understand why you feel that you must leave. Besides the children, what are some of the things that make leaving hard?”

“I don’t have anywhere to go and he says he’ll kill me if I leave.”

“Ok, I see. That does make it really hard. Putting your husband’s threats aside for a minute, have you considered other actions you could take in order to safely get your children and yourself out of this dangerous situation?”

“Well, I’ve been racking my brain trying to figure out an escape route. I’ve saved a little bit of money that he doesn’t know about. I’ve thought about grabbing the kids and getting on the bus to go to my parents’ house, but he knows where they live and he’d probably come looking for me there,” Brenda says.

“Do you have any other family or friends you could stay with?” Audrey asks.

“I have one close friend from childhood who has told me I could come stay with her anytime, but she has a really small apartment and I hate to invade her space with all of us.”

“OK,” Audrey says. “Let me see what resources might be close to you. What is your zip code, Brenda?”

“It’s 84001.”

“OK. Stay on the line with me, please. I need just a second to look this up.” Audrey checks her registry and locates a shelter in Brenda’s town.

“Here we go. Brenda, do you know about a place called Safe Shelter in your town?”

“No. What’s that?”

Audrey explains that the shelter is for families who are experiencing domestic violence and need a safe place to stay. She outlines the services the shelter offers, which include counseling and practical assistance in leaving an abusive relationship. She adds that it is in a discreet location, that her husband would probably have difficulty finding her there, and that there is high security to protect the residents.
"Oh, I had no idea," Brenda says.
"Are you in a position where you can call them?"
"Yes. Yes, I will call as soon as I get off the phone with you," Brenda says with a hint of hope in her voice.
"Great," Audrey says. "I can also call Safe Shelter and let them know we've been in contact and that you are in a dire situation. Is that OK with you?"
"Yes, thank you. Thank you so much," Brenda replies.
Audrey gives Brenda the shelter's contact information and obtains identifying information on her. They determine that it would not be safe for someone from the shelter to contact Brenda since her husband may discover the number on her phone.
"OK," Audrey says. "So the plan is that you will call Safe Shelter as soon as we hang up. I will also call and let them know about your situation. If you don't go to the shelter within the next week, call us back here at the hotline and we'll look at other options for you. Does that sound OK with you?"
"Yes, that sounds good," Brenda agrees.
Audrey continues, "And I want you to know that you can call the hotline anytime and for any reason. I know this is hard and I want you to know that there are people who want to help you."
"This really terrifies me but I know I've got to do something. If not for me, for my kids."
"Yes," Audrey validates. "It can be very scary and it's too much to tackle alone. I'm really glad you've reached out for help. Is there anything else I can assist you with right now?"
"Not now. I'm going to call the shelter before he gets back," Brenda says.
"OK. Best of luck, Brenda."
After Audrey ends the call with Brenda, she talks to her supervisor about the situation and if she needs to do anything further on behalf of Brenda and her children.

6.1. Analyze the case and locate the dialogue that demonstrates the stages of Roberts's Seven Stage Crisis Intervention Model.

6.1-2. How does the worker establish a relationship with Brenda over the phone?

6.1-3. How does the worker explore options with Brenda?

6.1-4. How did the worker interact with Brenda so that she can feel empowered to take charge of her life?

6.1-5. How else might the worker have been helpful to Brenda during this crisis?

6.1-6. What are Brenda's strengths?
CASE 6.2

Identifying Information:
Client Name: Jessica
Age: 13 years old
Relationship Status: Single
Race/Ethnicity: Vietnamese
Educational Level: Currently in the eighth grade
Members of Household: Jessica, her mother, and father
Setting: Middle school
Social Worker: Kim

Kim received a call from Jessica's mother who expressed concern that Jessica has appeared sad, lethargic, and highly irritable. She also stated that Jessica spends a lot of time in her room with the door closed and says her grades have dropped significantly in the last couple of months. Kim agreed to meet with Jessica to see how she may be able to help.

Kim called Jessica into her office and after some small talk said, "Jessica, I got a call from your mom. She was concerned about you and said that you seem to be really sad and stressed out. So, I wanted to check on you and see if I can be helpful in any way. How have you been doing?"

With some gentle coaxing from Kim and empathic listening, Jessica gradually opens up and shares with Kim that she often feels inadequate, that she doesn't like the way she looks, and she worries a lot that she will be negatively judged by her peers. She says that her group of friends sometimes excludes her and says there was a time when one of the girls communicated to her via another friend that she didn't want to be her friend anymore. A couple of days later, things seemed to be OK with this friend but Jessica was never told the reason for this. She indicated that she continually checks her phone to see how many texts she has and often feels disappointed that she doesn't have more. She also worries about her homework and pressures herself to be perfect in this area. Kim notices that Jessica's face is downcast and at times she appears to be fighting back tears.

Once Kim feels that she understands Jessica's stresses and expresses empathy for how difficult it is for her, she says, "It sounds like you often get really down on yourself." Jessica nods. "You know, we all carry around a lot of thoughts in our head. It's almost like we are having a continual conversation with ourselves. These thoughts are like white noise. They are always in the background and sometimes we get so used to them that we don't even realize we're having a thought. But these thoughts can be very powerful and can affect how we feel. I'm thinking it might be helpful for us to take a look at the thoughts you carry around and see if changing your thoughts could help you feel better. Would you like to give that a try?"

Jessica agrees and Kim gives her a handout that describes several different cognitive distortions in age-appropriate language. "This is a list of thinking mistakes that people commonly make. With all of these, there is something not completely rational or logical about this way of thinking, but we're not aware of that and so it feels like it's true. Let's go through this list and see if you find yourself thinking in any of these ways."
Together, they read the first description of all or nothing thinking. Kim provides some generic examples of this and then asks, "Do you ever find yourself, thinking this way, Jessica?

"Yes...yes, I think I do that a lot." Jessica says.

"Ok," Kim responds. "Can you tell me about an example of when you think this way?"

"If I only get one or two texts from my friends, I start thinking that everyone hates me."

"Yes, that could be an example of all or nothing thinking," Kim affirms. "What about this way of thinking is not quite logical with that example?"

After thinking a bit, Jessica says, "Well, just because I'm not continually getting a text message from someone doesn't mean everyone hates me. I wouldn't get any messages at all if that were true."

"That's right!" Kim says. "Can you see how thinking this way changes how you feel about your friendships?"

Jessica nods and they continue going through all of the cognitive distortions in this way.

"So, it looks like you do a lot of these," Kim says. Jessica nods. "And I want you to know that's not unusual. A lot of people, of all ages, tend to use a lot of thinking mistakes like these. After discussing these with you, it makes sense to me why you have been feeling so bad lately. Can you see that?"

"Yes, I can." Jessica replies. "Totally."

"So, I think it would be helpful for you to practice changing the way you think. It may require some effort because these thinking mistakes have now become habits. It's like your brain has created a groove making it easy to fall into this way of thinking. We need to help you create some new grooves that involve more rational ways of thinking. Does that make sense?"

Jessica nods.

"Ok. The first step is just practicing your awareness. Before today, you probably didn't realize you were having all of these thoughts and that they weren't rational. Is that right?"

Jessica nods again.

"So, I would suggest you practice being aware of what you are telling yourself when something upsetting happens or when you are feeling down. Ask yourself, 'what is the conversation in my head?' It would be really helpful if you could stop and write down your thoughts and then pull out this list and see if you can identify which thinking mistake you are using. Would you be willing to do that?"

Jessica agrees to this. Kim then asks Jessica to explain the exercise to her so that she can know that they are on the same page. Jessica does so accurately. Kim also suggests Jessica consider getting a journal or notebook specifically for this purpose.

"How does all of this feel for you, Jessica?" Kim asks.

"It feels good," Jessica responds. "I think this is going to help me a lot."

"Ok, good," Kim says. "I'd like to let your mom know that we met and I'd like to give her a summary of what we discussed. Are you OK with that?"

"Yeah, I guess so," Jessica says.

"Is there any part of what we discussed today that you don't want me to share with your mom?" Kim asks.
Jessica thinks for a moment, then says, "No, not really. I just don't want her asking me a bunch of questions about it. It's OK that she knows but I don't want her getting all in my business about it."

"I can understand that. I can let your mom know that you don't want her talking to you about it much and that you need a little space as you try to figure all of this out. How does that sound?"

"That sounds good," Jessica agrees.

Kim and Jessica agree they will check in with each other in a few days to talk about how things are going. "I've got some other ideas of things that might be helpful for you, especially once you have increased your awareness of your thoughts," Kim explains, in the hopes that this statement will encourage Jessica to do the exercise they discussed.

After sending Jessica back to class, Kim calls her mother and updates her on what she has learned about Jessica's stress. Jessica's mom listens attentively as Kim explains the approach she is using to help her daughter.

"Thank you so much for meeting with her," Jessica's mom says. "I really appreciate it!

Do you have any advice for me about how I can help Jessica?"

"Well, she knows that I was going to update you and she was OK with that, but she doesn't want you to try and talk to her about it a lot. She just needs a little space as she sorts through all of this."

"OK, I can do that," Jessica's mom says. "Now that I know she is talking to you, it will be easier for me to back off a little bit."

"OK," Kim responds. "I plan to check in on her again next week, see how she's doing, and give her some more tools that could be helpful. There are some pretty good phone apps that I might recommend if you are OK with that. Some of them may cost a little bit, $2 to $3, but I find that teenagers are more likely to engage with the material when it's in digital form."

"That's absolutely fine. I want to do whatever I can to help her."

6.2-1. What are Jessica's strengths?

6.2-2. What intervention is Kim using with Jessica and why did she select this intervention?

6.2-3. In what ways does Kim deliver the intervention so that it will be effective with Jessica?

6.2-4. What might Kim do with Jessica the next time she sees her?

6.2-5. List three goals that Kim might discuss with Jessica during their next visit.
CASE 6.3

Identifying Information:
Client Name: Sara Simmons
Age: 15 years old
Race/Ethnicity: Native American
Educational Level: Currently in 10th grade
Members of Household: Sara, her mother, and four younger siblings
Setting: Indian Health Services Mental Health Center
Social Worker: Sue Lightfoot

Sue Lightfoot is a social worker with the Indian Health Services Mental Health Center on a Native American reservation in South Dakota. Her primary focus is working with youth and adolescents attending grammar or high schools and who live on the reservation. A new client, Sara Simmons, is a 15-year-old high school sophomore who has requested an appointment.

Sue greets Sara in the waiting room and invites her to her office. Sara is a very attractive young woman with long dark hair and is appropriately dressed in blue jeans and a long-sleeved blue-flowered top. She quietly enters Sue’s office and waits for Sue to tell her where to sit.

Sue motions to one of the two chairs in front of her desk and asks Sara to have a seat. Sue sits in the other chair facing the desk. Without making eye contact, Sue says to Sara, “I'm wondering what brings you to the Center today, Sara? Are you missing a class at school?”

Sara turns her head toward the window and replies, “Well, I'm not really sure why I made the appointment. I guess I just wanted someone to talk to.”

“You needed someone to confide in and perhaps not a family member. Is that correct?” Sue says with a little smile on her face.

Sara nods her head and says meekly, “Yes, I can't talk to anyone in my family. They would kill me.”

“Who do you live with, Sara?” Sue says gently.

“My mom and four of my sisters and brothers. The other sister and brother are older and don't live at home anymore.”

“Okay, and your father?” Sue queries.

“He died two years ago from drinking too much,” Sara replies. “My mom has been trying to work and take care of us ever since. It's been real hard on her. That's why I can't talk to her. I don't think she can handle one more thing. I try to help her out as much as possible. I take care of my sisters and brothers when she's not there because I'm the oldest now.”

“That kind of responsibility must be hard for you, too, when you're in high school,” Sue suggests. She notices that Sara hasn't looked at her since she started the conversation.

“Well, yeah, sometimes. I cook dinner, too, if my mom doesn't get home until late. She sometimes works overtime to make more money. It's pretty hard with 5 kids, you know?”

Sue leans toward Sara and notices a red mark on her face and says, “Yeah, I can imagine it would be very hard. And how is it for you? Do you go out with friends or
date someone?" Sue knows that the girls on the reservation often start dating at 12 or 13 years of age so it wouldn't be unusual for Sara to have a steady boyfriend. Sara pauses for a moment and then replies, "Well, sort of."

Sue notices that Sara seems upset and says, "Sort of?"

"Yeah, well that's why I came here today. But you've got to promise you won't tell my mom because she'd kill me," Sara blurts out.

"Okay," Sue replies in a soothing voice, "I can't promise until I know what it is, Sara, but our conversations are confidential; so, unless you are going to harm yourself or someone else, our conversations are pretty much just between you and me. But since you aren't 18 yet, it still depends on what's going on."

Okay, well I've got to tell someone. You see, I've been dating this guy who is a lot older than me. He's 21 and I'm just 15 and I've only gone out with him twice, but he seemed like he really cared about me and wanted to hang out with me and all. So, anyway, I went out with him a couple of times." Sara pauses and seems stuck in the conversation.

Sue leans closer to Sara. "Okay, this seems hard for you to talk about so take your time. What is this guy's name?" Sue asks quietly.

"Chris," Sara replies. "He seemed really nice but last night ..." Tears well up in Sara's eyes and she covers her face.

"It's okay, Sara. Can you tell me what happened last night?" Sue says with empathy. "It sounds like it was pretty upsetting to you."

After another pause, Sara composes herself and looks over at Sue. "I think he raped me." A flood of tears comes out and Sara is crying uncontrollably.

Sue leans forward with her elbows on her knees and her face close to Sara. She allows Sara to continue at her own pace. "You see, we went out and had a good time. We went driving around and got some sodas and chips and sat in the car and just talked for a while and then we got out of the car and were just walking and he began kissing me and we walked over to this hill and sat down and that's when he started making a move on me and I said I didn't want to do that. I barely knew him and I wanted to wait and he got mad and started slapping me."

Sue thought for a moment and then carefully responded, "I noticed the red mark on your face, Sara; do you have other red marks?"

Sara rolled up her sleeves to reveal dark bruises on her upper arms and then pulled up her blouse to show Sue a dark bruise on her rib cage. "He got angry with me because I didn't want to have sex with him and began hitting me and then tore off my pants and began doing it anyways." Sara sobs. "I don't know what to do. A lot of my friends have babies and I'm scared I'll get pregnant and I just can't handle it. I want to finish school and go to college. How could this happen to me? I told him 'no' over and over again and he just got so mad that I finally just let it happen. I guess it was my fault but I didn't know what else to do."

Sue says comfortingly, "Sara, it wasn't your fault. You told him 'no.' You tried to stop it but you aren't as strong as he is and you couldn't. Did he threaten you if you told anyone?"

"No, after it was over he just acted like it was nothing and smiled and said, 'See, I knew you'd enjoy it.' I told him I wanted to go home and he said 'Yeah, get dressed and we'll go.' We didn't talk at all in the car and when I got out of the car
I told him never to come by my house again. I just heard him say ‘bitch’ and then ‘don’t worry’ as he tore off down the road. I went inside and took a long shower and went to bed. My mom was asleep so she didn’t see me last night and left for work early. I didn’t know what to do, so I called here and they said I could come in and see you today.”

Sue said, “That was the best thing you could’ve done, Sara. There are some things we can do when you’re ready. But one thing you can do right away is to get something called “emergency contraception” through the Indian Health Services Pharmacy. They just passed a law that IHS can provide emergency contraception to women no matter how old, no questions asked. But first you’ll need to see a doctor. I know a very nice female doctor whom I can call and schedule an appointment ASAP. Would you be willing to do that?”

Sara considered this request for a moment and finally said, “Yes, I guess so. I just don’t want my mother to know.”

“Let’s see what we can do. I’ll call you as soon as I have the appointment time. In the meantime, let’s find another time when you can come back and see me in a couple of days, OK? Do you feel you’ll be safe? Before you leave I want to set up a safety plan with you so if this guy bothers you again, you’ll know exactly what to do.”

“Sure, I guess that’s the best thing to do. I think I can trust you,” Sara says meekly.

“You can, Sara. I’m here to help and I don’t want to see anything else happen to you,” Sue says reassuringly.

Sue spends some time with Sara developing a safety plan so that if Sara feels she is in danger or threatened by the perpetrator of the sexual assault, she can access help and get out of the dangerous situation. She also schedules an appointment with the doctor who works for IHS for that afternoon. Sara gives Sue written permission to explain to the doctor what happened. Sue schedules another appointment 2 days later with Sara.

**Second Visit With Sue Lightfoot**

Sara arrives for the second visit with Sue and appears upset when she enters Sue’s office. She paces back and forth in the office with Sue standing at the door. “Sara,” Sue starts the conversation, “what’s going on?”

Sara goes to the window with balled fists resting on the window sill, “I’m so angry, I could murder him!” Sara says in a very angry tone of voice. “He’s ruined my life and I could just kill him!”

“OK, Sara,” Sue goes over and stands behind her, ”let’s sit down and tell me about it, OK?” Sara reluctantly agrees to sit down and says, “How do I go back to school? Everyone will know something happened. I can’t stand to face everyone. It will be mortifying,” Sara states emphatically. “My plans to finish high school and go to college were destroyed by that jerk. And then if I don’t go to school my mother will definitely know something is wrong. I haven’t missed a day of school in 5 years!” Sara stands up again and then sits down. “My friends will all laugh at me! I just don’t know what I’m going to do.”

Sue can see that Sara is moving through stages of this crisis. “Sara, let’s back up for a minute. Did you see the doctor?”
“Yes, and she did an exam and said I should report it to the police but I don't want to because then everyone will know and it won't help anyways. He'd just deny it and said I wanted to have sex with him. So, why report it?”

Sue allows for some silence in order to let Sara calm down a bit. “Sara, I'm glad you saw the doctor. Did she give you a prescription for the medicine we talked about?”

“Yes, and that really make me feel better,” Sara responded taking a deep breath. “I'm much less worried about getting pregnant.” She sweeps her hair back and covers her forehead. “I guess it's just settling into me what happened and I'm so upset about it. I wish I'd never met Chris. What a complete jerk!”

“Maybe it would be good to see a counselor, Sara. You've really had a very traumatic event happen and it might be good to have someone to call when you get these upset feelings.” Sue says carefully using Sara’s language for what happened. “We have someone here at the clinic who knows a lot about sexual assaults and she would understand and help you with your feelings. Would you be willing to do that?”

Sara sits back and thinks for a minute. “Do you think I can trust her?” Sara queries with a sigh.

“Absolutely,” Sue responds, “just like you trusted me.”

“Why can't I just see you?” Sara looks over at Sue, “You've already helped me.”

“Because I'm not licensed to deal with emotional issues and she is a real expert who has been here for a long time. I think you'd really like her.”

“OK. I'll see her,” Sara responds.

“I'll always be here, so if there is something else I can do, you can always call me, OK?”

“That sounds good; what is this other lady's name?” Sara says quietly.

“Lucy Goodfellow. If she's free, I'll introduce you before you leave today,” Sue responds.

“OK, thanks,” Sara says a little brighter. “And thanks for helping me out. I feel better than when I walked in the door the other day.”

“Good, you are a very smart young woman, Sara, and we’re going to get you through this,” Sue responds.

Sue catches Lucy Goodfellow walking down the hall and introduces her to Sara. They schedule an appointment for the following week.

6.3-1. What are Sara’s strengths?

6.3-2. What were some ways that Sue communicated empathy to Sara?

6.3-3. What are the two theories or approaches on which Sue based her intervention and why did she choose these approaches?

6.3-4. How might Sue or Lucy help Sara manage the stress she feels about facing her peers at school?

6.3-5. How would you assess Sara's statement concerning her desire to kill Chris? Should Sue have discussed this issue more thoroughly with Sara? Write the dialogue between Sue and Sara based on this concern.
CLASS ACTIVITIES

6.4  Research an intervention that is not discussed in this chapter and is commonly used with a population that interests you. Prepare a presentation for the class that includes responses to the following:
   a. Explain the intervention and how it is used.
   b. Identify the populations that typically benefit from the intervention.
   c. Discuss the scientific evidence that supports this intervention.
   d. Identify four scholarly articles that have used the intervention as part of a research project.
   e. Identify the strengths and limitations of the intervention from a cultural perspective.
   f. Identify any potential ethical concerns regarding the use of the intervention.

6.5  Write a crisis case scenario, and identify how you will apply each stage of Rogers’s Seven-Stages of Crisis Intervention Model.

6.6  Research methods for changing cognitive distortions. Create a list of seven strategies that can help clients change illogical thinking and provide an example for each strategy.

6.7  Choose a cultural group and find two articles that describe innovative interventions that have proven effective with that group. Be prepared to discuss the articles in class.

INDIVIDUAL ASSIGNMENTS AND PERSONAL REFLECTIONS

6.8  Select a minor annoyance you experience and make a table with the following columns: date, event, thoughts, feelings, behaviors. Keep a record of your thoughts, feelings, and behaviors regarding the event for 3 days. Identify any cognitive distortions. Use cognitive restructuring to reframe your thoughts and notice any changes in your feelings and behaviors.

6.9  Imagine being a caseworker in child protective services. Develop a case scenario of how you would intervene in a case involving two young children being abused by one of the parents. Reflect on personal emotions you might experience, ethical concerns you may have, societal and personal biases that you may encounter, and how you would overcome these professional challenges.

REFERENCES


