182968984F

072231

SENTRUM VIR BIBLIOTEEK- EN INLIGTINGSDIENSTE

CENTRE FOR LIBRARY AND INFORMATION SERVICES

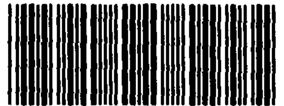
VERVALDATUM/DATE DUE

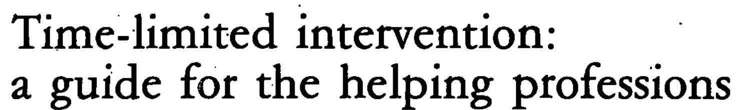
1988 -04- 25

26 SEP 1988

02 MAR 1989

1179-1085





Time-limited intervention: a guide for the helping professions

Time-limited intervention: a guide for the helping professions

Ina Snyman & associates

Human Sciences Research Council
National Programme: Affordable Social Security
Subprogramme: Affordable Social Provision
1987

RGN BIBLIOTEEK LIBRARY HSRC
1987 -10- 05
STANDKODE
001.3072068 HSRC
REGISTERNOMMER
ASSI
072231
BESTELNOMMER
R10

This is a publication of the Committee for the Subprogramme: Affordable Social Provision of the National Research Programme on Affordable Social Security.

Members of committee: Prof. Ceciel Muller (Chairperson), Prof. M. Cohen, Mrs Cecilia Dawson, Prof. E.A.K. Hugo, Miss Sheila Hurford, Dr J.M. Lötter, Dr Ina Snyman (Co-ordinator), Mr M.A. van Zyl

Specialist consultants: Dr D.B.T. Hackland, Dr J. Op't Hof, Dr Ritha Ramphal, Prof. Milla McLachlan, Prof. G.J. Welch

Programme secretary: Mrs Magriet Doorewaard

ISBN 07969 0497 9
© Human Sciences Research Council

The technical preparation and production of this publication were undertaken by the relevant divisions of the HSRC.

CONTRIBUTORS

Shathidd BOOLEY — M.Soc.Sc. (Social Work) (University of Cape Town) — Supervisor: Social work services at CAFDA (Cape Flats Distress Association).

Laetitia BOTHA — D.Phil. in Social Work (University of Pretoria) — Social work private practitioner in Pretoria.

Winifred A. BRYANT — M.A.(S.S.) in Social Work (University of South Africa) — Occupational social advisor, Council for Scientific and Industrial Research, Pretoria.

Steven J. COLLINGS — M.Soc.Sc. in Clinical Psychology (University of Natal) — Clinical psychologist and researcher in collaboration with Rape Crisis (Durban).

Annemie DE VOS — D.Litt. et Phil. (Rand Afrikaans University) — Senior lecturer in Social Work, RAU.

Amanda M. DIEDERIKS — Hons.(S.S.) in Social Work (University of South Africa) — Marriage guidance counsellor, Pretoria.

Gillian T. EAGLE — M.A. in Clinical Psychology (University of Natal) — Lecturer in psychology/Clinical psychologist, University of Natal.

A.E. GANGAT — M.Med.(Psych.) (University of Natal), D.P.M. (Dublin) — Consultant psychiatrist/Lecturer, Department of Health.

L.R. NAIDOO — M.Sc. (University of Durban-Westville) — Clinical psychologist/Student counsellor, University of Natal.

Ina SNYMAN — D.Phil. in Social Work (University of South Africa) — Senior research specialist, Human Sciences Research Council.

Herman STRYDOM — D.Phil. in Social Work (University of Pretoria) — Senior lecturer in social work, University of Pretoria.

Gary John WELCH — D.S.W. (University of California at Berkeley) — Professor and head of the Department of Social Work, University of Natal.

FOREWORD

The national research programme Affordable Social Security is housed within the Institute for Sociological and Demographic Research at the Human Sciences Research Council, and is operationalized through six subprogrammes, one of them that on Affordable Social Provision.

The main emphasis of the national programme and its subprogrammes is placed on issues of affordability and accountability in the broader field of social security and the provision of social services. This book, while publicly launching the subprogramme on affordable social provision, also serves two other objectives. Firstly it focuses on methods of helping in which time rationing is purposefully applied as a contribution towards greater affordability, and secondly, it is designed in such a way that it could be used as a tool in training and a guide for practitioners in different human service fields.

Moreover, as 11 persons from outside the HSRC contributed directly to the book, this is also an example of the kind of partnership research which the HSRC has been actively seeking for a long while. I trust that the publication of this book will encourage academics and professionals from different fields of social science to become involved in research under this programme.

J.G. GARBERS
PRESIDENT OF THE HUMAN SCIENCES RESEARCH COUNCIL

CONTENTS

PAGE

PREFACE ix

I TIME-LIMITED INTERVENTION: A GENERAL OVERVIEW — Ina Snyman 1

II POST-DIVORCE ADJUSTMENT: A STRUCTURED, TIME-LIMITED INTERVENTION — Gary John Welch 31

III RAPE CRISIS INTERVENTION — Steven J. Collings and Gillian T. Eagle 51

IV TIME-LIMITED THERAPY IN PRIVATE PRACTICE — Laetitia Botha 65

V TIME-LIMITED INTERVENTION IN OCCUPATIONAL SOCIAL WORK — Winifred A. Bryant 83

VI THE ORGANIZATION OF CONSTANT AVAILABILITY AT A CRISIS CENTRE — Annemie de Vos 99

VII TIME-LIMITED INTERVENTION AND COMMUNITY DEVELOPMENT — Sharhidd Booley 109

VIII THE SINGLE SYSTEM DESIGN IN SOCIAL WORK RESEARCH AND SOCIAL WORK PRACTICE — Herman Strydom and Amanda M. Diederiks 129

IX CONCLUSION: IMPLICATIONS FOR PRACTICE IN THE HUMAN SERVICES — A.E. Gangat and L.R. Naidoo 145

PREFACE

In this book the experience of a number of practitioner-researchers with different variations of shorter term intervention is explored. It is presented mainly by means of the case study design although the authors have incorporated a considerable amount of relevant reading into their contributions.

The first chapter demarcates the field of time-limited intervention and includes references to variations such as crisis intervention, task-centred therapy and brief therapy; the basic characteristics shared by all the variations; and target groups for whom and settings in which time-limited intervention is appropriate. Research in the field is referred to and advantages as well as contra-indications are discussed.

In each of the subsequent chapters there is a description in greater depth of some aspect touched on in the general overview. The authors of these chapters are all directly involved in the specific project or the kind of intervention they describe. "Kind of intervention" could also refer to a specific setting such as occupational social work and social work in private practice.

Although time-limited intervention is traditionally a more clinical approach where a therapist treats an individual in an office situation, some kinds of time-limited intervention, for example disaster aid, are community oriented. A third variation is that dealt with in the chapter on crisis intervention and community development; where community development has a mainly preventive focus, with the crisis therapy component of this agency then responding more swiftly to those cases where a problem has advanced to a stage necessitating individualized attention.

Readers may notice some overlap in content in the different chapters as well as the occasional paradox. The first can be ascribed to the fact that each chapter represents an effort to portray a specific situation as fully as possible; and the second to the nature of time-limited intervention as an art in which techniques are adapted to specific situations. Examples of the latter are the differential use of the "contract" and the way in which interviews are spaced.

Although the approach of time-limited intervention is suggested as being particularly valuable at a time when services are increasingly being examined for effectiveness and efficiency, some words of warning are ex-

pressed in the final chapter against the indiscriminate use of any approach merely because it appears to be less expensive. Practitioners should rather continuously arrange and analyse the considerable amount of data that reaches them regularly, in order that the theory and practice of human service delivery is refined in such a way that intervention will become more appropriate to the problems in hand.

INA SNYMAN
On behalf of the Work Committee for the Programme: Affordable Social Provision

I

TIME-LIMITED INTERVENTION: A GENERAL OVERVIEW

Ina Snyman

1. INTRODUCTION

The demands of accountability and affordability which are paramount in times of economic stagnation and shortage of trained manpower, require a new look at expensive, long-term restorative work in the fields of social work, social welfare and related fields.

Also, as fees have begun to be charged in the field of social work and private practice as is the case in other professions (see Cummings 1986:426-431 on psychology), time-limited or "brief", task-centred assistance at critical moments, when need is greatest or when intervention can have its biggest impact seems to have particular relevance.

The roots of this kind of intervention could nevertheless be traced back to different stages in the development of social work and psychotherapy. Already in 1920 psychiatrically trained, clinical workers in America distinguished between "intensive" cases which required an in-depth investigation into their social conditions, and "slight service" cases in which an immediate service based on more apparent facts, was provided (Golan 1978:38).

Some years later the unsettled circumstances of the 1930s resulting from the Great Depression created a need for different kinds of disaster relief, and in big cities stranded passengers and other transients necessitated the founding of the *Travellers Aid Society* which could offer short-term emergency care at railway stations and bus terminals. The situation of such people required immediate relief, and the beneficial effects of limited but tangible, immediately attainable goals became apparent in the later 1930s from the reports of the *Travellers Aid Society* (Golan 1978:39).

The Second World War left many soldiers psychiatrically disabled and created a need for more attention to be given to mental health. At this stage new drugs and an awareness of the ineffectiveness and often detrimental effects of long-term hospitalization resulted in a move away

from long-term, total care to community facilities providing preventive, short-term services (Golan 1978:28).

In the decades to follow many authors pointed to either the *effectiveness* of time-limited intervention — in other words it proved successful for certain clients — or to its *efficiency:* that is, it showed results that were as favourable or better than open-ended analytic therapy over a shorter period of time (cf. Garvin *et al.* 1976:238-267; Hepworth, Larsen 1982:10-11, 278-279, 296-297; Budman, Gurman 1983:277-292; Fisher 1984:101-106).

In the sections on research and on advantages and benefits, more attention will be given to the effectiveness and efficiency of time-limited intervention.

The characteristics of timeliness, greater brevity, focus and intensity of attention have therefore taken shape in a variety of approaches or strategies in different counselling and therapeutic fields or with regard to different situations that require problem solving.

In the next section a short exposition of the different strategies and approaches that fall under the concept of time-limited intervention is provided, followed by a discussion of the situations that are amenable to time-limited intervention, its main features, underlying theory, research in the field and the advantages and benefits of time-limited intervention.

2. MAIN STRATEGIES AND APPROACHES

The following terms are generally associated with time-limited intervention:

crisis
brief
time-limited
task-centred
behaviour
limited-goal
emergency
targeted

} therapy/work/intervention/practice

In the rest of this discussion the term time-limited intervention will be used to refer to the general concept of structured, short-term, task-centred, limited-goal work, while more circumscribed interventive methods will

be discussed in accordance with the term by which each one is known. Only a few of the above are defined briefly in the following paragraphs.

The first strategy, namely *crisis intervention,* refers to the giving of attention at times when people experience an event in their lives which is so unexpected or disruptive, or requires such new or unusual adjustment or problem-solving skills, that their regular coping resources prove insufficient. Some more specialized crisis interventive strategies have been developed, namely disaster therapy, bereavement counselling and grief work (Schoenberg 1980; Malherbe 1976; Strumpfer 1975; Lonsdale *et al.* 1979), while some types of short-term guidance are offered with regard to expected crises such as when a disabled person goes to live independently for the first time, or when a child leaves home to attend a boarding school. However, different types of crises and their special components are discussed more fully in later sections.

In *brief therapy* the emphasis is on the explicit understanding of the brevity of the therapeutic contact rather than on the circumstances under which it is applied. The setting in which it is used, nevertheless determines the exact time span of the therapy, for instance preparation for release from long-term institutionalization, or a holiday camp for the newly widowed or divorced, etc.; and "brief" could therefore refer to a limited number of meetings, a few weeks or even a few months (De Shazer *et al.* 1986:207-221; Budman, Gurman 1983:277-279).

By *time-limited* work is also understood that therapy is not going to be extended indeterminably, but the emphasis is on the fact that the duration of the therapy period is decided on beforehand, rather than on the actual brevity of it. However, as already stated, "time-limited" is also a handy all-embracing term which in this discussion will be used to refer to the short-term therapies as a group.

Task-centred practice is a technology for attending to specific, target problems perceived by clients — or in certain circumstances authorities — as requiring focused intervention. Tasks are framed to state what the client and practitioner are to do, and while the main tasks may be in the form of a general directive for action, there will be more tangible task specifications which may change form and content as intervention proceeds (Garvin *et al.* 1976:238-267; Epstein 1980:3, 11, 13).

The *treatment seminar* is here considered a specific approach, although it could also form part of a particular kind of setting, namely non-formal or unofficial education. It resembles an informal classroom learning

situation which, for some people, is a more acceptable format for problem solving. The kind of change of life-style necessitated by, for example, life transitions, may require physical and emotional accommodation, altered and/or new relationships and very likely, a restructuring of the hierarchy of value priorities (Welch 1986:5-9; Golan 1980a:265-266).

From these short descriptions it should be obvious firstly, that intervention is structured in each of the strategies, and that this distinguishes this category of intervention from the more free-flowing, analytical and growth-oriented, open-ended style of the traditional egopsychological approach followed by such professions as social work, psychology and psychiatry. Secondly "the time allotted to treatment is rationed" regardless of the way the allotted time is allocated, for example one-hourly sessions every day for three weeks or one hour a week for 15 weeks (Budman, Gurman 1983:277; De Shazer *et al.* 1986:207).

3. SITUATIONS AMENABLE TO TIME-LIMITED INTERVENTION

The situations which are particularly amenable to intervention of this kind, refer to:

- clients with certain characteristics,
- events or problems of a certain kind which have already occurred or seem imminent,
- settings in which a profession is practised and
- a combination of the first three, as found in situations calling for follow-up intervention.

3.1 Clients with certain characteristics

Often client behaviour is problem- or event-specific and not representative of a permanent characteristic of the client. For example, a person who has gone through divorce and one who has lost a child, might display similar symptoms of depression, preoccupation or despair, and both of them might be helped by time-limited intervention to return to satisfactory social functioning.

On the other hand, some clients are characteristically lacking in ability and tolerance for entering into, and continuing with, more traditional long-term insight therapy with its emphasis on reflective discussion, imaginative self-scrutiny, and analytic and abstract thinking. The association of many of these clients with therapists or welfare bodies

does not lead to the acquisition of coping skills that would sustain them in the long term, and they therefore need concentrated practical assistance every time a new problem arises.

This latter category of clients will be discussed first. For example, according to Fischer (1978) *working class* people do not like to reflect on their situation during lengthy interviews; they expect the help they are likely to receive to be demonstrated early in the contact; there should be rapid results and their complying with the therapist's expectations and requirements should be rewarded immediately and explicitly.

Reid (1978:86-87) and some colleagues have concentrated on developing a system of practice suited to the orientation of the *lower-class* client, and although they have not conducted many studies comparing the task-centred model to other approaches with regard to this particular type of client, they found that lower-class clients themselves evaluated this kind of treatment very positively because they understood the service better and felt they were more often getting the kind of help they wanted.

Irvine (1979:27-31, 95-134) discusses certain "immature" people, "hard-to-like" families and "inarticulate" mothers and identifies such special characteristics in them respectively as: greedy demandingness; impulsiveness, lack of control, aggression, compulsive expression of needs and limited sense of time, money and property; and self-centred babbling — without ever listening. The author describes the need such clients have for the therapist's demonstration of goodwill and for practical signs of his approval and willingness to "nurture", but at the same time to present himself as a strong, decisive parental figure who could tell them what to do.

Although work with such clients might appear to require long-term intervention, their dependency needs, chaotic life-style, impulsiveness, etc. make the prospect of a significant permanent improvement in social functioning unlikely, and intermittent brief intervention is probably more appropriate.

Some people might cope perfectly well under normal circumstances, but they might have a high-risk characteristic which makes them vulnerable at times or which creates a need for intervention at specific times; for example a disabled person whose disability necessitates a series of operations over a period of several years but who might only need social work or psychological intervention round about the time of the operation (see also Cummings 1986:429-430).

In *certain circumstances* people who might otherwise tolerate or prefer a different kind of intervention or service, could only use brief intervention which is non-analytic and clearly focused on a specific objective. For example, the patient in the waiting room or waiting corridor of a health facility can participate in or listen to discussions about alcohol abuse, sound diet or family planning, but would not feel that he has the time or privacy — or that the procedures of the hospital or the clinic would allow him — to enter into in-depth analysis of his alcohol or obesity problem or his family planning routine.

3.2 Events or problems

Crisis intervention has already been mentioned as an approach or strategy, and one of the types of events (or problems) amenable to time-limited intervention is therefore the *crisis*. There are different kinds of crises and the more common differentiations are developmental or transitional versus situational crises (Golan 1978) and expected versus unexpected crises (Adams, Adams 1984). Developmental or transitional crises are roughly those coinciding with the onset of different life cycles and are usually also anticipated crises. Situational crises are normally unexpected, for example a sudden death in the family, job loss, some natural or manmade disaster, etc.[1]

Another model (Janzen, Harris 1980) classifies crises according to two frameworks, one based on the *source* of the crisis, and the other on the *nature* of the event or of its main effect on people. The source categories are extrafamilial and intrafamilial, while nature categories are accession, as found in the case of marriage, pregnancy or the addition of a stepchild to a family; dismemberment, as found in the case of death or desertion; demoralization, as found in the case of non-support or infidelity of a spouse, drugtaking by a family member, or delinquency of a child; demoralization plus either accession — for example illegitimate pregnancy — or dismemberment — for example imprisonment of a family member; and change of status, as found in the case of acquisition or loss of wealth or a move to a different neighbourhood.

A special kind of crisis is the *disaster* of which the onset may be sudden like in the case of a flood, landslide, bomb explosion or accident; or it may develop over time and be of an enduring nature, like a drought or a war. However, in the latter case there usually still is a point at which those subjected to the disaster or others around them will realize that

a crisis is at hand or that the phenomenon has reached crisis proportions, and that unusual or extraordinary remedial measures have to be taken.

Disaster could take place on a macrolevel or a microlevel. For example, a whole community or region could be hit by retrenchment, a bomb, a flood or a fire, or a single family may have its house burnt down or its access to the outside world cut off by heavy storms.

What makes the crisis situation particularly amenable to time-limited intervention is the realization of the victims that their previous coping mechanisms have failed, their consequent readiness to try new strategies, and the sudden availability of extra resources that can be utilized on behalf of the victims.[2] However, it is possible that a situational crisis occurs while a person is struggling with a transitional issue, in which case the focus of time-limited intervention might prove too narrow or the timespan too brief (Golan 1980b:542-550).

Another type of event for which time-limited intervention is appropriate is *separation* of some kind. Temporary or permanent separation creates what Webb (1985:332) calls "a crisis of separation/individuation" displaying most of the symptoms of other crises such as disasters, a sudden death of a breadwinner, etc.

During any person's life, there could be several stages when separation takes place, but early childhood and adolescence are characterized by more pronounced severing of ties. Usually families have the necessary adaptational skills to handle these upheavals and they soon settle into a new satisfactory relationship.

Sometimes, however, the separation is more far-reaching, for instance in the case of long-term hospitalization of a parent; or the family is unable to come to terms with the departure of a child from home. In these cases the family might need some professional assistance over a short period of time to help it meet the demands of the changed situation.

More and more, short-term work is also offered as a preventative or developmental strategy to help people not merely to "grit their teeth and bear it" but to make the separation experience a pleasant or enriching one.

Other kinds of separation are those experienced when a long-term helping relationship has to be terminated, or when a person loses a limb or a sensory function and actually mourns the loss of the limb, eyesight or hearing in the same way as a bereaved person would mourn the loss of the deceased.

Short-term intervention is also called for with regard to various kinds of *abuse,* such as physical child or wife abuse, incestual events involving children, and rape. Although contact in these cases could be continued over a long period of time, the nature of the problem requires immediate intensive intervention over a short period as soon as it becomes known that the event took place or has been taking place — which often happens when multiple stresses create an episode of acute crisis for the victim[3] (White, Rollins 1981:103-109; Golan 1980b:545).

3.3 Settings

Sometimes the setting in which a profession is practised — rather than the client, a problem or a specific event — determines, or requires the emphasis of a certain approach or strategy. The private social work practice, independently or as a part of a multidisciplinary group practice, industrial social work and social work in some health care settings are examples of settings which lend themselves more to short-term, limited-goal work than to longer term, growth-oriented work.

In *private practice* there is usually a fee per interview which has been scheduled for a specific time and duration, and these elements of time and money create a more businesslike atmosphere. Clients get involved more readily and there is a more immediate evaluative tone in the sessions. In other words progress or the lack of it is assessed more swiftly, and either way, termination of contact is decided upon to prevent any waste of effort, time and money.

Industrial or occupational social work is practised in a business or corporate setting which determines the atmosphere in which the problem solving takes place, as well as the kinds of problems the social worker will deal with. The problems are mostly jobrelated ones for which fairly rapid solutions have to be found because of the profound effect such problems have on the operation of the industry or firm (cf. McBroom 1985).

There is therefore seldom any lengthy reflection on family and/or personality problems, and plans of action have to be speedily formulated and carried out, with quick follow-up evaluation of the outcome of the action.

Health care settings usually present some kind of crisis which could be divided into two kinds, namely those where the crisis is characterized by a specific disastrous event such as a heart attack or burning, and others where special preparation and planning are called for such as upon the

discharge from hospital of an elderly patient (Dhooper, 1984:294-303; Weinberg, Miller 1983:97-106; Kulys 1983:182-195).

Hospital social work or work in the health field could also imply work at a veterinary hospital, and here short-term intervention would be applicable in the case of the death of a pet. The example described by Quackenbush and Glickman (1984:42-48) indicates that intervention of this kind would be very similar to that practised in other cases of bereavement where an important member of the family social system has been removed. Examples of tasks needing attention are re-establishing equilibrium, coping with loneliness and finding support during the crisis of bereavement.

Other "situations" amenable to time-limited intervention are certain types of *non-formal* or *unofficial education*. Although this is not therapeutic intervention, it ties in with the developmental function of social welfare (Gindy 1970:33) and might be applied to upgrade the skills of various groups such as clients, resource persons like foster parents, paraprofessionals, management and trained staff. It could also, as stated before, provide the format for learning to adjust to the changes inherent in life transitions (Golan 1980a:265-266).

Birkenbach, Kamfer and Ter Morshuizen (1985:17-19) discuss "behaviour modelling" as an in-service training process for supervisors, and emphasize modelling or demonstration, role playing or rehearsal and social reinforcement or constructive feedback on performance. Although the training programme was an ongoing one, individual trainee-supervisors underwent it for a certain period only. As is typical in time-limited work, intervention was focused sharply on a specific target behaviour, namely on the supervising ability of the trainee, rather than on his general educational development. It was also directed at the acquisition of a skill rather than at the personal problems of supervisors.

3.4 Follow-up

Some situations call for *follow-up intervention* some time after the critical event has taken place. This is the case with returned soldiers, survivors from a disaster or a war attack and different kinds of refugees (Miller, Turner, Kimball 1981:111-116). Therapy might or might not have been rendered at the time of the event, but the victims usually experience a measure of geographical and social displacement at some later stage. For example, the soldier returns to a home which is totally different from

the war zone and probably also from the home he left; the refugee tries to settle down in a new country after a time of turmoil in his previous country and possibly a period of transition in a refugee camp, etc.

For some of these people a non-formal educational format might suffice in assisting them to learn new ways of doing things, while others might need a more therapeutic kind of intervention to deal with remnants of shock and emotional upset. However, in both cases the greater likelihood is that the intervention is needed for a limited period of time and that it will centre on a limited number of behaviours rather than on broad life spheres.

While this section dealt with the types of clients, events and situations amenable to time-limited intervention, the next concentrates on the components or characteristics of time-limited intervention.

4. MAIN FEATURES OF TIME-LIMITED INTERVENTION

Some of the main features of time-limited intervention derive from the characteristics of the clients, and others from the circumstances created by the events or problems necessitating the intervention.

In the previous section mention was made of certain characteristics of working-class and other types of clients, namely the need to be shown immediately what help to expect, to experience quick results and rewards and to get clear directives in a non-reflective atmosphere. Emphasis on *behaviour change* rather than personality change is therefore an important feature: "(t)he search is for points of leverage to effect immediate change rather than for a 'thorough understanding'" (Reid 1985:45).

Sometimes time-limited intervention is practised more for the purpose of prevention than for reasons of therapy or restoration, in which case *behaviour management* rather than behaviour change would be the distinguishing feature. This would for example be appropriate in a home for the aged where the long-term institutional environment tends to produce debilitating effects on the inmates, such as isolation, depression, passivity, depersonalization and withdrawal (Guy, Morice 1985/1986:11-17). However, at the same time this kind of environment provides opportunities for controlling and modifying behaviour, without purporting to change behaviour patterns that have evolved over decades.

Helping people to develop, to maintain or to revert to satisfactory behaviour, requires rapid *feedback,* that is an immediate response to indi-

cate the desirability of their actions. Feedback can therefore usually be divided into two kinds, namely reward in the form of words or actions showing approval, and punishment in the form of words or actions showing disapproval. Simply withholding approval could in certain circumstances also be used as a form of punishment.

A type of feedback which is becoming widely used, is the so-called ''token'' economy in which a range of rewards, often tangible, could be chosen, once tokens have been earned through ''correct'' behaviour. Behaviour accomplishments could include certain tasks — discussed in more detail in the following paragraphs — which have been performed or certain levels of performance which have been attained, such as cleaning a room, doing homework or losing a certain amount of body mass a week (Perkins, Rapp 1985/1986:32-34).

Giving or withholding tokens or other rewards act as encouragement or reinforcement to ensure that individual incidences of desirable behaviour settle into a firm pattern which becomes the general or characteristic conduct of the person concerned.

However, as stated at the start of this section, it is not just the type of client that determines the characteristics of time-limited intervention. Certain events and problems cause extraordinary stress particularly that brought about by the event or problem, or make such unusual demands that clients need to learn new strategies for handling their lives (Malherbe 1976:77). Another of the main features of time-limited intervention is therefore the emphasis on mastering such new ways of behaviour by practising a well-defined range of *tasks*.

Hepworth and Larsen (1982:299-300) see tasks as the means by which a subgoal, agreed on by therapist and client, will be implemented. Such tasks may consist of either behavioural or cognitive actions. Examples of the former are to study for a specified length of time each day or to follow a daily timetable for completing household tasks. Cognitive tasks may be: identifying feelings of jealousy when they are aroused or rehearsing in thought introductions to job applications by telephone (Hepworth, Larsen 1982:299-300).

Sometimes the tasks could form part of the interview situation, but more often than not they are tried out in those situations where the difficulties are experienced, for instance in school, at work and at home.

The task usually has to meet certain requirements, for example the client should understand and accept the reason for undertaking it, he should

be able to do it and should believe that it is worth doing. As tasks are operationalized objectives they should be defined in terms of the actions to be performed and not in terms of the expected results. For example "accept your husband's death", "learn to live with the move you have had to make", etc. refer to the objectives or outcome of actions, not the actions themselves (Oelofsen 1985:85).

However, not all tasks can be explained that easily. For example "material-arrangemental" tasks can be described with much less trouble than psychosocial ones (Golan 1980a:264-265). There is thus often a need to *demonstrate* "correct" behaviour or at least the boundaries of behaviour that would elicit a favourable response from the environment. In this respect behaviour *modelling* is appropriate, and the therapist or key persons in the community are called upon to display by example in living or in a specifically constructed setup how best to act in certain situations.

Simulation and role-playing sessions provide the opportunity of trying out and experimenting with behaviour within the protective therapeutic environment. This kind of session is appropriate not only where events or circumstances require new ways of acting, but also for clients such as those described under Paragraph 3. These and other inadequately socialized people need to learn appropriate behaviour by trying out how to act under everyday circumstances or how to manage day-to-day tasks such as housecleaning, personal care, etc. (Irvine 1979:28-29, 98).

Tasks and even the nature of rewards are often determined early in the contact and formalized in a *contract* which might be in writing and signed by both therapist and client (Pinkston *et al.* 1982:27).

Some of the advantages of the formal contract are its greater clarity, comprehensiveness and specificity; its visibility and tangibility which act as a reminder and motivator and the fact that it is easier to determine progress if objectives are clearly spelt out. There are however the dangers of impracticability or unrealistic undertakings, and oversimplification of the problem and its solutions (Oelofsen, Grobbelaar 1986:13-14).

A key feature of time-limited work is the early establishment of a *termination date*. This is usually accompanied by a timetable, setting out the milestones to be reached before or by the termination date. The timetable in turn places a limit on what can be attempted during treatment. In other words, irrespective of the characteristics of the client, if brief therapy has been decided upon, it cannot be expected to resolve com-

plex issues such as introjection, internalization or incorporation (Getz *et al.* 1983:138).

However, as Cummings (1986:429) has pointed out, time-limited intervention need not be a matter of only getting one chance. Briefly, in targeted psychotherapy, he prefers to think, therapy is interrupted rather than terminated, since the client/patient would return if a new problem were to arise.

When only a limited amount of time is allocated to a particular problem-solving effort, intervention has to take place at the appropriate moment, that is the point of greatest emotional accessibility. Good *"timing"* is therefore an essential feature of time-limited intervention and it is particularly relevant in the case of a crisis which moves through recognizable phases (Golan 1980a:265).

In the case of transitional or expected crises, intervention can have a preventative function and prepare people for what they might expect of the role and behaviour demanded by their new situation. In such a case the best moment for starting intervention will be some time, but not too long, before the onset or occurrence of the event.[4]

In other cases, the best time for intervention is soon after the crisis event has taken place or as soon as a crisis situation is perceived, for example when an aged person has run out of money, or a single parent can no longer manage and threatens to place all his children in an institution.

In order for intervention to take place at the right time, persons or agencies who offer crisis and/or emergency intervention will develop a system of *constant availability,* more commonly known as "standby" arrangements. For example, emergencies such as family violence, illness, etc. often occur at night or over weekends and cannot "wait" for the office to open at 09 h 00 the next morning, or on Monday after having closed on Friday.

The features discussed in this section derive partly from different theoretical perspectives and partly from application to practical situations. In the next section some of the theoretical perspectives are discussed.

5. THEORY UNDERLYING THE PRACTICE OF TIME-LIMITED INTERVENTION

Because of the emphasis on discovering new ways of coping rather than on bringing about profound insight or basic personality changes, many

of the concepts and techniques used in the intervention under discussion derive from behaviour and from learning theory. Social exchange theory aided the development of intervention in relationships, particularly in treating the family as a whole instead of individual members, and *crisis theory* helped shape the practice of intervening at the right time and attending to the client's ability to manage his new situation. This latter theoretical set will be discussed first.

A crisis is an upset in a steady state which calls for new behaviours, or which makes demands on a person for which his usual coping mechanisms and patterns are insufficient or incorrect. Building on the work of earlier crisis theoreticians, Golan (1978:63-71) identifies certain elements or states and maintains that a person goes through certain phases during these states. Although crisis is a generic process and groups or communities therefore go through these same phases, emphasis in this discussion is on the individual.

Firstly, there is the *hazardous event,* which, in the case of a transitional crisis could be school leaving or marriage, or in the case of a situational crisis might be the loss of a family member, the birth of a deformed child, a community disaster, etc.

The client — or someone else on his behalf — does not necessarily approach a therapist or a helping agency about the event itself. It is more often than not the *vulnerable state* caused by the event that leads the client to respond in a certain manner; and he might experience the blow as a loss of an object or ability or intrapsychic property such as meaning or faith, he might perceive it to be a threat to his current and future needs, autonomy or sense of integrity, and he may regard it as a challenge or "unperplexing opportunity" for survival, growth, mastery or self-expression (Golan 1978:65; 1980b:545).

Webb (1985:333-334) sees the termination phase of a long-term helping relationship as a crisis which normally creates a co-existence of all three elements. Firstly, there is the anticipated loss of regular contact with a meaningful person, which is typically expressed in a grieving reaction and concern about ability to function independently of the therapist. Secondly, the client may express anxiety because of the threatening prospect of functioning without a helping contact, but there may, thirdly, also be feelings of pride and energy in the face of the challenge provided by the experience of growth and independence implied by termination.

As mentioned before, the hazardous event may be a phenomenon recurring or ongoing in nature like child abuse or a drought. In such a case there is a *precipitating event* or factor (Golan 1978:66) that could bring anxiety and tension to a peak and bring the person from a vulnerable state to a state of disequilibrium or "breakdown".

Hazardous and/or precipitating events carry a certain stress potential, some more than others, and Holmes and Rahe (see Golan 1978:67) developed a scale in which stress potential values were attributed to different life events with a score of 11 for minor violations of the law to 73 for divorce and 100 for the death of a spouse. The purpose of this scale is to give an indication of the type and intensity of crisis intervention needed, although all people would not be affected to exactly the same extent by similar events.

The state of *active or acute crisis* is the condition created in the individual, group or community by the hazardous event and/or precipitating event or factor. Such an intense condition will seldom last for longer than about six weeks and during this time clients pass through physical and psychological turmoil manifested in aimless activity or immobilization, and disturbances in body and intellectual functioning. Coping ability is reduced and this leads to total exhaustion and/or a state of shock (Golan 1978:69).

Because of the extreme discomfort in clients at this stage, and their realization of the inadequacy of their regular coping resources, they are less defensive and more motivated to accept help. For the same reason minimal assistance from outside could produce maximal effect if it is focused appropriately.

Silverman (1978, quoted by Golan 1980a:262) summarizes these initial states into an "impact" and a "recoil" phase, but points out that the recoil phase is already the beginning of the final, namely the "accommodation" phase. Accommodation then, or *restoration of equilibrium,* starts to take place as the tension and anxiety of the state of active crisis begin to subside. However, such a new adjustment could be a maladaptive effort on the part of the victim(s) to reduce the psychic pain of the state of active crisis. In order therefore to achieve integrative and adaptive adjustment the client or victim has to perceive the situation correctly, he has to manage (accept and release) his feelings appropriately, and he has to develop constructive new coping behaviours which would normally include seeking and using help.

Adaptive resolution is inclined to produce a benign cycle of problem mastery, positive reactions to others, positive feedback from others and increasing self-activity and independence. Maladaptive resolution on the other hand could lead to increased use of defense mechanisms which antagonize other people who then respond negatively bringing less self-esteem, diminished coping ability, etc.

As people display certain reactions and experience certain needs during each of the aforementioned phases, the therapist will in the first place naturally focus his intervention on these. In general however crisis intervention implies first of all relief of symptoms — "holding" and "caring" — then restoration to former levels of functioning and linking victims to resources within and outside themselves for further problem solving.

Authors approaching crisis intervention from an ecosystems perspective, emphasize stress as a more measurable or operationalizable component of a crisis situation than the "state of crisis". In supporting the ecosystems point of view Panzer (1983:179-214) also criticizes the idea of consecutive stages and of a single appropriate time for intervention.

Within the ecosystems framework the relation between individuals and other parts or parties in their environmental system determines both the perceived amount of stress created by an event, and the amount of stress-buffering support offered. Within such a framework intervention is possible at different points; and the concept of "development of coping skills" is more relevant than that of "management of different stages".

However in the ideas of supporting and buffering, the ecosystems perspective recaptures the concepts of holding and caring mentioned above as part of the more traditional crisis theory.

Other features of crisis intervention which are common to most kinds of short-term intervention, are discussed in other sections.

The basic hypothesis of *social exchange theory,* is that a relationship between two persons continues if the rewards from the relationship are greater for each person than the costs. However, for the interaction and relationship to be entered into in the first place, there should be some desirable ends which can only be attained through mutual interaction and relationships with other persons (Brown 1975:260; Rank, LeCroy 1983:442; McDonald 1981:833). One of the types of ongoing relationships in which this kind of mutuality and reciprocity is most likely found to a larger extent than anywhere else, is the marital relationship extending into

family relationships. Social exchange theory is therefore looked at from the point of view of its applicability to the field of intervention in family problems, and, within the context of this discussion, its applicability to family crisis intervention is considered.

Family crisis and family crisis intervention could however be viewed according to different frameworks. Firstly, there is the assumption that certain families are crisis prone and that this is caused by the greater frequency and severity of stressor events in their lives and their own more frequent definition of such events as crises.

This latter definition, it is assumed, results from a certain exchange content leading to agreement that a crisis exists. Brown (1975:263) suggests on the other hand that if stressor events are experienced with greater frequency, the exchange among family members becomes more and more focused on those events, and that this contracting of the range of exchange-content among members removes the psychological satisfaction they would normally derive from their interaction with one another.

Within this framework, family crisis intervention would be focused on limiting stressor events, but more importantly, maintaining the breadth of the members' range of interactions with one another even where stressor events have been or are being experienced.

A second approach states that the nature of a family's exchange depends on the ways in which the family as a group perceives, respects and satisfies the basic needs of its members. In crisis situations, according to this viewpoint, there could be an impasse in the exchange content involving the basic needs. Intervention then requires that the point at which the impasse has occurred be located, that is at the point of perception of, respect accorded to, or satisfaction of someone's needs, and that problem-solving efforts would be directed at the specific behaviour exchange content of that point.[5]

Allied to crisis theory and social exchange theory is *family crisis theory* contributed to notably by Reuben Hill (1949 — as quoted by White, Rollins 1981:103-109). He developed an ABC = X formulation in which the crisis (X) consists of three components, namely the event itself (A), which is interacting with the family's crisis-meeting resources (B), which in turn interact with the way the family comes to perceive the event — that is, their definition of it (C).

Behaviour theory, when applied to family or marital therapy also relates to exchange theory by focusing on the establishment of "pleasing inter-

actions through reciprocal or equitable exchanges'' (O'Leary, Turkewitz 1981:159; Jacobson 1984:295-296).

The basic tenet of behaviour theory is however that observable action is a Response to a Stimulus from the environment, and that this response is elicited because the actor hopes to achieve a certain objective through it. If he finds that this objective is in part or in its entirety achieved, he repeats that kind of response. When he does not reach his objective, he adjusts or changes his response (Van Rooyen, Combrink 1980:42-45).

Because it is assumed that the response is brought about by the current, operational environment, behaviour theory does not value past experience very highly nor does it concern itself with underlying motivation or non-observable behaviour. In behaviour therapy, therefore, the symptom is dealt with as the problem, and only those behaviour manifestations causing difficulties in the person's functioning in relation to his social environment, will be the focus of change.

The counsellor or therapist uses the stimulus-response pattern and introduces a third step, namely Reinforcement (negative or positive) to feed back to the actor whether his behaviour is acceptable or not (S R R). In this way the latter develops behaviour or action patterns that will in general be adaptive through practice and trial and error.

Some of the main techniques of behaviour modification are

positive reinforcement, for example when other family members give some kind of reward (praise, gifts, assistance) when the withdrawing widowed mother takes the trouble to prepare a meal again, goes out or beautifies her home after some time of disinterest;

negative reinforcement, for example when a staff member in a residential centre ignores or frowns on a mildly disturbed inmate's efforts to attract attention by interrupting office work;

punishment, for example when a child who did not complete a school task loses a privilege, or the chance to accumulate credit or rewards; and

modelling, for example when the therapist or another person demonstrates correct child-rearing behaviour to a mother, or when another mother's behaviour is viewed as a model in this respect for the one whose child-rearing practices need modification.

Because relationship problems are usually brought about by a pattern of unsatisfactory interaction, behaviour therapy is often directed at more than one person simultaneously. The S R R pattern works in the reverse

haviour therapy or family behaviour therapy are therefore two important settings in which behaviour theory is applied.

Although behaviour therapy is usually task-centred, Jacobson (1984:295-305) and O'Leary and Turkewitz (1981:159-169) distinguished between specific tasks which would make the "environment" pleasanter for another person such as a marriage partner, and unspecific tasks such as communication skills that have to be tried out and developed to solve conflict as and when it arises.

A criticism of behaviour theory is that it implies a one-way control process, that is environmental forces elicit and therefore control the response from the otherwise passive actor (Unterhalter 1982:13-14). In an effort to avoid the earlier notions of purely "inner" causes of the physiological and psycho-analytic theorists, behaviour theorists ignored behaviour arising from cognitive functioning.

Social learning theory therefore explains a person's functioning in terms of a "continuous reciprocal interaction of personal and environmental determinants" (Unterhalter 1982:14). A person "learns" adaptive and appropriate behaviour, or maladaptive and inappropriate behaviour, although the learning process is not in itself new behaviour: it is rather a change in behaviour potential (Jehu 1975:3).

Problem behaviour is thus seen as having developed through a sequence or history of incorrect learning, although such sequences or histories could differ greatly in people showing similar, inappropriate behaviour (Stark 1975:141). On the basis of this theory therapists direct their intervention at the behaviour or response on the assumption that the problem "symptom" can be shed through unlearning or counterlearning.

The interventive techniques are similar to those of behaviour therapy, with emphasis on practice, rehearsal, and repetition and feedback to learn appropriate behaviour, or, when unlearning has to take place, the use of the technique of extinction. The latter refers to the no-emotion response shown by the therapist — not approval, disapproval or encouragement — whenever, for example, the client talks about his guilt regarding his child's failure. Gradually the subject and the emotion of guilt disappear from the interview because of a process of "fading out" (see also Mowrer 1950:152-173; Mowrer 1960; Jehu 1975:26, 81-84).

Although *systems theory* does not offer quite as much support to a therapy which emphasizes short-term intervention, it does tie in with social

exchange theory, family crisis theory and the components of interaction found in behaviour and learning theory. Some concepts of systems theory are therefore useful for time-limited intervention: *mutuality,* that is changes in one part of the system (client system, target system, etc.) influence other parts; *interwovenness,* that is outside influences having an impact on one part of the system will also indirectly influence other parts; *state of balance* or *stability,* i.e. a system always tries to reach a state of satisfactory general functioning among all parts, although this is never a perfect, static state (Van Rooyen, Combrink 1980:61-65).

What a therapist draws from the different theoretical sets will depend on his training, the needs of his clients, the particular events necessitating intervention and the field of practice — voluntary welfare, public health, etc. — in which he operates.

6. RESEARCH ON TIME-LIMITED INTERVENTION

While there may be a tendency in practice to diagnose a situation in terms of client or problem categories, more comprehensive assessment requires the determination of relationships between different components of a situation, either at a particular point in time — cross-sectional or dynamic diagnosis — or across time, that is, the aetiological or developmental diagnosis.

Similarly, studies in which an inventory of stress symptoms, client types, treatment situations or treatment approaches are described are only first level descriptive research, and have to be augmented by research in which at least correlations — but preferably also definite cause-effect relationships — between intervention and behaviour are established (Pinkston *et al.* 1982:16-20).

The development of instruments or indices to record and describe behaviour, is nevertheless a useful research activity. Adams and Adams (1984) for instance describe five categories of stress-reaction behaviours following the advent of a disaster, and discuss the results of predisaster and postdisaster measuring of these behaviours.

Miller, Turner and Kimball (1981:111-116) describe a follow-up study of two samples of flood survivors a year after the event. They went a little further than Adams and Adams and determined variables which *apparently* influenced the victims' ability to recover to an acceptable level of social functioning without resorting to less acceptable coping mechanisms such as an immoderate use of medicinal drugs or alcohol. Some of

the variables, such as the opportunity to return after having been evacuated or the presence or absence of "survivor guilt" (p. 115) are important pointers to the need for an interventive service.

Developing the structure and contents of an interventive programme, is also a research activity worthy of pursuance. It was mentioned earlier that certain kinds of short non-formal educational activities could also be regarded as time-limited social intervention, and in this respect Birkenbach, Kamfer and Ter Morshuizen (1985:17-19) describe the development and evaluation of an in-service training programme for supervisors. The training is based on behaviour modelling theory and certain criteria for measuring effectiveness were used, for example more immediate effect such as trainees' response, degree of learning by the participants in comparison with that of the non-participants and the degree of behaviour change as judged by trainees themselves as well as by supervisors; and then ultimate effect such as performance on the job.

Developing the contents and structure of an interventive programme or technique goes hand in hand with an evaluation of the effectiveness of such a programme/technique. In the latter case an experimental or quasi-experimental design with some before-and-after measurement is usually indicated. However, in order to gear the interventive process more and more to the needs of clients, as well as to be able to duplicate the research, it is necessary to describe what takes place, to evaluate or monitor continually and to refine or adjust the intervention according to new insights.

In this way it is possible to see which part of the therapy has the greatest influence. Jacobson (1984:295-305), for example described research in which it was determined that emphasis on one component of behaviour therapy (see Section 5 Theory) resulted in a better short-term effect, while the use of another behaviour therapy component for a different but comparable sample, led to better long-term gains. O'Leary and Turkewitz (1981:159-169) compared the same two components — although they defined them as two different therapies — and found the first one to have produced more change in younger couples, while older couples responded better to the second component.

Single system research is practice-based research in which the appropriateness and change potential of specific interventions or techniques for specific types of behaviour are evaluated (Strydom 1986:216-221).

It is a particularly relevant method of research for the clinician who wants to determine the success of his intervention with an individual client or

client group, rather than work with aggregates obtained from larger groups.

Single system research has a strong experimental character but its strongest control lies in repeated measurement or evaluation of change brought about by the intervention, as well as by a variety of multiple measures, for example applying the same technique in a different setting or with regard to a different component of the same kind of behaviour (Catania, Brigham 1978:83-90; Bloom, Fischer 1982:328-345).

Only observable behaviour is measured in this type of research design, and because the tasks or changes to be achieved are set as objectives, once such objectives are reached, or consistently fail to be reached, intervention and measurement are terminated.

Common types of settings and clients for this design are the classroom and disruptive pupils (Polster, Lynch 1981:381-382), the residential centre and unorganized or overwithdrawn inmates, and the family home and spouses experiencing problems in the spheres of budgeting, meal preparation or emotional support (Fischer 1978; Hersen, Barlow 1976:152-153; Liotta *et al.* 1985:286-294).

Although the single system research design can be used to study the effectiveness of different kinds of therapy or intervention, its emphasis on measuring a limited number of observable behaviours for which progress outcomes have been clearly operationalized, makes this research design eminently suitable for most strategies of time-limited intervention as described here.

However, no real-life situation could really be reduced to a few clearly observable and measurable actions. De Shazer *et al.* (1986:219) express this problem on behalf of researchers, stating that the latter "would prefer comprehensive ways of evaluating therapeutic results, (but) therapists frequently can only offer their clinical impressions". Therefore, in the work of De Shazer and his colleagues a position somewhere between "research findings" and "clinical impressions" is taken (1986:219).

For them an evaluation is based on a "comparison between what a therapy proposes to do and its observable results" (De Shazer *et al.* 1986:219; also Reid 1978:225-271). This could be considered a simple yardstick for effectiveness, but is still several steps short of a test of efficiency which expresses results in terms of the best output per unit of input. Some examples of the latter have nevertheless been recorded and Fisher (1984:101-106) *inter alios* describes a one-year follow-up study of time-

limited therapy with families in which it was found that time-limits shortened treatment while maintaining effectiveness previously achieved through long-term treatment. However, rigid control of all examples will remain hard to achieve in comparative studies of different treatment methods; and Reid (1985:286-287) therefore argues in favour of a "paradigm of developmental research in which more flexible experimental designs would be the major modality". As he defines a developmental research programme as "accumulating single-case trials of the (task-centred) model over time within the context of ordinary agency service" (p.287) attention is again focused on the single system design as being characteristic of time-limited intervention.

7. ADVANTAGES AND BENEFITS OF TIME-LIMITED INTERVENTION

In previous sections certain advantages have already been touched on: for example more economic use of time; more immediate focusing on aspects of problems that are amenable to change; greater involvement of the client right from the start by placing emphasis on well-defined tasks which are to be practised or accomplished, and/or a formal contract into which he enters; the rapid increase in the client's initiative and self-confidence as a result of the specificity of the guidelines, and the successful handling of tasks (Oelofsen 1985:39; Fischer 1978:144).

An important additional advantage is the opportunity afforded by this kind of intervention to make use of untrained people to assist clients with the tasks they have undertaken as part of their "contract" with the therapist (Fischer 1978:159). Volunteers also respond more swiftly in the initial phase when demands on time and emotional resources are greatest; so do members of the 'natural help system" such as family, friends and neighbours (Golan 1981:243-246; Budman, Gurman 1983:284-285).

An agency or professional that changes from longer term therapies to a time-limited therapy, also experience advantages in workload management. The waiting list for clients gets shorter and people get attended to more quickly. Very little time is wasted on the handling of files and other documentation of clients with whom there is no regular or active involvement. Accommodating more clients over a span of time means coping better with limited staff resources, and this in turn meets one of the main requirements of affordability (Hepworth, Larsen 1982:278-279; Budman, Gurman 1983:278-279).

Finally, time-limited intervention is an eminently researchable helping procedure, and one of the reasons for the increase in publications in which the single system research design has been used, is probably the emphasis in this design on short-term intervention in a limited number of well-defined behaviours (Reid 1985:14-15; Budman, Gurman 1983:288-289).

8. CONCLUSION

There are of course certain situations for which time-limited intervention is not indicated. Particularly some of the macrocrises such as a countrywide economic recession cannot be handled by anything but long-term planning and corrective government policies, although short-term or "patch work" intervention may be called for when regions, cities or families are first hit by the hazardous event or the precipitating one, such as large-scale retrenchment or urban terrorism.

On the other hand, certain kinds of time-limited intervention are not discussed here because the richness of their major theoretical bases or major therapeutic models merits separate discussion, for instance *intermediate intervention* and *milieu therapy* which often take place within a residential setting and for a duration of several months. It should be conceded however that when time-limited intervention extends over a period of months rather than days, and is offered in an institution — for instance preparation for discharge from a hospital — the boundaries between the different strategies are not all that clear.

Perhaps this makes intermediate intervention and milieu therapy equally appropriate when greater "affordability" is strived for, and it is hoped that readers of this volume will not only be encouraged to experiment with time-limited intervention as described here, but will also appreciate that there are other worthwhile therapies very closely related to it.

In fact, neither this chapter nor any of the others that follow sets out to proclaim the time-limited approach as superior to others. Rather, ideas are presented as guidelines for undertaking research or clinical work in different fields and professions.

NOTES

1. Sometimes a crisis is expected, although situational, such as death following a long period of terminal illness, but the terminal illness itself would most probably be an unexpected crisis.

2. People who never or seldom make donations towards welfare organizations are often ready to contribute to a disaster fund or to a neighbour who has been visibly struck by misfortune; if the fund is started soon after the event or as soon as people have become aware of the drastic nature of the situation — through the press, publicity campaign, etc.
3. When abusive or incestual activities are of a recurrent nature, the fact that they take place usually gets reported or becomes more publicly known, either immediately or soon after one of the recurrences. Intervention which follows will therefore focus on the most recent event, and will for the initial period at least, show the features of time-limited task-centred intervention.
4. The event and other concepts pertaining to the different phases of a crisis are discussed in the next section "Theory underlying the practice of time-limited intervention".
5. Murstein and MacDonald (1983:297-311) observe exchange as an attitude and/or personality dimension, and maintain that a relationship could be adversely affected when one partner has an exchange-oriented philosophy making him constantly overly sensitive to his own contribution to the relationship, and just as enduringly insensitive to his partner's or friend's contribution. They warn however that this *disposition* is not as amenable to therapy as specific episodes of conflict-creating exchange.

LIST OF SOURCES

ADAMS, P.R., ADAMS, G.R.
1984. Mount Saint Helen's ashfall. *American Psychologist* 39(3), March:252-260.

BIRKENBACH, X.C., KAMFER, L., TER MORSHUIZEN, D.
1985. The development and the evaluation of a behaviour-modelling training programme for supervisors. *Psychology/Sielkunde* 15(1), March:17-19.

BLOOM, M., FISCHER, J.
1982. *Evaluating practice: guidelines for the accountable professional.* Englewood Cliffs, New Jersey: Prentice-Hall.

BROWN, A.H.
1975. A use of social exchange theory in family crisis intervention. *Journal of Marriage and Family Counselling* 1(3), July:259-267.

BUDMAN, S.H., GURMAN, A.S.
1983. The practice of brief therapy. *Professional Psychology: Research and Practice* 14(3), June:277-292.

CATANIA, A.C., BRIGHAM, T.A.
1978. *Handbook of applied behavior analysis.* New York: John Wiley & Sons.

CUMMINGS, N.A.
1986. The dismantling of our health system. *American Psychologist* 41(4), April:426-431.

DE SHAZER, S. *et al.*
1986. Brief therapy: focused solution development. *Family Process* 25(2), June:207-222.

DHOOPER, S.S.
1984. Social networks and support during the crisis of heart attack. *Health and Social Work* 9(4), Fall:294-303.

EPSTEIN, L.
1980. *Helping people. The task-centered approach.* St Louis: C.V. Mosby Co.

FISCHER, J.
1978. *Effective casework practice. An eclectic approach.* New York: McGraw-Hill.

FISHER, S.G.
1984. Time-limited brief therapy with families: a one-year follow-up study. *Family Process* 23(1), March:101-106.

GARVIN, C.D., *et al.*
1976. A task-centered approach. In: ROBERTS, R.W., NORTHEN, H. *Theories of social work with groups.* New York: Columbia University Press. Pp. 238-267.

GETZ, W.L., *et al.*
1983. *Brief counseling with suicidal persons.* Lexington, Massachusetts: Lexington Books.

GINDY, A.
1970. Launching the second development decade: the challenge to social work education. In: KENDALL, K.A. *Social work education in the seventies.* Report of the XVth Congress of Schools of Social Work IASSW, 30 August — 2 September 1970, Manila, Philippines. New York: International Association of Schools of Social Work. Pp. 29-44.

GOLAN, N.
1978. *Treatment in crisis situations.* New York: Free Press.

GOLAN, N.
1980a. Intervention at times of transition: sources and forms of help. *Social Casework: The Journal of Contemporary Social Work* 61(5), May: 259-266.

GOLAN, N.
1980b. Using situational crises to ease transitions in the life cycle. *American Journal of Orthopsychiatry* 50(3), July: 542-550.

GOLAN, N.
1981. *Passing through transitions.* New York: Free Press.

GUY, D.W., MORICE, H.O.
1985/86. A comparative analysis of behavior management in the nursing home. *Clinical Gerontologist* 4(2), Winter:11-17.

HEPWORTH, D.H., LARSEN, J.A.
1982. *Direct social work practice: theory and skills.* Homewood, Illinois: Dorsey Press.

HERSEN, M., BARLOW, D.H.
1976. *Single-case experimental designs: strategies for studying behavior change.* New York: Pergamon Press.

IRVINE, E.E.
1979. *Social work and human problems.* Oxford: Pergamon Press.

JACOBSON, N.S.
1984. A component analysis of behavioral marital therapy: the relative effectiveness of behavior exchange and communication/problem-solving training. *Journal of Consulting and Clinical Psychology* 52(2), April:295-306.

JANZEN, C., HARRIS, O.
1980. *Family treatment in social work practice.* Itasca, Illinois: Peacock Publishers.

JEHU, D.
1975. *Learning theory and social work.* London: Routledge and Kegan Paul.

KULYS, R.
1983. Future crises and the very old: implications for discharge planning. *Health and Social Work* 8(3), Summer:182-195.

LIOTTA, R.F. *et al.*
1985. A behavioral approach for measuring social support. *Family Therapy* XII(3):285-295.

LONSDALE, G. *et al.*
1979. *Children, grief and social work.* Oxford: Basil Blackwell.

MALHERBE, B.R.
1976. *Krisishulp in die maatskaplike werk.* Bloemfontein: Universiteit van die Oranje-Vrystaat (M.Soc.Sc.-verhandeling).

McBROOM, E.
1985. Industrial social work. *Social Work Papers* 19.(entire volume).

McDONALD, G.W.
1981. Structural exchange and marital interaction. *Journal of Marriage and the Family* 43(4), November: 825-839.

MILLER, J.A., TURNER, J.G., KIMBALL, E.
1981. Big Thompson flood victims: one year later. *Family Relations* 30(1), January: 111-116.

MOWRER, O.H.
1950. *Learning theory and personality dynamics.* New York: Ronald Press.

MOWRER, O.H.
1960. *Learning theory and behaviour.* New York: John Wiley & Sons.

MURSTEIN, B.I., McDONALD, M.G.
1983. The relationship of 'exchange-orientation' and 'commitment' scales to marriage adjustment. *International Journal of Psychology* 18(3/4), August:297-311.

OELOFSEN, H.J.
1985. *Die taakgesentreerde benadering:* Bloemfontein: Universiteit van die Oranje-Vrystaat (M.Soc.Sc.-verhandeling).

OELOFSEN, H.J., GROBBELAAR, S.W.P.
1986. Die benutting van die kontrak as hulpmiddel by die toepassing van die taakgesentreerde benadering in die maatskaplike werk. *Welsynsfokus* 21(1), Junie:13-16, 40.

O'LEARY, K.D., TURKEWITZ, H.
1981. A comparative outcome study of behavioral marital therapy and communication therapy. *Journal of Marital and Family Therapy* 7(2), April:159-169.

PANZER, B.
1983. Crisis intervention. In: MEYER, C.H. *Clinical social work in the eco-systems perspective.* New York: Columbia University Press. Pp. 179-214.

PERKINS, K.A., RAPP, S.R.
1985/86. A behavioral weight loss program for a memory-impaired, elderly male. *Clinical Gerontologist* 4(2), Winter: 32-34.

PINKSTON, E.M. *et al.*
1982. *Effective social work practice.* San Francisco: Jossey-Bass Publishers.

POLSTER, R.A., LYNCH, M.A.
1981. Single-subject designs. In: GRINNELL, R.M. (Jr.) *Social work research and evaluation.* Itasca, Illinois: Peacock Publishers. Pp. 373-418.

QUACKENBUSH, J.E., GLICKMAN, L.
1984. Helping people adjust to the death of a pet. *Health and Social Work* 9(1), Winter: 42-48.

RANK, M.R., LECROY, C.W.
1983. Toward a multiple perspective in family theory and practice: the case of social exchange theory, symbolic interactionism, and conflict theory. *Family Relations* 32(3), July: 441-448.

REID, W.J.
1978. *The task-centered system.* New York: Columbia University Press.

REID, W.J.
1985. *Family problem solving.* New York: Columbia University Press.

SCHOENBERG, B.M.
1980. *Bereavement counseling.* Westport, Connecticut: Greenwood Press.

STARK, R.
1975. *Social problems.* New York: Random House. Pp. 140-142.

STRÜMPFER, D.J.W.
1975. *Mense in rampe: individuele en sosiale reaksies.* Port Elizabeth: Universiteit van Port Elizabeth.

STRYDOM, H.
1986. Die enkelstelselontwerp in maatskaplikewerk-navorsing en maatskaplikewerk-praktyk. *Maatskaplike Werk/Social Work* 22(4), Oktober:216-221.

UNTERHALTER, L.J.
1982. *Alcohol, expectancy and sexual fantasy: a social learning theory perspective.* Johannesburg: University of Witwatersrand (M.A.-dissertation).

VAN ROOYEN, I.J.J., COMBRINK, M.J.
1980. *Gevallewerk, 'n integrerende benadering.* Pretoria: Academica.

WEBB, N.B.
1985. A crisis intervention perspective on the termination process. *Clinical Social Work Journal* 13(4), Winter: 329-340.

WEINBERG, N., MILLER, N.J.
1983. Burn care: a social work perspective. *Health and Social Work* 8(2), Spring:97-106.

WELCH, G.J.
1986. Divorce adjustment group: methods and applications. *Social Work Practice/Maatskaplikewerk-Praktyk* 1.86, March:5-9.

WHITE, P.N., ROLLINS, J.C.
1981. Rape: a family crisis. *Family Relations* 30(1), January: 103-109.

II

POST-DIVORCE ADJUSTMENT: A STRUCTURED, TIME-LIMITED INTERVENTION

Gary John Welch

1. INTRODUCTION

Today's social worker must be ready to evaluate what he/she has accomplished. Government funding sources, our clients and colleagues all point to the need to evaluate and practice and to provide evidence of the effectiveness of our work. These calls for demonstrated effectiveness come at a time when social workers are taking on new roles and responsibilities which so far have seemed to be outside our traditional purview. The chapter that follows provides an example of social work intervention to facilitate post-divorce adjustment. The intervention is presented in enough detail to allow replication and the intervention is evaluated employing both ideographic and consumer validations. The chapter begins with a review of previous efforts and then moves on to the specifics of a structured time-limited intervention programme.

The divorce and separation literature describing heuristic models for group treatment is expanding (Fetsch, Surdam 1981; Granvold, Welch 1979; Bonkowski, Wanner-Westly 1979; Welch, Granvold 1977; Kessler 1976; Weiss 1975); however, few outcome-controlled studies exist (Broder 1981; Goethal 1980; Walker 1980). A review of heuristic and experimental models which follows sets the stage for the intervention programme presented herein.

2. INTERVENTIVE MODELS

2.1 Heuristic models

Weiss (1975) describes eight-week programmes, "Seminars for the separated", that aim to help recently separated individuals to manage the stress of separation by providing a framework to understand the adjustment process, a setting for people to discuss their situation, and a description of other individual's experiences of separation. Each meeting with the exception of the last begins with a lecture on a specific topic: emo-

tional impact of separation, continuing the relationship with the ex-partner, reactions of friends and kin, changes in the parents' relationship to children, starting over, dating and sexual relationships. After the lecture, one or more discussion groups are formed depending on the size of the group.

Kessler's divorce adjustment group (1976) combines lectures and restructures the group process in an attempt to meet the following goals: (1) help individuals to regain their emotional autonomy by focusing on present needs; (2) to mitigate the debilitating aspects of divorce (i.e. social withdrawal, existential *angst*, poor job performance); (3) to provide a safe place to express the emotional reaction to divorce; (4) to help individuals develop a broader concept of divorce; (5) to assist people in meeting new friends in a "meaningful way", and (6) to help individuals learn coping skills that can be applied to other situations where loss is involved.

Using Weiss' formulation of clinically relevant issues and topics in addition to a questionnaire to assess participant's needs and objectives, Welch and Granvold (1977, also Granvold, Welch 1979) adopted an educational approach combining therapeutic techniques of cognitive restructuring, interpersonal competency training, modelling, behaviour rehearsal, group discussion, and client homework assignments in their post-divorce/separation adjustment seminars. The weekly, three-hour seminars for the 30 participants ranging from 19 to 57 years of age, were co-led for seven weeks. Each of the intervention components were independently demonstrated to be effective in helping individuals adjust to transitions and acquire social skills. The educational model is of heuristic value and omits experimental validation.

Bonkowski and Wanner-Westly (1979) developed an eight to ten-week group approach using educational information, group support and the group's interpersonal relationships as the therapeutic modalities. The group leader serves in the following capacities: (1) as a resource person to disseminate information on community services in respect of legal and financial concerns, and vocational and educational enquiries; (2) as a consultant to parents with children, and (3) as a discussion facilitator to keep interaction constructive. The size of the heterogeneously designed group varies from six to fifteen individuals and includes both divorced individuals and those contemplating divorce. The format includes group members setting specific goals for themselves.

Fetsch and Surdam (1981) developed a seven-week counselling programme at the University of Wyoming to help uncoupled students with their "new beginnings". Using Kessler's (1976) model for the understanding of the stages of uncoupling, Fetsch and Surdam (1981) developed a programme that included trust-building exercises, didactic material regarding the uncoupling process, and discussions to express feelings and needs. Participants were encouraged to select issues that they wished to have addressed.

2.2 Experimental models

Goethal's study (1980) was based on the acquisition of empathy and self-disclosure skills. Written measures designed to assess both attitudinal and behavioural changes were administered to an experimental group (n = 12) and a control group (n = 13); a one-month follow-up was included. Comparisons between the experimental and control groups were analysed on general adjustment to divorce, self-esteem, and empathy skills. Results suggested that participants receiving the training increased significantly during the period of pretest to follow-up relative to general adjustment to divorce and empathy skill. Seventy per cent of this group perceived improvement in all attitudes and behaviours assessed relative to readjustment. No significant changes occurred with respect to self-esteem although a trend toward positive growth was indicated.

Walker (1980) designed an outcome-controlled study to determine factors associated with change in divorced and separated persons attending a didactic seminar. Sixty-four people attended a four-week seminar and thirty divorced and separated individuals served as a control group. The didactic content of the seminar was not reviewed. A regression model was developed and results indicated that no significant difference existed between males and females, divorced and separated, or treatment and control group in respect to the *Ds* scale of the MMPI, and the tension/anxiety, anger/hostility, and depression/dejection scales of the Profile of Mood States. Factors found to be significant were months married, presence of children, age, educational experience, a belief in chance causality of circumstances. These results suggest that the most positive change occurs for those who are younger, better educated, from longer marriages, have children, and less belief in the chance of causality of circumstances. Other variables under study such as time divorced or separated, being the one who suggested, time mentioned to time of occurrence, degree of trauma associated with divorce, attitude toward spouse, and internal

control were not found to be significantly related to change on any criterion.

Broder (1981) evaluated the outcome of a programme consisting of an all day eight-hour workshop and a three-hour follow-up session four weeks later. The programme ROADS (Rational Options in Adjustment to Divorce and Separation), was designed to help participants with rational and logistical issues of divorce and separation. The programme incorporated a cognitive behavioural approach and included the use of leaderless support groups comprising four to six participants of the same sex who met a number (unreported) of times between the workshop and the follow-up session. A control group was not utilized. Analysis of *t* tests suggested that there was a significant difference between pretest and posttest scores on the Fisher Divorce Adjustment Scale. The programme was implemented twice and the results appeared to be replicated in both ROADS groups.

3. STUDY OBJECTIVES

The present study has three objectives: (1) to present an eclectic approach to facilitating post-divorce/separation adjustment; (2) to provide a heuristic model for examining the relation between specific treatment variables and specific client selected treatment objectives, and (3) to describe an idiographic approach to outcome measurement that accommodated the phases of adjustment and participants' personal objectives. Treatment variables were paired with outcome measures and are presented in Table 1.

The particulars of each treatment variable have been described elsewhere (Welch 1986). A brief rationale for the inclusion of each area is included.

3.1 Area one

The meditative process is consistent with the process of thought substitution and metacognition and may serve to develop self-control (Shapiro 1978) and the ability to substitute thought, thereby increasing the value of coping with statements *in vivo*. In addition meditation has been shown to produce a state of relaxation (Throll 1982; Smith 1975; Benson, Beary, Carol 1974).

The inclusion of a meditational technique with cognitive restructuring was based on the belief that the regular practice of meditation is more likely to facilitate the learning of a new belief than the periodic and sporadic use of coping statements. Moreover it has long been recognized that learning is the result of conditions of practice.

TABLE 1
THE RELATION BETWEEN NESTED TREATMENT VARIABLES AND TREATMENT OBJECTIVES

	Treatment variables	Treatment objectives
Area 1	Cognitive restructuring	To increase self-control over moods and actions
	Systematic relaxation	To increase ability to relax
	Meditation	To provide relief from tensions and unpleasant feelings
		To facilitate the development of a new belief
Area 2	Didactic presentations	To increase acceptance of emotional reactions to divorce/separation as a
	Phases of adjustment	universal experience
	Impact on family and friends	To increase understanding of reasons behind behaviour feelings
	Starting over	To give reassurance, encouragement, and hope with the support of research
Area 3	Group discussions	To provide an opportunity to self-disclose
	Use of emphatic [illegible] by seminar le[illegible]	To provide an opportunity [illegible]
		To provide an opportunity for mutual support, community, and vicarious learning
Area 4	Problem-solving model	To develop ability to partialize problems and facilitate decision-making

Further research is needed to determine whether a combination of meditation and cognitive mediational strategies is in fact more powerful in dealing with applied clinical problems.

The efficacy of systematic relaxation is well established. Although systematic relaxation was originally developed as a therapist-administered technique in conjunction with systematic desensitization, self-systematic relaxation has been shown to be effective as an anxiety reduction strategy (Rosen, Glasgow, Barrera 1976; Phillips, Johnson, Geier 1972). Progressive relaxation is an essential component of self-systematic desensitization; however it may be used alone to achieve relaxation.

3.2 Area two

The presentation of educational material was designed to (1) help participants realize the relation between their cognitions and perceptions, emotions, and behaviour; (2) identify faulty or self-defeating cognitions, and (3) replace self-defeating cognitions with self-enhancing cognitions. Consistent with these goals the content of the lectures includes a modified version of Ellis's RET (McKay, Davis, Fanning 1981) and the presentation of empirical findings to provide rational information on which to build and support new cognitions. In addition to these goals, the didactic presentations aimed at (1) increasing the acceptance of the emotional reactions to divorce/separation as a universal experience; (2) increasing participants' understanding of the reasons behind their feelings and behaviour, and (3) giving reassurance, encouragement, and hope with the support of research. Toward these objectives, other lecture topics included the emotional impact of divorce/separation impact on family and friends, and starting over.

3.3 Area three

The utilization of group discussion is based on previous research (Jourard 1971; Kangas 1971) that demonstrated participant response to self-disclosure was self-disclosure, the result of which was the realization of similarity and universality. Other researchers (Lieberman, Yalom, Miles 1973; Yalom 1970) have postulated that the most effective change for an individual takes place in a group counselling situation in which participants can experience and analyse their interactions with others who are perceived as equals. This is consistent with the observations of Gran-

vold and Welch (1979) that participants are able to release themselves from a sense of failure upon realizing their commonality with others.

3.4 Area four

The effect of stress on problem solving need hardly be documented. Studies on diverse age, socio-economic status, and clinical samples have shown that individuals who have better interpersonal problem-solving skills are better adjusted people (Spivack, Platt, Shure 1976). A problem-solving model was presented to increase problem-solving efficiency at a time when members were vulnerable to disorganization and self-defeating methods for dealing with personal distress.

The concept of transition/adjustment assumes that the frequency, intensity, duration, and/or latency of certain behaviour and attitudes, are associated with stages of adjustment. A measurement tool that allows clinicians to assess behavioural and attitudinal change of an individual from "one stage" to another must be considered as an essential component of any post-divorce/separation group. The attainment of intermediate outcomes needs to be emphasized to participants to negate any unrealistic expectation for the ultimate outcome of complete recovery during a short seminar. The need to "tailor change criteria to each individual rather than employ global improvement indices" has been cited by Bergin and Lambert (1978). Goal Attainment Scales provided a behavioural and attitudinal baseline and a continuum of intermediate goals (rather than ultimate goals) to evaluate treatment success for facilitating the emotional and social progress of participants.

A structured educational format, combining lecture, assignments, and group discussion was utilized based on the use of structured group models in personal education and self-management (Cudney 1975; Thoreson, Mahoney 1974; Bandura, Perloff 1967). The seminar was organized around a series of presentations and discussions:

- Post-divorced/separation adjustment phases
- Emotional impact of divorce/separation:
  - (a) Common ambivalent feeling
  - (b) Frequency of divorce
- Cognitive mediational model of human learning:
  - (a) Relation between thinking and emotion
  - (b) Distorted styles of thinking and counter-effective strategies

(c) Irrational ideas that cause and sustain emotional disturbances
(d) Letting go of self-defeating thoughts
(e) Meditation: affirming a new belief
(f) Occurrence of cognitive/emotional dissonance

- Impact of divorce/separation on family and friends
- Starting over
- Systematic relaxation
- A model for problem solving

Participants were given a transition survey (available from author) designed to assess problematic areas and identify individuals' concerns and objectives. The seminar was conducted over a four-week period with weekly three-hour meetings.

4. METHOD

4.1 Participants

The participants in the seminar were five university students, three of whom responded to on-campus announcements, and two to whom reference was made by other counsellors at the university's counselling centre. Four of the five members were female. One of the five attended the last hour of each session and consequently, the data gathered from her was used for clinical rather than statistical purposes. The length of time of separation ranged from one week to seventy-two weeks. The seminar was conducted by the author.

4.2 Treatment procedures

Cognitive mediational model

The seminar began with a warm-up introductory exercise. Following the exercise, the emotional impact of divorce/separation was presented as an adjustment reaction with adjustment phases. It was emphasized that while there was a normal period to be expected, the seminar was aimed at facilitating adjustment when adjustment was desired. The rationale underlying this approach was to provide a non-judgemental atmosphere for those members who had recently separated.

The cognitive restructuring process began by presenting empirical findings to 'normalize'' both the event of divorce/separation and the reaction to it. The cognitive mediational model described earlier was presented

emphasizing the individual's active rôle in growth and development and the significance of mediation in learning. As a foundation, the author utilized Ellis' (in Ellis, Grieger 1977) literature review that found overwhelming empirical evidence (over 900 studies) to support the following hypotheses:

1. Thinking creates emotion.
2. Self-statements affect behaviour.
3. People are capable of changing their beliefs.
4. Emotional difficulties are not necessarily indicative of a character disorder or personality disorder.

To help participants experience the relation between thought and emotion, a guided visualization was used. The rationale for the seminar was restated as a systematic approach to identifying the personal internal dialogue in order to allow its modification when it was irrational or self-defeating.

A list of common distorted styles of thinking and counter-effective strategies, and common ideas that cause and sustain emotional disturbance were presented. Members were asked to review and discuss their "conclusions or beliefs" regarding themselves, their previous relationship, and their future. Following this discussion members were instructed to answer the following questions:

1. What kind of emotions accompany this belief?
2. Will this thinking or belief help me to achieve my goals?
3. Am I willing to relinquish this belief?
4. What new belief could be developed to replace this habituated belief?

A model of cognitive dissonance (Maultsby 1977) was presented to help members from having unrealistic expectations regarding the length of time required to change a belief fully and "normalize" the period when the individual would begin to think rational thoughts but still experience old discomforting feelings.

In presenting meditation to the participants it was emphasized that the practice was not magical, but required patience and practice. Meditation was referred to as a technique of affirmation or making a firm new belief in order to further separate meditation from a religious and cultural context. Participants were given the following instructions:

- Summarize the new belief into a statement or phrase that can be divided into two sections; the first section is to be said internally while inhal-

ing and the other half of the phrase is to be said internally on the exhalation.

- Select a quiet environment to practice the technique.
- Sit comfortably so that a minimum of muscular movement is required; employ a passive attitude: if distracting thoughts do occur during the repetition they should be disregarded and one's attention should be redirected to the technique; one should not worry about how well one is performing the technique.
- Practise three times a day for 10 minutes, preferably at the same time each day and if possible in the same environment.

Systematic relaxation

Participants were trained in the procedure of systematic relaxation by having them practice the components of self-talk and muscle tension/relaxation of the various muscle groups (Cormier, Cormier 1979). Systematic relaxation was selected by participants after they had been given explanations of various options for relaxation.

Group discussion

Presentations were followed by group discussion and members were encouraged to self-disclose through the seminar leader by means of emphatic response (Fischer 1977), the establishment of a non-judgemental atmosphere, and through the reinforcement of mutual empathy and support by other seminar members.

Problem solving

The following model was presented:

- A problem is a failure to find an effective response.
- State the problem so it is solvable; problems have solutions (the proper statement of a problem is one that stimulates searching behaviour).
- Outline the previous response; identify the attempts that have been made to solve the problem in the past.
- List the alternatives: it is important not to immediately adopt the first possibility; delay a decision until additional ideas are generated and problem situations become choice situations; partialize the steps to carry

out a solution and evaluate the alignment of personal values to each alternative and rank each value.

- View the consequences of a decision; identify the positive and negative outcomes of the decision; predict new problems that can be anticipated as the result of the decision; select the alternative by consequences of greatest personal satisfaction and least risk.
- Evaluate the results: did anticipations transpire? What could be done differently?

Handouts

Numerous handouts were utilized to complement the lecture materials and to address individual concerns expressed in the transition survey that would not be covered in the lectures nor the discussions (available from author). The following handouts were utilized: *Assertion Theory; Sexual Assessment; Discussion Sheet; Ideal Relationship Game;* and *Dealing with Another's Anger*. The handouts utilized to complement the lecture materials included the *Social Readjustment Scale* and *Irrational Ideas That Cause and Sustain Emotional Disturbance*.

5. OUTCOME MEASURES

The evaluative design incorporated the assessment of treatment procedures, the achievement of personal objectives, and therapeutic gain by utilizing Goal Attainment Scales and a seminar evaluation survey.

5.1 Goal Attainment Scales

Each individual responded to an individually tailored GAS designed by the author using the participants, stated objectives for enrolling in the seminar (acquired in transition survey) and subsequent group discussions as criterion. Each member's own language was incorporated into the scale as much as possible. In the third session members were asked to review critically their individual scales and to comment on the validity of the scales in reflecting their objectives. The scales were returned to the leader to allow for any necessary revisions. In the fourth session the scales were returned to each individual with instructions that they be filled out.

5.2 Seminar Evaluation Survey

A 28-item survey was developed by the author to assess the seminar's components, the self-report of therapeutic gain, the participants' perception of the seminar leader's degree of empathy, and to assess the relation between the perceived usefulness of seminar components and the report of therapeutic gain (available from author). The seminar's components were itemized in the survey according to presentation topic, experiential exercises, and handouts. A 5-point scale was used; 1 = not useful; 2 = slightly useful; 3 = moderately useful; 4 = very useful; 5 = extremely useful. To assess the self-report of therapeutic gain a 3-point scale was used: 0 = No; 1 = Some; 2 = A lot. To assess the existence and extent of leader empathy a 5-point scale was used: 1 = Understood exactly how I thought and felt; 2 = Understood very well how I thought and felt; 3 = Understood pretty well, but there were some things that he did not seem to grasp; 4 = Did not understand too well how I thought and felt; 5 = Misunderstood how I felt and thought.

6. RESULTS

Overall, the participants' ratings of the seminar were favourable as shown in Tables 2, 3, 4 and 5. The seminar components were arranged in two groupings, didactic and self-management procedures: didactic included the lecture presentations of the emotional reactions as an adjustment process, frequency of divorce, the relation of thinking to emotion, impact of divorce/separation on family and friends, starting over, and the problem-solving model; the self-management procedures included the systematic approach to letting go of an old belief and replacing it with a new and more functional belief, meditation, and systematic relaxation. The participants viewed the seminar leader as empathic (x = 4,0; 1 = low, 5 = high), and the participants rated their level of outcome success as meeting their individual expectations of change as a result of the seminar (GAS x = 7,9; 1 = most unfavourable outcome of seminar, 10 = best anticipated success with seminar).

Correlations were computed for self-management procedures X (to) gain of self-control, didactic + self-management procedures X gain of self-control, didactic X increased understanding, didactic + self-management procedures X increased understanding, leader empathy X chance to get things off chest, and leader empathy X encouragement; no significant correlations however were found.

TABLE 2
MEAN PARTICIPANT RATINGS OF SEMINAR COMPONENTS

Component	Mean	Standard
Overall	3,74	1,32
Didactic presentations	3,61	0,07
Self-management procedures	4,00	0,87

1 = not useful; 2 = slightly useful; 3 = moderately useful; 4 = very useful; 5 = extremely useful

TABLE 3
PARTICIPANT RATINGS OF SEMINAR COMPONENTS IN PERCENTAGES

Seminar Component	5	4	3	2	1
Presentation of emotional reaction as an adjustment process	75	25			
Identifying distorted styles of thinking and counter-effective strategies		75			
Exercise of systematica letting go of belief		75	25		
Meditation		75	25		
Systematic relaxation	75		25		
Relation between thinking and emotion		25	75		
Problem-solving model			100		

1 = not useful; 2 = slightly useful; 3 = moderately useful; 4 = very useful; 5 = extremely useful

TABLE 4
MEAN PARTICIPANT RATINGS OF THERAPEUTIC GAIN

Item	Mean	Standard
Overall	1,53	0,497
Chance to let go and get some things off my chest	1,75	0,433
Relief from tension and unpleasant feelings	1,50	0,500
Understanding my feelings and thoughts	1,50	0,500
Reassurance and encouragement about how I am doing	1,75	0,433
Ideas for better ways to deal with people and problems	1,00	1,15
Self-control over moods and actions	1,00	1,15
Re-evaluation of thoughts and feelings	2,00	0,00

0 = nothing; 1 = some; 2 = a lot

TABLE 5
PARTICIPANT RATINGS OF THERAPEUTIC GAIN IN PERCENTAGE

Item	A lot	Some	Nothing
Chance to let go and get some things off my chest	75	25	
Hope that things will work out for me	50	50	
Relief from tensions and unpleasant feelings	50	50	
Understanding of my feelings and thoughts	50	50	
Reassurance and encouragement about how I am doing	75	25	
Ideas for better ways to deal with people and problems	75	25	
Self-control over moods and actions	25	50	25
Re-evaluation of thoughts and feelings	100		

7. DISCUSSION

In general the findings suggest that each of the treatment approaches, didactic presentations, self-management procedures, and group discussion contributed to the therapeutic value of the seminar. The difficulty in obtaining a sufficient number of clients suitably matched to constitute required groups made an outcome-controlled study impossible. The attempt to analyse the correlation of the three approaches was limited by the small *n*; however the mean ratings and Goal Attainment Scores suggest the clinical improvement of the participants.

In the initial stages of developing a knowledge base, heuristic models function to generate new hypotheses that may later be subjected to more rigorous experimental control. The present pilot study attempted to provide a model that would serve both researchers and clinicians by describing the issues relative to each perspective. In respect to research, further study is required to determine which combination of techniques will in fact be more powerful in facilitating post-divorce/separation adjustment. Hypothetical questions generated from the study include the following: (1) Is there a subject profile that determines treatment procedures in facilitating adjustment?; (2) Do specific treatment procedures correlate to the specific topography of the adjustment reaction of individuals?; (3) Is there an optimum ordering of treatment in an eclectic approach to post-divorce/separation adjustment?

The clinician-researcher faces many difficulties in designing and evaluating an eclectic approach to post-divorce/separation adjustment. The impracticality of using an exacting screening process results in treating clients with topographically different adjustment reactions, with background variables that do not match, which further results in making replication impossible. Recognizing these inherent limitations, the clinician meets the challenge of accountability by implementing controls when reasonable to evaluate applied practice and to stimulate more rigorous research. Idiographic models provide quasi-experimental designs that allow the clinician some control over therapeutic and environmental influences. The use of Goal Attainment Scales suggests an approach to measurement that is sensitive to the intermediate needs of participants in a transition phase. Jayaratne and Levy (1979) describe component analysis designs (i.e. simultaneous treatment designs and strip construction designs) that allow for the comparison of the proportional efficacy of different strategies and of combined treatment strategies. These and other models that

accommodate participants' objectives and the experimental demands of an eclectic approach need further exploration.

LIST OF SOURCES

BANDURA, A., PERLOFF, B.
1967. Relative efficacy of self-monitored and externally imposed reinforcement systems. *Journal of Personality and Social Psychology* 7(1), September:111-116.

BENSON, H., BEARY, J.F., CAROL, M.P.
1974. The relaxation response. *Psychiatry* 37(1), February:37-46.

BERGIN, A.E., LAMBERT, M.J.
1978. The evaluation of therapeutic outcomes. In: GARFIELD, S.L., BERGIN, A.E. *Handbook of psychotherapy and behavior change: an empirical analysis.* (2nd ed.) New York: John Wiley and Sons. Pp. 139-189.

BONKOWSKI, S.E., WANNER-WESTLY, B.
1979. The divorce group: a new treatment modality. *Social Casework* 60(9), November:552-557.

BRODER, M.J.
1981. Descriptive study of a program designed to help participants deal with issues related to divorce and separation from long-term relationships. Temple University (Doctoral dissertation). *Dissertation Abstracts International* 42(2-B), August:825.

CORMIER, W.H., CORMIER, L.S.
1979. *Interviewing strategies for helpers: a guide to assessment, treatment and evaluation*. Monterey, Ca.: Brooks/Cole Publishing.

CUDNEY, M.R.
1975. *Eliminating self-defeating behaviors*. Kalamazoo, Michigan: Life Giving Enterprises.

ELLIS, A., GRIEGER, R.
1977. *Handbook of RET* [Rational emotive therapy]. New York: Springer Publishing.

FETSCH, R.J., SURDAM, J.
1981. New beginnings: group techniques for coping with losses due to divorce. *The Personnel and Guidance Journal* 59(6):395-397.

FISCHER, J.
1977. *Effective casework practice. An eclectic approach*. New York: McGraw-Hill.

GOETHAL, K.G.
1980. A follow-up study of a skills training approach to postdivorce adjustment. Texas Tech University (Doctoral dissertation). *Dissertation Abstracts International* 40(8-A), February:4763.

GRANVOLD, D.K., WELCH, G.J.
1979. Structured short-term treatment of postdivorce adjustment. *International Journal of Group Psychotherapy* 29(3):347-358.

JAYARATNE, S., LEVY, R.L.
1979. *Empirical clinical practice*. New York: Columbia University Press.

JOURARD, S.M.
1971. *Self-disclosure: an experimental analysis of the transparent self.* New York: John Wiley and Sons.

KANGAS, J.A.
1971. Group members' self-disclosure. *Comparative Group Studies* 2:65-70.

KESSLER, S.
1976. Divorce adjustment groups. *Personnel and Guidance Journal* 54(5), January:250-255.

LIEBERMAN, M.A., YALOM, I.D., MILES, M.B.
1973. *Encounter groups: first facts*. New York: Basic Books.

MAULTSBY, M.C.
977. Emotional re-education. In: ELLIS, A., GRIEGER, R. *Handbook of RET* [Rational emotive therapy]. New York: Springer Publishing.

McKAY, M., DAVIS, M., FANNING, P.
1981. *Thoughts and feelings: the art of cognitive stress intervention*. Richmond, California: New Harbinger Publications.

PHILLIPS, R.E., JOHNSON, E.D., GEIER, A.
1972. Self-administered systematic desensitization. *Behaviour Research and Therapy* 10(1):93-96.

ROSEN, G.M., GLASGOW, R.E., BARRERA, M.
1976. A controlled study to assess the clinical efficacy of totally self-administered systematic desensitization. *Journal of Consulting and Clinical Psychology* 44(2), April:208-217.

SHAPIRO, D.H.
1978. Behavioral and attitudinal changes resulting from "A Zen Experience" workshop and Zen meditation. *Journal of Humanistic Psychology* 18(3):21-29.

SMITH, J.
1975. Meditation and psychotherapy: a review of the literature. *Psychological Bulletin* 32(4):553-564.

SPIVACK, G., PLATT, J.J., SHURE, M.B.
1976. *The problem-solving approach to adjustment*. San Francisco: Jossey-Bass.

THORESON, C.E., MAHONEY, M.J.
1974. *Behavioural self-control*. New York: Holt, Rinehart and Winston.

THROLL, D.A.
1982. Transcendental meditation and progressive relaxation: their physiological effects. *Journal of Clinical Psychology* 38(3), July:522-530.

WALKER, S.G.
1980. Factors associated with change in divorced and separated persons attending a didactic seminar. Texas A & M (Doctoral dissertation). *Dissertation Abstracts International* 40(8-B), February:3975-3976.

WEISS, R.S.
1975. *Marital separation*. New York: Basic Books.

WELCH, G.J., GRANVOLD, D.K.
1977. Seminars for separated/divorced: an educational approach to post-divorce adjustment. *Journal of Sex and Marital Therapy* 3(1):31-39.

WELCH, G.J.
1986. Unpublished manuscript, Department of Social Work, Durban: University of Natal.

YALOM, I.D.
1970. *The theory and practice of group psychotherapy*. New York: Basic Books.

RAAD VIR GEESTESWETENSKAPLIKE NAVORSING
HUMAN SCIENCES RESEARCH COUNCIL

III

RAPE CRISIS INTERVENTION

Steven J. Collings and Gillian T. Eagle

1. INTRODUCTION

Although overtly a sexual act, rape is more accurately construed as a crime of violence with sex utilized as the weapon (Brownmiller 1975; Burgess, Holmstrom 1974; McCombie 1980). Rape combines elements of both physical aggression and psychological coercion, in a situation which is often perceived as life threatening, and invariably thrusts the victim into a state of acute emotional crisis.

Despite the trauma experienced by rape victims there has been, up until recently, no adequate service or agency to meet their needs. In an attempt to fill this void, Rape Crisis was established in Cape Town during the late 1970s, and soon spread to other major centres. These rape crisis centres have set themselves numerous tasks, the primary one being the provision of support and assistance to rape victims. Rape Crisis (South Africa) has formulated its own procedures and counselling techniques, based on crisis literature and on procedures developed in crisis clinics around the world.

This chapter has been written in an attempt to provide an overview of the intervention model developed by Rape Crisis (South Africa) with particular reference to the intervention strategies and procedures employed by Rape Crisis (Durban). Presentation of the model falls into three parts: (a) an overview of basic theoretical components; (b) a summary of the structure of intervention, and (c) a discussion of the practice of rape crisis intervention.

2. BASIC THEORETICAL COMPONENTS OF RAPE AS A CRISIS

2.1 An overview of crisis theory

Crisis theory provides a conceptualization of the nature and psychogenesis of crisis states which serves as a framework for rape crisis intervention. The basic tenets of crisis theory[1] are embodied in the following points:

072231

The precrisis phase. All persons strive to maintain a balanced or *steady state* of functioning. This steady state (sometimes referred to as equilibrium) is characterized by balance between the two mental systems of emotion and thought.

The impact phase. The impact of a hazardous event disrupts a person's homeostatic balance, throwing him or her into a *vulnerable state*. This vulnerable state is characterized by increased tension and a subjective experience of distress. In an attempt to regain equilibrium the individual goes through a predictable series of phases. First, customary problem-solving techniques are employed. If these techniques succeed, the person returns to a steady state and the stress is considered constructive. If normal coping mechanisms fail, the intensity of stress increases and attempts are made to mobilize emergency-coping strategies.

The crisis phase. If self-correcting and emergency-coping strategies fail, tension rises to a peak and the individual enters a *crisis state*, characterized by disequilibrium and disorganization. The crisis state is neither a pathological experience nor an illness; it reflects rather an individual's realistic response to his or her current life reality. The individual in a state of active crisis tends to be particularly amenable to help, with the crisis state being a phase during which minimal therapeutic effort is likely to produce maximal effect.

The resolution phase. Crises are short in duration, with resolution of active disequilibrium occurring within four to six weeks. Crisis resolution tends to follow a predictable series of stages, each characterized by specific emotional reactions and behavioural responses.

The postcrisis phase. Successful crisis resolution equips the individual to cope more successfully with future crises. (Existing coping mechanisms are strengthened or new coping strategies acquired.) If adequate help and situational support is not made available during the crisis period, inadequate or maladaptive patterns of adjustment may occur, resulting in permanent emotional injury and a weakened ability to cope effectively with future crises.

2.2 The rape-as-crisis conceptualization

The tenets of crisis theory can be readily applied to sexual assault (Baum, Shore, Sales 1982). Studies of rape victims have shown that the trauma of rape invariably precipitates a crisis state characterized by emotional, cognitive, and behavioural disequilibrium (Burgess, Holmstrom 1973,

1974; Fox, Scherl 1972; Sutherland, Scherl 1970). This state of active disequilibrium tends to be short-run, usually lasting for a period of no more than several days.

The resolution phase of the rape crisis tends to follow a predictable series of stages. Fox and Scherl (1972) provide a framework for understanding the patterns of response among rape victims as a typical sequence:

Acute reaction. The victim's acute reactions may take a variety of forms, including shock, dismay, self-blame, anger, fear, and anxiety. Burgess and Holmstrom (1974) describe two styles of emotional response evidenced by rape victims during this phase: (a) *the expressed style* — in which feelings of anger, fear and anxiety are expressed overtly in behaviours such as crying (often uncontrollably), smiling, restlessness, and tenseness, and (b) *the controlled style* — in which the victim's true feelings are masked or hidden beneath composed or subdued behaviour.

Outward adjustment. As the victim moves out of the crisis state various psychological defence mechanisms, such as denial and rationalization, are brought into play. Victims resume their normal activities and *appear* to be adjusting to the assault. The openness to help and outside influence which characterized the crisis state tends to wane noticeably during this phase.

Integration. The final stage of crisis resolution is associated with a resurgence of depressive symptoms and a renewed openness, on the victim's part, to discuss the assault. Central issues which emerge at this time, and which need to be worked through with the victim, include the victim's feelings about himself or herself (often involving feelings of worthlessness or self-blame) and the victim's feelings about the assailant (usually involving anger and resentment).

Studies of rape victims in the postcrisis phase have revealed that, while some victims achieve complete recovery in a matter of months, others continue to exhibit a discernible core of distress for years following the assault (see e.g. Atkeson *et al*. 1982; Collings 1985; Kilpatrick, Resick, Veronen 1981; Santiago *et al*. 1985).

3. THE STRUCTURE OF RAPE CRISIS INTERVENTION

Rape crisis intervention is not a sloppy, haphazard method of helping people. It is a structured mode of time-limited intervention, guided by tried and tested theoretical principles, and incorporating explicit and

predetermined goals and procedures. As detailed outlines of rape crisis procedures are available elsewhere (see e.g. Abarbanel 1976; Golan 1978; Hardgrove 1976; Holmes 1984; McCombie 1980) only an overview of these procedures is provided here.

3.1 Main features of rape crisis intervention

- Intervention is short term (usually 12 sessions or fewer).
- The nature of the crisis state dictates an active and directive involvement by crisis workers.
- Intervention is directed at re-establishing precrisis levels of
- functioning and *not* at attempts to effect fundamental personality change.

3.2 Goals of intervention

The primary objectives of rape crisis intervention are threefold:

- To shield the victim from further harm and stress
- To assist the victim to organize and mobilize all possible resources
- To restore the victim, as far as possible, to a precrisis level of functioning.

3.3 Intervention techniques

Techniques[2] employed in rape crisis intervention include the following:

- A focus on the here and now
- The adoption of an active and directive stance
- Encouraging the victim to take an active role in proceedings
- Giving advice
- Sympathetic listening and empathic understanding
- Realistic reassurance
- Mobilization of existing support systems
- Clarification and partialization of action alternatives
- Anticipatory guidance and rehearsal for problematic situations that are likely to occur.

3.4 Phases of intervention

Making contact. The crisis worker's first task is to initiate a supportive relationship with the victim. Techniques that are useful in this process

include realistic reassurance, sympathetic listening and the communication of empathic understanding.

Assessment. A comprehensive assessment of the crisis state involves an evaluation of *victim risk* (Is there a danger of further victimization? Does the victim require emergency medical or psychiatric treatment? Is the victim suicidal?); an assessment of the severity of *victim disequilibrium* (Is the victim completely disequilibrated? Is the area of dysfunction limited to specific areas?) and an assessment of *victim needs*. According to Abarbanel (1976), the rape victim's needs are likely to encompass the following areas: (a) information on how to obtain medical, mental health and legal services; (b) immediate and follow-up medical care for physical trauma, collection of medico-legal evidence, prevention of venereal disease, and protection against unwanted pregnancy; (c) immediate and follow-up counselling for emotional trauma; (d) sensitive treatment by police officers, medical personnel and lawyers; (e) support from significant others, and (f) legal assistance, including information about rights and legal representation (p. 478).

Formulation. On the basis of the assessment a preliminary plan of action is formulated and an agreement made with the victim about the *counselling contract*. In McCombie (1980) it is suggested that the counselling contract should include a tentative formulation of the focus of intervention, a clarification of the counsellor's role and an approximation of frequency and duration of contact (p. 154).

Intervention. The intervention phase involves two modes of intervention: (a) *crisis counselling* — in which the crisis worker assists the victim to cope with her inner feelings and re-establish precrisis levels of functioning, and (b) *advocacy* — in which the crisis worker provides information regarding, and ensures effective access to, the medical, legal, and welfare services that the victim may require. Karen Holmes (1984) stresses the importance of both modes of intervention:

> "Although most interventive efforts with rape victims have been directed towards the individual via the crisis intervention strategy, the advocacy strategy must also be consciously implemented to effect institutional change aimed at helping *all* rape victims" (p. 19). "In the long run ... it is the advocacy strategy that may have the greater impact, especially when the advocacy role is extended to the macro level of social change with the aim of eradicating rape. If, as the feminists contend

by their definition of the problem, rape represents predatory sexual inequality, a means of control whereby women are 'kept in their place', then only the restructuring of society and resocialization toward sexual equality can be the advocate's final objective'' (p. 34).

Termination. Termination is effected, either in the period specified in the counselling contract, or at an earlier stage, if the victim feels that she can cope without further support. It is the crisis worker's responsibility to ensure that the victim is adequately prepared for termination and made aware that further counselling is available in the event of future need. If, in the counsellor's opinion, no significant resolution of the crisis state has occurred by this stage, the victim is advised to seek further assistance of a professional nature (i.e. medical, psychological, or psychiatric).

4. THE PRACTICE OF RAPE CRISIS INTERVENTION

In this section the *practice* of rape crisis intervention is examined as an expansion of the theoretical components already discussed. A brief history of rape crisis counselling is presented, followed by a discussion of the organization of Rape Crisis (South Africa) and a description of the intervention model adopted by Rape Crisis (Durban).

4.1 History and formative influences

The first facilities specifically designed to address the issue of rape, and other forms of violence against women, were established in Britain, Canada, and the United States during the late sixties and early seventies. Several European countries soon followed suit and many such facilities, both state and privately funded, now exist in these countries. The genesis of rape crisis centres can be linked quite clearly to the growth of feminism and the women's movement over the last two decades. The focus on issues affecting women in particular, and a growing awareness of the nature of women's oppression, led to a reconceptualization of the violence women are subjected to in society, particularly rape (cf. Brownmiller 1975). Rape came to be understood as a structural problem (i.e. a manifestation of the abuse of power by men against women) rather than a personal problem, and women began to see rape as an area around which they should organize. Rape crisis centres, providing counselling for rape victims or survivors (the currently preferred term) were established by groups

of women concerned with this particular aspect of women's oppression. As a result most rape crisis centres were run by women and were feminist in orientation (i.e. they viewed rape as a manifestation of a wider power imbalance between men and women). This perspective forms the background against which most rape crisis counselling takes place (cf. Rohrbaugh 1979).

In South Africa small numbers of women became aware of these developments, and in 1975 the first rape crisis organization was established in Cape Town, strongly influenced by input from both Canadian and British centres. Over the next five years similar organizations were established in other major centres (Durban, Johannesburg, and Pietermaritzburg). Organizations in each centre function independently but maintain informal links and meet annually to discuss issues of policy and organization.

4.2 Current organization of South African rape crisis groups

Structure. Rape Crisis (South Africa) restricts membership to women and the organizations consist of voluntary members. Although some organizations employ a small number of paid staff, the vast majority of members offer a voluntary service. There is no discrimination of members along the lines of race, class, age, or religion, although some selection of members takes place according to motivational factors. The organizations run on democratic lines, attempting to involve all members in the decision-making process.

Training. New members are required to attend a training programme, usually involving 8 to 12 sessions of several hours each. The training course covers (a) a conceptual basis for understanding rape and other forms of violence against women; (b) knowledge about the legal, law enforcing, and medical procedures involved following a rape; (c) public education skills, and (d) training in crisis counselling skills. The nature of the rape trauma syndrome (Burgess, Holmstrom 1974) is covered and both general and specific counselling skills are taught, demonstrated, and role-played by trainees under supervision. Ongoing training, involving talks, discussions, and workshops, takes place thereafter for all members of the organization.

Functions. Rape crisis organizations appear to perform two main functions: "crisis invervention" and "advocacy" (cf. Holmes 1984). Rape Crisis offers support and counselling to individual rape survivors and concurrently does a great deal of work in educating and challenging the

general public and the media concerning violence against women. This advocacy or educative function is viewed as essential in terms of correcting the many misconceptions about rape (which often lead to ostracism and rejection of rape survivors) and in ensuring that institutional agents (police officers, district surgeons, public prosecutors, etc.) are responsive to the needs of rape victims. Thus, while the balance of this chapter focuses on the counselling function of Rape Crisis, the importance of a more macrolevel type of intervention should not be underestimated.

4.3 Counselling rape survivors, their families and friends[3]

Initial contact. Rape Crisis (Durban) offers a 24 hour counselling service in response to telephone contact via a paging service. If a concerned person, other than the rape survivor, contacts the organization, Rape Crisis always establishes whether or not the survivor herself wishes to talk to a counsellor. If the rape survivor phones in person, the counsellor on duty attempts to establish rapport as quickly as possible and to assess what the immediate needs of the caller are. In emergency cases the counsellor may arrange to meet the survivor as soon as possible, but in most situations a convenient time and meeting place are arranged for future contact.

The counsellor will spend some time listening to the survivor's account and offering support and will also clarify the fact that Rape Crisis offers a limited support-orientated counselling service (i.e. support and advice rather than psychotherapy). On occasion survivors may choose to be counselled only telephonically, in which case lengthy discussion will follow, but in most cases survivors are encouraged to make use of face-to-face contact with the crisis worker. It is also important to establish what support network the woman has immediately available and to encourage her to make use of sympathetic friends or family where possible.

Intervention. Counselling sessions are conducted in the survivor's home or at a convenient, pre-arranged venue. Counsellors always work in pairs, for a number of reasons: (a) safety; (b) in order for the survivor to have some choice in establishing a counselling relationship; (c) to keep a mental note of practical and procedural problems while simultaneously responding to emotional issues; (d) in order that counsellors can provide each other with support, and (e) to obviate any problems that may arise relating to counsellor countertransference. The system of counselling in pairs also provides the opportunity for new counsellors to gain practical experience

in a relatively "safe" context with an experienced counsellor. No adverse response to this method of counselling has been received from rape survivors.

Active intervention involves two main features of crisis intervention, namely: (a) emotional catharsis or support, and (b) the re-establishment of coping responses and problem-solving skills. While counselling usually involves intervention at both these levels, it is important to establish initially what the client's expectations and needs are. Is there a need for specific information, or for emotional support and acceptance, or both?

If there is a need for specific information or practical support, the crisis worker will provide information concerning the reporting of rape, the district surgeon's examination, possible medical repercussions of rape, court procedure, the procedure involved in obtaining a legal abortion (should the woman fall pregnant) and the implications of these various actions.

Decisions about how to deal with the rape, for example whether to tell significant others or whether to report the rape, are discussed in a structured but non-directive manner, assisting the survivor to come to some definite decision about a suitable course of action for herself. If necessary, rape counsellors will accompany survivors to the various authorities, in order to provide support and to ensure that the women's rights are recognized.

In relation to emotional support and acceptance, the usual techniques of crisis counselling are adopted (i.e. empathic listening, reflection, clarification, acceptance of emotional responses, reassurance, and containment). It is important that feelings of guilt or self-blame are identified and effectively dealt with. For this purpose a non-judgemental attitude of unquestioning acceptance is recommended. The woman needs to be reassured that the responsibility for the attack lies with the rapist, that the majority of rapes are planned, and that her status as a victim is one which could equally have befallen any other woman under the same circumstances.

When one is facilitating emotional expression, it is important to bear in mind the differences in coping styles between the "controlled" and "expressive" survivors (cf. Burgess, Holmstrom 1974). While it is generally accepted that women who express and share their feelings immediately following the rape experience face better long-term adjustment, it is important not to "push" survivors towards catharsis. Some encouragement

to describe the details of the experience, and careful reflection on the feelings involved at the time, are often sufficient to allow the ventilation of repressed feelings. If the woman is able to express anger in relation to the experience this may be a positive indication that she is regaining a sense of control.

Counselling family and friends. Although not competent to offer marital or family therapy, Rape Crisis workers will offer supportive counselling to family members or concerned friends, if so requested. In many instances men related to the survivor (e.g. husbands, boyfriends, fathers) display markedly ambivalent reactions, ranging from extreme overprotectiveness and anger to withdrawal and rejection. Parents of rape survivors, particularly young children, may feel guilty, confused and angry. The reactions of people close to the rape survivor are often crucial in determining how she adjusts to the trauma. It is important to acknowledge and hear the feelings of these significant others and, wherever possible, to correct any misconceptions. It is also important that these people do not impose their feelings on the victim, but rather deal with them in relation to the counsellor, and attempt to offer the survivor what support they can.

Cases requiring professional referral. Rape Crisis recognizes the limitations of voluntary, non-professional counsellors. In particular cases counsellors are advised to make referrals to appropriate professional organizations. The following indications would warrant referral: (a) suicidal ideation and severe depression (involving clinically characteristic symptoms); (b) a previous history of psychiatric problems; (c) the presence of physical, psychological, or social problems, not related to the rape (e.g. alcoholism, previous family conflict, chronic migraines, etc.); (d) a failure to make expected adjustments over a period of six weeks, and the development of secondary symptoms (e.g. phobias and ongoing sexual problems), and (e) most cases of incest (which usually require family therapy and medium-term or long-term psychotherapy).

There are several professional people (social workers, clinical psychologists, doctors and lawyers) who are members of Rape Crisis, and the above categories of cases may be referred to them in their professional capacities. Rape Crisis also maintains a referral list of professionals, who have been recommended on the grounds of having knowledge and experience in the area of sexual abuse. Clients who are advised to seek professional help are, of course, always at liberty to make their own choice in this regard.

Duration of intervention. The duration of Rape Crisis intervention ranges from one to twelve sessions (with an average of three or four sessions). In keeping with the tenets of crisis theory, it is expected that the crisis state should be resolved in a maximum of six weeks; and the need to maintain regular contact beyond this point indicates the necessity for referral to a professional counsellor. In many cases it is the survivor who decides when to terminate contact with Rape Crisis. As her life starts to return to normal, and she feels able to cope without outside support, the woman will often indicate that this is the last contact she feels she needs. Many women will ask for some reassurance that they can contact the counsellor at some future stage, should they encounter unexpected difficulties, and counsellors will almost invariably agree to this.

Follow-up. In most cases no formal follow-up is arranged. However, if the woman is due to appear in court, the counsellor will prepare her for the experience and provide her with emotional support throughout the proceedings. The court case often takes place some months after the assault, and may evoke old feelings in relation to the rape, which need to be dealt with.

Rape Crisis (Durban) maintains records of all interventions. These records, which include biographical information, the circumstances of the rape, and the nature of intervention offered, are maintained for statistical purposes and are treated in the strictest of confidence.

4.4 Variations of the counselling model

The counselling model presented here is that which is employed by Rape Crisis (Durban). It should, however, be recognized that other centres and organizations may adopt somewhat different approaches.

For example Rape Crisis (Cape Town) has assisted in training hospital staff working in crisis units at Tygerberg and Groote Schuur hospitals, where rape survivors can be referred for multidisciplinary assessment and counselling. While the Cape Town organization has maintained its own counselling service, the establishment of hospital-based crisis facilities has been useful in coping with the increasing number of rape survivors requiring assistance.

In Johannesburg a one session counselling intervention model has been adopted by POWA (People Opposed to Woman Abuse). This involves very structured, practical intervention aimed at empowering the survivor to make informed choices, given the circumstances of the rape. Inter-

vention is aimed at helping survivors to reconceptualize the rape in such a way as to understand it as a structural problem, rather than seeing themselves as personally responsible, thus alleviating feelings of shame and guilt. This once-off intervention model is seen as more useful in the case of certain women who do not expect to engage in an ongoing counselling relationship, and who may be unable (e.g. for socio-economic reasons) to return for further counselling.

Depending on work loads and the availability of other resources it is likely that modifications to the basic counselling model will be made in other centres in future. It is also important to bear in mind that for most organizations concerned with violence against women, rape is only one intervention target, with sexual harassment and battery in particular constituting important areas of concern.

5. CONCLUSION

South African rape crisis organizations are performing an important function, which is not offered directly by any state or welfare agency. Based largely on British and Canadian methods of counselling, and ongoing experiential assessment, a short-term crisis counselling approach is adopted. Despite a high turnover of members, these organizations have continued to survive and indeed thrive over the last decade, and have broadened and expanded their functions. It would seem that while the demand for services continues, Rape Crisis will continue as a valuable, voluntary facility.

NOTES

1. The overview of crisis theory presented here has been synthesized from the work of others. See, for example, Rapoport 1965; Pasewark and Albers 1972; Caplan 1974; Golan 1978; Mitchell 1981; Foley and Davies 1983, and Holmes 1984.
2. A detailed discussion of crisis intervention techniques is provided in Golan 1978, pp. 96-117. See also McCombie 1980, and Holmes 1984.
3. This information is based on the case records and training manuals of Rape Crisis (Durban).

LIST OF SOURCES

ABARBANEL, G.
1976. Helping victims of rape. *Social Work* 21(6), Nov.:478-482.

ATKESON, B. *et al*
1982. Victims of rape: repeated assessment of depressive symptoms. *Journal of Consulting and Clinical Psychology* 50(1), Feb.:96-102.

BAUM, M., SHORE, B., SALES, E.
1982. Rape crisis theory revisited. In: WEICK, A., VAN DIVER, S. *Women, power and change*. Washington, DC: National Association of Social Workers. Pp. 43-55.

BROWNMILLER, S.
1975. *Against our will: men, women, and rape*. New York: Simon and Schuster.

BURGESS, A.W., HOLMSTROM, L.L.
1973. The rape victim in the emergency ward. *American Journal of Nursing* 73(12), Dec.:1741-1745.

BURGESS, A.W., HOLMSTROM, L.L.
1974. Rape trauma syndrome. *American Journal of Psychiatry* 131(9), Sept.:981-985.

CAPLAN, G.
1974. *Support systems and community mental health*. New York: Behavioural Publications.

COLLINGS, S.J.
1985. Delayed rape trauma in victims of unreported rape. *Psychotherapeia and Psychiatry in Practice* 37(2), May:33-35.

FOLEY, T.S., DAVIES, M.A.
1983. *Rape: nursing care of victims*. St Louis: Mosby.

FOX, S., SCHERL, D.J.
1972. Crisis intervention with victims of rape. *Social Work* 17(1), Jan.:37-42.

GOLAN, N.
1978. *Treatment in crisis situations*. New York: Free Press.

HARDGROVE, G.
1976. An interagency service network to meet the needs of rape victims. *Social Casework* 57(4), April:245-253.

HOLMES, K.A.
1984. Working for and with rape victims: crisis intervention and advocacy. In: STUART, I.R., GREER, J.G. *Victims of sexual aggression: treatment of children, women and men*. New York: Van Nostrand and Reinhold. Pp. 18-35.

KILPATRICK, D., RESICK, P., VERONEN, L.
1981. Effects of a rape experience: a longitudinal study. *Journal of Social Issues* 37(4), Autumn:105-122.

McCOMBIE, S.L.
1980. *The rape crisis intervention handbook: a guide for victim care*. New York: Plenum.

MITCHELL, J.T.
1981. Understanding crisis. In: MITCHELL, J.T., RESNIK, H.L.P. *Emergency response to crisis*. Bowie: Robert Brady. Pp. 1-14.

PASEWARK, R., ALBERS, D.A.
1972. Crisis intervention: theory in search of a program. *Social Work* 17(2), March:70-77.

RAPOPORT, L.
1965. The state of crisis: some theoretical considerations. *Social Service Review* 6(2), June:22-31.

ROHRBAUGH, J.B.
1979. *Women: psychology's puzzle*. London: Abacus.

SANTIAGO, J.M. *et al.*
1985. Long-term psychological effects of rape in 35 rape victims. *American Journal of Psychiatry* 142(11), Nov.:1338-1340.

SUTHERLAND, S., SCHERL, D.J.
1970. Patterns of response among victims of rape. *American Journal of Orthopsychiatry* 40(3), April:503-511.

IV

TIME-LIMITED THERAPY IN PRIVATE PRACTICE

Laetitia Botha

1. INTRODUCTION

The importance of time in everyday life is universally acknowledged. "The link between time and reality is insoluble. We can divorce ourselves from time only by undoing reality, or from reality only by undoing the sense of time" (Mann 1973:3). Time is also a prominent factor in therapy which includes the beginning phase, actual intervention and termination. It is a reality that both therapist and client take into account; it structures the therapeutic process; and plays a role in evaluating therapeutic effectiveness.

Private practice in social work is a newer helping structure whose success is determined mainly by a practitioner's ability to use the available time effectively for therapeutic interventions and the administration of therapy. Unfortunately not all practitioners realize this. "One of the dimensions of commitment less immediately visible in deciding to practice ... privately is that of time" (Levin 1983:36).

In view of the fact that: demand exceeds supply, therapy is expensive without compensation from medical aid funds and the average problems that arise in private practices cannot be solved by means of long-term therapy, short-term therapy should without reserve be included in the helping model.

The point of departure of this chapter is that because of the unique nature of private practice as a helping structure and the nature of the problems presented, time-limited therapy has a special significance and value. In the light of these facts, the nature and role of private practice in the welfare structure is examined and the role functioning of private practitioners and private practice clients as well as the essence and content of the services rendered in private practice clarified, with special reference to the therapeutic process to indicate the relevance of time-limited therapy.

2. PRIVATE PRACTICE AS A HELPING STRUCTURE

The practice of social work in welfare organizations is institutionalized in the community. The general image of a social worker is that of a person who works for a welfare organization, while training institutions preeminently equip prospective social workers to practise the profession in welfare organizations.

Provision of services in private practice started on the following assumptions: people who approach welfare organizations for services are not the only ones in society in distress; some people do not like the charity aspect of the help provided by welfare organizations; the quality of social work service is such that it can be offered in marketable units; and, some social workers prefer to work autonomously. In the USA, where private practice started as early as the late twenties, one out of every three social workers was already in private practice in 1983 (Barker 1983:13). In the Republic of South Africa, private practice as a helping structure is a phenomenon of the seventies and eighties and is still of limited extent. In 1985, for example, there were approximately 40 known private practitioners in the whole of the Republic.

To understand the application of time-limited therapy in private practice, it is first of all necessary to have knowledge of the essence of private practice. Therefore social work private practice is defined as a PLACE where:

- a registered social worker who subscribes to social work values and standards renders services;
- the helper has recognized qualifications and adequate experience in practice to act in a professionally responsible manner;
- the client voluntarily approaches the private practitioner for assistance and becomes his primary responsibility;
- helping services are organized professionally and not bureaucratically;
- the private practitioner autonomously decides on methods and techniques of assistance;
- a fee for services rendered is paid directly by the client or on behalf of the client, and
- provision of assistance is sanctioned by registration with the statutory body of the social work profession.

The independence and autonomy of private practice as well as the fact that success is not only measured in terms of the interventive goals realized but also, and in particular in terms of financial success, entails that special consideration be given to helping inputs.

3. THE PRIVATE PRACTITIONER AND TIME-LIMITED THERAPY

The private practitioner in social work, like any other social worker, is primarily concerned with interpersonal relations. To render assistance at an interpersonal level, a helper should be able to reach out, show empathy and be genuine. Unfortunately these human traits sometimes lead to a therapist becoming inactive and passive and simply mirroring the client's emotions. Hence the therapeutic process is often lengthy without any noticeable progress. Services rendered in private practice which the client pays for, must foster growth and progress.

Apart from humaneness, time-limited therapy requires flexibility, involvement, participation and spontaneity on the part of the private practitioner. A practitioner must know himself, know what he is doing and understand his client's requirements. His participation in the helping process is such that it enables the client to identify his potential and guide his development. This does not imply, however, that the practitioner becomes so active that he takes over and runs his client's life.

To establish equilibrium between overactive and passive participation in the helping process, a practitioner should focus on the central problem and the concomitant therapeutic goal. Aspects of secondary importance should not consume time, and the practitioner's participation should relate to the client's ability to effect behaviour change in the allocated space of time.

The role of time in time-limited therapy necessarily entails activity on the part of the private practitioner in the helping process. The concept of limitation of time is explained and discussed and an agreement concluded. Thereafter it is the practitioner's responsibility to keep the therapeutic process within the time schedule.

A private practitioner's attitude to time-limited therapy is important. He must convey to his client optimism, or a positive attitude about the success potential of therapy in a short period of time. In fact, if the therapist is not convinced that the treatment will yield results in the predetermined time, he will not be able to convince his client. It could happen that when the practitioner makes a therapeutic proposal to the client,

who keenly feels the burden of the problem, the latter might strongly doubt that the time allocated will be sufficient. A practitioner who believes in this therapeutic model and is convinced that it is appropriate for a particular client, can, with the necessary enthusiasm, generate similar faith and motivation in his client.

A social worker with enough experience in the complexity of human and social problems and who has often worked for long periods on cases at a welfare organization without any limitation of time, will have difficulty accepting time-limited therapy. As the demands for private practice increase — due to the greater need for it and to its proven effectiveness — and as client satisfaction becomes evident, more private practitioners will move towards time-limited therapy. As Mann (1973:83) so aptly states: "The more thoughtful and more experienced in the field in general will realize that the limitation in time and in goals requires a high order of knowledge and self-discipline in conjunction with a disciplined treatment rationale ... It is a means for treating a great number of patients in a substantial and meaningful way, and it also offers high promise as an accurate research tool into the process and effectiveness of ... therapy."

In South Africa private practitioners work mainly part time — hence a viable practice must be developed in conjunction with another job. The structured nature of time-limited therapy and the possibility of assisting a larger number of clients underline the value of this approach to helping. Private practitioners, however, are obliged to conduct self-analysis and determine whether or not they have the ability to work according to a structure, and whether they are in a position to help their clients more rapidly to achieve greater maturity, accept realities and function independently.

4. CLIENTS OF PRIVATE PRACTICES AND TIME-LIMITED THERAPY

The feelings, defence mechanisms and expectations (with regard to helping) of the clients of private practices have the same effect on the helping process as those of clients associated with non-private practice. The lower-order needs of most clients who approach private practitioners have already been met but these clients are obstructed in the fulfilment of higher-order needs. Such clients, without exception, seek assistance of their own accord which ensures positive motivation for co-operation in the therapeutic relationship. Moreover, they have the financial means

to pay the fees for services rendered which most welfare organization clients are unable to pay.

Clients who approach a private practice usually realize that they require help to solve their problems. In fact in the initial contact they usually relate what steps they have already taken. Hence they expect the practitioner to do the necessary intervention to effect change. They then expect fast results.

The types of problems that clients present to private practitioners mainly concern poor premarital, marital and family relationships. A case load analysis of one part-time private practice revealed that besides relationship difficulties other problems such as work stress, unplanned pregnancies, reactive depression, identity crises and "acting-out" behaviour came to light. One should not, however, overlook the preference and resultant selection that a private practitioner must apply. The fact remains that no cases with statutory functions or severe mental deviation would be accepted by private practitioners.

As is the case in other helping professions, private practice clients in social work, are usually women (cf. Tanney 1979:46; Berger 1983:567). They are also generally below the age of 50. It seems that private practitioners select clients who are workable — "... the kind of client with whom almost every therapist prefers to work because prognosis and progress are generally more hopeful" (Barker 1983:18).

It is clear from the aforementioned discussion that private practice clients, because of their socio-economic background and level of functioning, will welcome time-limited therapy. Its structured nature offers the experience of a purposeful helping action. Setting goals, task-directedness, continuous feedback and evaluation of progress provide clients with perspective on areas for further change, while right of participation reinforces the partnership principle. By setting a final date for terminating treatment, a practitioner gives his client hope that his problem can in fact be solved and encourages him towards constructive change.

The main problems dealt with in private practice are pre-eminently suited to short-term treatment because statutory functions are not prevalent, environmentally deprived clients tend to rather approach welfare organizations, and private practitioners do not in any event accept psychotic patients.

5. STRUCTURE AND CONTENT OF PRIVATE PRACTICE SERVICE RENDERING

"In order to enhance his own security and sense of well-being it is preferable for the practitioner to control his practice. The first step in controlling a practice is to structure time so that it can be controlled — in one's own and one's patient's interest" (Levin 1983:143).

Time is therefore an essential aspect in the arrangement and provision of private practice services. In his earliest considerations about starting a private practice, time is the factor that will influence a practitioner's decision as to whether he should practise full time or part time. In the case of the latter where the practitioner usually works for an agency as well, constructive allocation of time to both commitments is imperative in order to function effectively but also be ethically accountable.

Structuring of services chiefly concerns organizing one's work programme and planning the therapy as such.

5.1 Organizing the work programme

A work programme is the mould in which helping is cast in a practice. It determines the tempo and work flow in the allocation of time to various tasks performed by private practitioners. A structured work programme not only facilitates decisions about the acceptance or referral of cases, or about when to perform what tasks, but helps to reassure the practitioner that he is in control of the service he is rendering.

In designing a work programme an appointment system, the duration of appointments and the size of the case load enjoy prominence:

- An appointment system provides a work plan for every day, week, month and longer. It not only regulates the flow of clients, but sets aside time for administrative functions, tea and lunch breaks, continuing education, community services and recreation. It is thus essential to keep a diary, while appointment cards setting out the practitioner's policy regarding cancellations, serve as a further aid.
- The duration of appointments or sessions determines the amount of time that a practitioner spends with his client. Variations in this regard range from fixed times for all cases to differentiation in the allocation of time for various problems or the different phases of the therapeutic process. It is important, however, that an appointment should provide enough time to realize the determined therapeutic goals at the

client and practitioner's pace. Obviously, the therapeutic pace can be modified, and the goals set and time allocated to achieve them should be spelled out to clients.

- The relevant service fields and the nature of the therapy provided obviously also determine the duration of sessions. A practitioner will, for example, require less time to advise a prospective social work student about his choice of subjects than to treat a student with behaviour problems. It is therefore advisable to arrange appointments according to a specific time schedule and if necessary to reserve more than one session for a case. Practice has proved that one-hour sessions, of which the final ten to fifteen minutes are set aside for administration, are adequate. A practitioner must, however, be able to handle the session with ease, both in his own interest and for the sake of rendering an adequate service. "Wise therapists know their energy level and cycle and pace themselves accordingly" (Levin 1983:143).

- The size of a case load has special implications for the work programme and for the quality of service rendering in a private practice. Practitioners, especially beginners, sometimes make the mistake of accepting all referrals in order to ensure financial success. The result usually is an unmanageable practice, that is, too many clients and too little time — and a professionally "burnt-out" therapist. Hence it is advisable to conduct a case-load analysis once a month at least, to establish the maximum number of cases that the practitioner can effectively cope with. In the USA 39 cases seem to be the maximum for full-time practitioners, as against the 35 that South African practitioners cite as an appropriate number (Botha 1984:244). Part-time practitioners are guided by the time at their disposal for private practice activities, and here again regular case-load analysis is important. Great demands are made on dual-career therapists in respect of the allocation and use of time in both work situations, loyalty to one's employer and one's own business and one's simultaneous roles of employer and entrepreneur (Weinrach 1980:87-89).

It is clear therefore that a work programme must be compiled in conjunction with decisions about the size of a case load to ensure that enough time is allocated for problem solving in every case. A practitioner's work programme and the nature of the therapy offered in his practice are inseparable.

5.2 The therapeutic process

Service rendering in private practice is not very different from that in welfare agencies — it is at all times and in all cases professional, purposeful, accountable and based on the concept of improved social functioning with a view to enhancement of quality of life. This broad or comprehensive goal of social work is the personal motto of every private practitioner and all his decisions and actions are geared towards realizing it. However, a private practitioner sets himself an additional goal, namely to render services to distressed people who usually do *not* approach welfare agencies. The needs, problems and expectations of the particular target group should be borne in mind in constructing the therapeutic service.

A particular practitioner's training, experience and personal style guide him in his selection of service fields and methods of practice. Many beginners tend initially to work generically to make the practice viable, but gradually they select cases in a specific service field, for example, marriage and family therapy. Research in South Africa shows that more than 70 per cent of private practitioners specialize in marriage therapy and more than 50 per cent in family therapy (Botha 1984:330). With regard to the method of helping, individual therapy seems to be the norm, whereas therapy with married couples and families occurs primarily in groups. Group therapy, however, hinges on client flow, the facilities available for accommodating groups and a practitioner's skill in handling groups. In some practices community, research and administrative projects are undertaken as part of the service, while supervision, consultation and training courses are also offered (cf. Kurzman, Solomon 1970:67; Goldmeier 1986:98).

The giving of help is almost always based on fundamental principles which constitute the epistemology of a programme of service rendering. A practitioner must have a basic philosophy of life and man, and must know how its acceptance has influenced his particular theoretical approach to helping. The *modus operandi* followed in a practice can then be explained and justified. The theoretical approach adopted also relates to a practitioner's perception of the methods that can be applied to realize therapeutic goals. If his basic premise for example is that man is continually developing, but is sometimes unwittingly caught up in a certain cycle, it would be appropriate to adopt the gestalt approach which focuses on the here-and-now, on settling unfinished business of the past, on self-regulation and on accepting responsibility for one's own feelings.

The particular nature of a private practice regarding the fees payable for services and clients' specific expectations about visible growth and results, also play a role in the selection of a therapeutic approach. Although (according to the Goldmeier inquiry (1986:98)) ego-psychology, psychoanalysis, the problem-solving and systems approaches appear to be the most popular methods used by private practitioners, time-limited approaches such as crisis intervention, behaviour therapy, directive therapy and the task-centred approach are widely used.

We shall now discuss the method and process of rendering assistance in private practice in order to show the place and value of time and time-limited therapy in it.

5.3 The process of service rendering

As in the case of service rendering at welfare agencies, private practitioners also follow certain procedures in helping patients. Likewise, certain phases are identifiable in the process in which time plays an integral part.

Intake and selection

Most clients telephone the social worker, although intake may be face-to-face or through referral systems. At this early stage of contact the client is informed about the nature of the initial interviews, the assistance available and the conditions to which the service is subject. The potential client must realize that initial interviews are conducted to establish whether or not the practitioner will be able to help in this particular case. This *modus operandi* has been found to boost clients' self-confidence which in turn generates co-operation, while an early understanding of structured assistance fosters motivation for change. At this stage, however, a client can decide not to go ahead with the treatment proffered or the practitioner may decide not to accept the client, and refer him to another source of help.

Assessment phase

Although clients are informed beforehand about the nature of the first interview, most of them still arrive with preconceived ideas about social workers and about what they are "in" for. The practitioner reaches out by showing empathy, and focuses on establishing the relationship. He reiterates the goals of the interview to enable his client to understand the reason for exploration. The practitioner then focuses on the problem

presented, by referring to the problem that the client mentioned telephonically. Once the latter has vented his feelings and the practitioner has collected enough information on the present problem, diagnostic tools are used to gather background information. Examples of such tools are filling in the intake or family history forms, genograms or echograms. Clients are usually enthusiastic about these activities because they regard them as constructive, and at this stage they themselves have started to gain insight into their own ineffective functioning.

Sometimes more than one interview is necessary to make an initial diagnosis. The central problem as well as the type of defence mechanism used by the client are identified as quickly as possible. A practitioner endeavours to answer three questions at this stage: Who is this client? What does the client see as the problem? Is it the real problem and if not, what is the relationship between the client's view of his problem and the actual problem? Example: A practitioner is approached by a final-year female student in a state of depression, which, according to her, is caused by unreadiness for starting a career, as well as having made a possibly incorrect occupational choice. She comes from a stable middle-class family that places a high premium on the traditional role of women.

The client underwent comprehensive aptitude and interest tests in her final year at school, while above-average academic achievement at university contradicts her perception of an incorrect occupational choice. The client brings the symptoms and depression to the consulting room but the reasons she advances for the problem are not convincing. It is clear from the background information, that she is actually dissatisfied because she cannot satisfy her own expectations and those of her parents about having a fixed relationship with someone of the opposite sex before the completion of her university training.

The practitioner formulates a general statement which reflects his understanding of the client's discomfort. He might say the following: "From what you have told me I gather that you are disappointed in yourself in feeling as you do at this stage of your life". The practitioner, by showing empathy, prevents intellectualization or destructive defence by the client, and this leads to greater confidence in the practitioner.

The next step involves selecting the most suitable therapeutic model for the case concerned. Matching the problem and type of help is an extremely demanding task, and unfortunately the literature provides few guidelines in this regard. In time-limited therapy the immediate planning of

suitable assistance is imperative. Unlike in long-term therapy, there would be few opportunities for correction or adjustment later on.

Feedback to the client usually occurs at the end of the first interview, but may also be deferred to the second interview provided that the client at this stage understands that more exploration is necessary. If it is evident that the client can be helped more effectively elsewhere, the practitioner explains the situation and obtains permission to refer him to a more suitable source of help. Otherwise the client is told what the preliminary diagnosis seems to be and when the latter has had the opportunity to discuss it, the final goals for therapy are formulated. The therapeutic plan is presented and any questions the client may ask, are answered.

Structuring the therapeutic programme

Further feedback to the client involves the structure in terms of which treatment will be given, that is, the client is informed about the duration of therapy and the frequency and spacing of sessions. Private practitioners have not reached consensus about the number of sessions that distinguish time-limited from long-term therapy (cf. Comfort, Kappy 1974:486-487; Koss 1979:210-212). South African practitioners, however, hold that six and more interviews may be classified as long-term therapy which means that half of all clients seen in private practices receive short-term therapy (Botha 1984:426).

The nature and intensity of the problem and the client's rate of growth are used as indicators for estimating and spacing the number of interviews. The programme may, for example range from weekly to monthly interviews extending over six weeks or six months.

Whatever the form of the therapeutic programme, the practitioner must explain it to the client and substantiate his choice. He must also explain the following: the need for regular feedback and doing of homework; that termination occurs on the predetermined date by which time the goals should have been realized; and that subsequent follow-up interviews will be held. At this stage no contract has been entered into. This enables the client to consider the consequences of the proposed therapy without the practitioner in any way influencing his choice. Once he is ready, the client will make the next appointment, whereupon the contract will be drawn up and the therapeutic programme will start.

The therapeutic contract

A contract is "... an explicit agreement about terms of exchange and responsibility between therapist and client" (Barker 1982:101). Although a formal contract is concluded in the initial phase of the helping programme, it is regarded throughout as part of the treatment. The contract primarily includes the following: an introductory statement on the aim of the practice and the practitioner's approach to people in need and to the assistance being rendered; procedures regarding appointments, fees, settling accounts and insurance; the client's expectations regarding openness and partnership and an undertaking of confidentiality. Space is left for recording the therapeutic goals and allocation of time, as well as for a termination date. Hence a contract indicates the following: what the client must do; what the practitioner must do; a time limit for the contract; and, if behaviouristic methods are to be followed, what the consequences of adhering to or ignoring instructions would be (Frankel 1984:36-37). Obviously the contract may be revised during therapy and adjusted if necessary.

Initially, most of the clients of private practitioners regard a written contract as somewhat unusual because they have not encountered the like in other helping professions. Hence a practitioner must help his client to interpret the aim and value of the contract and when the latter understands it he will use it himself as an aid to direct his personal growth. Clients have been known to refer the practitioner directly to a clause in the contract in order to strengthen their own point of view.

In concluding a contract, the client accepts the therapeutic goals and conceptualizes the therapy. The scene is then set for intervention and change.

Therapeutic intervention

Therapeutic intervention in private practice is the same as that offered by welfare organizations. Counselling is the basis of practically all interventive actions, although variations do occur in the form of game, relaxation and bibliotherapy, environmental change and concrete aid. Depending on the theoretical model employed, the different forms of intervention are: dealing with emotions, direct influencing, improving clients' insight and bringing about attitude and behaviour change.

Because most clients approach a private practice for short-term therapy, and every session with a practitioner costs money, the helping action must be approached purposefully. Hence each interview must have specific goals

and intervention must be directed towards achieving them. Because of the kind of clients, in most cases the most effective method seems to be coupling interpretations with emotional support.

At the start of the interview the practitioner refers back to events in previous interviews, then the goals of the present interview are outlined. The client thereafter usually relates what has happened since the last session, while the therapist supportively challenges him to greater frankness and insight. A practitioner's acceptance of his clients as people with dignity, irrespective of their problem or behaviour, fosters co-operation and willingness to learn new behaviour. They become actively involved in the process of understanding and changing their own behaviour. Various kinds of interpretations are used: hypothetical reasons are advanced for negative behaviour; the client's motive for using destructive defence mechanisms and maintaining conflict is outlined; the relation between specific behaviour and feelings is indicated, and the role of past events with regard to present action is pointed out. The client's acceptance of a specific interpretation serves as confirmation that the interpretation is correct.

If clients are not given enough support in the changing process, or feel that the therapy is not worthwhile, they simply drop out. Every practice has some dropouts. Each case must be carefully examined to establish why the client has left and to what extent the practitioner has been responsible.

As the therapeutic process advances it is advisable to refer to the time aspect in terms of the number of sessions that have been completed or the date fixed for termination. In this regard, both partners must consider the progress and rate of change. As the therapeutic process nears its end clients tend to arrive late, cancel appointments or keep interview events superficial. It is the practitioner's responsibility to relate these actions to previous terminations that clients have experienced, and, if transference is identified, to handle it therapeutically.

The termination phase

This phase is always emotionally charged for practitioner and client alike. Because of the short duration of treatment they have worked intensively throughout and their involvement with each other has become more deep-rooted. The separation process must therefore be thorough and complete. Emphasizing what the client has achieved and a demonstration of utmost confidence in his ability to carry on independently usually facili-

tates termination. Obviously an evaluation of the goals realized and reinforcement of newly acquired behaviour will feature prominently in the final interview.

Follow-up procedures

Following up clients who have undergone time-limited therapy is important. The point of departure here is that clients are usually not told about this during the therapeutic process because it contradicts the presupposition that problems can be completely solved in a short period (Mann 1973:45). However because clients pay for services it is necessary that they are in agreement about the necessity for follow-up treatment/appointments. Such appointments are made for two months in advance and a reminder postcard is sent to the client a week before each appointment.

To summarize: the therapeutic intervention usually starts with a beginning phase where the necessary information is gathered to formulate a tentative diagnosis. The goals of treatment are spelled out and a therapeutic programme designed, while a sound relationship in which the client feels secure, is established. In the middle phase the main focus is on the problem and change, while the client is assisted with new insight to overcome his problem. In the termination phase the treatment is rounded off, the realization of goals evaluated and new behaviour functionalized with the assurance of the therapist's future interest in the client's progress.

5.4 Group therapy

The purpose of group therapy is to devise a treatment package that limits the use of time. It is usually a quicker and less expensive method for the client and affords fewer opportunities for game playing and sabotaging therapeutic goals. It does, however, incline towards complicated situations and treatment obstructions because the practitioner has to analyse numerous inputs from group members and does not always observe everything.

Groups are kept relatively small with five to six members, not necessarily homogeneous in sex, age or the problem presented. In a heterogenous group there is greater scope for the development of unknown circumstances. A group series usually comprises ten weekly sessions, each approximately two hours long.

When the group meets for the first time a group goal and objectives to achieve it are formulated and placed within a fixed schedule. Cohesion and group pressure ensure that the schedule is adhered to, while members who develop faster, carry the slower ones forward. The practitioner remains task-oriented, he monitors and gives feedback on progress.

Married couples and students with relationship problems seem to be particularly willing to be involved in groups. For example, high school pupils have presented themselves at one private practice with a request to acquire interpersonal skills through groupwork.

The fees for group members are not based on the duration of sessions but on the amount of administration required for preparation, compiling reports and designing functional aids.

5.5 The administration involved in rendering a service

Helping clients in a private practice involves continual analysis of the situation, further data collecting, planning with a view to further action and implementing and evaluating results. This process applies to each individual case handled, as well as in the practice in general.

Once the clients have been seen, the practitioner writes reports on the sessions to place on record events in the helping process and to enable him to render account of his actions. A card-index or filing system is used for documentation and a practitioner must exercise self-discipline in order not to fall behind with his task. The information is required for clients' accounts and subsequent auditing.

A complete and tidy record system not only indicates a well-organized practice, but is also a precautionary measure should a practitioner have to defend himself against complaints from a client before a professional disciplinary committee. As part of feedback action, clients can be asked to write process reports or they may be allowed to read and sign process reports.

Sending out accounts and reminders before the due dates, keeping records of the practice's income and expenditure and auditing the financial statements every six months are administrative functions that need continual attention. Awareness of the practice's financial position provides regular feedback on the effectiveness of the organization and the marketing of the service. In the case of negative feedback a practitioner should apply nine marketing principles to the service: "re-define generic product, re-

define the target group, develop a different marketing approach, analyze customer behaviour, determine and emphasize advantages, develop a variety of new marketing tools, develop an integrated marketing plan, obtain regular and continuous feedback, and apply marketing audit'' (Hochhauser 1984:65-66).

6. CONCLUSION

Running a successful private practice requires an understanding of the role and effect of time. Most private practitioners practise part time and therefore have a dual responsibility in respect of allocating their time to different duties. The clients of private practitioners, on the other hand, have specific expectations of the therapy for which they pay handsomely. Hence the type of assistance rendered must be structured in such a way that it satisfies demands, fosters client satisfaction and places the practitioner in control of the service.

Short-term therapy provides substantial and meaningful support for a greater number of clients. Regardless of a practitioner's philosophical approach, time-limited therapy affords him the opportunity of building up a viable practice. ''Whether you like or dislike it may be an important value judgment to make — but you cannot afford to ignore it'' (Frankel 1984:5).

LIST OF SOURCES

BARKER, R.L.
1982. *The business of psychotherapy*. New York: Columbia University Press.

BARKER, R.L.
1983. Article in: *NASW Network* 28(12):1-4, 13, 18.

BERGER, J.
1985. Private practice: the first five years. *Canadian Journal of Psychiatry* 30(8), December: 566-571.

BOTHA, L.
1984. *Privaatpraktyk in maatskaplike werk*. Pretoria: Universiteit van Pretoria (D.Phil. proefskrif).

FRANKEL, A.J.
1984. *Four therapies integrated*. Englewood Cliffs, New Jersey: Prentice-Hall.

GOLDMEIER, J.
1986. Private practice and the purchase of services. *American Journal of Orthopsychiatry* 56(1):89-102.

HOCHHAUSER, M.
1984. Marketing for the psychologist in independent practice. *Psychotherapy in Private Practice* 2(2):61-74.

KURZMAN, P.A., SOLOMON, J.R.
1970. Beyond advocacy: a new model for community organization. *Social Work Practice* Vol. 1:67-73.

LEVIN, M.
1983. *The private practice of psychotherapy*. New York: Free Press.

MANN, J.
1973. *Time-limited psychotherapy*. Cambridge, London: Harvard University Press.

WEINRACH, S.G.
1980. Part-time private practices for the reluctant entrepreneur. *The Counseling Psychologist* 9(1):87-89.

V

TIME-LIMITED INTERVENTION IN OCCUPATIONAL SOCIAL WORK

Winifred A. Bryant

1. INTRODUCTION: THE EARLY PRACTICE OF SOCIAL WORK IN AN OCCUPATIONAL SETTING

Social work and industry have been closely linked since the time of the Industrial Revolution in Britain (1750-1850). Before this, charitable work was undertaken by the extended family, concerned individuals, the monasteries and the churches. In response to the needs engendered by the appalling social conditions that developed as a result of industrialization, *Poor Relief Societies* sprang up during the nineteenth century. However these societies were small and without adequate resources. Their services were unco-ordinated, given without investigation, and open to fraud and duplication. No attempt was made to restore the individual to productivity or self-respect and the accent was on relief of physical distress. It was only in 1869, with the establishment of the *Charity Organization Society*, that applications for poor relief were investigated and the concept of the "alms of good advice" introduced, thus laying the foundation for the practice of modern social work.

At about this time a few industrialists such as Lord Shaftesbury and Robert Owen in Britain, and Marken and Stork in the Netherlands, gave a lead in acknowledging the employer's responsibility for the well-being of his workers by appointing "welfare workers" in their factories. At that stage, according to Botha (1968:32), the tasks of the welfare workers were undefined, superficial and concentrated on the provision of material assistance to low-paid workers, and the improvement of conditions outside the workplace, for example, housing and recreational facilities.

During the First World War the demand for welfare workers in the factories increased drastically as women replaced men in industry. The emphasis of the welfare work that was done remained outside the workplace and concentrated on home visits, material assistance and recreational facilities. During the Second World War, influenced by the sociological and psychological theory developing at that time, a change in emphasis

occurred and the focus of industrial social work shifted from alms-giving to assistance with interpersonal relationship problems, although the demand for material assistance still existed.

In the late forties, with the emergence of the concept of industrial relations, the needs of the worker within the workplace were given greater attention. It was recognised that if employers wished to attract and keep a stable workforce, they would need to improve working conditions.

In Europe after the war several international conferences were held at which attempts were made to place *Personnel Social Work* (as it was then called) on a professional footing. The term *Personnel Social Work* was preferred at the time since it included work undertaken on behalf of personnel in hospitals, commerce, government departments and transport services, not just in industry. At present *Industrial Social Work, Personnel Social Work* and *Occupational Social Work* are used interchangeably to refer to social services in the workplace.

In 1960 principles for this type of social work were laid down at the European Seminar on Personnel Social Work in Brussels, (UNO Report, UN/TAO/1961 Rep.3), and these have been incorporated into the policies governing most modern occupational social service programmes.

The main focus of modern occupational social service programmes is the "troubled employee" — that is, an employee whose personal problems may affect, or are affecting his/her job performance. The objective of assistance is to restore the employee to an acceptable level of functioning at work, hereby reinforcing job security. The service is directed at both the productivity needs of the employer and employee well-being.

Social services programmes have been introduced into various work situations under various names, including *Troubled Employee Programme, Employee Assistance Resource, Occupational Rehabilitation Programme, Substance Abuse Programme* and *Employee Assistance Programme.* In some cases the programme has been directed at a specific problem, such as alcohol and drug abuse, but more commonly a "broad brush" programme is followed which addresses any problem that affects productivity. (Cf. Akabas, Kurzman 1982, for a more detailed history of social work in industry.)

The demands of the work situation place restrictions on the amount of time the employee can be spared from his job, and also require a quick return to acceptable work standards. Therefore time-limited intervention characterises most of the therapeutic work undertaken in industry.

2. PRINCIPLES OF OCCUPATIONAL SOCIAL WORK

2.1 The principle of neutrality

An important principle contained in the Brussels Report is the requirement that the occupational social worker should act as consultant and be precluded from taking managerial decisions. He should also play no role in the development of his client's career nor should he exercise any controlling function.

2.2 The principle of accessibility

The helping service should be available on site or within easy access of the workplace, and should be available within working hours. It is also important that workers should not have to wait a long time for an appointment, as motivation to resolve a problem is usually at its highest during a time of crisis.

2.3 The "broad-brush" principle

The service should offer assistance with any problem that affects the work performance of employees of all ranks. Such problems may be work-related, such as interpersonal conflicts, work stress, job dissatisfaction, discriminatory practices, unfair labour practices, job misplacements or management problems. Domestic problems, however, can equally affect the worker's ability to concentrate on his job, impair judgement and time management, disturb interaction with other workers and increase accident risk. Such problems include marital, family, legal, financial, health, psychological and addiction problems.

2.4 The principle of availability

The service should be available to all workers, irrespective of rank, race or sex, and, when necessary to the family of the employee. Effective marketing of the service is aimed at encouraging entry into the assistance programme at an early stage in the development of the problem.

The service is founded on a policy that accepts the legitimacy of offering assistance to troubled employees, and permits the employee to take time off for consultations without having his work record jeopardized in any way.

2.5 The principle of confidentiality

Employees need the assurance that confidentiality will be maintained, and in particular that management will not be involved without the explicit permission of the employee. Where the client approaches the social worker on his own initiative, no contact is made with the supervisor unless the client agrees that this would be beneficial for the resolution of the problem. In the writer's experience the majority of cases are self-referred or arise at the suggestion of colleagues or supervisors, and therefore management is not involved in any way.

Obviously management is involved in the case of mandatory referrals by supervisors. In this case the problem has affected productivity to such an extent that the employee is confronted with the choice of either seeking assistance or facing disciplinary action. Under these circumstances report-back to and from the supervisor is necessary and is done with the full knowledge of the client. Very often the client, supervisor and counsellor get together to clarify evaluation and report-back procedures. The worker is usually given a period of time within which an improvement is expected to become apparent. At the end of this period his position with the company will be reviewed. There is an understanding that all disciplinary action will be suspended during the period he receives assistance. There is therefore an urgency affecting both the employee and the counsellor to produce noticeable change within the time agreed upon. The treatment programme must be carefully planned to this end.

2.6 The principle of constructive coercion

The workplace offers a unique opportunity for overcoming the denial that frequently accompanies personal problems, particularly dependency problems. When an employee fails to recognise or admit he has a problem which is affecting his work, the supervisor can precipitate a crisis in the life of the employee by presenting him with the choice of accepting help and improving his work performance, or accepting the consequences of continued poor work performance or disruptive behaviour in the workplace. This is a valuable motivator not only in seeking help, but also in co-operating with the counsellor in resolving the problem as speedily as possible.

Clearly, this type of coercion is directed at the improvement of specific behaviours that are not acceptable in the workplace, and an attempt by the counsellor to bring about major personality change would not be

appropriate. Restoration of job status and resumption of previous standards of work will bring approbation from counsellor and supervisor, and this will act as a reinforcement to promote continued practice of the improved behaviour patterns.

3. THE PHILOSOPHY BEHIND PROVIDING ASSISTANCE SERVICES FOR EMPLOYEES

According to Starker (1986:2) the philosophy for providing such a service is based on four main assumptions:

- Personal problems adversely affect an employee's work resulting in deteriorating work performance.
- Unless some intervention is initiated the problems are likely to worsen.
- The kind of relationships that exist at work provide a good environment for effective intervention.
- It is in the interests of management, unions, troubled employees and their families, to effect intervention at the earliest possible time.

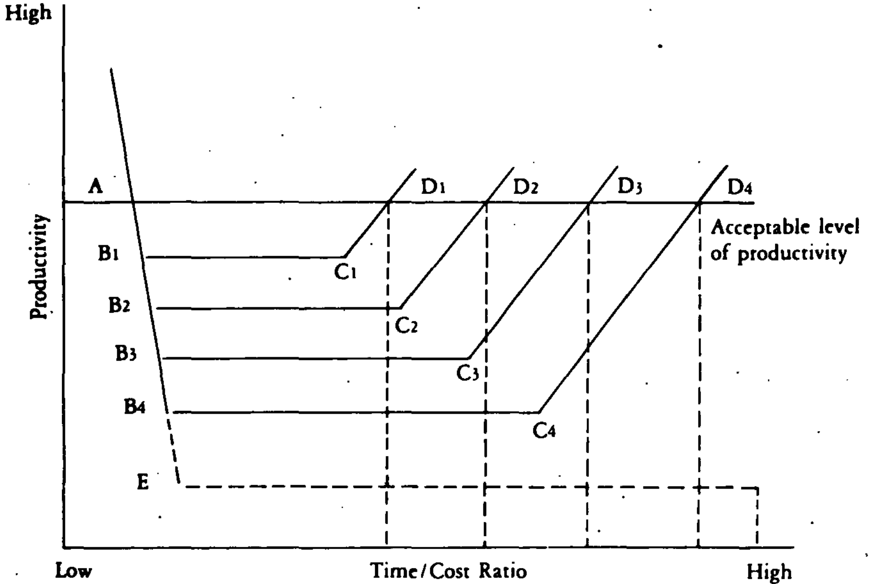
The benevolent, paternalistic approach of early industrial social work has therefore changed as employers recognise the advantages inherent in providing a service to the troubled employee. It is more cost-effective to help him improve his productivity than to dismiss and replace him. The increase in profitability more than covers the cost of providing the social service (Akabas, Akabas 1982:19-20).

Whereas previously the emphasis of the social service was on providing material assistance and improving living conditions outside the workplace, now the focus is on resolving any problem, either within or outside the workplace that affects productivity. Normal service benefits are expected to provide for the material needs of employees, although in some organizations, the social service staff operate a benevolent fund to assist special cases.

With the accent on cost-effectiveness, it has been necessary to use treatment methods that will promote the fastest possible return of the troubled employee to an acceptable level of productivity.

Starker (1986:12) diagrammatically shows the relative cost in terms of time and productivity loss of the different means of recovery.

DIAGRAM 1
IMPACT OF PERSONAL PROBLEMS AND DIFFERENT MEANS OF RECOVERY ON PRODUCTIVITY AND COST



A — Problems start affecting productivity
B — Intervention — recovery starts
C — Productivity improves
D — Satisfactory job performance levels reached
E — Termination through dismissal or death with high replacement costs.

This diagram shows that where the employee is able to resolve his problems himself, the decrease in work performance (A-B1), the time taken to restore productivity (C1-D1) and the consequent cost to the employer, are relatively low. Where self-help skills are insufficient to resolve the problem, but the employee has sufficient confidence in the assistance programme to ask for help, the loss in productivity before intervention begins (A-B2) will be slightly greater, the recovery will take longer (C2-D2) and the cost to the employer will therefore be greater. Nevertheless relatively early intervention is possible with self-referrals.

Suggested referrals occur at a later stage when deterioration of work performance is more pronounced (A-B3) and has been noted by colleagues and/or supervisor. Before the situation becomes critical a friendly suggestion is given to the worker to seek help. In this case the helping process (B3-C3) takes longer and more time is needed to restore productivity (C3-D3).

If none of these alternatives have been put into practice and there has been considerable deterioration of work performance with consequent loss to the employer (this can reach 25 % of the employee's remuneration, according to Starker 1986), mandatory referral becomes necessary. This is the most costly method of intervention and the length of the helping process (B4-C4) is also more than for other means of recovery. However, even with a mandatory referral, return to an acceptable level of productivity (C4-D4) is still possible, preferable, and less expensive than dismissing the employee and bearing high replacement costs and a further period of low productivity during the training of the new employee.

In summary, Diagram 1 shows that the longer it takes to resolve the problem, the greater the loss in productivity and the greater the cost to the employer. Self-resolved problems cause the least disruption in the work situation.

4. THE NEED FOR TIME-LIMITED INTERVENTION

It has been shown that it is to the benefit of the employer and employee that an assistance programme should be provided, that its aim should be to increase the problem-solving skills of employees, and that it should operate in a climate conducive to self-referrals. From a productivity point of view, the intervention process should be time-limited so that absences of the employee from work for counselling sessions are kept to an effective minimum, and so that an acceptable level of productivity is restored as soon as possible.

Another reason for a time-limited approach is that there is an abundance of opportunities for both preventive and therapeutic social services in the workplace and usually a limited professional staff to carry them out. Therefore the time spent with each client needs to be conserved. Kurzman and Akabas (1981:54) agree that clinical practice in industry requires models of relatively brief and responsive intervention. Waiting lists would be a disadvantage as the chief advantage of a work-based service is its accessibility to a client in a crisis situation. In order to serve the client with

the minimum of disruption of work schedules, task-centred intervention, planned short-term treatment and crisis intervention constitute the basis of this type of service.

Weissman (quoted by Kurzman, Akabas 1981:56) notes that many of the problems presented by employees do not require long-term treatment or basic changes in attitudes, beliefs or life-styles of the clients. Clients' requests are often for services and not for treatment, for systems negotiation and for linking with specific helping resources. The writer's experience supports this view in that a large proportion of problems presented by employees comprised requests for assistance in negotiating work issues with supervisors or colleagues, or for assistance in obtaining institutional care for aged parents, day-care for children, bursaries or specialist help for family members. Kurzman and Akabas (1981:56) observe, significantly, that: "The ability of social workers to honour and dignify a client's concrete requests for service, which may or may not have broader implications for treatment, and to feel professionally fulfilled by meeting them may be a test of their ability to serve workers well in these settings".

5. METHODS AND TECHNIQUES USED IN TIME-LIMITED INTERVENTION

In this section, methods and techniques that have been found useful by the writer in five years of social work practice in an occupational setting will be outlined. The emphasis will be on casework, but it should be noted that time-limited intervention is also applicable to community work within an occupational setting. In this case the concept would refer to a limited amount of time being allowed for the professional to motivate either management or the workers to bring about some desired change in the work environment. Generally speaking, community change is a relatively slow and long-term process, but when it is achieved with a minimum of professional input and continued by the workers themselves with only the guidance and supervision of the professional worker, this could also be regarded as one variation of time-limited intervention.

In casework the most useful methods and techniques have been the following:

5.1 Constructive use of the first interview

Usually one-and-a-half to two hours are allocated to the first interview

to allow time for catharsis, building a working relationship and exploration of the problem. Catharsis in self-referrals will relate to ventilation of feelings aroused by the problem, but in the case of mandatory referrals, ventilation of negative feelings aroused by the referral itself also needs to be encouraged, otherwise such feelings can affect the client's motivation and co-operation.

In order to establish a position of trust, the counsellor's neutrality in the management hierarchy needs to be clarified and the principle of confidentiality re-affirmed. It is assumed that the "presenting" problem will be the focus of the counselling programme and other issues will only be addressed by mutual agreement. Lengthy case histories are avoided unless they relate directly to the present problem. These factors are important in limiting counselling time and they also show respect for the client's integrity of purpose and give him the responsibility for directing the counselling programme toward relevant issues.

5.2 Contracting

The definition of the problem leads to negotiating the terms of a verbal contract between client and counsellor before the end of the first interview. Agreement is reached to work on an explicitly stated problem area for an agreed number of one-hour sessions (usually an additional four sessions, but this can be extended by mutual agreement). Brammer (1979:9) maintains that such an agreement should imply a growth contract, and that the client will try to change under his own initiative, with minimum helper assistance. This reinforces the view that the client is capable of acting responsibly, given adequate knowledge and support. The counsellor's role is that of interpreter, educator, advocate or mediator, rather than problem solver.

Before the end of the first interview the contract is also put into effect and some assignment is given to the client to work on before the first of the treatment sessions. This task could be *exploratory* such as when the client is required to find out certain facts or to examine his attitudes towards certain aspects of the problem, or when he is encouraged to approach his spouse with an invitation to join in the counselling process. Or, the task could be *corrective* such as when a recently divorced woman who is depressed and has extremely low self-esteem, is asked to look at herself in a mirror first thing every morning, and proclaim out aloud that she is a good person and that she has important things to accomplish

during *that* particular day. An example of the successful accomplishment of such a corrective task was a woman whose appearance had improved markedly, and who had gained a considerable measure of self-confidence after only one week of seriously attending to the assignment.

5.3 Teaching understanding of human actions and interactions

It has been found that once a person understands what is happening in a disturbed relationship, he can more easily accept responsibility for the part he plays in the problem and concentrate on his own behaviour rather than blame the other. It is vital that the client accepts that he has a choice of various reactions to the behaviour of others, and no-one has the power to make him feel happy, angry or miserable unless he chooses to play their game.

For example, in the case of parent-child conflicts it could be useful to explain the developmental stage and needs related to the age of the particular child, in accordance with Erikson's theory on developmental stages (as discussed by Hjelle and Ziegler 1981:113-149), in order to help the parent understand the reasons for the child's behaviour. Suitable parent-effectiveness skills can be taught to help the parent cope with the problem (Gordon 1975).

With respect to other interpersonal problems (e.g. marital or work relationships) aspects of Berne's theory of Transactional Analysis (Berne 1972) have been taught with good effect to employees of varying levels of education, provided such aspects are explained in terms the employees can understand. Freed and Freed (1977) give a simple version of Transactional Analysis easily understood by adults and children alike. In order to help a client understand his own problematic relationships, three aspects should be taught:

- An appreciation of self and the individual's right to strive towards self-fulfilment and self-direction of his life.
- The importance of "strokes" in all human transactions (strokes being defined as units of social recognition that are essential to survival) (Coburn in Turner 1979:295). Strokes can be positive, negative, conditional or unconditional.
- An understanding of the three ego states existent in the personality, namely the Parent, Adult and Child, which regulate patterns of behaviour between people within a relationship. Such patterns of be-

haviour are called "games" in Berne's terminology (Coburn in Turner 1979:296).

An example of the dramatic effect of insight gained through Transactional Analysis Theory is provided by the case of a female employee married to a man much older than herself. He had retired a few months earlier and had taken over the housekeeping role while she worked. Frequent quarrels arose over money management and she was accused of wasteful spending. As she had married relatively late in life and had successfully managed her own income for years, she found her husband's accusations degrading and was contemplating leaving him. However, in discussion, she came to understand the parent-child games they were playing: she realized that she had married an older man who was as protective of her as her father had been, but that now she resented his parental treatment, and rebelled by spending money irresponsibly in an attempt to display independence. Many of her purchases had been unnecessary and made in a spirit of defiance. She realized that she had played these games because of low self-esteem and therefore reacted positively to encouragement to move into an adult role by asserting her rights as a wife and at the same time proving her ability to manage money responsibly.

She also came to appreciate the reasons for her husband's concern over money matters after he was no longer the breadwinner in the family, and realized that her notion of leaving him was merely a childish threat of retaliation. The client was intelligent and a good working relationship was easily established with her, with the result that the above insight and changed attitudes were achieved within four interviews and two follow-up telephone interviews, supported by the loan of suitable literature.

5.4 Teaching problem-solving techniques

Problem-solving techniques need to be taught, particularly in helping a client come to a decision in a multiproblem situation. Perlman was one of the first exponents of the use of a cognitive problem-solving approach in social work, and according to her this includes "conscious, focused, goal-directed activity between client and caseworker" (1957:87). A problem-solving orientation requires an assertive counselling component in which the worker intervenes in a crisis situation, corrects disparities between perception and reality, points out the undesirable consequences of certain behaviours, links behaviours and goals, takes a stand on vital

issues when needed and suggests possible objectives, solutions or strategies to the client (Hallowitz, in Turner 1979:95). This type of counselling is suited to the time-limited self-help approach of occupational social work in that it facilitates the transfer of skills from the counsellor to the client.

Egan's technique of Force Field Analysis (1975) has been used to good effect in teaching problem-solving skills by the writer. The client is encouraged to formulate the problem (and subproblems) on paper and indicate the desired outcome for each component of the problem. The desired outcome can often be derived by asking the client what he would wish for if he could wave a magic wand over the problem. He is then required to list all the forces in the field of the problem area which will either help or hinder the attainment of the desired outcome.

Force Field Analysis is a practical technique which helps the client to: perceive the extent and nature of his problem, formulate, test and perhaps modify his own wishes for the desired outcome, and select strategies to overcome the negative and strengthen the positive forces in order to arrive at a satisfactory solution. This technique has been found useful in parent-child conflicts as well as in helping clients come to a decision when faced with the possibility of a change in job. Money management can also be improved by adopting this type of practical approach to problem solving.

5.5 Teaching improved communication techniques

Many interpersonal problems arise, or are perpetuated because of poor communication. By teaching clients better communication skills the counsellor is not only helping them to resolve their existing problems, but is also providing the tools for improving the quality of all their relationships.

Miller, Nunnally and Wackman (1975) provide a useful overview of what happens when people communicate, and describe methods for improving communication. One of the most useful aspects of their work is their description of the four styles of communication (1975:123-212). This theory ties up well with Transactional Analysis and teaching the appropriate use of each of these styles usually follows the teaching of transactional behaviour patterns. In summary, the first style is a superficial, contact-making style which has little relevance in problem-solving situations, but is valuable in creating warmth (strokes) and in bridge-building between

people. The second style is more complex and often, though not always, destructive. In this style the intention, (either recognised or unrecognised) is to manipulate, change or correct (compare Berne's Parent state), or put down, ridicule or tease (compare Berne's Child state). In other words, the user tries to elevate himself at the expense of the other. Style 2 also perpetuates itself in that it engenders a defensive reaction in the other person which inevitably leads to another Style 2 response. However this style also has a more constructive use, for example in education and in disciplining.

Style 3 is a more rational approach in which discussion centres on finding a reasonable solution to a problem. It follows a logical approach of analysis, exploration of alternatives and decision making. It is an "Adult" approach but unfortunately ignores the feelings generated in any problem situation. The fourth style is concerned with open expression of feelings in a non-blaming way, in an atmosphere of mutual goodwill and trust. It is a difficult style to achieve and requires a good deal of concentrated practice, but it is a necessary prelude to the effective use of Style 3 in Adult transactions.

The concept of the four styles is a new one for most clients and it is important that it should be properly understood so that the styles can be recognised and practised appropriately. It is useful to include role-play in teaching these styles, and the same family situation can be played out, either spontaneously or with a pre-prepared script, in each of the four styles. If the whole family can be involved in learning to communicate in this way, it is able to discuss problems that formerly gave rise to unresolved conflict. This opens the way for applying one or other problem-solving technique.

6. RECORDING AND REPORTING

Record-keeping and reporting are also important aspects of the effective use of professional time. Since all records are for the exclusive use of the social worker, they can be concise and cover only as much of the background to the problem and counselling process as is necessary to refresh the counsellor's memory, should the client return for further help after a passage of time. A card system has been developed, similar to those used by doctors, and it has not been found necessary to open files for each case. If the case should need to be handed over to another social worker at a later stage, the existing records would not be made available

to the new worker. The latter would have to establish a new counselling relationship and could be told about the previous intervention by the client to the extent that the client deems necessary. This would also reinforce the belief in confidentiality.

For the same reason written reports are avoided whenever possible. When they are required in the case of some mandatory referrals, they are confined to a report on attendance, co-operation and progress, and may include recommendations relating to work conditions. By reducing the time spent on recording and reporting, much professional time can be saved which can be more properly focused on direct service.

7. CONCLUSION

Although some of the techniques described in this paper are usually associated with long-term counselling, they are also useful in time-limited work. Only those aspects of the theory that are relevant to the client's particular problem are introduced. The writer adopts a very practical approach and pen and paper are used to define the problem and explain the reasons for its development, as well as to outline the course of action agreed upon. No overt attempt is made to change the life-style or total thinking practices of the client. The assumption is that the client is normally able to regulate his own life satisfactorily and has called for assistance only with a particular problem. This attitude of respect, aided by the demands of the workplace for a quick solution to a problem, motivate the client to work actively on his problem between and during the counselling sessions, and after the contract has ended. He therefore becomes, in a sense, his own therapist.

Very often, the skills taught are successfully applied to later problems and these successes are reported to the counsellor. On the other hand, the client will sometimes return for further help with another problem after a break of months or even years, or possibly because he feels a temporary need for support and encouragement and knows that it is readily available at his workplace.

It should be noted that at the organization in which the writer is employed, a large proportion of the personnel are well educated and all have passed through pre-employment selection tests. The proportion of seriously disturbed clients is therefore limited, and most of the employees are able to benefit from the type of treatment outlined in this paper.

LIST OF SOURCES

AKABAS, S.H., AKABAS, S.A.
1982. Social services at the workplace: new resource for management. *Management Review* 71(5), May:15-20.

AKABAS, S.H., KURZMAN, P.
1982. The industrial social welfare specialist — what's so special? In: AKABAS, S.H., KURZMAN, P. *Work, working and work organizations — a view from social work.* Englewood Cliffs, New Jersey: Prentice-Hall. Pp.197-235.

BERNE, E.
1972. *What do you say after you say hello?* New York: Grove Press.

BOTHA, P.M.C.
1968. *Bedryfsmaatskaplike werk — ontwikkeling, aard en stand.* Port Elizabeth: Universiteit van Port Elizabeth (D.Phil. proefskrif).

BRAMMER, L.M.
1979. *The helping relationship: process and skills.* Englewood Cliffs, New Jersey: Prentice-Hall.

COBURN, D.C.
1979. Transactional analysis — a social treatment model. In: TURNER, F.J. *Social work treatment.* New York: Free Press. Pp. 293-311.

EGAN, G.
1975. *The skilled helper.* Monterey, California: Brooks/Cole Publishers.

FREED, A., FREED, M.
1977. *The new TA for kids.* Sacramento: Jalmar Press.

GORDON, T.
1975. *Parent effectiveness training.* New York: Plume.

HALLOWITZ, D.
1979. Problem-solving theory. In: TURNER, F.J. *Social work treatment.* New York: Free Press. Pp. 93-122.

HJELLE, L.A., ZIEGLER, D.J.
1981. *Personality theories.* Washington, D.C.: McGraw-Hill. Pp. 113-149.

KURZMAN, P.A., AKABAS, S.H.
1981. Industrial social work as an arena for practice. *Social Work* 26(1), January: 52-60.

MILLER, S., NUNNALLY, E.W., WACKMAN, D.B.
1975. *Alive and aware: improving communication and relationships.* Minneapolis, Minnesota: Interpersonal Communication Programs.

PERLMAN, H.H.
1957. *Social casework — a problem-solving process.* Chicago: University of Chicago Press.

STARKER, J.P.B.
1986. *Employee assistance programmes: a theoretical exposition.* Report of the Employee Assistance Programme Seminar, Institute of Personnel Management (Southern Africa), Johannesburg, August.

VI

THE ORGANIZATION OF CONSTANT AVAILABILITY AT A CRISIS CENTRE

Annemie de Vos

1. INTRODUCTION

The assignment given to this contributor was to describe the establishment and nature of a small-scale crisis service centre serving an urban community of limited size and the problems encountered at such a centre. The experience gained at an existing centre in Randburg, Transvaal was used as the basis for this chapter.

In attempting to meet the assignment the following themes were briefly dealt with: the reasons for establishing the service, a prevention model as a theoretical framework, brief historical overview of the establishment of the service, the method or procedure followed, supportive structures and resources that are utilized and the nature of the volunteer training programme. Subsequently the problems that may be encountered while establishing and running such a service are briefly discussed. The chapter concludes with a summary of the suggestions that were put forward.

2. REASONS FOR ESTABLISHING THE SERVICE

Ideally the establishment of health and welfare services should follow after identifying and describing — statistically and otherwise — the needs experienced by a community, as perceived by its concerned representatives. This implies properly-conducted needs surveys and the logical, systematic introduction of services to meet such needs.

However it is doubtful whether most services are ever really initiated in this manner. It is more probable that many services originate from some form of emotional motivation or argumentation in the mind of a particular person or closeknit group of people who have become aware of a "problematic human condition" (Thomas in Grinnell 1981) and who feel strongly enough about the matter to want to do something about it.

The latter situation prevailed in the circumstances that led to the establishment of the Randburg Crisis Centre after a false start had been made

in 1983. The emotional and intellectual considerations that served as motivators were briefly the following:

A parent-training programme (Systematic Training for Effective Parenting by Dinkmeyer and McKay, 1976, the so-called STEP programme) had been conducted in Randburg twice a year since October 1981. It became clear to the programme leaders that the easily unsettled delicate relationships between parents and children were a prime source of friction, sometimes of a very serious and traumatic nature. The friction often resulted in an enormous dissipation of human potential, happiness and quality of life. The present author was one of the programme leaders. We gained the impression that preventive measures lagged very far behind the desperate needs that existed in this regard and that much more needed to be done to deal with crisis situations that arose. Although aware of the fact that a properly conducted needs survey would be the more professional approach, we felt that this critical need was obvious enough from our interaction with the parent groups.

However with a view to verifying our impressions we arranged an evening symposium for 6 May 1983, to which we invited some 100 representatives of the Randburg community who were directly concerned with parents and children. They included nursery, primary and secondary school teachers, community nurses, school and other psychologists, social workers, the Commissioner of Child Welfare and other magistrates from the area, representatives of the South African Police, and other interested individuals. The theme of the evening was child abuse, and speakers from Pretoria were invited. During the discussions after the lectures our impression that grave social problems existed was confirmed beyond doubt by many members of the audience, who related their own experiences.

A steering committee, the members of which were elected from the audience, was formed. The need for a crisis service was confirmed even more strongly at each of two subsequent meetings of this committee, also held in 1983.

In summary: The basic reason for establishing the service was therefore an emotional and intellectual response to a needs awareness that forcibly suggested itself to us in our dealings with groups of parents, afterwards confirmed and strengthened by other professionals who also deal with parents and children in Randburg.

3. A MODEL OF PREVENTION AS A THEORETICAL FRAMEWORK

We were aware of the necessity of having a theoretical foundation for the service rendering that we envisaged as a prerequisite for its ultimate effectiveness. We reminded ourselves of the following statement by Polansky (1975:21): "One of the shortcomings in President Johnson's skirmish with poverty was its lack of a coordinating theory, and most of those at work in it had no dynamic theory at all. It has been observed in psychiatric hospitals that when a staff is following a consistent theory, even one that is not quite accurate, the hospital is more likely to cure patients than are the many places that exist without an 'overall philosophy' (as their treatment theory is miscalled). So a mutually accepted theory helps coordinate services which are offered by groups of people."

We decided to be guided by the well-known medical model of primary, secondary and tertiary prevention. Primary prevention implies the application of a factor — be it medication, an injection, an item of information, a training programme or whatever — *before* any sign of a disease or problem becomes visible. In this respect we saw our STEP programme as an attempt at primary prevention. This programme is aimed at the "well parent" who seeks to improve his relationship with his child or children further.

Secondary prevention implies the immediate availability of a helping service at the first sign of a problem or disease, in order to alleviate the problem immediately and to prevent its deterioration and spread. We conceptualized the establishment of a crisis centre in Randburg with this purpose in mind.

As tertiary prevention is often identified with remedial health and welfare services, we envisage certain developments in future to fulfil this purpose. However the latter are not relevant in this context.

To summarize, this section states that the establishment of the present crisis centre was planned and executed on the basis of a model of primary, secondary and tertiary prevention. Even though our "overall philosophy" is rather flimsy it does exist, and it is sometimes analyzed, refined and restated at management committee meetings. Some of its features have been embodied in our constitution.

4. BRIEF HISTORICAL OVERVIEW OF THE ESTABLISHMENT OF THE CRISIS CENTRE

As was indicated above, the concept of a crisis centre slowly developed in our minds from October 1981, when the first parent groups were met on a regular basis. On 6 May 1983 an evening symposium on child abuse strongly confirmed our impression that more vigorously preventive measures were needed in the area. Two steering committee meetings were subsequently held in 1983 and the need for a crisis centre, which would make crisis counselling immediately available to the public as a secondary preventive measure, was agreed upon.

At one of the steering committee meetings a chairman was elected. By courtesy of another member of the steering committee we obtained the use of one of the municipal health clinic buildings situated in one of the Randburg suburbs. We arranged for a certain amount of publicity for the project, and on 1 August 1983 we opened our doors on an experimental basis to the public during evening hours every night, excluding Sundays.

Owing possibly to a lack of sufficient publicity, this first experiment did not get off the ground. In December 1983 we closed our doors.

Early in 1984 a new steering committee met once again. The reasons for the initial failure were analyzed, and the basic question of whether or not we should have a crisis centre, was posed. The committee was convinced of the need for such a centre. One of the new members of the steering committee volunteered to assume the leadership. She continued the negotiations that had been commenced with the then Department of Health and Welfare, finalized the constitution and saw to it that all requirements of the National Welfare Act (100/1978) were met. As registration by the appropriate Regional Welfare Board was a virtual certainty, the new crisis centre (re)opened its doors, in the same clinic building, on 1 April 1984. In due course we received the relevant documents, confirming the registration of the Randburg Crisis Centre.

During 1985 we moved from the health clinic to a community centre in the area, and in 1986 to our present premises, a house leased to us by the Randburg Town Council at a nominal rental.

5. PROCEDURE

The procedure developed at the Randburg Crisis Centre can be briefly

described as follows:

The use of a radio page service on a 24-hours a day, 7 days a week basis, was donated to the centre by a businessman in Randburg. As soon as new volunteers have completed their ten-week basic training course with our clinical psychologist, they are expected to place their names on the duty roster and to assume duty immediately. This means that they carry a "bleeper" with them wherever they go during their period of duty, which may last from one to three days, or even up to a week at a time, or over weekends if the volunteer is unable to do duty during the week.

Their responsibilities during each tour of duty entail the following: they are expected to respond immediately to all requests to return calls. In the course of doing this, he or she handles all routine and simple direct enquiries immediately and personally. In the event of a serious personal or social crisis, such as someone attempting suicide, an alcohol-related problem or other type of family crisis, the volunteer on "bleeper" duty has to make a quick, basic decision. If circumstances permit, he or she may decide to proceed personally with the case, as indeed trained volunteers are at liberty to do. Alternatively the counsellor on duty call can be contacted and the case handed over to him/her.

The above implies that counsellors are expected to make themselves available for a second kind of duty, namely the handling of serious enquiries passed on by the "bleeper" attendant.

A third kind of duty that was initially expected from volunteers was to be at the centre for two hours between 17h00 and 21h00 in the evenings from Mondays to Fridays. The fact that clients hardly ever used this facility led us to abandon this aspect of our service at the end of 1986. The lack of street lighting in Randburg was probably *the* reason why people, especially single women, were unwilling to visit us at night.

During the financial year 1 April 1984 — 31 March 1985 exactly 200 calls were dealt with. During the year that ended on 31 March 1986, 362 client calls were recorded. The indications are that a further increase has occurred during 1986 — 1987. The relatively modest scale on which the centre is operating can be concluded from the figures. However, this is no reason for despondency. Dr Gordon Isaacs, Senior Lecturer at the School of Social Work, University of Cape Town and well-known expert on crisis intervention issues, states: "It takes at least three to four years for a new crisis service to gain credibility" (Isaacs 1987).

6. SUPPORTIVE STRUCTURES AND RESOURCES

The Randburg Crisis Centre commands the goodwill, limited availability and aid of a group of professional consultants, some of whom are available in rotation, according to a duty roster. Others simply declare themselves available in a more informal manner and on an *ad hoc* basis. These consultants are available to our volunteers — regardless of whether they are "bleeper" or "call"/volunteers — for advice, guidance and assistance.

In addition, our clinical psychologist holds regular group meetings to discuss cases and to advise on any special problems that may arise.

We also maintain an up-to-date list of health and welfare agencies over a wide geographical area, in addition to the published resource lists known to the field. Our own list was initiated by a former Rand Afrikaans University student, who did commendable work in locating many health and welfare resources not listed elsewhere. His list has since been augmented by volunteers who continually locate new resources, which are then added on an ongoing basis.

7. TRAINING OF VOLUNTEERS

All our crisis counsellors are required to complete a ten-week basic course in counselling offered by a clinical psychologist before they are allowed to do duty. Counsellors then contract for a certain number of basic hours of service per month for both "bleeper" and "call" duties. After acceptance as counsellors, they are required to undertake to attend a certain minimum number of additional advanced training courses that are offered from time to time.

8. PROBLEMS SURROUNDING THE ORGANIZATION OF CONSTANT AVAILABILITY IN A CRISIS SERVICE

A wealth of experience has been gained during the brief existence of this crisis centre, which, appropriately shared, could assist other groups of concerned citizens who wish to establish a similar service. Such sharing will now be attempted.

8.1 Establishing the need for a service

Although it can be assumed that most services are initiated in a manner similar to the service described here, there is a problematic dimension to such a type of procedure that may take some time to overcome. The

lack of a properly conducted needs survey beforehand will manifest itself in some way or other. One has to rely on the opinions and impressions of interested individuals, instead of on the results of a needs survey. This can prove to be a somewhat flimsy foundation, as the opinions of the person with the loudest voice or the strongest will could dominate the others to the detriment of the cause.

An answer to the above problem could be that, after all, needs surveys are basically merely opinion surveys. That may be true, but they are normally surveys of the views of a substantial number of individuals, as against the handful of persons interested enough to become members of a steering committee. Such views are also gathered systematically, on certain well-defined areas of concern, and the result is a more reliable version of the situation than would be obtained otherwise.

The problem that most small communities face in this regard — and this was our problem as well — is, who is to conduct the survey; and who will bear the cost of conducting the survey?

The time required for a needs survey is another matter that was considered. However, as it turned out, much more time was wasted by the false start than would have been required had we studied the situation scientifically and objectively at the outset. Further time was wasted in moving from one location to the other, as we failed to find a suitable permanent location for our crisis centre. This problem has still not been entirely solved.

It is of course debatable whether a needs survey would have prevented all situational problems. Arguably few problems can ever be entirely foreseen. Instead they only tend to manifest in practice. However upon reflection the results of a needs survey could possibly have avoided some of our problems, for example by choosing more suitable premises from the outset (assuming that such premises were available).

We should therefore suggest to persons contemplating the establishment of a crisis centre to conduct the nearest approximation to a needs survey that is possible in their particular circumstances. Should this be impossible, but they are convinced that such a need exists in their area, they should not be daunted, but continue to establish their service. We believe that the benefit to each person who has been helped during a period of crisis is well worth the time, energy and effort involved.

8.2 The problem of leadership

The major problem facing any new health or welfare service that is initiated on a modest scale in a relatively small community is that of leadership. The ideal leader would be a professional person, trained in community work and employed by a major agency, so that a well-planned launching strategy can be professionally devised and executed. At the outset therefore the know-how and leadership of a professional person, preferably from the field of social work and employed for the purpose, can be very helpful. This person can even assume the chairmanship for a limited period of time during the project's initial stages. By the time the social worker hands over, the management committee should have adequate self-confidence and be able to elect a chairman representing the concerned community.

However, the choice of a chairman is not always the only problem. Working with a group of volunteers can be most rewarding, but it also may pose some problems. One of these is how to curb an overassertive volunteer who, by virtue of his or her assertiveness (that can at times become aggressiveness) can become an undue threat to the other volunteers. Friction and tension can result, which needs to be handled with circumspection and professionally. This type of problem can be seen as a "normal" feature of such a situation. New crisis centres experiencing similar problems need not feel despondent or guilty if this occurs.

The issue of leadership should however be consciously considered by any group of people contemplating the initiation of a new service such as a crisis centre. Who is available to assume leadership? Is the person trained, knowledgeable and dedicated? Does he or she at least have a minimal amount of time available to devote to the project? If the ideal person to assume leadership in your situation has very limited time at his or her disposal, what measures could be devised to counteract the resulting voids?

8.3 Keeping the duty roster filled — or the problem of keeping volunteers interested and motivated

In spite of the supportive structures and resources described above, the practical situation is that duties are undertaken mostly by a handful of dedicated volunteers (about six or seven of them) while officially a core of about 20 are retained and replenished from time to time as some drop out, move away, or emigrate. These six or seven people are often overburdened, while those on the periphery hang on and do an occasional

tour of duty when specifically approached by the person responsible for co-ordinating the duty roster. This is the reason why recruitment and training of new volunteers should remain an ongoing process, as most agencies working with this model will testify.

The management committee is continually considering possible solutions to the problem of retaining volunteers. The following "causes" of the problem have been suggested: during quiet periods, when few clients contact the centre, some volunteers lose interest and drop out. It has been suggested — and this suggestion is being implemented — that interesting advanced training and other programmes be offered regularly to help stimulate and retain interest. Other volunteers are simply deterred by the onerous responsibilities involved and immediately or gradually drop out. Others experience genuine personal crises such as illness of self or family members, death in the family, or personal emotional crises that disrupt them temporarily or permanently.

Consultation with other crisis agencies has convinced us that the situation described above also constitutes a "normal" profile. Therefore, we should venture the following suggestion: be prepared for the "normal" situation that only a small percentage of every intake of newly trained volunteers will be retained. However, do not despair of the others. They have been enriched and have experienced growth in their personal lives through the training course. It can be postulated that some preventive work is being done in this manner.

9. CONCLUSION: SUMMARY OF SUGGESTIONS

This chapter attempted to suggest the following:

- the establishment of a crisis service should best be based on the results of a needs survey conducted beforehand;
- a crisis service should select a theoretical framework, usually called an "overall philosophy", that appeals to most members of the leadership group and that helps to co-ordinate the service; important features of such a philosophy could be embodied in the constitution;
- leadership of a crisis service should be considered and planned as thoroughly as possible beforehand; if someone undertakes the initial leadership, this person should endeavour to make some semipermanent commitment; if a leader becomes overassertive to the detriment

of the others the situation becomes delicate and must be dealt with tactfully;

- the expertise of a social worker is helpful during the establishment of such a service;
- the services of a competent, sympathetic clinical psychologist or social worker are essential for the training and continuous supervision of volunteers;
- only a small percentage of every intake of newly trained volunteers is normally retained and remains motivated to offer service; an on-going recruitment and permanent basic training programme is, therefore, essential;
- an interesting and stimulating advanced training programme is a further essential feature of a successful crisis service.

Here in Randburg we believe that every effort to help someone in a crisis, even if it is only one person per day, is a contribution towards the secondary prevention of human misery; an achievement well worth the many hours of hard work and the continuous input on the part of our dedicated volunteers and professionals.

LIST OF SOURCES

DINKMEYER, D., McKAY, G.D.

1976. *Systematic training for effective parenting*. American Guidance Service, Minnesota: Circle Pines.

ISAACS, G.

1987. Review of paper entitled *The organisation of constant availability in a crisis service*. Cape Town: University of Cape Town, School of Social Work, 29 January.

POLANSKY, N.A.

1975. *Social work research*. Chicago: University of Chicago Press.

THOMAS, E.J.

1981. Developmental research: a model for interventional innovation. In: GRINNELL, R.M.(Jr.) *Social work research and evaluation*. Itasca, Illinois: Peacock Publishers. Pp. 590-605.

VII

TIME-LIMITED INTERVENTION AND COMMUNITY DEVELOPMENT

Sharhidd Booley

1. INTRODUCTION

As a preamble to the topic under discussion, the following brief profile of the organization is considered necessary in order to clarify the generic nature of its various activities.

CAFDA (Cape Flats Distress Association) is a community-based registered welfare organization which has as its overall policy the promotion of stable individual, family, and community life for the inhabitants of its area of operation through the elimination of the social pathologies affecting the community. Since its inception in 1943, its mission in pursuit of the realization of this policy has been the provision of material assistance, leisure time activities, and welfare services. At the same time it focuses public attention on and enlightens public opinion about the problems of poverty, poor housing, and living conditions, and all other relevant social limitations.

Its area of operation includes Retreat, its own housing scheme in Retreat, Steenberg, Grassy Park, Parkwood Estate, Lavender Hill, and Heathfield. These areas fall within a radius of six kilometers. Its services include:

Two preschool centres:	Care for 270 children from 1 to 6 years old in crèches and nursery schools, while both parents work.
Clothing and merchandise store:	Supplying clothing and merchandise to a great number of persons in dire need, especially victims of fires; some sold at very nominal prices to persons who can afford to pay something.
Soup kitchen:	Supplying 9 923 litres of soup per week to some 24 schools on behalf of the Peninsula School Feeding Association.

Housing/Rehabilitation scheme:	Administering units for 336 families consisting of some 2 500 persons, on behalf of the utility company.
Service centre/Meals on wheels:	Food for the physically/mentally disabled senior citizens. The service centre for the more ablebodied.
SHELTER FUND:	Administration of moneys collected for semi-permanent and permanent housing.
Community activities:	Providing facilities for leisure time activities for all age groups. Promoting the arts with particular emphasis on ballet, modern dancing and drama; training for youth and community leaders.
Social work services:	Employing 14 qualified social workers dealing with a variety of problems. Their main functions are to investigate causes of deprivation and initiate programmes to address such deprivation; provide social case, group and community work services, provide places of safety and alternative care for neglected and abandoned children.

In order to gain insight into the background and development of social work practice at CAFDA it is suggested at the outset that the reader refer to an article called "CAFDA's Story" in the 1983-1984 Annual Report. Here the development of CAFDA's services from being non-professional and paraprofessional to being highly organized, well managed and professional, is fully described; this applies to all its services, including welfare services. This chapter is concerned especially with welfare services.

2. HISTORICAL BACKGROUND

Between May 1976 and June 1977 CAFDA entered into two important new ventures in this field.

Firstly, after prior planning and study of "crisis intervention" as it was then called, CAFDA's method of long-term casework with each social worker carrying a heavy and unmanageable case load of often "dead wood" cases was replaced by time-limited intervention. In January 1977 this was followed by a rapid expansion and development of community

work or more specifically community development, as a third method of social work practised by the agency. This was considered a logical progression from its change-over to time-limited intervention. This is due to the fact that through CAFDA's experience in casework and provisional community services at its Mary Attlee Community Centre, together with ongoing follow-up studies of client types, social conditions, etc., certain macro-indications of large-scale problems in the area of operation have emerged as a social barometer. These two methods were complimentary, as "primary prevention" could be undertaken through community work, i.e. when crises were anticipated steps could be taken to avoid such situations before they developed into crises such as aggression, crime, battering, etc. that would then have required secondary and tertiary intervention.

A careful study was made of the case loads and of what had in fact been achieved by the long-term "aggressive outreach" which so bogged down the workers that they had little time to give to those clients who needed immediate attention in a crisis situation. An analysis of CAFDA's findings conclusively warranted a change in approach.

Naturally CAFDA had to be selective and retain certain families and individual clients in the case loads for more extensive and long-term treatment, but on the whole it concentrated on crisis intervention as a more effective method of treatment given its particular set of circumstances, i.e. a large community suffering cultural and material deprivation.

3. REASONS FOR CHANGE

Prior to the change-over to time-limited intervention one social worker (intake officer) performed intake and screening duties, and referrals were then made to "fieldworkers" for follow-up and treatment. Often there were considerable delays between this initial contact by the intake worker and the fieldworker's establishing contact with the client. With the introduction of time-limited intervention, clients in crisis were seen directly by the area worker and they could be helped promptly and effectively. Below are listed some of the reasons for favouring the new approach.

(a) In the old method it was felt there was a breakdown in services between intake and fieldworker.

(b) The client would be better motivated to want change if the problem were dealt with immediately.

(c) The social worker would be better motivated when he/she dealt directly with the problem from the outset.

(d) Counselling and casework is much more gratifying to the worker in the here-and-now approach.

(e) It is preferable for the worker not to be burdened with a case load of extreme long-term cases.

(f) There is a need for more goal-directed planning.

(g) Clients would have much more confidence in this kind of approach by the social worker (improves the relationship).

(h) Clients are made to develop coping capacity so that they would call only in times of real need.

(i) Previously clients were saturated with casework techniques and knew all the answers — with the new approach they are motivated and treated at the same time.

(j) Clients are able to internalize methods used to solve their problems and apply them without seeking social work intervention for future recurrences.

The change-over to time-limited intervention was further prompted by the need for a new strategy since it was found that work on the majority of long-term cases proved to be expensive, time-consuming, lacking regular goal attainment, and encouraging dependence of clients on social workers. Also, in many cases neither the social worker nor the client found it easy to terminate intervention. Some of the agency's case recordings reflect this difficulty.

Simultaneously, the macro-indications of large-scale problems in CAFDA's area of operation warranted equal and similar attention. It was realized that the community services at its community centre were not such that these large-scale problems were adequately addressed. The need for a more professional, goal-directed approach was obvious. Consequently at a time when little or no significant community work or development was being done in the Cape Peninsula, CAFDA pioneered work in this field in the squatter area of Vrygrond. Here were 16 000 shack dwellers whose community needs centred mostly around the lack of proper roads, accommodation, recreational facilities, and joint community participation in responding to these needs. CAFDA realized that these needs were pressing ones. Thus, various projects were initiated. These served as a

forerunner to CAFDA's entry into the field of a more *professional* type of community work.

4. THE INITIAL IMPLEMENTATION OF THE TIME-LIMITED INTERVENTION AND COMMUNITY WORK APPROACHES

During the months of September and October 1976 the actual change from the old to the new methods was set in motion. A timeous inspection by a representative of the South African National Council for the Aged, to which CAFDA is affiliated, also concluded that on the basis of the aforegoing factors the changes undertaken seemed appropriate.

As is still the case now (1987), cases were then classified according to the categories prescribed by the Department of Social Welfare and Pensions for family welfare organizations. Furthermore, the then administration of Coloured Affairs suggested that an average of eight clients per social worker per day be kept in mind as the norm. For CAFDA's purposes this would include visits, interviews, or telephone calls, provided that a process note was written on each activity. The actual implementation of the new approaches was accompanied by the following:

(a) Closure of all long-term cases, to be reopened only when clients returned during a crisis. This created the impression that CAFDA's social casework approach had changed to only crisis intervention. Although it largely resembled this type of intervention, it was in fact envisaged that cases "in crisis" would reach CAFDA, whereafter short-term or time-limited intervention would be embarked upon, after contracting had taken place between the therapist and client.

(b) The format for all file entries was restructured, i.e. whereas previous file records show lengthy, verbose, and unstructured accounts of intervention, the changed formats showed structure and direction. Subheadings such as information, action, evaluation and plans of actions were standardized.

(c) Under regular supervision (individual and group) caseworkers were guided on the use of strategies, time-limited intervention techniques, treatment modes, goal-directness, ongoing evaluation, and the importance of worker-client contracting in the time-limited intervention approach. On the one hand this was merely a reiteration of previous expectations; on the other, it meant adapting previous professional expectations to the new approach.

(d) Outreach to unco-operative or apathetic clients (sometimes referred to as "aggressive social work") was continued, but now on a time-limited basis.

(e) A brief programme of operational research was conducted in which simple enumeration techniques were used; and the results of the combined case loads indicated broad community problems, such as poor housing, unemployment, etc.

Consequently, whilst no clear-cut community social work *policy* was as yet formulated, two of CAFDA's caseworkers were re-assigned, and started community work in Vrygrond, as well as in the CAFDA housing scheme of 336 families.

Their work was determined by their orientation to the community's felt needs, community self-help and involvement, and the provision of appropriate services. The main thrust of this initial community work effort was the formation or hosting of groups and clubs, such as the hire purchase group, baby-shoe making group, and Vrygrond newsboard committee. Some of these such as the hire purchase group only existed for a short period, others continued for a longer time while others are still in operation. Examples of the latter are the CAFDA Village Residents' Association, and the CAFDA "Sunshine Crèche".

The courses, miniprojects, or workshops mentioned above were considered lacking in professional social work input. Dr Homero Ferrinho, representing the University of Cape Town School of Social Work, volunteered his services to help CAFDA re-evaluate its community social work. Much knowledge, observation, and guidance were offered by him; in the long term this led to the professionalization of CAFDA's community development programme. His primary philosophy revolved around the need for *continuing education* for communities and for *organizing* them into motivated entities, with a view to taking *action* on identified needs. This philosophy with its three main concepts was operationalized in a series of training centres offering a variety of workshops, courses, and small projects.

A subsequent re-evaluation of the work of, and suggestions for a community work programme for CAFDA community workers, was drawn up by Mr Peter Hancock, an experienced social worker, the then senior supervisor at CAFDA.

Simultaneously he and others found the training centre concept acceptable but not feasible and practicable in some ways. Many of their sug-

gestions for change were then incorporated in CAFDA's subsequent programmes in 1980, continuing into the present programmes described hereunder. These suggestions are contained, *inter alia,* in a comprehensive paper by Mr Hancock (vidè "Some initial thoughts on a community work programme for Cape Flats Distress Association", unpublished, 1980) of which the main ones seemed to be for:

(a) a reduction in the use of the concept of "self-help",
(b) an increase in clear-cut goal setting,
(c) planned management and management by objectives,
(d) starting where the community is, and
(e) the need for applied research as opposed to the "felt needs" approach.

On the basis of these premises it was also proposed (and now implemented to a large extent) that the following areas receive attention, i.e.

housing
preschool education
economic upliftment.

As a result, projects such as the SHELTER self-ownership housing scheme, upgrading of existing CAFDA crèches, and aid for improving employment prospects were started by CAFDA. The majority of clients who qualified for assistance in these categories were referred to the community work section by caseworkers. This procedure is still being followed today, albeit far more systematically.

5. THE CURRENT IMPLEMENTATION

Of the 14 social workers at present employed by CAFDA, only three are still using a combination of crisis and time-limited intervention. These workers comprise the agency's "Intake Section". This reduction in the use of time-limited intervention was introduced in 1980, when statutory child care work in CAFDA's area of operation was transferred to CAFDA by the Department of Health Services and Welfare. CAFDA nonetheless continued work in all other previous categories. Fieldworkers' case loads consist of an average of 60 cases, of which about 80 % are statutory cases. On the other hand, CAFDA's "Intake Section" also undertakes long-term intervention in selected cases, but these are few in number. Its time-limited intervention cases (sometimes referred to as short-term cases) are recorded immediately after completion of interviews and related activity. These are also monitored daily by the agency's two social work supervisors.

CAFDA's tradition of undertaking ongoing research on its casework to gauge community trends in large-scale problems is continuing. Analysis of the results of this research is helping in the formulation of CAFDA's community work policies and strategies.

CAFDA is today engaged in community work in a more professional, updated fashion, having learnt from its mistakes in the past, and having adhered to its principle of equipping its staff with more knowledge, skills and opportunities in order to render a better service than in the past. It has been possible to formulate the following operational definition of its community work goals:

1. To mobilize and develop human resources and to promote awareness of social problems.
2. To bring pressure to bear on authorities for structural change. This pressure should be applied by people's organizations, and the community worker's role is to assist in the establishment or strengthening of these organizations.
3. To create or orchestrate resources to enhance lower level technical training for urban commercial and industrial employment and to explore and institute ways and means of enhancing employment opportunities.
4. As a basic aim of community development, to enhance people's opportunities to improve their standard of living, perhaps by all of the above three means, as well as by improving educational opportunities (at all levels, from preschool onwards).

Attempts to upgrade the quality of our community social work services resulted in "old" projects mentioned earlier, being restructured, categorized, and placed in some order of priority. Currently the community work projects, run under the direct auspices of CAFDA's two community workers, continue to revolve around preschooling (e.g. homevisitors programmes) and housing (e.g. the SHELTER self-help project), whereas plans are being made to implement the concept of economic upliftment.

Other meaningful projects now in operation include the establishment of trade schools for retardates leaving adaptation or special classes at school, career guidance and recreational programmes. Future projects will include money-saving projects, such as lift clubs, educational projects such as informal adult learning, and increasing employment opportunities, such as location of industries in the CAFDA zone.

As far as accountability is concerned, our community workers are presently required to keep regular progress, process, and summary records of their work. This too is an improvement on past experiences where no format of any kind was used. CAFDA regards accountability by its community workers as being just as important as it is for its caseworkers and group-workers. The formats used at present are proving to be highly effective in monitoring progress of projects, setting goals, and measuring the volume of input by the worker.

6. EXAMPLES OF CURRENT TIME-LIMITED INTERVENTION AND COMMUNITY WORK PRACTICE AND RECORDING

The case studies given below are examples that are characteristic of the time-limited intervention approach. Some success has been accomplished in both case studies. They were still being attended to at the time of writing.

6.1 Case No. 1

Assessment of situation

Case diagnosed as one of child neglect since mother abused alcohol, and left her 2 and 5-year-old children unattended for the whole day; also house was found dirty, unkempt.

Action taken

1. In initial visit, gathered information, assessed attitudes, motivation and unmet needs and feelings of mother. Made her aware of the possibility of a children's court enquiry as well as the effect of neglect on the children. Obtained a commitment from mother to co-operate with social worker in changing her behaviour and meeting children's needs. Also assessed mother's ego as far as her integrative and executive capacity is concerned.
2. Contracted with mother for a short period, e.g. two months. Advised that if situation is not improved/rectified within time period, alternative care to be considered for children. Contracted to visit every week.
3. Worked with a person in mother's environment (after consulting her) — someone responsible who could monitor the situation and notify social worker of further neglect or problems, as well as someone who

could encourage mother to change her behaviour, in this case the employer and a relative (arranged joint interviews on occasions).

4. Paid weekly visits to monitor, encourage, and help restructure cognitive ability, reality testing, and judgement in mother. Also set tasks for behaviour modification, e.g. clean house, register 5 year-old at school, take to day hospital, and attend A.A. sessions.
5. Social worker educated mother on needs of child and mother role.

Action planned

1. To bring client into contact with other community resources, e.g. A.A. members, women's groups, if and when she has improved executive capacity in this respect.
2. Use collaterals to educate mother on needs of children.
3. Reassess situation after one month, with mother, employer and relative.
4. After discussion with mother, terminate intervention leaving relative and employer with the responsibility of monitoring the situation and contacting social worker in the event of a breakdown; or, refer to a fieldworker for long-term intervention (preventative services or a children's court enquiry and alternative placement).

Evaluation

Mother, made aware of the effect of her behaviour on children, already showing desire to improve, co-operate and carry out her side of the contract. By the second visit her behaviour had changed significantly. The children were clean, her house tidier, she had gone back to fulltime work and had cut down on alcohol abuse. Both the relative and employer were very encouraging and pleased with the change.

Prognosis

Mother is expected to continue her co-operative behaviour. It is felt that her rehabilitation will last, her newly acquired executive capacity will grow, and it seems that the crisis situation originally reported will not recur. Perhaps this will be ensured if the action planned could be implemented as soon as possible.

6.2 Case No. 2

This family consisting of mother, father and five school-going children was threatened with eviction for non-payment of rent. At the same time, the family applied for a transfer to a large house as their children were getting bigger and needed more room. Head of household receives a disability grant as he has a permanent lung disorder; wife receives a maintenance grant and does casual work to supplement the grant, but this still seems inadequate.

Assessment of situation

The danger of eviction for non-payment of rent was a strong one. This situation had developed through poor budgeting; debts exceeded income; both parents appeared to lack ability for financial management.

Action taken: On basis of a 3-6 month contract:

1. Drew up chart illustrating how debts exceeded income.
2. Following discussion, arranged with clients for the maintenance grant to be administered, i.e. grant to be drawn by CAFDA and then official debts paid with the grant, as a temporary measure.
3. Encouraged clients to discuss their repayments with the shops concerned and then report back.
4. Referred clients to groupworker in order to join budgeting education group.
5. Initial repayments do not leave money over for food so interim food parcels were issued.
6. Left the disability grant in hands of the family thereby not removing all responsibility.

Action planned

1. Continue to educate couple regarding budgeting within contract period.
2. Continue administration of the maintenance grant by CAFDA pensions administrator to ensure that all outstanding debts are paid.
3. Return the disability grant to the couple for self-administration, once ability for self-management developed satisfactorily.

Evaluation

After two months, the caseworker concerned has already seen progress in the overall functioning of the family. In practical terms, the family has succeeded in averting eviction, reduced the number of bad debts, and the mother has found extra casual work to augment income.

Prognosis

Both parents appear capable of bringing about further improvement. The present situation will be further relieved, on condition that all planned action is carried out.

6.3 Examples of community work reports

(a) The format used for the recording of the *community worker's daily work* tries to reflect as much of the nature and analysis of the work as possible.

The following is a reproduction of the actual format used:

DAILY PROCESS REPORT

DATE .... **REPORT NO:** ....

Nature of contact or with whom:

	Where	Interview	Meeting	Visit of observation	Consultation	Report writing and administration
1.						
2.						
3.						
4.						
5.						
6.						

MATTERS DISCUSSED NEW INFORMATION GAINED: (NOs refer to above numbering)

1. ....
2. ....
3. ....
4. ....
5. ....
6. ....

EVALUATIVE REMARKS:

....
....
....

Short-term goals: ....
....
....

(b) The format used for *monthly summary or progress reports* is standardized for all projects. The aim here is to cover as many of the various aspects of the projects as possible. It reflects the monthly totals of interviews, meetings, etc. But more importantly, it is meant to be evaluative rather than statistical. The following is a reproduction of the actual format used:

MONTHLY SUMMARY AND PROGRESS REPORT

Month: ....
Community worker: ....
Project: ....
DESCRIPTIVE/STATISTICAL DETAIL

Nature, or with whom	Interviews	Meetings	Consultation	Reports
Individual: Tenants				
: Parents				
: Resource persons				
: Staff members				
: Exco members				
: PTA members				

Executive committee
P/Teachers Assoc.
Supervisor
Administration
Research
Planning

TOTALS:

(1) **INTRODUCTION:** (Say what is described in report and which aspects are of special importance):

____

____

____

(2) **MAIN TACTICS AND TECHNIQUES USED** (relating to areas of focus, implementation of plan):

____

____

____

(3) **CURRENT STATUS OF PROJECT** (environment and personal changes? Have other needs been identified, etc?)

____

____

____

(4) **GENERAL ANALYSIS** ("How are we doing?")

(a) **Evaluation of new knowledge gained:** ______________________________

____

____

(b) **Evaluation of process of development/Progress:**
Goal attainment:

____

____

____

Growth of individuals:

____
____
____

Prognosis:

____
____
____

(c) **EVALUATION OF COMMUNITY WORKER'S PERSONAL GROWTH (quality of worker/community relationship: ups and downs, etc.)**

____
____
____

(5) **FUTURE PLANS:**

(a) **New:** ____
____
____

(b) **Modified:** ____
____
____

(6) **RECOMMENDATIONS:**

____
____
____

DATE WRITTEN: ....

Finally, it is stressed that accountability is gauged both from the written reports of the social workers and in individual supervision sessions. The format for the different reports of our social workers is devised mainly for the practical situation, but does not completely exclude the theoretical component. In fact, supervisors endeavour at all times to guide workers in the task of integrating the practical with the theoretical, in an

eclectic, considered manner so that the work retains its professional nature.

7. EVALUATION

Casework

In comparison to the old method of long-term, ongoing intervention, the time-limited intervention approach brought with it distinct advantages that to a certain extent were anticipated, namely

(a) closer collaboration developed between intake workers and fieldworkers, as well as with group and community workers,

(b) clients showed more motivation to both co-operate with social workers, and to work for change in their situation,

(c) social workers appeared more motivated since problems were addressed without delay,

(d) social workers found it more gratifying to work on a here-and-now basis,

(e) clients showed much more confidence in the worker's role and planning,

(f) ongoing evaluation during the contract period and within the problem-solving process was more concise,

(g) the improved format for file entries and reports was far more succinct, lucid, and readable.

The following breakdown of this method of intervention became particularly evident; it was also clear that the method had become easier to analyse in terms of the breakdown:

Formulation phase (Beginning)

- The worker was immediately able to focus on the situation/problem area. This then allowed for formulation of a strategy of intervention.
- The current predicament was evaluated, and action could then be executed accordingly.
- Partializing of the problem took place, and certain target areas were focused on.
- Contracting allowed for the identification of realistic expectations by the client, and the exclusion of unrealistic ones.

Implementation phase (Middle)

- Workers sifted through all information provided by client, and organized this into a comprehensive whole. This led to very lucid case detail and helped in action planning.
- By using the main features of the chosen model of intervention — for example problem solving or behaviour changing through task goals — the work became more professional and streamlined.
- By maintaining ongoing evaluation (as required in all casework approaches) adjustments and other appropriate changes could be made with good effect.

Termination phase (Ending)

- By jointly deciding with client on termination, thus continuing the practice of client participation in the entire casework process, acceptance of termination by the client was easier and better timed.
- Prior to actual termination, social workers reviewed progress with the client, offered realistic reasons for such termination, and pointed out what had been achieved.
- As part of the termination phase, clients were given guidance as to how to act when problems recur. This helped in creating independence and encouraged the practice of the "self-help" principle.

The switch to statutory work during 1980 which had reduced time-limited intervention also changed the nature of success in the agency's casework. By virtue of their nature, case loads of statutory work required long-term, prescribed work which inhibited the use of generic social casework models; this restriction led to "success" within the limits of the statutory requirements of "supervision of foster placements". However, attempts have recently been initiated to incorporate the use of casework models of a broader choice in this type of social work, in some cases to serve as problem prevention, and in others as additional to the work done in accordance with the stipulations of the Child Care Act.

Community work

CAFDA's community work experience in its initial projects was not consistently successful; many projects were terminated through lack of community morale, motivation, and co-operation. Also, it appeared that some

projects lacked clear direction, objectives, and proper management. It appeared too that more theoretical perspective and application was needed. CAFDA's community work programme of 1977/78 may be evaluated as follows:

- Training courses where direct education was provided formally at training centres were successful only when the initial ground work, i.e. preparation of the course and arousing interest in the "community", was thorough and the courses were specific. These courses were useful in improving specific skills, e.g. management skills for members of a crèche management committee.
- The training centres concept failed to highlight the fact that the socio-economic level of the people involved has an important influence on the type of need related to (whether it is primary or secondary) and on the potential of the members to cope independently.
- It was not realized at the time that where direct education is the sole purpose of a group, the community worker's role should be supportive and co-ordinative in order for this type of group to become independent.
- Feasibility studies, whereby some unforeseen difficulties such as dwindling client morale or lack of facilities could have been avoided, were not the order of the day. This probably led to the failure of some projects.
- Community workers were overly directive in certain projects instead of acting as resource persons. Consideration could also have been given to other roles which community workers play in relation to different projects.
- Projects dealt with individual issues rather than broader structural ones. Most people required advice and guidance in dealing with such issues and in finding their way through bureaucratic procedures. The community worker's role as resource person, however, failed to respond to this need.
- It was found to be difficult to measure progress achieved in attaining the goal of the programme. This was because "social and economic development" and the steps towards achieving it had not been defined. The only "economic" project which succeeded in providing permanent economic benefit was the baby-shoe project. Three attempts at establishing producer co-operatives which ended in failure would

have succeeded had subcontracting or individual enterprise as a resource to those already involved in economic activities been used.

- Growth did occur in members of many other groups and personal attributes such as leadership were developed. Those who attended courses improved their skills in or knowledge of a certain subject, and were usually willing to share this with others. However, it was difficult to measure growth and therefore it was difficult to evaluate whether the programme had been effective in this respect and whether in fact the results achieved warranted the high input required.
- It was found that people who were involved in the training centre programme shared a "sense of community" only with a small group of their associates. In other words "a community of interests" was a very limited and narrow practice. Reference to a geographic area as a "community" and phrases such as "developing a sense of community identity" and "community involvement" in a broader sense, did not apply; this limited the significance of the projects.
- It was realized that as far as possible, future planning of project goals should be very specific, and subgoals should be linked with time phases, so that progress and "success" can be measured.

Evaluation of CAFDA's current community work projects is comparatively more positive. There appears to be a general improvement in both input and results of such input. This is due *inter alia* to the professionalization of its projects, for example the training of home visitors drawn from the community at large has succeeded in producing two fully trained persons.

Evaluation of CAFDA's current projects is an ongoing process. However, certain significant factors have already emerged, e.g.

- the supportive, co-ordinative role of its community workers is helping participating members to be independent,
- a combination of community self-determination and self-direction is encouraging more realistic growth and progress in participants,
- the encouragement of more community involvement allowed for greater community identification with structural problems,
- the comprehensive recording of work done by community workers allows for basic, elementary measurement of success/failure in goal attainment. This is an improvement on past experiences.

LIST OF SOURCES

BEZUIDENHOUT, A.M.
1976. Crisis intervention — a literature study. *Department of Social Welfare and Pensions. Research and Information.* No. 3. Pretoria: Government Printers.

FERRINHO, H.
1980. *Towards a theory of community development.* Cape Town: Juta & Co.

HARKER, B.M.
1973. Role and function of a crisis clinic. *Social Welfare and Pensions* 8(2), December: 13-17.

OVERTON, A., TINKER, K.
1970. *Family centered project casework notebook.* St. Paul, Minnesota: Community Health and Welfare Planning Council of Greater St. Paul.

PARAD, H.J., CAPLAN, G.
1960. A framework for studying families in crisis. *Social Work* 5(3), July: 3-15.

RAPOPORT, L.
1973. Working with families in crisis: An exploration in preventive intervention. In: PARAD, H.J. *Crisis intervention.* Eighth impression, New York: Family Service Association of America. Pp. 22-31.

ROSENBERG, B.N.
1975. Planned short-term treatment in developmental crises. *Social Casework* 56(4), April:195-214.

SMIT, S.J.
1974. Die krisisteorie en korttermynbehandeling. *Maatskaplike Werk/Social Work* 10(3), Aug.:142-147.

VIII

THE SINGLE SYSTEM DESIGN IN SOCIAL WORK RESEARCH AND SOCIAL WORK PRACTICE

Herman Strydom and Amanda M. Diederiks

1. INTRODUCTION

Every social worker should be both a social worker and a researcher, and the two roles should form a basic unity. According to Duehn (in Grinnell 1981:11) "the focus is on the practitioner-researcher's [sic.] problem-solving process in formulating problems, selecting strategies, implementation, and evaluation to resolve social work issues".

Social workers are supposed to help persons who have social problems, but there is little proof that the work done by social workers is effective. There is a growing need among social workers on the one hand and the community on the other to justify the existence of social work services. Polster and Lynch (in Grinnell 1981:418) stress the fact that: "In times of budgetary restrictions and a demand for accountability, practitioner-researchers [sic.] must show evidence that what they do is effective and important". The single system design is definitely one of the most suitable ways of conducting research in everyday practice. According to this design, every researcher can regard his own case load as an opportunity for research — either the total case load or only a number of cases from it.

In this chapter the writers aim to offer an integrated discussion of the theory and practice of the single system design. An example from practice is used throughout the discussion in order to elucidate the theory that is discussed. This example is taken from the field of marriage counselling and concerns intervention with a married couple.

A number of concepts are defined in this article and reference is made to the question of measurement. Finally certain characteristics, the course and some of the pros and cons of the single system design are discussed.

2. DEFINITION OF CONCEPTS

Although Bloom and Fischer (1982:7-9) prefer the term *single system designs* because there are different variations to the basic *design* of col-

lecting data repeatedly and by phases, the singular of the word also implies these variations. The term *single system design* will therefore be used most of the time in this chapter to signify the repeated collection of information on a single subject or system over time. This single subject can be either an individual, a group or a community. It is now possible to measure the progress or failure of a particular intervention programme in one or every case of a particular worker's case load. The quality of service and accountability can thus be enhanced. Bloom and Fischer (1982:16) add the following remark: "Probably the most productive way of assessing whether or not our practice is successful, then, is through the use of systematized, objective methods of research that are capable of being repeated (replicated) by others". Research and practice can be linked through the use of the different variations of the single system design. The concepts "researcher", "therapist", "social worker" and "practitioner" are interchangeable.

3. MEASUREMENT

Until recently it was believed that research is an activity that should be conducted by highly specialized personnel and that the same social worker cannot be a good researcher and at the same time be a good practitioner (Briar 1980:31). Currently a new perspective is gaining momentum, namely that social workers are increasingly analysing their own daily practice and observing their own treatment strategies in a critical fashion. Duehn (in Grinnell 1981:12) remarks as follows in this regard: "Conducting practice within this paradigm will not only contribute to the advancement of professional knowledge but will enable social workers to gain a more objective, less biased evaluation of their own practice effectiveness".

Thorndike said that if something actually existed, it existed in a particular quantity and if it existed in a particular quantity, it could be measured (Bloom, Fischer 1982:34). Hudson added to this statement and said: "If you cannot measure the client's problem, it does not exist and you cannot treat it" (Bloom, Fischer 1982:34).

Therefore if a problem is too vague and too subtle to be measured, it will also be too vague and too subtle for therapeutic intervention. If the problem can be outlined clearly, it can be measured. If a problem cannot be defined and thus cannot be measured, a social worker will never

know how successful a particular intervention programme was, or to what extent the objectives have been met.

If a problem is said to be measurable, yet only with difficulty, it is a completely different matter. Most problems are complex and seem obscure at first. In the example under discussion the therapist's first task was to identify the measurable components of the problem. The modes of behaviour were identified by the social worker and the clients. The four modes of behaviour focused on during the intervention, were the following:

- the husband's contacts (especially telephone calls and letters) with his mother without his wife's knowledge;
- reproaches by the wife concerning the above and other things that happened in the past;
- the wife's inability to share her feelings with her husband;
- physical contact between the husband and wife.

4. THE CHARACTERISTICS OF THE SINGLE SYSTEM DESIGN

4.1 Identification and definition of the problem

A very distinct and thorough outline should be given of the particular problem situation that has to be changed and the social worker and the client have to agree on this point.

After exploring the problem area with the married couple, the specific problem was identified and the baseline could be determined subsequently.

4.2 Baseline

The baseline is unique to the single system design. Measurement during the baseline phase should be continued until the behaviour that will be focused on during intervention appears to be reasonably stable. Thus the baseline is the planned, systematic gathering of information on a particular problem before intervention is commenced (Bloom, Fischer 1982:9; Arkava, Lane 1983:121). Initially this information is used to measure the problem and it serves as a basis against which any positive or negative change occurring during intervention can be measured. The *modus operandi* of the single system design was explained to the couple during the first interview, and subsequently an agreement was reached.

During the following three interviews the four problem areas that were specified earlier were measured every time they occurred. These areas were:

- the husband's contact with his mother, without his wife's knowledge;
- the wife's accusations that her husband was disloyal towards her;
- the wife's inability to share her feelings with her husband;
- the physical contact between husband and wife.

It was agreed that the husband and wife would measure the modes of behaviour separately, while the social worker would measure certain components during the interview.

4.3 Measurement of the problem

Social workers should be bound ethically to meticulous investigation and objective evaluation of the everyday activities in their practices.

There are a variety of forms of measurement, such as observation of behaviour (frequency count), standardized measures, self-anchored scales, rating scales, logs and certain unobstrusive forms of measurement. Every social worker has to decide upon the most suitable and applicable form of measurement in each individual case. In this case use was made of behaviour observation. However the woman's (in)ability to share her feelings with her husband was measured on a self-anchored scale.

4.4 Clear definition of intervention

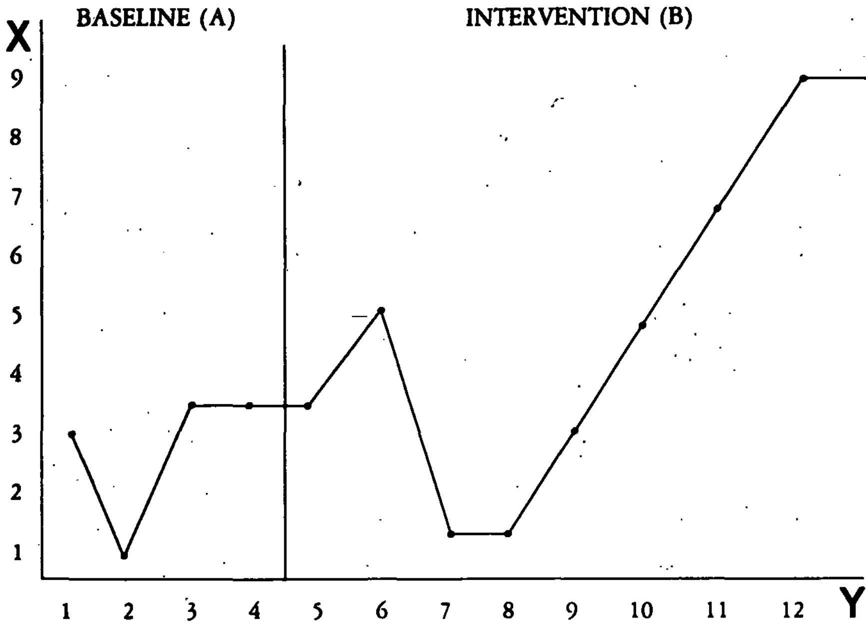
In order to be able to gather reliable information, the therapist has to be specific about the intervention programme that will be offered. Meaningful measurement is possible only when the different phases and the planned intervention have been defined very clearly, and only then can it be stated that a particular intervention brought about the change in the behaviour. The intervention programme was explained to the married couple specifically in terms of change of behaviour envisaged by the social worker; and role playing was used to suggest and practise a communication model and ways of handling conflict. They were encouraged to share with one another feelings that had been revealed during discussions, and to make physical contact with one another if they felt like it.

4.5 Analysis of the data

The single system design depends predominantly on the visual analysis of changes by means of charting and not so much on complicated statis-

tics. Charting offers a graphic representation of changes in the problem situation from baseline up to and including the conclusion of treatment. The different phases are distinguished from one another on such a graph by means of a vertical line. Graphic representation No. 1 is an example of a basic single system design (A-B).

GRAPHIC REPRESENTATION NO. 1 — CHANGES IN THE CLIENT'S BEHAVIOUR



X	Score according to rating scale
Y	Weeks

5. THE STAGES OF THE SINGLE SYSTEM DESIGN

Certain stages are common to research and practice and thus make a union of two domains possible. Bloom and Fischer (1982:16-18) believe

that "the essence of successful practice is the ability to demonstrate that what we have done (our intervention) has worked (is effective)". They also refer to "practice as research, and research as practice".

5.1 Formulation of the problem

The social worker, in collaboration with the client, selects particular problems from the relevant problem areas, arranges them in order of priority, selects one problem on which to concentrate, demarcates it and formulates a clear and specific definition of the problem.

In the example the husband's contact with his mother was isolated and concentrated on as the main problem area, while the other three modes of behaviour emanated directly from the husband's contact with his mother, of which his wife was not aware.

5.2 Literature consultation

The therapist should familiarize himself with the relevant literature in order to prepare himself and to overcome a situation where he is faced with a problem about which his knowledge is inadequate. He can possibly base his own investigation on other investigations and so establish a more comprehensive body of knowledge. Social workers may possibly also use their own experience and other similar investigations as guidelines for handling the problem.

In order to prepare herself, the social worker concerned consulted literature concerning women's emotional experience of the sexual relationship in marriage.

5.3 The development of objectives

The researcher sets up certain general and other specific objectives to direct the course of the investigation. In the example case the short-term objective was to completely eliminate the husband's habit of contacting his mother without informing his wife. The long-term objective was to create a happy marriage, which would be evident from the fact that the husband and his wife finally shared their feelings and developed a satisfying sexual relationship. Subsequently certain hypotheses were formulated on the basis of these objectives.

5.4 The development of hypotheses

The therapist should formulate hypotheses dealing with the ways in which certain variables may affect the problem and the extent to which either of these variables or the relationship between them can be changed.

The hypothesis that was formulated for the investigation concerned can be divided into a main hypothesis and certain subhypotheses. The main hypothesis was defined as follows: If the husband *avoided* contacting his mother without his wife's knowledge, it would have a positive effect on their marriage. The following subhypotheses could be formulated on the basis of this main hypothesis:

- if the wife felt more secure in the marital relationship, she would be able to share her feelings with her husband;
- if the wife experienced her husband's loyalty, she would not find it necessary to reproach him for things that happened in the past;
- if the wife experienced her husband's loyalty in a positive manner and felt more secure in the marital relationship, she would be able to start a physical relationship with him.

These hypotheses coincide roughly with the four modes of behaviour that were referred to under MEASUREMENT (Paragraph 3).

5.5 Setting up the design

Planning the collection and analysis of the data is at issue here. This includes all the administrative matters, such as who would gather the information, how the information would be gathered and when it would be done.

An agreement was reached with the couple that each partner would keep a separate notebook at home in which he/she would record incidences of three modes of behaviour directly whenever it occurred. The fourth mode of behaviour, namely the extent to which the wife managed to share her feelings with her husband, was indicated daily at home by the wife on a self-anchored scale whenever it occurred.

The couple were asked to consider this information as confidential and not to discuss it with one another.

During the course of the interview the social worker measured the following whenever it occurred:

- the incidence of the reproaches for disloyalty and occurrences in the past;
- the sharing of feelings between the husband and his wife;
- the physical contact between the couple.

The measurements recorded by the married couple and by the social worker were collected on a weekly basis and analysed by the latter.

5.6 Definition of the dependent variable

The dependent variable is the dimension in which the social worker expects changes to occur. In order to evaluate even the smallest change, it is therefore essential to define this variable very specifically in measurable and exact terms.

As was clear from the development of hypotheses, the problem in the example was described very specifically in terms of measurement. Thus it was possible to evaluate all changes in any of the dependent variables.

The following were the four dependent variables:

- the husband's contact with his mother without his wife's knowledge;
- the wife's accusations that her husband was disloyal towards her;
- the wife's ability to share her feelings with her husband;
- physical contact between husband and wife.

5.7 Definition of the independent variable

The independent variable is that which is expected to affect the dependent variable. This variable should also be described in specific and measurable terms so that the therapist can be sure that it has actually been applied. The dependent variable is therefore the problem which is attended to, while the independent variable is the particular intervention programme that is applied.

The programme that was described in specific and measurable terms and defined in Paragraph 4.4 was adopted as the *modus operandi.*

5.8 The determination of possible obstacles

The researcher tries to consider all relevant facets of the proposed study in order to determine whether any stumbling blocks are likely to affect the implementation of the programme.

In the example case two possible hindrances were identified, namely visiting by the husband's mother, and the couple's arrangement of sleeping in separate bedrooms. The husband was therefore asked to discourage his mother from visiting them during the implementation of the programme, while the wife was encouraged to share a bedroom with the husband in order to facilitate spontaneous physical contact.

5.9 The baseline phase

The baseline phase concerns the planned collection of data before the independent variable is applied, in order to ensure that the therapist will have control over the course of the research project (Forcese, Richer 1973:261).

As mentioned earlier, a baseline was determined in the case under discussion before the social worker started with the treatment programme. As a result the social worker was eventually able to prove the effectiveness of the programme that had been implemented.

5.10 The intervention phase

The intervention phase is the phase during which the independent variable, in other words the particular intervention programme, is applied.

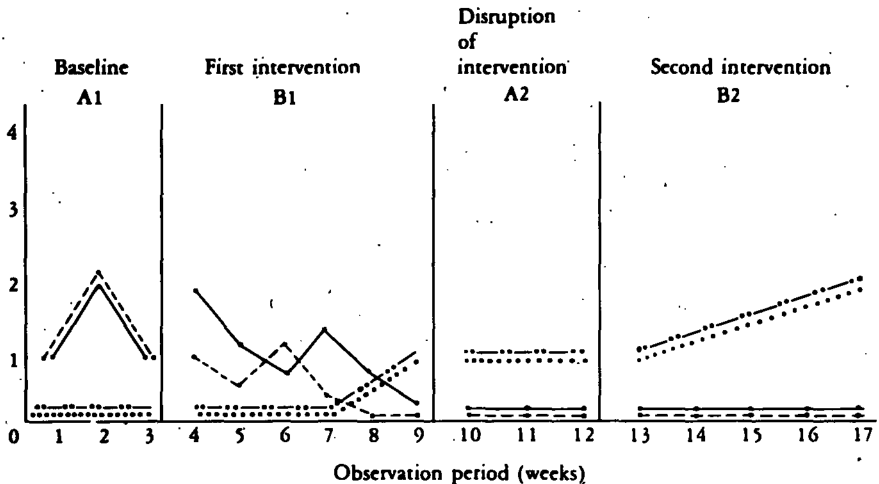
The husband and wife in the example case had to learn to communicate with one another in such a way that they could share their feelings. For this reason a communication model was introduced to the interview situation by means of role playing. Unsolved conflicts were discussed based on the guidelines for handling conflict that had been explained to them previously. Initially they discussed imaginary conflict situations concerning the husband's mother. In the course of the second intervention phase actual situations and other sensitive matters were discussed in depth. The couple were encouraged throughout to emphasize positive aspects of the relationship with one another. After having acquired and practised communication skills, they increasingly managed to share their physical needs with one another and in this way the stumbling blocks that made physical contact impossible, were gradually eliminated.

5.11 The analysis of the data

Once intervention has been terminated, the researcher analyses the data to determine whether any changes in the dependent variable occurred,

as well as whether certain relations between variables could be found. An attempt is also made to determine whether it was actually the independent variable that caused the changes in the dependent variable.

GRAPHIC REPRESENTATION NO. 2 — AN A-B-A-B DESIGN TO INDICATE CHANGES IN THE BEHAVIOUR OF CLIENTS



Forms of behaviour 1-4 that were measured.

KEY		
	- - - -	The man's contact with his mother
	——	Wife blaming her husband for disloyalty and things that occurred in the past
	—••—	Feelings that the woman shared with her husband
	••••••	Physical contact/sexual intercourse between the husband and wife

As mentioned in Paragraphs 5.6 and 5.7 the data that were obtained enabled the social worker concerned to establish if changes in the main dependent variable (that is the husband's contact with his mother without his wife's knowledge) indeed took place. The data also enabled her to determine that certain relations could be established, namely between the man's contact with his mother and his wife's behaviour. Furthermore the social worker established that the independent variable, i.e. the treatment plan that was adopted, was responsible for the changes that occurred in the dependent variables. The charting of the information enabled her to present the information in a simple and visually attractive manner.

5.12 Reporting

Compiling a report is important in order to convey findings to colleagues. This enables other researchers and practitioners to repeat the particular investigation, with the result that data generalization becomes possible and a contribution is made to the cumulative body of knowledge on the subject.

A concise report was prepared on the example case since valuable information had already been conveyed by means of the visual representation of the data.

Better utilization of the method of charting by social workers can definitely be applied with great effect in terms of cost and time. The visual representation of data enables the social worker at a glance to perceive any change, whether positive or negative, in the behaviour of the client.

6. SOME ADVANTAGES OF THE SINGLE SYSTEM DESIGN

- It offers a model of accountability to social workers, clients, organizations and especially financial supporters. According to Arkava and Lane (1983:149) "... (it) allow(s) the well-trained practitioner to satisfy both practice and research objectives: to provide service and to evaluate the effectiveness of that service".
- The cost of the design is low since it is basically a do-it-yourself procedure.
- As the single system design requires the social worker to clearly define the time-frame of the intervention, a rationing of time is encouraged; in other words, time-limited intervention rather than an open-ended approach to time.

- The problem of outside researchers is eliminated since every worker conducts his own research (Bloom, Fischer 1982:15).
- It is a direct form of research and results are available immediately whether before, during or after the intervention.
- By demarcating the problem in order to establish the baseline, the design strongly encourages the social worker to work purposefully.
- The single system design can help to determine the special circumstances of the client and, if necessary, a more appropriate programme of intervention can be adopted. Adjustments to the intervention programme can easily be made and this design is therefore not as rigid as, for example, the experimental procedure. If in the example case the social worker found that the husband's contact with his mother *with the knowledge of his wife* did not result in the desired change in the wife's behaviour, the social worker could ask him to break off all contact with his mother. Thus the programme could be adjusted at any stage of the intervention.
- It is possible to evaluate the effectiveness of the treatment programme applied to every client, group or community.
- As appears from the graphic representation of the data in the example, the single system design also makes it possible to compile an ongoing report of changes occurring during the course of the entire intervention effort.
- Hypotheses concerning the relation between a specific intervention procedure and changes that take place in the client can be tested. Thus the hypothesis formulated for the example case, namely that the husband's making contact with his mother with his wife's knowledge would lead to certain changes in the wife's behaviour, could be tested on a continual basis.
- It is clear from the example that the single system design is easy to use and understand.
- The single system design represents an attempt to obtain quality information. From the example that was used it can be deduced that awareness of the mere presence of a problem is insufficient and that it is essential also to establish the degree of seriousness of the problem.
- The design goes further than mere descriptive research and it attempts to be explanatory (Polansky 1975:50). For example, the behaviour of the woman in the sample case could be explained on the basis of the

husband's contact with his mother, namely whether it was with or without his wife's knowledge.

- In the final instance the single system design is based on social work practice and it is both practitioner oriented and cost-effective.

7. SOME DISADVANTAGES OF THE SINGLE SYSTEM DESIGN

- Initially the application of the single system design may take up too much time, since the social worker first has to learn how it functions. However, later on this disadvantage is changed into an advantage, since once he has acquainted himself properly with the system, the social worker can deal with all cases in the same way and accountable social work is performed within the shortest period of time.
- Some critics feel that the single system design offers nothing new. However if social workers have already started to implement this procedure in their practice, they can possibly go further by systematizing existing information and comparing results, so as to be able to communicate with other professional persons in a meaningful and scientific fashion (Bloom, Fischer 1982:21).
- In order to be able to say that a specific independent variable caused a specific change, all other variables have to be controlled; this restricts the variety that is found in real life with regard to any single variable, and the single system design may therefore seem artificial. (Cf. Hersen, Barlow 1976:13-17; Arkava, Lane 1983:120.)
- In future more and more follow-up studies of terminated cases will have to be conducted in order to confirm whether the particular treatment strategy that was adopted is still successful.
- According to Arkava and Lane (1983:148) it is difficult to make a watertight case for the withdrawal and reversal of treatment, especially in cases where treatment has already shown signs of success.
- It is said that the single system design will eventually replace classical research procedures. However the former rather supplements and supports the classical procedures of research, because all researchers are not necessarily able to execute the classical procedures without incurring additional expenses in terms of money and time.
- It is very difficult to make generalizations on the basis of the single system design — in future the same experiment will have to be repeated for numerous clients. Schuerman (1983:67) remarks in this regard that

the single system design "... suffer(s) from the lack of comparisons. Without something with which to compare the results, we have problems in drawing conclusions".

8. SUMMARY

The aim of this contribution to the study was to stimulate social workers to adopt a more accountable *modus operandi.* The practical application of the single system design by means of an example taken from marriage counselling was highlighted throughout.

The special features of the single system design render the system appropriate and accessible to the therapist and the researcher in all fields of social work intervention and assistance.

First a definition was formulated of the concept, followed by a discussion of certain facets of measurement and some characteristics of the single system design. Next the various stages of the single system design were looked at closely and finally some of the advantages and disadvantages of the design were examined. From the latter it was clear that the pros far outweighed the cons of the design.

It is hoped that this contribution will encourage many social workers to use the single system design. After application of the design, every social worker will have to evaluate whether the intervention has been effective in terms of the money and time spent.

LIST OF SOURCES

ARKAVA, M.L., LANE, T.A.
1983. *Beginning social work research.* Massachusetts: Allyn and Bacon.

BLOOM, M., FISCHER, J.
1982. *Evaluating practice: guidelines for the accountable professional.* New Jersey: Prentice-Hall.

BRIAR, S.
1980. Toward the integration of practice and research. In: FANSHEL, D. *Future of social work research.* Washington: National Association of Social Workers. Pp. 31-37.

DUEHN, W.D.
1981. The process of social work practice and research. In: GRINNELL, R.M. (Jr.) *Social work research and evaluation*. Illinois: F.E. Peacock Publishers. Pp. 11-34.

FORCESE, D.P., RICHER, S.
1973. *Social research methods*. New Jersey: Prentice-Hall.

HERSEN, M., BARLOW, D.H.
1976. *Single-case experimental designs: strategies for studying behaviour change*. New York: Pergamon Press.

POLANSKY, N.A.
1975. *Social work research*. Chicago: University of Chicago Press.

POLSTER, R.A., LYNCH, M.A.
1981. Single-subject designs. In: GRINNELL, R.M. (Jr.) *Social work research and evaluation*. Illinois: F.E. Peacock Publishers. Pp. 373-418.

SCHUERMAN, J.R.
1983. *Research and evaluation in the human services*. London: Collier MacMillan Publishers.

IX

CONCLUSION: IMPLICATIONS FOR PRACTICE IN THE HUMAN SERVICES

A.E. Gangat and L.R. Naidoo

1. INTRODUCTION

There is a growing trend in capitalist societies towards the establishment of practical strategies for managing cut-backs that are critical for the survival of many service organizations dependent on gradually-diminishing government financial support. Research teams the world over have undertaken studies aimed at eliciting specific strategies which community mental health services and other service agencies could use, to weather these financial cut-backs while simultaneously maintaining a high standard of service. These strategies namely crisis intervention, brief intervention, time-limited intervention, behaviour management and limited-goal intervention are not separate management styles. Rather, they overlap in many ways – so much so that time limited intervention as a result of its eclectic nature may be regarded as the broadest category of management.

Similar developments have taken root in South Africa in recent years. The preceeding chapters outline efforts made by a variety of organizations and academics to conceptualize and empirically validate time-limited interventions within the local context.

2. PRACTICAL STRATEGIES

The empiricists, i.e. crisis and social work units, appear to be utilizing all or some of the following practical *strategies*:

1. Adopting organizational structures that have a large community, self-help component.
2. Providing a service that is regularly evaluated for cost effectiveness and productivity.
3. Making optimal use of existing resources.
4. Making provision for constant and immediate availability of services.

5. Making available services in areas of high risk for secondary and tertiary complications, for example, rape and divorce.
6. Providing services directed towards saving working hours and enhancing the work environment.
7. Using clearly planned management approaches tailored for a specific socio-economic class.

An attempt will be made to show how the organizations and/or individuals that contributed to this publication have endeavoured to follow these strategies. Further, the implications of their use will be discussed.

2.1 Strategy One

CAFDA (Cape Flats Distress Association), Randburg Crisis Centre and Rape Crisis appear to be effectively utilizing the first strategy in that all three organizations have a large community-based, self-help component. Volunteers are drawn from the community to provide first-line services for both curative and preventative matters. CAFDA has initiated numerous self-help groups to foster upliftment of the deprived community that it serves, upliftment in terms of skills, knowledge and income. It follows that this preventative scheme would pre-empt the massive social worker case loads where basic financial, physical and educational poverty is perpetuating emotional and interpersonal strife. Randburg Crisis Centre and Rape Crisis are utilizing trained volunteers to provide immediate help for individuals with a variety of psychosocial problems. Invariably such a service helps to screen-off many individuals who would have occupied the case load of the professional worker.

Further, this service makes for prevention of secondary and tertiary complications as a result of its "walk-in" nature. Rape Crisis, which is a specialized service, has found the need to disseminate its specialist information to other first-line organizations to reduce its increasing case loads, that is, to hospitals, schools, student hostels and social work agencies.

2.2 Strategy two

Strategy Two, namely providing a service that is regularly evaluated in terms of cost-effectiveness and productivity, is offered, for example, by CAFDA which has a methodical and scientific evaluation procedure including *inter alia*, the use of detailed recording sheets. Naturally, the single system design described in the publication which has as impor-

tant features setting clear goals and developing specific evaluation criteria, could be used most profitably by any organization rendering the kind of services discussed in this publication.

In general, interventions should relate to the specific needs of a given client with priority being given to a return to or a development towards appropriate occupational, social, physical and emotional functioning.

2.3 Strategy Three

Strategy Three, namely, making optimal use of existing resources, is followed in and by most of the projects or approaches referred to in the publication. The use of trained volunteers, volunteers with more than one grade of expertise and part-time professional consultants, all make for the spread of services to a greater number of individuals at a reduced cost.

Yet it is realized, and was sometimes specifically mentioned, that within the field in general there is a lack of co-ordination and a measure of overlap in the use of such resources because of ignorance about their presence or knowledge on how they function. Education of organizations and the public in general with regard to the existing facilities and the nature of services provided, will greatly promote the distribution of such services to more people within the limits of *existing* structures.

2.4 Strategy Four

Strategy Four, that is making provision for constant and immediate availability of services, is a characteristic of most time-limited intervention projects. Round-the-clock availability is usually made possible by the use of trained volunteers who, as a result of their numbers, are able to provide an immediate, constant and regular service. However therapeutic intervention is mostly done by fulltime professionals, and they ensure their prompt availability by means of a roster system, shorter waiting lists, a limit to the kinds of problems they attend to and briefer involvement with clients. A telephone service operating around the clock is an important aid for both professional and volunteer. An expansion of this strategy is the provision of crisis services at catchment areas such as factories, schools, hostels and transport terminals.

However, in the field of psychiatry, this consideration is often ignored. To date, psychiatric departments exist largely in teaching hospitals. It

is inconceivable how emotional emergencies or casualties could be ignored in any health facility which already boasts adequate infrastructure for physical emergencies. Availability of psychological and psychiatric help within all general hospitals will most definitely facilitate early and prompt intervention in those cases where patients require treatment for an emotional problem. Referral would be immediate; and patient motivation would be higher as problem management would be perceived as being performed by one team. Furthermore, the stigma of attending a separate psychiatric institution would be avoided. This would invariably lead to a higher rate of success in management of both psychiatric and physical disorders which are intimately related. Inevitably the cost of psycho-psychiatric management would be greatly reduced.

2.5 Strategy Five

Strategy Five, i.e. making available services in areas of high-risk for secondary and tertiary complications, like rape and divorce, is highly potent. However, services related to this strategy are limited.

In the instance of rape, besides Rape Crisis, the victim has hardly any other easily-accessible and supportive service. Moreover, Rape Crisis centres are only available in major cities. Often rape victims remain silent for various reasons, not the least being the brutal exposure to insensitive legal investigations and the traumatic exposure in news media. Moreover rape victims are usually in a state of acute emotional crisis known as the post-traumatic stress syndrome. Clearly our task is to provide immediate support and assistance. It is clear, too, that Rape Crisis, though filling a void since the middle 70s, cannot meet the growing demand. In fact rape crisis units now train other intake facilities in order to share the growing case loads. Although such a development has the advantage of cost-effectiveness, there may be the danger of lower efficiency as a result of inadequate knowledge arising from too short periods of training. This argument most probably holds true for most voluntary non-professional counsellors. Admittedly an early referral for appropriate professional help, as in the case of suicidal ideation or attempts, depression, exacerbation of an underlying psychiatric vulnerability, drug abuse and failure to adjust, will certainly help in preventing secondary and tertiary complications.

The above arguments will also hold for psycho-social work intervention to facilitate post-divorce adjustments. However, in divorce, the development of an emotional reaction is very rarely sudden as in rape. Mostly

it is gradual, often extended and fraught with legal issues. Marriage guidance agencies, social work agencies, mental health societies and psychiatric services would profit from utilizing a time-limited intervention model in the management of post-divorce adjustment. Furthermore, close attention to persons at risk could prevent more complex problems.

2.6 Strategy Six

Strategy Six, i.e. providing services directed towards saving working hours and enhancing the work environment, can be achieved by employing principles already outlined earlier. The basic principle should be the following: just as the factory provides *first aid* for physical injury/disorder, "first-aid" or first line treatment for emotional disorders should also be available for workers. This as already pointed out, means the presence on the factory floor or in the office of mental health counsellors trained to assist with emotional problems on the spot. Besides cutting the burdensome red-tape of referral and lessening the need for referral to professional agencies (not to mention the delay involved in this procedure) such quick intervention can prevent complications and allow for the provision of early supportive services. Besides keeping the worker at his job during the working day the work environment is perceived more favourably and this in turn enhances productivity. In view of this industrialists should be encouraged to employ industrial psychologists or trained counsellors. Alternatively industrialists could ensure that industrial nurses receive appropriate training in *primary* mental health care.

The principle of first-aid for emotional disorders as promulgated for the factory can be argued for all institutions catering for large numbers of people such as schools, universities and large department stores. Often, in instances where financial productivity is not overt as in the case of schools and hospitals primary care for emotional health of staff is neglected as it is not readily evident that lower stress states result in more efficient decision-making, concentration and compliance.

2.7 Strategy Seven

Strategy Seven, namely using clearly planned strategies tailored for a specific socio-economic class, is illustrated *inter alia* by the work of CAFDA. Working in a socio-economically deprived community, this organization found that the use of conventional social work leads to the development of large case loads with problems steeped in issues related to housing,

transport and financial matters. It was evident that a more "grass root" type of approach was necessary to deal with individuals coming from such a community; the initiation of a large number of self-help groups within the community followed. The aim of this move was to educate and develop basic skills to raise the general level of functioning of the community. Such an approach would naturally reduce case loads with major reality problems, and in instances where "intra-psychic" types of problems presented, environmental overlays would be greatly reduced.

Furthermore, in the context of direct problem management, *practical assistance* should be the primary approach, and only where relevant, should there be an attempt to achieve profound insight and/or personality change. A practical management approach would entail the use of brief, task-centred, directed interventions with a sharp focus on the immediate problem. This approach is most productive in a service that is immediately available and crisis-orientated.

Such a practical approach would also satisfy the need of an individual who wants the short-term difficulty resolved in a rapid, often symptomatic, manner. In summary, it should be remembered that the client-perceived target problems require immediate, focused attention.

However most of the clients discussed by the occupational social worker and the private practitioner in this publication are found on the other end of the socio-economic continuum; and these clients, because of the very fact of their generally *high* level of education and economic functioning, usually benefit swiftly from limited, prompt intervention.

3. IMPLICATIONS IN PRACTICE FIELDS

The foregoing discussion relates to the implementation of time-limited interventions mostly within the context of existing state, parastatal and state-aided services — services utilized by the majority of people.

However, to further the goal of cost-effective high quality service, change in strategies within existing services alone may not be sufficient. Change in actual service structure may be necessary for people who are resistant to the use of these services.

One such group of people are those who are reluctant to use the existing public services because of the stigma associated with using state and welfare types of services which may be regarded as catering for lower socio-economic classes or for people who have failed in some area of their lives.

Furthermore, as a result of most of these services catering for large numbers, the consequent congestion, long waiting periods for consultation and economized waiting facilities may also have a negative influence on many people. These people may respond poorly to the most well-designed management plan and they may show this through poor compliance. Entirely private, or state-subsidized private, facilities could provide a more cost-effective alternative to existing state and state-aided services; the compliance of the clientele of such services would be expected to be greater and they would be more likely to respond at an earlier stage, thus preempting secondary and tertiary complications.

Unfortunately, while this scheme is theoretically positive and attractive, the practical position in our country points to major problems regarding fees and medical aid societies. For example, after years of negotiations clinical psychologists have not been successful in having their fees gazetted. It is hoped that the approximately 100 social workers that have gone into private practice to date (mid 1987) will have better success.

Another very large group of people, such as those showing a preference for private services, also reluctantly respond to centralized state and state-aided services. These are people who have to travel great distances at considerable personal cost to receive help. Provision of decentralized services to such people would vastly improve motivation, compliance and positive response to help, probably also at earlier stages. The practice of time-limited intervention within such a development could only enhance the cost-effectiveness of services provided.

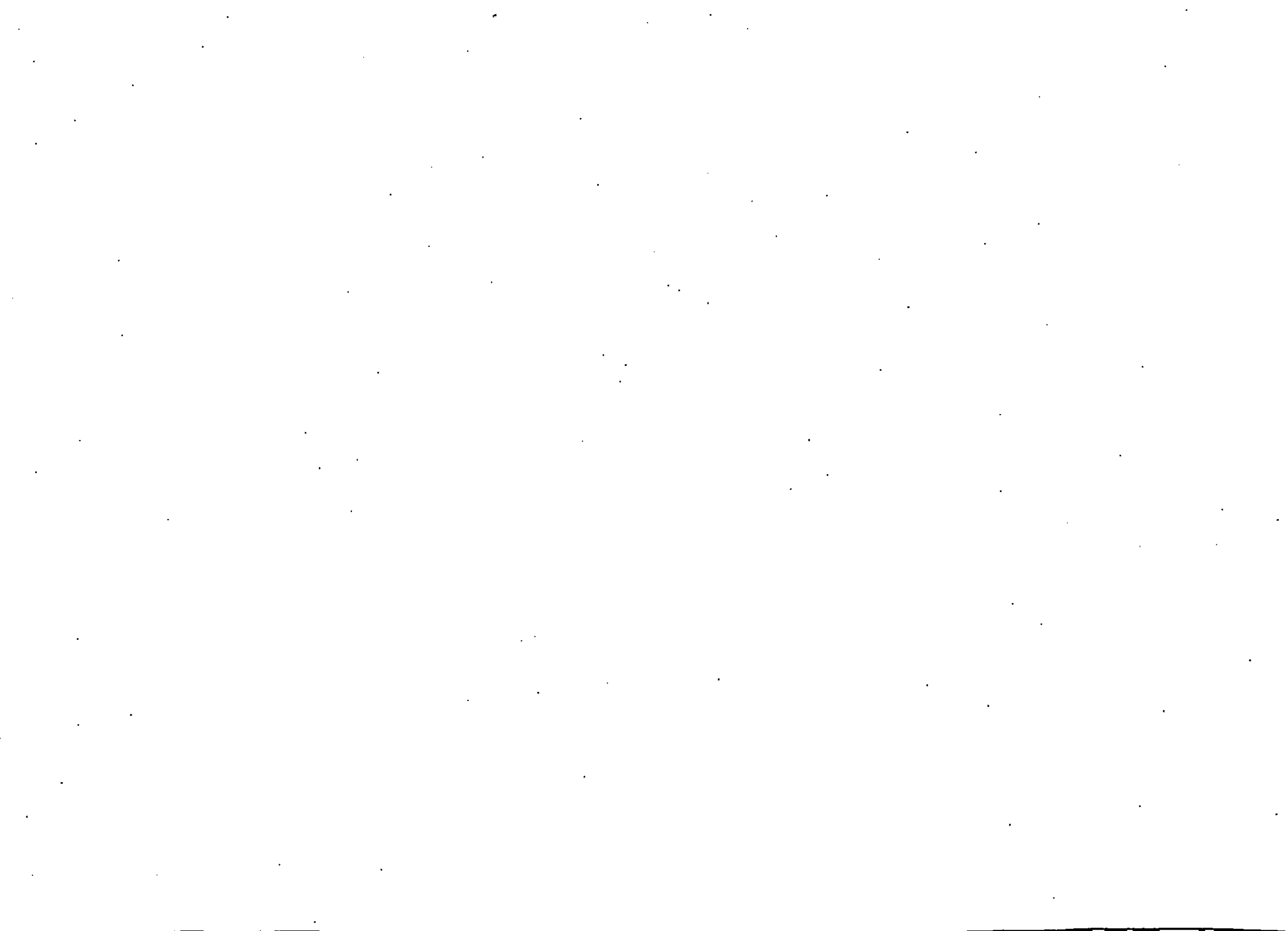
In conclusion it is evident that time-limited intervention has major advantages namely satisfaction of needs as perceived by the patient, earlier intervention with resultant prevention of secondary and tertiary complications, optimal use of the time and expertise of highly-trained professionals, and much needed cost-effectiveness in the face of increasing financial cut-backs. While these gains are attractive, this concept can be easily abused. This therapeutic approach cannot and should not be used in a rigid, inflexible manner. Treatment modes must be tailored to meet the need of the individual client. A failure to follow this principle will make mere "technicians" of mental health and other human service workers.

Furthermore, the economist in these fields should guard against blindly demanding time-limited intervention just for the sake of saving money in the short term. If the latter becomes the sole object the inappropriateness of the time-limited approach for some types of clients or for any

client under certain circumstances, and the consequent frustration of staff will neutralize the positive effects the approach might have had. The outcome might be the total collapse of a therapeutic system which, although very costly and slow to achieve success, was at least a functioning system. Rebuilding the system might prove to be more expensive than anything previously undertaken in the field concerned.

3. CONCLUSION

Utilized in a progressive, empathic context, time-limited intervention will be well received by patients or clients and human service workers — especially those who feel bogged down by increasing demands for help which cannot be met through classical psychotherapeutic approaches. Over and above the implementation of time-limited intervention, and in the interest of cost-effectiveness, restructuring of existing services requires attention; for example the provision of decentralised services and private services to cater for the needs of people requiring such services.



Doc no: 160347
Copy no.. 160348

RGN BIBLIOTEEK
HSRC LIBRARY