A TASK-CENTERED APPROACH IN

DEALING WITH VULNERABLE ELDERLY CLIENTS

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BY

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To my wife Eileen, for her patience and perseverance in helping me out with life's tasks.

CONTENTS

PREFACE

This practicum report examines the use of a task-centered practice as it relates to intervention with the vulnerable aged client. It is based on a review of the literature and the writer's practicum experience

"Each morning some task begun
Each evening sees it close
Something attempted, something done
Has earned a night's repose".

Longfellow:

INTRODUCTION

"Problems in living" are explained by Reid and Epstein (1972, p. 42-48) as problems which are defined by the individual, as both psychological and social, that most of us encounter and cope with in some form, they are resolved or alleviated through the individual's own actions. These problems fit into the following categories: (1) interpersonal conflict, (2) dissatisfaction in role relationships, (3) difficulties in role performance, (4) problems in social transactions, (5) reactive emotional stress and (6) inadequate resources being available. The student has focused his intervention with the elderly, who are experiencing problems in living in the above six catagories.

The objectives of the student were to (1) examine the application of a task-centered approach as a therapeutic tool in understanding and intervening in the "problems of living" presented by the vulnerable elderly client, (2) to acquire and demonstrate an advanced level of skill in task-centered therapy.

The student met these objectives in two ways: a) a review of the relevant literature on a specific segment of the population, i.e. the vulnerable elderly, and on task-centered therapy

b) completing the practicum in a setting that supported social work practice with the vulnerable aged client, specifically within the Department of Health in Portage la Prairie, Manitoba.

The term "client" has been used to define someone who has accepted an offer of help with their "problems of living".

In presenting the following information, the student hoped to help the reader to understand some aspects of the aging process. The student attempted to provide a perspective from which to view and identify specific hazards and deficiencies in the lives of the elderly. It is these hazards which make them vulnerable as a group and for approximately twenty percent may create imminent and severe danger.

Chapter I

Perspectives on Aging

A. Does Aging mean Impairment

Erickson (1959) comments that aging is not a disease, but rather a final stage of the normal life cycle, yet many studies suggest that anxiety and depression reach their highest prevalence in old age, and that the somatic manifestations of anxiety become more pronounced with age (Sallis and Lichstein, 1982, p. 207). It is these somatic manifestations of anxiety and depression that increase the level of impairment in the aged population to a greater extent than "age" alone.

In looking at the extent of impairment of the aged, Harel et el (1982) point out that approximately twenty percent of the aged are impaired to some extent with regard to their mobility and functional competence. Causative factors of impairment can be linked in some cases to depressive reactions and in some cases to societal reactions (Pfeiffer and Busse 1973, p. 117). Elderly people are twice as likely to become hospitalized for most mental and health conditons as are younger individuals. (Source book on Aging 1977)

If only twenty percent of the aged are impaired, then eighty percent have aged relatively successfully. To age successfully

means the elderly person has found ways to adapt, using what they have attained in a life time of learning, conserving their strength and applying their resources appropriately, while adjusting creatively to changes and losses (Butler, 1975, p. 2)

Gerontological literature (Harel et el, 1982 Busse and Blazer, 1980) indicate that successful aging includes good physical health, sufficient resources and adequate mental health. Good physical health and sufficient resources are being continously evaluated in today's society the focus for this practicum will be to look at ways to enhance adequate mental health conditions through the use of a task-centered approach (Reid W. J. and Epstein L., 1977).

In looking at the extent of impairment in Manitoba, Havens (1982) points out that there are approximately 120,000 elderly i.e. those over 65 years of age who maintain themselves in reasonable health, i.e. they are able to manage independently with only minimal intervention. She also states that approximately 100,000 of these elderly lead a meaningful and comfortable life, with only six percent of these requiring institutional care and only fourteen percent using health and social services to a greater degree than the rest of the population. The focus of this practicum will evolve around the needs of this twenty percent who may be having difficulties adapting to the many changes and adjustments they are forced to make.

Germain (1973) states the elderly are a people who suffer

from a disturbance in adaptation to a rapidly changing environment. They are undergoing biological, psychological and social changes (Vigoda et el, (1980) which have to be accomodated and adjusted to, changes which incur multiple losses and problems which are not solely related to aging and may be societal in nature.

Today's society, which is increasingly more mobile and undergoing continous change, tends to impose excessive demands on the aged. These are demands which many are unprepared or incapable of meeting. (Minter, 1980 Bergston, 1973 Abrahams & Patterson, 1978-79)

Kral (1973) suggests that there are two main reasons for this:
(1) a lack of adaptability and (2) an aged linked decline in stress resistance. He states that these two factors create a diminished capacity for rapid and adequate adjustment to stress, anxiety and disease as well as to role change, loss and the changes in mental functioning that aged individuals are frequently exposed to.

Sallis and Lichstein (1982) suggest that what exists within the elderly population is a reciprocal model where physical disease interacts with the anxiety process and the two reinforce one another, i.e. physical disease leads to increased anxiety and the increased anxiety leads to further deterioration in the disease process. This reciprocal interaction, combined with the elderly's diminished capacity to withstand stress, and

their poor adaptation qualities causes seemingly manageable problems to overwhelm them.

They soon find themselves becoming incapacitated, and in need of external assistance. (Williams, 1970 Soul, 1974)

B. Multiple Losses

Many theorists in the field of aging (Kral, 1973 Butler, 1964 Walker, 1981) look at the process of multiple losses in the aging process and the frequency and degree of change and loss which occur as one of the fundamental processes within the cycle of aging which leads to deterioration. Significant losses become a constant and steadfast companion to the elderly (Ford, 1965), i.e. death of friends, sibling, extended kin. It is interesting to note that every one of the clients seen within this practicum had one form of significant loss or another. Butler (1973, p. 29) states that losses occur in almost every aspect of later life, forcing the elderly to expend enormous amounts of physical energy in both the grieving process, and in attempting to resolve this grief - energy which is quickly depleted.

The elderly are compelled to cope with their own waning physical capacities, losses increase stress, anxiety and disease, the loss of roles, i.e. husband, brother, friend, accompanying these circumstances and the decrease of their ability to deal with these changes. Walker (1981) comments that those elderly

who become laden with these stressful situations, i.e. losses, are more likely to experience a high degree of emotional illness, i.e. depression, chronic anxiety, aggitation, etc. Butler (1974, p. 31) comments that losses alter not only the elderly's living circumstances, but requires a series of adaptations which may lead to stressful life situations, i.e. living alone, isolation, illness, etc., thus putting the elderly "at risk" of further breakdown. (W.H.O., 1974. p 10)

C. Age as a Determinant of Deterioration

Alex Comfort (1976) estimates that only twenty-five percent of age related deterioration are accounted for by physical aging. The other seventy-five percent is accounted for by "sociogenic" aging, i.e. our folk-lore, myths, prejudices, and our misconceptions about age which are still imposed on the old.

Kral (1973) suggests that health status, income, marital status and environmental stress, i.e. societal attitudes, etc., increase the stress level of an elderly population even more than their chronological age. Chronological age, although an important determinant, does not seem to be a large factor in the process of becoming vulnerable. Biological age, on the other hand, may play a more important role. Based on comprehensive measurements in a well defined population, biological age was demonstrated to be associated with life style, health and possible genetic endowment. (Special Report on Aging, 1980,

p. 12) Dr. Borkan in the Special Report on Aging (1980) states that individuals in poor physical or mental health, fat or less active tended to be biologically older than their chronological years.

Therefore, chronological age alone does not connote disability. Many of the problems found in the vulnerable elderly population are not necessarily age related.

It is important to note that even though there is an age related decline in most of the organ's systems (W.H.O., 1974, p. 11), two precipitating factors must be remembered when dealing with an elderly population. First, physiological functioning for most of the organ systems does not drop off suddenly. This functioning gradually declines over a period of years. There is no specific chronological age where organ systems cease to function. (Population Aging, 1982, p. 39). Secondly, there are considerable inter-individual variations in the rate of this decline, (Population Aging, 1982, p. 39) i.e. the rates of decline in organ functioning vary with each individual, this means that there is no one magical year when one becomes old and body organs cease to function due to age. Aging and the process of becoming old and vulnerable is a slow variable function unique to each individual person, and not necessarily chronologically related.

Harel et el (1982) suggests that the oldest person with poorest mental health status may be in that state not so much because of increasing age, but because of declining health and

functional status, reduced and inadequate financial resources and to a considerable extent absence of adequate social supports and satisfactory social relationships. "Social Supports" are defined as information which leads the person to believe that he is cared for, esteemed and a member of the network of mutual obligation. (Cobb, 1976, p. 301) Harel et el's findings imply that if an elderly clients ability to improve upon their social support network and social relationship network were enhanced, their mental state may be improved. The student feels that with the implementation of a task centered approach, the skills needed to improve these functions can be taught. This would lead to immediate and long term ramifications. Initially it would help the client through relationship skill development allowing for an immediate increase in support and relationship networks. Secondly, through the development of increased coping skills it would allow for "future" problem solving behaviors to occur.

These factors have important implications for both the client and therapist. They change the focus of the problem from an unchangeable unworkable factor, "age" to one which is able to be measurably changed via a new learning experience i.e. the ability to gain skills in developing relationship and support networks.

D. Problems Which Occur

Many of the problems which occur amongst the elderly, i.e. adjustments to health status, depression, anxiety, aggitation, as well as stress related problems such as alcohol and drug abuse, (see page 9 "Problems in Living') can be considered problems in coping or "problems in living". "Problems in living" may occur irrespective of age. (Fales et el, 1979)

"Problems in living" are seen as trans-generational problems which may occur at any time, but within the aged population occur at a time when the elderly are least likely to be able to cope successfully, to adjust adequately, or to adapt effectively to quickly changing circumstances. (Kral, 1973) This may result in an increased state of vulnerablilty vulnerability being described as being a state where the client is seen as someone who is capable of being wounded or susceptible to injury. Thus the vulnerable person is one for whom loss or damage is possible. (Breakley, 1982)

E. Use of A Task-Centered Approach With the Aged

Reid (1977, p. 1) states that task-centered treatment is a short term model of social work practice, designed to alleviate specific problems of individuals and families. He states that this model grew out of experimentation with methods of planned brief treatment (Reid and Shayne, 1969) and from intervention

strategies organized around helping clients define and complete courses of action or tasks (Stydt, 1968). It as well drew upon Perlman's (1957, 1970) formulation of social treatment as a problem solving process.

The task-centered approach has been used in education in Gerontology (Fortune and Rathbone, McCuan, 1981) and in working with isolated elderly people to help them begin to resocialize (Rathbone-McCuan and Hashimi, 1982). It has been used successfully in cases where abuse and maltreatment of the elderly has occurred (Rathbone-McCuan et el, 1981) and with the elderly who suffer from organic syndromes (Korber, 1983). The student feels that the task-centered model itself works well with elderly clients, although some modifications are suggested similar to those suggested for children (Fortune, 1979), for example "familiarizing" techniques to enhance relationship, trust, etc., breaking down the incremental tasks into small behavioral steps and increased involvement of the practitioner in formulating and constructing tasks - all of which increase the probability of a successful resolution of the goal statements.

One of the reasons task-centered therapy is appropriate in working with an elderly clientele is because during the evaluative stages a clear definition of the intervention makes it possible to distinguish positive progress, i.e. when an action (task) is challenging the problem and when it is not.

CHAPTER 2

Aging and the Vulnerable Elderly

A. Aging and the Aging Process

> "Aging is a biological process, determined by our genes. Growing old is a social process determined by the attitudes, expectations and traditions of society." (Brearley et el, 1982, p.26)

Cormigan (1980) states that in reviewing the literature during the five year period, 1970 through 1974, social workers have evolved in their views of the elderly and the aging process from an essentially negative view of aging, i.e. aging is always (only) a process of loss and deterioration, to a more positive view, eventually settling into a neutral position which states aging itself, is neither negative nor positive but is a neutral process which effects individuals in a unique and individualistic way according to their personalities and physical health.

Friedmann (1960) comments that what is expected of the old is not based on individual ability alone, but on societal expectations and what society has defined as age appropriate behavior. Society views age appropriate behavior as 1) a time of general decline encompassing a deterioration of intellectual ability, and 2) a time of negative changes in personality.

(Tibbits, 1979 Tuckman and Lorge, 1952 Slater and Slater, 1976) Both these myths, deterioration of intellectual ability and negative changes in personality, have been disspelled. Research findings indicate that intelligence continues to increase into adulthood and that negative changes in personality are not indicative of the normal aging process. (Schaie-Labourie, Vief, 1974)

In dealing with concepts of "aging" and the "aged" it is important to look at chronological, biological, societal and psychological concepts in order to establish an operational view of what "Aged" really means.

1. Operational Definition of "Aged"

For the purpose of this practicum, the term "elderly" will be interchangeable with the following terms "old" and "aged". The term "aging" has several meanings.As a biological term it is used to identify inherent biological changes. These changes take place over time and end in death.

The concept of "aged" and what it entails has been changing and evolving throughout the centuries. The average life span, according to Kirchner (1979, p. 10) has increased from eighteen in the days of ancient Greece, to thirty-three in the year 1600, forty-two during the civil war period, and forty-seven in the 1900's. Presently the average life span is 73. (W.H.O) Mann (1980) comments on present day predictions "that within

a few years it may be feasible to survive to the age of one hundred and twenty." Old age therefore is a subjective and a relative (relative to life span) concept.

This type of subjectivity is seen in the literature on Aging. Seltzer (1975) found in an analysis of forty-two professionally published articles dealing with gerontology, operational definitions of "old" varied widely from over 59, 59-90, 62-86, 68-87. For the purpose of this practicum, those 65 and over are considered "elderly" or "aged." The selection of this age (Comfort, 1979) as a point of demarcation between middle age and those considered to be elderly, is an arbitrary decision borrowed from social legislation used in Germany in the 1880's under Barron Von Bismark.

Age 65 in present day society has also been used to gain eligibility for pensions and social security programs, i.e. C.P.P., eye-glass programs, etc. (Blau, 1973 Cormican, 1980 Eckman, 1973) The age 65 as a cut off point, is used for the practical purposes of giving a reference point within this practicum.

The literature on aging makes it clear that no one chronological year separates the concept of "being young" from that of "being old," but rather aging is seen as a developmental process occurring during the passage of time. (Neugarten, 1973 Eusdorfer and Lawton, 1973 Weinberg, 1976)

"Being old" may be defined not by chronological or biological age alone, but rather by occurrences and specific life events

such as retirement, grandparenthood, etc. (Fales et el, 1980) Aging represents a pattern of changes and adaptations occurring within the body's structure and function. (Fales et el, 1980 Haynes, 1980) Birren et al (1974) defines aging as specific changes which occur behaviorally as well as other characteristics which occur due to an intrinsic biological code which is time related and cannot be reversed. The term "aging" connotes biological changes, i.e. wrinkles, loss of hair, eye sight, stamina, which are inherent and occur over a period of time. (Vigoda, et el, 1980)

Age differences that are a result of specific and/or accumulated life experiences or from environmental events including the accumulated effects of both injury and disease cannot be ascribed to aging. (Schaie, 1977 Maddox and Wiley, 1976) Because of this, the aged themselves have been separated into two distinct subgroups - the well elderly and the frail or vulnerable elderly. The student herein will be dealing with the frail or vulnerable client who is proceeding through the aging process.

2. The Aging Process

Is aging normal? Normal is a word with several meanings, i.e. conforming to a usual or typical pattern. (American Heritage, Oct. 1970) Normal when used in systematic studies of a population is a standard for comparison of deviations, the standard being based on a set of observations that can be

measured and the average or the median determined. A normal individual is often the one who is considered to be relatively free of disease and disability and whose life expectancy is not reduced by the presence of serious pathology. A normal individual is one who usually has the capacity, and the ability, to meet his basic human needs and to solve "problems of living" in a manner acceptable to himself and to society. Therefore, an individual who successfully is free of disability can be considered a normal individual.

Busse and Blazer (1980, p. 4) suggest that for operational purposes declines in functioning can be separated into primary aging (senescence) and secondary aging (senility). Primary aging is a biological (internal factors) process whose first cause is apparently rooted in heredity. This inborn first cause of aging produces inevitable detrimental changes that are time-related but are etiologically relatively independent of stress, trauma, or acquired disease. Secondary aging refers to defects and disabilities, whose primary cause comes from hostile factors in the environment (external factors), particularly trauma and disease. Included within this are factors such as grief, loneliness, social isolation and feelings of uselessness. (Guttman, 1978 Busse and Blazer, 1980 Hayness, 1980)

What appears to affect aging and the aging process is the persons psycho-social adjustments to these internal and external factors. The internal factors being ill health and mental status and the external factors are availability of environ-

mental supports, i.e. family, friends, or the excess of environmental stressors, poor nutrition and inadequate resources. (Population Aging, 1982 Fales et el, 1981)

Bloom and Neilsen (1971) suggest that while physiological decline with age is usually inevitable, the psychological reaction and decline may occur but is not inevitable and in fact may be deferred. By using a task-centered approach the student helped the vulnerable elderly client adjust to and deal successfully with these hostile factors i.e. grief, loneliness, social isolation, etc.

B. The Vulnerable Elderly: Who They Are

Burnside (1981, p. 243) describes the vulnerable aged as those elderly past the age of 65 who have throughout their lifespan accumulated multiple disabilities and/or chronic illnesses. These changes combined with aged physiology, that is the decreased ability of all major organ systems to respond to stress and maintain homeostasis, increase their risk level of both physiological and psychological debilitation.

Kutorski (1977) states the vulnerable aged individual is one who incurs multiple life needs combined with a reduced coping capacity. Their needs relate to basic survival needs with both health related problems and lack of social supports.

Therefore the vulnerable elderly person can be seen as someone for whom loss or damage is a possibility. Within this

population range there are two elements to consider: 1) they are statistically more likely than younger people to experience certain inevitable losses, i.e. death of a spouse, extended kin or significant other (Bearley, 1982), and 2) they are less well equipped for social and biological reasons to adapt readily to loss and change. (Butler et el, 1963 Ford, 1965 Kral, 1973 Minter, 1980)

The elderly as a group are disproportionally vulnerable to medical and emotional problems. They are poor at assessing their own needs and at finding resources that can offer help, partly because of a lack of resources and partly due to their fear, reluctance or incapacity to seek them out. (Sadaway, 1983)

The elderly may be considered within two perspectives, both of which leave them open to increased vulnerability: 1) as a mentally competent well functioning individual who is susceptible to a wide variety of disorders such as those that may effect any segment of the population, or 2) someone who is susceptible to disorders that are more age specific such as those that lead to inability to make competent decisions and that interfere with behavior, thought process and activity. These disorders can be broadly classified as acute and generally short lived, or insidious and usually chronic.

C. Variables Elliciting Vulnerability

Gerontological literature (Harel et el, 1982 Busse and Butler, 1980 Sherman, 1979 Lowental et el, 1975 Abrahams & Patterson, 1978-79) indicate that successful aging includes good physical health, sufficient resources and adequate mental health. Without these three factors the aged are placed in a vulnerable state.

As people age, a normal increase in dependencies through maturation occurs. Poor health and an increase in chronic illnesses lead to physical impairment, loss, multiple losses and accumulated losses as well as a breakdown in social supports which may lead to psychological impairment. Children moving from the home, removal of responsibilities i.e. retirement, decreases the possibilities of the elderly to achieve a sense of self-esteem and self-purpose in life.

Without continued nurturing, and supplements to the amounts of responsibility, a sense of self worth, perceived meaningful and purposeful direction in ones life, neuroses, depressions, and behavioral disorders such as anxiety and paranoid states are more likely to be precipitated, (Botwinick, 1973 Cavin, 1949) leaving the elderly in a vulnerable state and in need of intervention.

Abrahams and Patterson (1978-79) found that vulnerability to stressors of aging, i.e chronic illness, accumulated losses, etc., seemed to increase where there had been: 1) a habitual

pattern of dependency, 2) underdeveloped interpersonal skills and, 3) a lack of social initiatives. They found in their study group of elderly clients, 46% were reluctant to use human service facilities, i.e. counselling, health care resources, etc. They postulated that this was caused by apathy, lack of involvement in self and future, and an intense desire to maintain feelings of self reliance and a state of independence. Of the 20 clients referred, 25% refused any form of intervention for the above named reasons.

Other contributory factors Abrahams and Patterson found that places segments of the elderly population at increased vulnerability were poor educational background, physical impairment and being unable to develop relationships beyond the household, nearly 90% of the clients referred fell into this category.

They commented that feelings of loss were strongly associated with psychological impairment, i.e. depression, anxiety, forgetfulness and confusion, and that people tended to experience loss and a accumulation of losses as they proceeded through the aging process, i.e. sensory loss, loss of significant others, chronic illnesses, leading to loss of roles, i.e. sexual partner, mate, head of household, etc., self esteem and functioning ability. All of the clients referred had suffered one or more of the above losses.

They also questioned whether the number of losses alone determined the likelihood of the development of a psychological impairment. Abrahams and Patterson felt that if this were the

case there should be a strong correlation between psychological impairment and advanced age. Their study disproved this. What they did find was that the elderly who were defined as psychologically healthy were those who could take social initiatives beyond the household, i.e. build new relationships outside the family. It was these elderly who had a higher capacity to cope with losses through finding adequate substitutions for their losses.

Sherman (1979, p. 43) suggests that those who have aged successfully attributed different meanings to the inevitable physical detrements and other development events of aging. They viewed the losses as unfortunate but not catastrophic and found alternative ways of coping with them, developing a more philosophical view of such losses within their total life span perspective. Those who were unsuccessful saw these losses as catastrophic, debilitating and often unfair.

Lowenthal et el (1975) in studying stress related symptoms during four transitional stages of the life cycle, has shown that people with a very stressful life pattern show divergent paths, they may either become challenged or overwhelmed by their stresses. He commented that close personal relationships, i.e. social support, or the absence of same, distinguish those elderly who are challenged by impending stressors from those who become overwhelmed by them. He found in his study that relationship losses in aging, i.e. loss of significant others, siblings or mate, were less psychologically damaging for those elderly

whose previous life style showed the ability to show social initiative. (Abrahams & Patterson, 1978-79). It was this ability to develop interpersonal skills that allowed the elderly to be able to make a satisfactory substitution for role loss and relationship loss. According to Neugarten (1977) these personality traits are the most powerful predictors of the individuals adaptability or coping ability. Therefore having social support, or the absence of same, distinguish those elderly who are challenged from those who became overwhelmed. The student feels that the task-centered approach used in this practicum, provided the elderly client with a constructive problem solving experience and enhanced their ability to problem-solve in the future, i.e. helped them develop the ability to seek out and secure both social supports and relationships if this was needed. This would enhance and develop their own coping skills. This in turn would lead to a sense of control over self and improved self-esteem.

There seemed to be a direct relationship between psychological impairment and level of social participation and activity. The correlation being, the less social participation and activity the more psychological impairment. This is not true in all cases, i.e. the life long isolate. (Lowenthal, 1975) When looking at the factors which create psychological impairment, Abrahams found that the three major factors were: 1) relational loss, 2) chronic illness, and 3) retirement.

In order to deal with these stresses, Abrahams states that

the fit between internal resources and external stressors is a crucial factor in gauging the individual's adjustments. He comments that many elderly have developed internal coping resources which have enabled them to lead a meaningful, purposeful and healthy existance in spite of the severe stresses impinging upon them. Other elderly become overwhelmed by their physical handicaps, becoming both distressed and physically ill, i.e. through the inability to call upon their internal resources when faced with a high rate of external stressors.

It is important to note here that Abrahams comments that psychological distress in old age is three times more likely for those who reported a past history of psychopathology, indicating the accumulating disadvantageous effects of continued dependency and poor coping abilities throughout the life cycle.

Therefore the factors which illicit vulnerability are poor health, i.e. physical or mental impairment poor educational background lack of ability or opportunity to be nurtured or nurture, i.e inability to develop relationships or underdeveloped interpersonal skills poor self worth apathy, i.e. lack of involvement or lack of social initiatives habitual pattern of dependency or the excessive need to remain independent and self reliant. This excessive need to remain independent may cause a reluctance to seek out needed help.

In a study conducted by Rosen and Rosen (1982) they state that there is a reluctance amongst the elderly to approach mental health facilities or to ask for assistance in coping with

problems of living, because of the negative stereotype of mental hospitals, professionals, and mental illness itself, within the elderly subsystem they found there was a reluctance to use formal or informal support systems. Rosen states that this may indeed prove to be a barrier in gaining access to the vulnerable elderly client. This reluctance to seek help is seen as a factor in increasing the elderly persons vulnerability, and something that must be dealt with within the therapeutic approach.

The ability to be able to "neutralize" negative emotions is needed, this can be accomplished by eliciting and clarifying the apprehension, rationally analysing it and modelling and rehearsing the behavior required to successfully implement the task. This is accomplished through the use of the "Task Implementation Sequence" found in the task-centered approach. (see p. 65 this practicum)

In developing strategies to remove barriers the therapist must consider 1) the nature of the barrier, and 2) the personality of the client. Some barriers to be considered are lack of commitment, defeciencies in social skills, reactions to therapy, misconceptions and irrational fears.

There are as well psychological barriers to the provision of care which both limit the therapist's desire to be involved as well as the elderly client's desire to be involved.

D. Barriers to Providing and Receiving Care

There are a number of psychological barriers, each of which work to limit the therapist's desire to be involved in providing therapeutic services to the elderly and to the clinical effectiveness in the therapeutic setting. They are explained by Hadgebak and Hadgebak (1980, p. 266) as

- The "Can't Teach An Old Dog" Syndrome in which the therapist has the attitude that a lifetime of learning one set of behaviors can not be overcome, or only with the greatest difficulty. Their learned behaviors work to handicap the elderly patient in coping with the pressures of modern life.
- The "My God, I'm Mortal Too" Syndrome in which the therapist comes face-to-face with the unpleasant realities of his own morality and effects of the aging process in his own life, fearing or resenting this forced personal awareness, shuns close personal relationships.
- The "Why Bother" Syndrome where the therapist sees little value in working with persons who have relatively short life-expectancy seeing the elderly as having little potential to become productive members of society in the conventional sense.
- The "I'm the Child" Syndrome where a role reversal occurs in therapy due to the differences in age between "helper" and "helpee". The therapist's response to the elderly patient is as though to a parent. It is difficult to help a parent in therapy, or to be a parent to your therapist.

- The "Patient is a Child" Syndrome where the therapist holds that older people are "just like children" and treats the elderly in that manner, failing to recognize that while dependency needs may be similar , the lifetime of experience and accumulated knowledge of the elderly client make this an incorrect analogy.
- The "Senility Is Natural" Syndrome where the therapist believes that virtually all of us become senile as we grow older, and that forgetfulness is a natural part of the aging process. As a result, many organic problems which might be successfully treated are not and therapy becomes useless.

The first hurdle to be overcome, obviously, is to recognize that the older person is a person who happened to grow old. The "personhood" has not changed. The older person does not present a set of basic needs or desires different from those of other younger clients. Many of the psychological barriers to effectively serving the elderly can be resolved via expanded knowledge, understanding basic aspects of the aging process, and using this knowledge within the therapeutic process to more realistically identify those behaviors which give evidence of the need for professional care. (Hadgebak and Hadgebak, 1980)

A further hurdle to be overcome by the therapist requires some introspection. How does the therapist view his or her own mortality? What mechanisms are at work to cause the therapist to relate as parent or as child in the therapeutic relationship? Self-understanding is as much a key to successful service delivery for the elderly as is the more academic knowledge of

the aging process.

Like the clinician, elderly persons are faced with a number psychological barriers influencing their desire to participate in therapy and which work to limit the effectiveness of the therapeutic process. Hadgebak and Hadgebak (1980, p. 267) suggest they include:

- The "Senility is Natural" Syndrome - the elderly person believes that virtually everyone becomes senile as they grow older, a common attitudinal barrier held by the therapist as well. It works to block the elderly person from seeking services which might identify conditions of a physical or psychological nature that may have an excellent prognosis for successful treatment.
- The "Who/Why Am I?" Syndrome - the elderly person has lost most meaningful life roles - work roles, parenthood roles, marital roles. Without these roles to hang the self-concept on, with no role except "me", the elderly person may experience such reduced feelings of self worth that no effort is exerted to seek help.
- The "Do For Yourself" - the elderly person adopts a fiercely independent stance, particularly with regard to the services provided by public agencies. Public service is equated with "welfare" and is rejected.
- The "I'm Distrustful and Afraid" Syndrome - the elderly client holds an image of mental health services accurate enough a generation ago, but hardly in keeping with the active deinstitutionalized programs available today.

- The "Doing What's Expected" Syndrome - some elderly clients may very well display behaviors in therapy which reinforce the role of child or parent played by the therapist, or support stereotypes held by the public. It's as if the client were saying "I'm getting old, and old age is depressing, therefore I'm depressed." or "You want me to be this way, therefore I am this way."

These barriers exist because the elderly person is unaware of the realities of the aging process. Some arise because the elderly person is unaware of the nature and conditions under which community based mental health services are offered. Most notably the psychological barriers of poor self-concept motivated by loss of productive societal roles, and barriers created when the elderly act out what they see as societal expectations, can be best dealt with in the therapeutic setting itself. This can be undertaken by developing tasks to begin to break down the psychological barriers and help the elderly person develop new productive societal roles such as volunteer, church member, etc.

E. Dealing with these Barriers Using a Task-Centered Approach

These barriers affect both the elderly person's desire to use community services and the effectiveness of services offered. They are unlikely to be resolved by the elderly acting alone. The therapist - and the entire community mental health program - must assume responsibility for providing the type of indirect and

direct services which can overcome these barriers. A program of re-education and re-evaluation of needs must be undertaken. This can be undertaken by the development of self help groups, senior centres, courses geared for the elderly about the elderly and a community based information program, i.e. radio, T.V., pamphlets, etc.

The task-centered approach is a functional approach that dissipates many of the barriers. This therapy is short-term and time limited. It breaks down the goals into manageable tasks and successes can be seen immediately. This helps the client and the worker in dispelling such myths as "too old to learn anything new." This therapy is also structured to allow the client to "do for himself" with support and encouragement from the worker. This helps the client maintain their sense of independence.

With the use of the Task Implementation sequence found in the task-centered approach (see p. 65 this practicum) many of the psychological barriers are removed as part of the implementation of the therapy. This in itself leads to a higher success ratio.

CHAPTER 3

Application of the Treatment Model

This chapter presents the internal workings of the practicum, explaining the setting, personal, and the provisions made for intake, supervision and termination of the cases. Also included is a brief description of the application of the task-centered approach to the clients found in the practicum.

A. Practicum Setting

1. Setting

The setting for this practicum was the Department of Health and Community Services, Portage la Prairie, Manitoba. This head office serves the central region with a population of approximately 12,143 elderly. (Populalation of Manitoba by Health Region, June 1, 1983)

In the office are situated most of the government services being provided to the community, i.e. Public Health, Mental Health, Probation, etc.

2. Personnel

The student worked under the supervision of Peter Klassen,

M.S.W., and received referrals from local physicians, the Portage General Hospital and the Continuing Care Program in MacGregor, Man. Referrals for this practicum were reviewed by Mr. Klassen and discussed with the student prior to implementation of the intervention. Intake procedure consisted of discussing the concern of the client, the appropriateness of the referral and the utilization of the program as set out in this practicum.

Because the student was working with the Department of Health as a Continuing Care Case Coordinator, special perameters were built into this proposal to ensure that the practicum was separate and apart from his daily employment. This was accomplished by using an intake system to separate Home Care eligibility vs practicum eligibility. Those clients that were accepted for work within this practicum were separated from those clients who had been accepted on the Home Care Program, i.e. they were not in initial need of direct Home Care services as an intervention process, but rather they were seen as being appropriate for task-centered intervention. This was ensured through supervision procedure.

3. Supervision

Supervision of the student was done jointly by Peter Klassen as an immediate supervisor, and by Prof. Don Fuchs, Chairman of the Practicum Committee. Supervision consisted of: a) Intake

meeting with Mr. Klassen , looking at the appropriateness of tne referrals b) Evaluation of the content recording, file recording, via tne tapes, etc. by Prof. Don Fuchs. Evaluation goals were the development of skills in a task-centered treatment program as explained on pages 300-304 by Epstein, 1977 (see Appendix A) c) Progress of the client as to goal attainment and problem resolution d) Evaluation of tne practicum as a whole. Evaluation of the practicum consisted of a review of work being done and presented, review of client progress, and the evaluation within the practicum by Prof. Don Fuchs, Prof. Walter Driedger, and Peter Klasen. These reviews occurred approximately three times throughout the practicum, during the initial, middle and end phases.

4. Recording

The recording process included the use of a tape recorder for content recording as well as the use of a problem assessment schedule, a task review schedule, client questionnarie, and tne closing interview schedule found in Epstein (1978, p. 286-293) (see Appendix B)

5. Procedures for Referral Intake

Referrals from the community were directed to the Department of Health and Community Services, and an intake procedure was

undertaken. The referral was assessed for its appropriateness and an initial appointment was set up to see the client either at the office or in his own home.

The initial and subsequent interviews were taped for later review and evaluation. Referrals were accepted from both the City of Portage la Prairie and the town of MacGregor, Man.

6. Procedure for Termination of Case

Termination of a client occurred for the following reasons:

1. problem resolved (criteria met)
2. inappropriate referral (no problem)
3. client cannot set goals
4. client will not set goals
5. insufficient progress (plateau)
6. transferred out
7. client moved or died
8. services refused by client

Termination occurred as part of the closing out procedure and will be seen as an integral part of case work procedure.

7. Description of the Applications of Task-Centered Approach to Practicum Clients

Over a three month period, a total of twenty clients were referred. From March 1984 to May 1984, thirteen clients met the criteria, i.e. aged, vulnerable and wished to work on their problem. Seven clients did not meet the criteria. One was admitted to a personal care home due to need for 24 hour care, one was transferred onto the Home Care Program and work began under that program, five refused service or were inappropriate for a task-centered approach (Sadway, 1983 - fear or reluctance), i.e. would not come in to receive service nor wished to have anyone come out to see them.

Of the clients who accepted help and were willing to participate using the task-centered approach three had been through recent separations either by death or spouse being placed within a personal care home, one male had been going through a separation phase that had been going on for the last five years without reaching a final termination phase. Two female clients had their spouses die suddenly and tragically many years previously, one having had a heart attack at the dinner table while having supper with his wife and children, the second having drowned leaving his wife and three children under the age of five. Another client had been through multiple losses, i.e. her daughter had recently suffered a stroke, she had lost her husband, a son had died in a fire and a second had been diagnosed as suffering from lukemia.

Two other clients, one male and one female, had recently undergone below the knee leg amputations due to diabetic complications. The other five clients had suffered multiple losses of one kind or another.

Many of these clients, were suffering from the absence of adequate social supports and satisfactory social relationships. (Harel et el, 1982) All the above mentioned clients were suffering from "problems in living" which had occurred irrespective of their ages. (Fales et el 1979) All had suffered losses that had altered their living circumstances and had required a series of adaptations. Many had problems with adapting, this led them into stressful living situations. (Butler 1974, p. 31) All of these clients were considered to be at risk of further breakdown and in need of intervention.

The following section will provide an in depth description of the framework and intervention commonly carried out in this approach.

The Application of the Task-Centered Approach

Meyer (1970) comments that the primary aim of social work practice is to enable people to command their own lives and destinies to the greatest extent possible, in light of the isolating technology, specialized and hopelessly complex world in which we live in the twentieth century.

The student has chosen as a method of intervention, task-centered therapy. (Reid, W. J. and Epstein, L., 1972, 1977) This is a short term intensive treatment in which the client and student agree on all the problems which exist for the client. The worker makes certain that the problem for work is one which the client acknowledges as the one which has highest priority.

Bilinsky and Reid (1980) comment that in task-centered practice, unlike some models, it is assumed that a direct attack on a problem is the most effective way to modify it. A hypothesis underlying the use of this model is that "Task-centered social work, like many other short-term treatment models, assumes that the degree of concentration on a problem is positively related to change." They state that any model of treatment can be viewed as a list of behavioral rules outlining appropriate client and worker conduct. Typically, they include some delineation of 1) the kind of issues to be included in and excluded from the therapy process and 2) a description of the steps the participants are to take if the issues are to be resolved.

The student uses these rules, usually in an individually modified form, as a guide to behavior with clients. Similarly, clients attend with their own ideas about the proper course of treatment these often differ from the expectations of the therapist. If constructive change is to take place, large discrepancies in expectations and attendant behaviors should be resolved rapidly. The client and practioner share with each other role expectations. This role induction does not end once major differences are resolved. Socialization is renewed with each interview, and differences between client and therapist are resolved during each session if treatment is to be useful to the client. The practitioner's ability to maintain focus in the session on an agreed-on topic is an indication of successful socialization of the client, which, in turn, becomes a predictor of outcome.

Bilinski and Reid state that the findings support a principal hypothesis underlying the task-centered model - that the amount of focus on target problems is related to the degree of change in those problems. Secondly, the results are in accord with the theories of Haley Watzlawick, Beavin, and Jackson and Lennard and Bernstein - that the client must be socialized or inducted into the client role if treatment is to be successful. (Watzlawick, et el, 1967)

This system of intervention consists of: 1) a model of brief time limited case work, i.e. Mr. J., we are going to work on this problem for the next three months and then we will re-evaluate

the whole process 2) an underlying practice theory, i.e. problem focus and change in a brief treatment model 3) a set of value premises, i.e.the client is capable and responsible for the Ocknowledged problems he is having and 4) a body of empirical data supporting the theory and the model. (Reid and Epstein, 1972 and 1977)

In task-centered case work, tasks can be considered as goals which are set out by the client. These goals can then be worked on, by contracting with the student. Within this system there are two basic value premises which are vital to the intervention process. The first of these premises states the primacy of the client's expressed considered request, i.e. the basic premise that the practitioner deals with what the "client says" they wish to have changed versus what the "practitioner's view" is of what he tninks the client's wishes are. Secondly, there is a solid background of research based knowledge as opposed to knowledge which has been accumulated through other sources such as practice wisdom, practitioner's insight, and untested theory. The background of research knowledge gives this form of therapy a framework, direction and a rationale for the expected behaviors that make up this model. It sets out the essential functions of a task-centered approach. The force for change is the client's own initiative and motivation to alleviate his own distress.

The skills which the client learned/relearned are generalized to other problems which the client has. At termination the worker and client talk about how these new/refurbished problem

solving techniques can be applied in the other problems which need solutions.

This is a very significant departure from most other traditional intervention models. The psychoanalyst was convinced that the client had to stay in treatment until every problem was solved.

1) Overview of the Intervention Strategy

The strategy of task-centered therapy and the model for this form of therapy flows from two purposes - to help the client alleviate problems that are a concern to him, and to provide him with a constructive problem solving experience that will 1) help solve his present problem and 2) possibly enhance his abilities to problem solve in the future.

The intervention strategy was aimed at helping to alleviate the target problems. The process began during the initial interviewing phases the student helped the client through role induction. The student explained his role, expectations and the purposes of treatment. The student explained the procedures and how intervention was to proceed and repeated the explanations of the role, the purpose and procedures as needed. The student explored problem areas throughly and selectively asking questions and making observations, gathering information to learn what and how the client was doing, thinking, feeling and thus was able to make a judgement towards direction for change. Information gathering was limited to areas related to the target problems. The student obtained the necessary facts about the client's objective reality in a disciplined and empathetic way.

The student helped the client identify specific problems that arose from their unrealized wants, those that could be defined in terms of a specific condition or conditions that could be changed to alleviate these unrealized wants. The student then went on to

"contract setting." Such things as "target problems", the goals of the therapy, and the nature and duration of service were explicitly stated and agreed upon prior to intervention beginning. It is this format of analysis of the problem areas that leads to the consideration of the type and kind of action or actions that are needed to begin to solve the stated target problems.

Change begins to occur through problem solving behavior. Actions or tasks which have been undertaken by the client, though they may be developed and undertaken within the therapeutic setting, should be transferable to the client's real world, i.e. a client who has a problem making phone calls and has practiced making phone calls to a second party (the student) using role play, should be able to have this behavior transcend the therapy session and use the skills gained in making an actual call.

In this practicum the student helped the clients select tasks which facilitated the realization of his wants, i.e. tasks were specified, assisted the client in planning and task implementation, helped the client through motivation, encouragement and an educational process to carry out the goal plan. The student used therapeutic interventions such as role play and relaxation within the contractual relationship to bring the client a goal achievement, i.e. if a client was having a difficult time reaching a goal, role play was used to give him a sense or experience of what it would be like to actually attempt to reach the goal. Relaxation procedures were used to help alleviate anxieties when

the client was attempting an objective he found particularly anxiety producing. These procedures were linked as enhancers to help reach achievement of a stated task.

Reid and Epstein (1977) suggests that the therapist may carry out some tasks in the client's social system to assist in facilitation of the client's set out tasks, i.e. (further client's interests). The student secured resources from the system which were unattainable to the client, i.e. allowing the client to gain information from government or a medical institution he could not otherwise be likely to gain.

The client's, as well as the student's efforts were limited to construction, implementation and review of tasks within the major goal. The task being to put the client's problem solving behaviors and abilities to work on tasks relating to presenting problems.

Another major goal of the student was to help the client take constructive action in response to setbacks and difficulties by building on the capacities of human beings to take action when needed, i.e. the fight or flight response. The task-centered approach consists of and is based on natural responses most people have in dealing with problems, i.e. by doing something about them, and not allowing them to become overwhelming. It is the responsibility of the therapist to put problem solving action to work acknowledging and respecting the inherent right of the client to manage their own affairs. It is the "action" taken in this regard that becomes part of the client problem solving

strategy for continued coping with present and future problems.

Throughout this process, there is a relationship development and enhancement going on. It is the relationship that provides the means of stimulating and promoting or activating the client into a problem solving stance (relationship development).

The strategy of the therapist calls for the actualization of these conditions within the context of a treatment relationship that is problem focused, task centered, and highly structured, i.e. the worker deals specifically with the problem of focusing in on the obstacles to achievement, then centers the task on overcoming these obstacles, structuring the process in a step by step procedure and breaking these steps down into their smallest or simplest components. Using this process the client is faced with small achievable tasks which when completed have given him a sense of accomplishment and success and when added up, he has accomplished the task or goal he has set out to achieve. This also allows the therapist to reinforce and encourage the success of the client in achieving these set out tasks.

It is during the middle phase of treatment that behavioral tasks were developed and carried out. These achieved tasks resulted in problem amelioration. It was during this time that the attention of student and client were focused on task reviews, the implementation of current tasks and exploration and removal of potential barriers to successful task completion.

2) Essential Functions of Task-Centered Therapy

Task-centered therapy deals primarily with the current rather than historic issues. Current issues are creating the problems, and attention was given to factors which could be acted upon in the present. (Task-centered therapy is reality and behaviorally oriented.)

In task-centered case work, problems are designated as target problems. A target problem is one that is potentially resolvable through the client's own action and which has been designated, acknowledged and explicitly set aside as a problem by the client. The student helped the client towards independent action, or action that the client was capable of doing on their own outside the treatment milieau, i.e. an elderly person who is having difficulty getting out of the house would be asked to attend one function outside of his home, then two, and so on. Intervention strategies such as role play, role reversal, etc., can be used to help the elderly person decrease his anxiety about doing so.

These target problems were broken down from the often global problems presented by the client, i.e. "I am a failure in life," to a reasonably clear and a behaviorally manageable problem, i.e. "now that my wife has died I'm very lonely. I don't seem to go anywhere anymore it seems that no one cares." The problems were defined in a specific and clearly spelled out set of boundaries, this meant breaking the larger problem into small workable and less contentious problems, i.e. breaking

the problem into its smallest definable units.

"Problem" is defined by Reid (1972) as a set of conditions which a client expresses a wish to change, i.e. "I'm lonely and I would like to change that." The student used this definition of a problem for the purposes of this practicum. Reid (1972) describes a client as someone who has accepted an offer to be helped with problems and concerns. The designation of a "client" for the practicum had to fit into the following three categories:

1) The client expresses his/her problem with a willingness to work on it.

2) The client must be in a position to take action to alleviate this problem with the student serving as the agent of change.

3) The problem must be defined specifically and be limited in nature.

This creates the possibility of setting up an explicit contract between the therapist and the client, and it helps the client and therapist with problem formulation and resolution.

3) Problem Formulation and Resolution

In using task-centered therapy the student attempted to understand the precipitating factors which impeded problem resolution. The student focused on what was keeping the problem active, rather than what brought it about.

Riple (1964, p. 25) comments that there are modifiable factors which are able to be found within the client's current

wants and beliefs systems, their emotions, actions, and social systems of which they are a part. Social systems are defined as a set of "individuals" that are considered relevant to the maintenance or resolution of the client's target problems. (Reid, 1972) Using these factors, i.e. social systems, wants and beliefs allows for access to the client's motivation for change, and can be used to engage the client in a change oriented behavior, i.e. becoming more socially active.

4) Framework of the Model

Within the framework of the task-centered casework model, the student used direction, encouragement and techniques to help clients increase their understanding of self and others, and their social situations, i.e. techniques such as role modeling, relaxation, role reversal, etc.

The student's diagnosis was centered around the target problem and agreed upon tasks, rather than the client's personality traits or functioning.

The primary role of the student was to serve as the agent of change, to help clients satisfy their stated needs within the limitations of their resources, skills, and the mandate of the student's agency. The student's main strategy was to help the client carry out "tasks."

5) Types of Problems Task-Centered Approach Deals With

The task-centered approach has categorized the "problems of living" into seven major groups. (Reid and Epstein, 1972) These are:

(a) Interpersonal Conflict

Problems which occur between specific individuals or within families i.e. this could be between husband and wife, mother and child, etc. and within society at large i.e. this could be between doctor and patient or between neighbours.

An example of interpersonal conflict can be seen in the case of Mr. C. Mr. C. was married and had lived with his wife over the last 55 years. In the last five years there had occurred a great deal of interpersonal conflict, leading to complete marital breakdown. Because of this conflict Mrs. C. had ceased speaking to Mr. C., had removed the elements from her kitchen stove and the fuses from the washer and dryer, forbiding Mr. C. the use of these facilities. She had changed the lock on the front door, and allowed him entrance only through the back door. Because of his wife's behavior Mr. C. had become initially angry and then depressed. (See Case Summary Mr. C.) The student helped Mr. C. with this interpersonal conflict.

(b) Dissatisfaction in Social Relationships

With this problem the client usually perceives deficiencies or excesses in his interactions with others, i.e. not assertive enough, too shy, too dependent, etc.

An example of dissatisfaction in a social relationship can be seen in the case of Family A. (See overview of cases No. 1, Table 1A, Page 72)

Mrs. A. aged 40 lived with her 70 year old husband, they had been married approximately eight years. Mrs. A. complained that she could not be assertive with her husband. She commented tnat she would give in to his every command, without concern for her own personal needs. She stated she felt too dependent on her husband and wished to be able to implement her own judgement in making decisions. The student helped Mrs. A. to become more satisfied with her social relationship.

(c) Problem With Formal Organizations

These are problems between a client and a specified other where the client may not be receiving services he/she is entitled to, i.e. hospital, personal care home, etc.

In the case of Mr. I. (See case summaries Family I, Page 85), he had been placed in a personal care home against his wishes and due to circumstances beyond his control, i.e. poor health. Mr. I's main complaint about the personal care home was the fact that

they would not allow him any freedoms, i.e. freedom to come and go as he pleased, to stay in bed, instead of getting up for breakfast, freedom to keep his bedroom door closed instead of open. Mr. I. had been in the personal care home for approximately one year. The problems increased and Mr. I. became more withdrawn and more difficult for the staff to deal with. Finally they referred Mr. I. for counselling hoping something could be done. The staff at the personal care home felt the problem belonged to Mr. I. The student helped Mr. I. come to final decision regarding his decision to stay in a peersonal care home.

(d) Difficulties in Role Performance

"Role" is one that the client has attained rather than one that has been ascribed. The client may have a problem in a social role, family role, etc. The problem may revolve around how the client executes the role and how they would prefer to execute it.

In the case of "Family I". (See case summary Family I, p. 85) Mrs. I. resided in her family home in the community. Her husband had been placed in a personal care home. Prior to placement Mrs. I. had been a very devoted wife. Now that Mr. I. had been placed in the personal care home Mrs. I. no longer felt she knew how to treat him. Mr. I's care needs were all being taken care of by the staff of the personal care home. Mrs. I. no longer knew what role to play as Mr. I's wife. She still considered herself

married to him, yet was unable to do the things she had been able to do for her busband at home. Mrs. I. was having difficulty with role performance. The student helped Mrs. I. sort out what her future role performance was to be.

(e) Problems in Social Transactions

The client may move from one social position to another, i.e. movement into a personal care home, etc., creating a problem in adjusting, due to lack of needed information or resources, creating a feeling of upset regarding the change.

In the case of Family G (See Case Summary Table 1A, Page 72) Mr. and Mrs. G. had been admitted to the hospital. Mrs. G. aged 69 suffered from terminal cancer. Mr. G. aged 73 had been left with leftsided hemiplegia due to a recent stroke. The hospital had made arrangements for seperate rooms for this couple due to their different levels of care. Mr. G. who was used to being the decision maker in the home and wanting to be close to his wife would not hear of seperate rooms. Mr. G. had moved from being independent and decision maker to the dependent role of patient, moving from one social position to another, thus creating a problem in adjusting and a great deal of upset regarding the change. The student helped Mr. and Mrs. G. in their social transactions within the hospital setting.

(f) Re-active Emotional Stress

Stress such as anxiety and depression must be viewed as reactive to a particular event or set of circumstances such as loss of limb, death, separation, etc.

An example of reactive emotional stress can be seen in the case of Mr. E. (See overview No. 5 Table 1A, Page 72) Mr. E., a 76 year old diabetic alcoholic was admitted to the hospital severe leg cramps. Upon examination it was found the veins in his lower legs had collapsed. Mr. E. was informed and a below the knee amputation performed. One day post surgery Mr. E. went into a depression denying the need for the amputation and stating the doctors had made a dreadful mistake. Mr. E. was suffering from a reactive-emotional stress. The student helped Mr. E. deal with his reactive-emotional stress.

(g) Inadequate Resources

Inadequate resources include the need for money, food, housing or a place to live which includes some care. This type of problem is only applicable if the therapist is in a position to help the client secure them through systematic effort.

An example of inadequate resources is the case of Mrs. I. (See case summaries "Family I", p. 85) Mrs. I. aged 69 was diagnosed as a cardiac cripple and thus incapable of caring for her 73 year old husband in the community. He was therefore placed

in a personal care home. Because half her finances had gone with her husband she was unable to maintain herself in the community. The student helped Mrs. I. move into a subsidized elderly persons housing unit and helped her to secure a single persons pension cheque.

6) Determining and Defining the Target Problem

In defining and determining the target problem, Reid and Epstein (1972) state there is a process of six steps to be followed. These are:

(a) The array of problems that are of concern to the client are initially elicited.

An example of eliciting problems can be seen in the case of Mr. C. (See case summaries "Mr. C.") In looking at the array of problems the student jotted down as many problems as could be elicited, compiling the following problem list,

A. Health problems 1) CHF 2) emphysema 3) loosing weight 4) not eating properly 5) not sleeping

B. Marital problems 1) communication breakdown 2) wife abusive to husband (verbally)

C. Emotional problems 1) anxious 2) depressed/withdrawn 3) frustrated 4) angry

D. Accomadation problems 1) wishes to go to personal care home 2) wishes place of his own

E. Inter-personal problems 1) wishes to seperate but

unable to take action to do so, i.e. lack of initiative to change

(b) The problems are then defined in specific behavorial terms. In the case of Mr. C. these looked like this:

1) Health Problems:
   1) Mr. C. is extremely short of breath when he exerts himself or becomes anxious.
   2) Mr. C. is only eating one good meal a day
   3) Mr. C. sleeps only four to six hours per night
   4) Mr. C. has lost sixteen pounds in two months time

2) Marital Problems:
   1) Mrs. C. only yells when speaking to Mr. C. otherwise she will not talk to him.
   2) Mr. C. is only allowed the use of the back door, the guest room and the kitchen.
   3) Mr. and Mrs. C only interact once every two or three days, usually of an abusive nature.

3) Emotional problems:

   A) Anxiety
      1) Mr. C. paces the floor or sits and rocks

most the night.

2) Mr. C's problem with emphysema causes hospitalization when he gets anxious

4) Depression:

1) Mr. C. only leaves the house two times in a one week period.

2) Mr. C. sits at the kitchen table all day "thinking."

(c) These problems are priorized with the client according to where the major emphasis is places by the client in some cases the therapist may rank priority, i.e. in the case of the safety or best interests of the client.

In the case of Mr. C. the student priorized the problem of getting Mr. C. other accomodations and helping him deal with the final separation process. This would remove him from his unhealthy situation, decrease much of his anxiety, and possibly increase his health status. It would as well alleviate the inter-personal difficulties he was having with his wife.

(d) A target problem is agreed upon in collaboration with the client.

The target problem that was agreed upon with Mr. C. was to a) help him find new accomodation, and b) to help him deal with the final seperation process, this included dealing with his anger, frustration and depression.

(e) This target problem is then classified by the therapist, i.e. the therapist decides into which category the problem belongs.

The problem for Mr. C. fell into the categories of a) interpersonal conflict, b) inadequate resources, c) reactive emotional stress.

(f) This target problem is specified through further observation, i.e. the scope of the problem is narrowed down into workable units and the characteristics are delineated into first and second levels of expression, i.e. 1) depression over interpersonal conflict - first level, 2) need for other accomadations - second level, 3) inability to get around - second level.

In the case of Mr. C. this would be further classified as a) anxiety/depression, due to the conflict he found himself in with his wife and b) his own physical illness, which decreased his coping skills.

7) Duration of Service Using Task-Centered Approach

Task-centered approach is a short term form of therapy, i.e. six to twelve weeks. This planned brevity is used as a control method in keeping the "action" of change occurring. This does not mean that long term service is prevented from being offered to clients who have completed a short term course and are motivated to go on.

An example of this can be seen in the case of "Family A". (See overview No. 1 Table 1A, Page 72) Mrs. A. showed a change during the short term treatment sessions yet was motivated to join an assertiveness training group. She wished to continue on changing through continued group work and self discovery.

8) "Task" Within Treatment Model

Bartlet (1970) describes task as a way of describing demands made upon people by various life situations. In the terms of treatment, the term "task" may refer to either the therapist's actions, the client's actions or both.

Stadt (1968) conceives the task to be the common goal for the the therapist and the client. For the purposes of this practicum a task was considered to be what the client agreed to attempt to do to alleviate a problem. The task was therefore important for two reasons (Reid and Epstein, 1972):

(1) To provide a theoretical link between the client's stated problem and the student's intervention.

(2) To provide a mode of action providing a central means of problem change.

An example of a "task" within the treatment model is seen in the case of "Family I" (See case summary Family I)

Mrs. I. due to an inadequate income could no longer manage financially within her home in the community. This caused a great deal of stress, i.e. (External stressors, Abrahams and

Patterson, 1978-79) Mrs. I. was becoming overwhelmed by this as well as other stressors (see Lowenthal, 1975) The goal then was to decrease this financial stressor. The task for Mrs. I. was to initiate change, alleviating this problem. She could choose to a) become a better financial manager, b) change her lifestyle, spend less than she was accustomed to, c) change accomodations thus decreasing financial strain and increasing socialization opportunities. Since Mrs. I. chose C, the tasks set out for her were to contact the Portage Housing Authority and make application for an elderly persons housing unit.

This initiated the first task leading to further "action" oriented decisions on the part of Mrs. I. Eventually leading to a problem change.

9) Shaping Up the "Task"

Tasks are broken down into two main categories - open tasks and closed tasks. An open task has no neutral or set point of termination, i.e. to make new friends. A closed task has a fixed point of termination, i.e. placement in a personal care home. The development of an acceptable task is gauged on three criteria (Reid and Epstein, 1972):

(1) The level of client motivation, i.e. what the client is willing to do about the problem.

(2) The feasibility of the task - can it be done.

(3) Desirability of task - should this task be done, i.e.

possibility of negative consequences outweighing the positive ones.

In the case of Mrs. I. the task was acceptable because the client was motivated to carry out the task. It was a task which was feasible and desirable.

10) Removal of Resistance

Hepworth (1979) and Messerman (1965) state that sources of resistance may be a result of defects within the treatment mode. In order to overcome resistance a technique called Task Implementation Sequence (T.I.S) was developed and refined (Reid 1975, Hepworth, 1979, p. 318). T.I.S. was considered a powerful technique for accelerating the possibility of therapeutic change by removing barriers before they arise, and anticipating or resolving these barriers before rather than after they become impediments to therapeutic progress. T.I.S. is used to facilitate the clients accomplishments of tasks.

The following steps as outlined by Hepworth (1979, p. 318) constitute the T.I.S. method:

(a) Enhancing Commitment

The therapist asks the client to consider the potential benefits of carrying out the task. What good will come of it? The therapist reinforces and encourages realistic benefits and may

draw the client's attention to positive consequences that the client may not have perceived.

In dealing with Mr. C. the client stated he wished a change, i.e. to move and seperate from his wife. He had been unable to do so over the past five years. He commented he wanted to leave but he "just couldn't." He stated he didn't know where to go, or how to go about leaving.

When questioned as to the potential benefits of carrying out his plan to leave, Mr. C. could only state that this would mean an end to their fighting. At this point the student pointed out other benefits such as 1) Mr. C. having a place he could call home, a place of his own, 2) the change could possibly bring less worry, increased sleep, and better health, 3) that the continous fighting would be over and he would have an increased sense of peace, 4) over the long run he would also be helping his wife adjust better.

(b) Planning Task Implementation

The client is helped to specify the task and develop a plan for carrying it out. The therapist may ask questions to enable the client to spell out exactly what he plans to do, when and where. He may help the client explore alternative ways to achieve the task, may develop a sequence of steps for carrying it out, or may encourage the client and offer suggestions.

In the case of Mr. C. a step by step plan had to be formu-

lated, with the use of a lot of encouragement. Initially questions had to be asked to establish if he were to sell the house, where he wished to move, i.e. room and board or an elderly persons housing unit, etc. When this was established the tasks had to be broken down even further, i.e. in selling the house he had to a) call the realtor, b) call the lawyer, (here a role-play was needed to help establish what to say to the lawyer), c) call his son in the city and ask for help, etc.

(c) Analyzing Obstacles

The therapist asks the client to consider problems that may be encountered in carrying out the task. If the client sees none, the therapist may present likely contingencies - for example, "What if this happens?" or "What if that occurs?" Or he may suggest possible psychological obstacles that may interfere with the client's task achievement. Or he may probe for possible negative consequences that the client may face if the tasks are carried out. The therapist clarifies the nature and causes of the obstacles, then discusses with the client ways of handling them.

Many of the obstacles which were foreseen in the case of Mr. C. were circumvented through the use of modeling, rehersal and guided practice.

(d) Modeling, Rehearsal, and Guided Practice

The therapist may model possible task behavior or ask the client to rehearse what he is going to say or do. Modeling and rehearsal may be carried out through role play. For example, the therapist may take the role of the client's boss, and the client may be asked to rehearse how he might ask his boss for a raise. The therapist may then take the client's role in the situation and model various ways to ask for the raise. Guided practice may be used to help the client carry out actual (as opposed to simulated) task behavior in the interview thus a child may practice reading or a marital pair may practice constructive kind of communication.

In the case Mr. C. a role play was needed to enable Mr. C. to call the lawyer and explain exactly what he wanted. Initially all the information that was needed from the lawyer and that was to be shared with the lawyer were written out. Then a simulated role-play occurred with the writer first playing the lawyer, then playing Mr. C. After the role-play was complete Mr. C. was able to call the lawyer and communicate his needs successfully.

(e) Summarizing

The therapist restates the task and the plan for implementation. He makes sure the client has a clear idea of what is to be done and indicates that he expects the client to try to do it.

In the case of Mr. C. summarizing was similar to the following

"Mr. C., I want you first of all to write down the things we have discussed that you want to explain to your lawyer. Then you can make the phone call on Thursday and let him know what it is you wish. Do you understand what it is your are to do next. Can you explain it back to me? Good. I will expect you to have phoned on Thursday."

11) Structure of the Task-Centered Approach

Structure within a therapeutic framework provides a substantial system of rules, methods and procedures which organize the treatment process. The previously mentioned methods and procedures in the task-centered approach have three other structual rules which help to implement and sustain the efficacy of treatment. These are 1) planned brevity, 2) focus and 3) the use of contracts.

Planned Brevity: For example, sessions lasting from six to twelve weeks over a period of two to four months sharpens up

the focus and specificity in defining and working on target problems and treatment goals, emphasizing the need for "action" to occur.

Focus: Using focus and specifying the target problem sharpens up the area of task development into a narrowly defined workable project that allows both the client and therapist to visualize the area which needs work.

Contracts: Allow for the use of explicit agreement, ensuring the therapist and client have a shared understanding of the purpose and content of the treatment phase. The contract is formed prior to the intervention beginning and serves to guide the course of service. The contract may be written or oral, general or detailed, and thus avoids misunderstandings as to the nature of intentions or the difficulties involved.

Using planned brevity, focus and contracts within this practicum, moved the therapautic process along from development to implementation, due to the expectations that had been set up within this kind of structure. Sharpening the focus within each interview, and contracting (both verbal and written) allowed for a sense of shared responsibility between the therapist and the client, avoiding many inherent misunderstandings, i.e. "You were supposed to do that not me!"

CHAPTER 4

Analysis of the Application of Task-Centered Approach

Case Studies

In the following chapter the student has included an overview (Table 1A) of the cases tnat were seen within this practicum. This allows the reader to view the scope of the problems and the amount of problem reduction. Three more fully detailed case summaries are given to illustrate how the task-centered approach worked with an individual client, and two families. THe two family cases were included to show how a task-centered approach could be used within an institution, both for the benefit of the families and the institution.

TABLE 1A

Client Identification	Age	Reason for Referral	Duration of Problem	Primary Target Problem	Primary Task	Length of Service (weeks)	No. of Interviews	Rating of Task Achievement (by S.W.)	Rating of Problem Reduction Client-follow-up by Independent Assessor
1. Family A	W40+ H70+	1. marital problems 2. problem with child	2 years	interpersonal conflict	to work out ways to cope with problems as they arise	11	8	complete	not done
2. Mrs. B	72	handle depression, anxiety; family and friends treatment of her; get along with people	8 months	reactive emotional distress	to find a way of coping with family and friends	6	6	complete	complete
3. Mr. C	78	separation anxiety find accommodations	5 years	interpersonal conflict inadequate resources	to help separate from wife find accommodation	10	8	complete	complete
4. Mrs. D	67	marital conflict suicidal depression	8 years	interpersonal conflict reactive emotional distress	to alleviate suicidal behavior	16	9	partial	not done
5. Mr. E	76	adjustment to recent amputation; alcoholic placement accommodation	2 weeks	problem with formal organ. reactive emotional distress inadequate resources	to find accommodation to deal with loss of leg to alleviate depression	13	8	complete	complete
6. Family F	W67 H 73	family unable to accept condition and demands of father	1 year +	interpersonal conflict relationship with formal organization, reactive emotional stress	to help family accept Mr. F's new personality to alleviate hostility to personal care home	17	12	complete	complete
7. Family G	W65 H 81	wife dying of CA husband recent CVA	1 year	inadequate resources reactive emotional stress relationship with formal organization	to deal with dying process to cope with separation help find accommodation	8	8	complete	much better
8. Mrs. H	85	depression/anxiety	7 months	dissatisfaction in social relations; reactive emotional stress	help find accommodations	17	12	complete	complete
9. Family I	W69 H73	move/handle finances family conflict W-depression/anxiety H-depression/angry	1 year +	inadequate resources reactive emotional stress relationship with formal organization interpersonal conflict	find accommodation deal with institution cope with husband's unrealistic demands	14	12	partial	partial
10. Mr. I	85	Depression	1 year +	reactive emotions/distress	help alleviate loneliness	14	12	complete	complete
11. Mrs. K	70	anxiety/depression	8 months	reactive emotions/distress	help alleviate loneliness	14	12	complete	complete
12. Mrs. L	82	skin problem	1 year	reactive emotions/distress relationship with formal organization	help alleviate anxiety get rid of itch	14	13	complete	complete
13. Mr. M	86	wants to get over depression	1 year	reactive emotional stress	deal with loneliness	8	8	partial	N/A

Case Summaries

a) Mr. C.

Background Information

The case of Mr. C. is an excellent example of an elderly client who has become overwhelmed by his situation. The situation had been going on for over five years prior to intervention. Mr. C., on his own was unable to call upon his inner resources effectively enough to deal with the external stressors he found inpinging upon him. He had become overwhelmed with the situation and was slowly deteriorating, through poor health and increased periods of depression (gauged by frequent amount of hospital admissions). This is a good example of how, through a structured approach the client was allowed to become self-reliant again.

Mr. C. was a 78 year old who resided in town Y. He suffered from congestive heart failure and a chronic case of emphysema. Mr. C. had been married and living with his wife over the last 55 years. Within the last five years there had occured a complete marital breakdown, yet both Mr. and Mrs. C. still resided within the same home. Mrs. C did not wish any contact or input from either Mr. C. nor the student.

Over the last five years the relationship had progressed to

the point that neither partner spoke to one another. Mrs. C. had gone so far as to remove the elements from the stove and the fuses from the washing machine to prevent Mr. C's using these facilities. She had installed a bolt on her bedroom door and ordered Mr. C. to use the guestroom and come and go only through the back door. Mr. C. had endured all of this. The student assessed him as suffering from a reduced coping capacity, (Kutofski, 1977) Mr. C. remained within his home, not knowing where to go or how to proceed. He seemed to be afraid to seek outside help. (Sadway, 1983)

Referral Source

Mr. C. was referred by the Portage General Hospital. Mr. C. had been admitted due to an exacerbation of his emphysema and was suffering from depression and anxiety. (Botwinick, 1973) He was also extremely angry and frustrated at his wife who he described as "mentally ill".

Presenting Problems

The student having assessed the situation felt that Mr. C was suffering from an interpersonal conflict and a lack of adequate resources. He was suffering from a lack of social iniative and a physical impairment. (Abrahams & Patterson, 1978-1979)

After several sessions Mr. C., stated he would like to have help to finally separate from his wife, to find suitable accomodations for himself within the community.
Initially he wished to be placed in a personal care home, but after exploring this idea he felt it would not be a good choice. He wasn't ready yet for the "old folks home".

Intervention Goals

The intervention goals as agreed upon and priorized by Mr. C. and the student were to 1) bring the separation process to a point of termination, 2) enable Mr. C. to find suitable accomodation, either a room and board situation or an apartment within an elderly persons housing unit, and 3) enable Mr. C. to deal effectively with the anxiety and depression he was suffering due to his present situation.

An oral contract was set up with Mr. C. and it was agreed we would work on these goals over a period of two to three months, entailing approximately eight to twelve sessions. The student saw Mr. C. over a period of three months for eight sessions. During this period Mr. C. had been sent to Winnipeg for an evaluation of his emphysema.

Two of the barriers (Hadgebak & Hadgebak, 1980) which seemed to be holding Mr. C. back from receiving the kind of care he needed were the "do for yourself syndrome" - Mr. C. had become stuck in a fiercely independent stance and the "I'm distrustful"

syndrome - Mr. C. felt that whoever might be there to help might blame him for the problem, see it as all his fault.

Example of Task Development on Goals 1 and 2

Initially the tasks as set out for Mr. C. were constructed by the student using a behaviorally oriented construct, i.e. behavior that could be observed. For example - "Maybe Mr. C., you could go and visit the personal care home to see exactly what it is like there then decide for yourself if you really want to go to a personal care home."

As the sessions progressed, the tasks were contructed conjointly by both Mr. C. and the student. Obstacles were analyzed, i.e it was okay to accept help in this situation. Mr. C. and the student agreed that he could: a) look through the paper for room and board situations, b) phone and make an appointment to see these and, c) go to see the places on his own - Mr. C. was still driving his car and was mobile, yet hesitant to try these options. Through encouragement he agreed to go. Mr. C. accomplished these tasks successfully for two separate board and room situations finding both situations unsuitable for his purposes.

The student then contracted with Mr. C. to have his son who lived in Winnipeg become involved in helping him find accomodations. This was to enhance Mr. C's feelings of close personal support. (Lowenthal, 1975) Mr. C.'s son agreed to come out to Portage to help his father with this task. The student spent one

session with Mr. C's son clarifying issues, i.e. what still needed to be done, see a lawyer, divide up the furniture,etc.

The student had Mr. C. agree to go and get an application from the Housing Authority for Elderly Persons Housing in Portage and advocated for the client by helping him complete the application. The student then agreed to write a letter to the Portage Housing Authority requesting an apartment as soon as possible. A follow-up phone call and personal visit was made to the Portage Housing Authority requesting an apartment. This yielded an apartment. At the same time Mr. C's son had contacted some family friends who offered a room and board situation to Mr. C. Mr. C. chose to live in the room and board situation.

Other tasks which had been conjointly constructed to help increase Mr. C's social initiative were:

a. seeing a lawyer regarding selling the house, making a will, etc.

b. contacting a real estate agent to sell the house

c. planning the move, using resources available to him, i.e. son

d. executing the move

The tasks were constructed in such a way as to increase Mr. C's involvement in decision making. Primarily through the use of direction, then encouragement and explanation, Mr. C. was able to achieve his goals.

Outcome

Mr. C. is now separated from his wife of 55 years, and his house has been sold. He is living in a room and board situation with family friends and states he is content with his accomodations. The separation process was terminated. Mr. C. is now living in comfortable accomodations. He states that he no longer feels as anxious and depressed since the separation has occurred. He is presently beginning to develop a closer relationship with his immediate family, i.e. son, daughter, and his landlord. Mrs. C. was helped to find other accomodations through family members.

b) Family F

Background Information:

The case of "Family F", a good example of how a poor relationship with the staff at a personal care home impedes adjustment to the personal care home. Also it illustrates the problems faced by families in the community in adjusting to the placement of a family member. Mr. F. had not adjusted to placement in the personal care home and neither the staff at the personal care home nor his family were helping him make this adjustment. This left Mr. F. with reactive emotional stress, a poor relationship with the personal care home staff and inter-

personal conflict.

Mr. F. was a 71 year old who had been placed in the personal care home approximately a year prior to referral. He was suffering from a breakdown in his social support system. Mrs. F. was 70 years old and had suffered an emotional breakdown about six years proir to the referral. She suffered from a reduced coping capacity (Kutofski, 1977) and had shown a habitual pattern of dependency (Abrahams and Patterson, 1978-79).

Mr. F. suffered from congestive heart failure and had been placed the care home due to his wife's inability to care for him at home. Mrs. F. could not care for his multiple disabilities, nor his chronic ill health.

While Mr. F. was in the personal care home, he had a complete hip replacement. While he was under the anesthetic, his heart stopped for approximately five minutes, causing unknown, yet somewhat severe, brain damage. This precipated bouts of erratic behavior and angry outbursts, developing into a habitual pattern of dependence on his wife. These episodes caused great concern to both his family and wife, causing apprehension about him returning to the family home for visits (Mr. F.'s home was directly accross the street from the personal care home and he could see his home from his bedroom window). Because of his erratic behavior, Mr. F.'s family had decreased their visits and Mrs. F. refused to have him at home, alone.

From the period of time of the operation to the point of referral, Mr. F. had continued to improve his erratic behavior

showed only with the family and his wife. While he was in the personal care home, he was able to carry on normal conversations and behave within a normal range. His "abnormal" behavior seemed to be encapsulated with the provocation coming from his wife and family, Mr. F. was also suffering from a reduced coping capacity.

Referral Source

Mr. & Mrs. F. had been referred by the Personal Care Home. They were unable to manage the situation. They stated that Mr. F.'s behavior was within the normal range and he had not been declared imcompetent. When he wished to walk across the street to visit his wife, they felt this was within his rights and they could not legally, nor morally, stop him. Mrs. F., on several occasions, refused his admission to her home and had "pretended" there was no one home on several occasions.

Presenting Problems:

The student, having assessed the situation, felt the F. family were suffering from interpersonal conflict, had a problem in their relationship with a formal organization and that both Mr. & Mrs. F were suffering from re-active emotional stress. Mr. F. had lost most of his meaningful roles, i.e. husband, father, etc.

Mr. F.'s problem statement "I'm lonely here, no one comes to

visit it's like a prison I just want to go home and be with my family. You know after having farmed on my own for over fifty years, a man just can't take this type of behavior."

Mrs. F.'s problem statement "You know I'd take him home in a minute if I thought he'd behave, but I'm scared of him. He's threatened me and himself. I just can't trust him alone I have to watch him every minute."

Intervention Goals:

The intervention goals as agreed upon and priorized by Mr. and Mrs. F. were to:

(1) Help Mr. F. reduce his feelings of loneliness, isolation and depression.

(2) Help Mr. F. increase the incidents of (a) having his family visit him and (b) having time at home with his wife.

(3) Mrs. F. wished to (a) be able to deal with Mr. F at home, (b) be less frightened and more knowledgeable of his behavior.

Focus of Intervention:

The focus of the intervention for the student was to help Mrs. F. and her family remove the resistance to having Mr. F. at home and to understand fully the nature of Mr. F.'s physical impairment, i.e. brain damage, via a psychological assessment and explanation of same by the student. It was also necessary to

help Mrs. F.'s medical conditions via a psychogeriatric assessment.

The goal of the student was to work with the F. family to develop and generate tasks and task alternatives. To illustrate the goal objectives, rather than go through the whole case as it developed. The student will Work through the goal process used in helping Mr. F. increase the incidents of (a) having his family visit him and (b) having time at home with his wife.

Example of Task Development:

Initially two family conferences were called. The student sugessted to Mr. F. that at the family conference he "explain" to his family how it was for him living in the care home, knowing his home and wife were just accross the street. In oder to implement this task, the student implemented a role play session with Mr. F. to help him clarify his thought process and decrease his anxiety in doing this. Mr. F. succeeded in this task. Mrs. F. stated that she was concerned about his increased care needs and she was unsure of his predictability or safety within her home. The student suggested at this point that a psychological assessment be completed in order to measure the extent of brain damage. Mr. F. and his family agreed to this. The conference continued with the family members all stating they were unaware of either his present physical capabilities or his mental capabilities. The task that was left with them was to contact

the family physician and find out exactly the capabilities of their father. Mr. F. suggested he wanted more contact with his family. A suggestion was made by Mrs. F. and a contract was drawn up with the family members that would see each of them making one visit a week to the personal care home. (The family consisted of two sons and a daughter). Three visits a week were contracted for, i.e. Tuesday, Thursday and on the weekend.

Mrs. F. also agreed that Mr. F could come home on a day pass as long as he phoned first and she was not left alone with him, i.e. one of her family was present, possibly a grandson, during the visit.

Role of the Student:

The student's role in this case was to advocate for Mr. F.'s rights within his family while still maintaining the family's and Mrs. F.'s right to know (a) what exactly was wrong with Mr. F., (b) what could be expected behavior-wise from him and (c) if there were any further treatments that could be tried.

A second role was to help Mr. F. maintain his family status and his freedom to make decisions regarding his life, i.e. re-establish social roles and freedoms.

A third role of the student was to help with giving direction to Mr. F. and his family, encouraging them and helping both Mr. F. and his family understand exactly what was happening, helping them to achieve the explanations they so desperately

needed to make future decisions on. The student worked with this family for approximately seventeen weeks. This broke down into twelve sessions. These sessions were with Mr. & Mrs. F. alone, together with their family and sessions with individual family members.

Outcome:

At the end of twelve sessions, Mr. F.'s family were visiting on a regular basis, three times a week.

Mr. F. had been going home alone with his wife on a consistent basis: at one point during student's involvement, this included fourteen days in a row. Mr. F. did not present as being depressed or lonely, i.e. weepy periods decreased, irritability towards staff ceased. The personal care home reported Mr. F to be much better, more settled and getting along extremely well with the staff.

Mr. F.'s physical health improved. At the point of referral, Mr. F. was in a wheelchair and would not give this up, even though he was capable of walking. At the end of the sessions, Mr. F. was using a cane consistently and no longer wished to use the wheelchair. He had undergone a successful cataract operation and his incontinence had cleared completely. Mrs. F. was much happier with the results and was considering having him home for three weeks holidays. All the above stated goals were achieved.

A Post-Script:

Two weeks after termination of this case, Mr. F., while he was home, displayed a bout of irrational behavior, i.e he took the keys to the truck and was attempting to go for a drive. His wife attempted to stop him and he threatened her. This initiated a crisis and the student was called again. This time Mr. F.'s goal was to move out of the personal care home into his own home permanently. Mrs. F. was resisting this because of his bout of erratic and frightening behavior.

At the time of writing, this case is still receiving input from the student, with new goals having yet to be determined.

(c) Family I

Background Information:

"Family I" provides a good example of poor relationships with a formal organization and one of long standing interpersonal conflict. As in the case of "Family F", Mr. I. had not adjusted to the personal care home and wished to be at home, not necessarily with his wife. The two cases of "Family F" and "Family I" are good examples of how a poor relationship with a personal care home leads to further inter family problems after placement has been accomplished.

Mr. I. was a 71 year old residing in a Personal Care Home. Mr. I. was suffering from reduced coping capacity. He had resided in the home for approximately one year. Prior to coming into the personal care home, Mr. I. was incontinent of bowel and bladder and could no longer be cared for by his wife.

Mrs. I. was a 69 year old who had sufferd from chronic ill health and physical impairment throughout her life. She had been classified as a cardiac cripple by her physician. Mrs. I. could also be described as someone who suffered from a habitual pattern dependency. (Abrahams & Patterson, 1978-79)

Referral Source:

This couple were referred by a Continuing Care Nurse. Mrs. I. had begun making statements, i.e. "I'd just like to die, I'm tired of all this pain." "I'd like this to be all over with." She was considered to be extremely depressed.

Presenting Problems:

Having assesed the situation, the student felt that tne "I's" were suffering from interpersonal conflict and that Mrs. I. was suffering from reactive emotional stress to her husband's placement and his treatment of her (this was a life long problem).

Mrs. I's problem statement "I want to be able to handle my

husband and his displays of anger and hostility shown towards me for placing him in the personal care home. I also want help with my financial problems, I can't manage in my home, on my pension and my husband won't give me any money."

Mr. I.'s problem statement - "I want to be left to myself, this place is like a prison, everyone poking around you, never letting you do what you want, I want to get out of here as often as I feel like. I'd like to go home and stay there but my wife is too sick to look after me."

Intervention Goals:

The intervention goals as agreed to by Mr. and Mrs. I. were to help Mr. I. adjust to the personal care home. Mr. I.'s goal was to be allowed more personal freedoms within the home and to be allowed to go home whenever he wanted. After having Mr. I. become more specific, what he wanted was to spend more time in his home, which translated into a weekend a month to begin with.

Mrs. I.'s goals were to alleviate fear and be more comfortable in dealing with her husband's anger and hostility shown towards her and the staff of the personal care home. To help her find more suitable accomodations, i.e. "one that is more affordable for me'. Mrs. I. wanted the student to help her deal with her sense of loneliness and isolation.

The student will explain the progress towards achieving one of the goals, i.e. helping Mrs. I. deal with her inadequate

financial abilities. Both Mr. and Mrs. I. were fiercely independent people and only after several sessions would they consent to openly share their problems with the student.

Example of Task Development:

In regard to Mrs. I.'s wish for help in dealing with her inadequate financial situation, it was agreed that the solution to her problem was to give up her home and move to an Elderly Persons Housing Apartment. Here her rent and cost of living would be minimal, and her ability to socialize would be enhanced. Also her mobility and access to services not now available to her would be improved, i.e. meals on wheels, taxi service, senior centre, etc.

The first task constructed by the student was to have Mrs. I. request an application form for Elderly Persons Housing, then with the student's help complete it and send it in. This was accomplished and the student agreed to write to the Housing Authority on behalf of Mrs. I. (working as an advocate for the client).

The second task developed out of the first. Mrs. I. felt she needed her husband's permission to leave their family home, she also felt that he would under no circumstances allow this to occur. After an initial meeting with Mr. I. at the Personal Care Home, the student also felt there would be a lot of resistance to this move therefore, a T.I.S system was implemented, i.e. the

exact nature and parameters of the problem to be encountered were defined by both the student and Mrs. I. The information she wished to share and the goals she hoped to achieve were prioritized. The student reinforced and expanded upon the benefits she would receive, i.e. alleviation of guilt feelings, etc. Then the student helped the client specify the task and develop a plan for carrying it out. Together the student and client worked through any problems that might have been encountered and rehearsal or guided practice took place. A clear statement of what was to be done was made and Mrs. I. followed through with the plan.

Sub tasks needed to be constructed to achieve the task of receiving permission from Mrs. I.'s husband.

When confronted with this problem, Mrs. I. wished the student to go and speak with Mr. I. at the personal care home and get permission for her. The student through negotiation, had Mrs. I. agree to having Mr. I. home for a weekend, at this time she was to explain her plan, the reasons for her plan and her need for his approval. After this had been completed, the student agreed to explain the medical reasons why Mrs. I. could no longer care for her husband and her need to live in a situation where she could receive extended care in the community, care which was unavailable to her now. All of the above tasks were completed successfully although Mr. I. was still reluctant to allow his wife to move.

At this point, Mrs. I. felt her minister might have some success in dealing with this problem with her husband. The task

constructed was to have Mrs. I. phone her minister, explain the situation and have him speak to her husband. This task was completed successfully.

Eventually, after speaking with Mr. I. regarding his wife's move he reluctantly agreed to let her move. Once Mrs. I. had received her husband's permission, much of the anxiety surrounding the move decreased.

Role of Student:

The role of the student was to help Mr. and Mrs. I explore alternatives in dealing with each other, helping them develop interpersonal skills in communication while still being somewhat directive in task generation. The role of enhancing skill development and increasing the drive levels of Mr. and Mrs. I. were brought about by decreasing resistance to goal attainment, by perceiving where the resistance was and defusing it through the use of T.I.S.

Outcome:

The student saw this family for twelve sessions and the outcome of these sessions were

1) Mrs. I. moved into an Elderly Persons Housing Apartment. She states her level of depression and loneliness has decreased, she no longer wishes to die, nor does she spend days weeping.

Her sense of humor has increased. Her two daughters visit regularly, and both have commented on the positive change.

2) Mr. I. moved out of the personal care home back into the family home and was functioning very well at home as reported by his family and the home care nurse assigned to him. His daughter checks on him regularly.

3) Mr. and Mrs. I. are much more comfortable, less hostile and more agreeable with one another - as displayed at the family wedding they attended together. They also phone each other on a regular basis and attempt personal contact regularly.

4) All of the goals as set out by Mr. and Mrs. I were achieved.

CHAPTER 5

Evaluation

The problem assessment schedule serves as a means for gathering preliminary data on each client . (Refer to Appendix B, No. 1) The general situation as viewed by each client was recorded. During the first two to three sessions, a specific problem was identified by each client as a target problem in behavioral, specifiable and workable terms. For instance, Mrs. I. required help in telling her husband she wished to move into an Elderly Persons Housing Unit. Once the problem of prime importance was selected, tasks, i.e. the course of action needed to be undertaken during and between visits, to help alleviate the the problem, were identified and agreed upon.

The overall duration of treatment, i.e. 6-10 weeks and the number of interviews, i.e. 1 to 2 each week, were specified and either an oral or written contract was struck. Each of these constructual items, tasks, related to the stated problem, duration and frequency of treatment were also entered in the task review schedule. (Appendix B, No. 2)

The major evaluative method used within this practicum was the clients, the student and significant others, i.e. nurse, doctor, family members, assessment of progress on the specified tasks and problems. That is these actors perceptions of goal

attainment was the major indicator of effective treatment outcome.

Scales used to measure goal attainment were the:

1) Problem Assessment Schedule (Appendix B, No. 1) which gives a statement of the target problems, when agreement was reached to work on the problem, direction and evidence of change as well as need for further help.

2) Task Review Schedule (Appendix B, No. 2). This itemizes the tasks in behavioral terms, relates it to the problem being worked on, level of commitment and progress being made.This schedule gives an ongoing account of progress and direction of change being made.

3) The Closing Interview Schedule (Appendix B, No. 3) giving the client's conception of the problems and tasks, the client's assessment of progress and the client's assessment of service.

4) The client Questionnaire which is completed by the client giving a summation of how well the service achieved the stated goals and client satisfaction of service given. These schedules were used to guage both ongoing task achievement level and outcome results. The clients were asked to give verbal statements substantiating the extent to which they believed goals have been met. The student also sought out both verbal and written reports from significant others surrounding the client, i.e. personal care home personnel, family doctor, members of the immediate and extended family.

This emphasis which serves both clinical and research

requirements (Reid and Epstein, 1977) includes a summary of the clients progress during treatment, the identifaction of target problems to be dealt with and the significance to the client of having had an alliance with a helping person. The evaluation process used a systematic monitoring and evaluation of both progress and outcome of treatment, on a continuous basis throughout the assessment, implementation and follow-up stages similar to that found in Jayaratne and Levy (1979).

Evaluation Results

1. Task Attainment

During this practicum the student found the need to be somewhat directive during task development. Tasks were primarily constructed by the student although the clients initially stated "what would be of help". The tasks also tended to be mostly global in nature and had to be reconstructed into a specific chore or task which was attainable. The tasks after having been given by the client, agreed upon by the student, had to be reintroduced in a more specific and achievable format.

Out of the 13 clients seen during this practicum, 69% had little or no problem with task attainment 31% had some difficulty with task completion. Through the evaluation process, it was found that the following problems were barriers to task completion:

a) misinterpretation or self interpretation of the agreed upon task

b) forgetfulness

c) fear of completing the task, i.e. unknown consequences, fear or failure, etc.

In order to alleviate these barriers with the 31% of the clients who had difficulty with task completion, a written agreement usually alleviated the problem. Further, the misinterpretation was reduced ty the student attempting to be clear and precise during the initial period of task development. The student also learned to use "cues" to help the forgetful elderly remember their task assignment, such things as reminder notes were put up on the fridge. In the case of Mr. I. phone calls were made by the student both to encourage and to remind him of the task assignments.

The student also found the task implementation sequence most useful in helping many elderly clients deal with the fear of unknown consequences.

2. Goal Attainment

Out of the 13 clients who were seen, 69% completely reduced their target problem (refer Table 1A p. 72). 15% partially completed their target goals and 15% were unable to attain their stated goals. This last 15% all requested further service and they were switched over to a long term program either through the

Community Mental Health Program or the Continuing Care Program.

These levels of goal attainment of the task-centered approach varifies its usefulness as a viable intervention when used in dealing with the vulnerable elderly client.

The results also showed most clients to be pleased and on one occasion surprised with the positive results. Mrs. L. commented that "You promised you would be able to help me, and you did. At first I was skeptical about anyone being able to help but I'm certainly glad you came along, I'm feeling much better now." Mrs. B. commented "I didn't think I was going to make it through the depression without being hospitalized. I'm glad I came to see you, I think I'll be alright now." Mrs. B. also commented that if ever a similar problem occurred in the future she felt confident about being able to deal with it on her own.

Most of the comments were positive from the clients seen. Many of the comments which were not as positive dealt with the short period of time the student saw the clients. Even though their problem had been alleviated they felt they would like the student to continue on visiting and spending time with them. They felt the student had been a friend and they did not wish the relationship to end.

CHAPTER 6

Summary and Conclusions

The task-centered approach has been found useful and appparently effective with the vulnerable aged client. Effectivness is suggested by the achievement of substantial improvement at least in the clients view, in about 69% of all target problems.

Controlled studies are needed to assess the contribution of other factors,i.e. the client's capacity to improve on his own, medication effect, etc.

Once the target problem has been agreed upon, the emphasis of the therapy became one of helping to preserve and enhance the elements in the individual's ability to adapt and work towards changing those elements that are dysfunctional within their life processes. The goal became one of increasing social competence in coping with life situations, i.e. the student's job was to support and foster adaptive behaviors.

When the client's problems were readily able to be defined, planned short term therapy was widely recognized as being appropriate for the following reasons:

a) brings relief more quickly

b) brings relief more effectively than open ended procedures

(Hollis and Woods, 1964)

Task-centered casework appears to be a viable interventive approach to work with the elderly client because it eliminates

aimless drifting and unnecassarily exhaustive explorations within the interviews. While Mr. I. was mildly confused he was able to focus on the problem and ways of eliminating it.

The flexible contract made the agreement between student and client explicit and becomes helpful in maintaining a clear, distinct direction in treatment flow. This allowed clients like Mr. I. to be clear in his expectations of the student and of himself.

Because progress can be seen immediately with each task accomplishment, this form of therapy provides reinforcement to both client and therapist and one which as one elderly client stated "makes me feel like something is happening."

Reid (1975) comments that task-centered casework helps clients carry out specific tasks through a concentrated program of preparation. This feature helps mobilize the client to action in a specified and pre-arranged direction emphasizing the therapist-client intraction as a principle medium creating change. This approach increases the ability of the therapist to be accountable. It maintains the need to be specific, and set out behaviorally oriented tasks, spelling out who will do what, and when. This helps both the client and the therapist become specific about tasks and goals and the progress made towards achieving them.

The practicum was a great learning experience for the student. The student was able to examine the application of a task-centered approach with vulnerable elderly clients and see

positive results, not only in problem resolution but as well in relationship development. The student feels that the evaluation showed that this form of intervention (Task-Centered Approach) proved to be a valuable tool in directing social work practice with the aged vulnerable client. As a practitioner, through applying this intervention and carrying out this practicum the student feels that he has acquired an advanced level of skill in the use of the task centered approach. Through developing this skill the student now feels he would be capable of providing a better quality of service to the elderly and their families.

Throughout this practicum the student continued to gain experience through practical learning, i.e. books, articles, etc., and from having shared experiences with the clients, experiences which could not have been obtained through books alone.

Strengths and Limitations of the Task-Centered Approach

This form of intervention is not viable for the severely forgetful and confused or the organically damaged elderly, i.e. those suffering from advanced Alzheimers disease etc. Although certain aspects of the intervention may be used to teach these impaired elderly some basic tasks (Korber, 1983).

A) Concluding Comments

It is important to note that while the outcome shows a propensity toward the original hypothesis, i.e. that a task-centered approach is a valuable tool in working with the vulnerable elderly. Change could also have occurred for reasons other than the work of the therapist since it was impossible to control for extraneous variables within this setting.

Permanence of change was examined within a one week period, followed by a two week follow-up - implemented change seemed to be permanent at the time of follow-up assessment.

The student feels it is very important to note the use of written contracts with the elderly to alleviate any misunderstanding and to counteract forgetfulness. The student also feels it is important to note that in working with the elderly, four aspects of task-centered approach have to be implemented thoroughly and carefully - these are:

1) narrowing down and specifying the task into a workable achievable form - from a global to a more specific statement
2) focusing and maintaining the focus of treatment
3) using a tremendous amount of verbal reinforcement for tasks achieved and pointing out other reinforcing aspects of outcome results
4) developing and maintaining a very strong relationship throughout the therapeutic session. This is especially important

in the initial stages of therapy.

The British Association of Social Workers' "Guidelines for Social Work with the Elderly" (1977) offers useful guidelines. They state that clear decision rules can provide:

1) An outline of the best available practice and knowledge to serve as a model to strive for.

2) A basis for social worker and social-work agency self-protection if decisions are made according to established practice there is a measure of justification and freedom from blame if loss occurs.

The student tends to agree with Brearley (1982) that, "good risk management and good practice depends, with any group, on thorough analysis and purposeful planning. This is no less true of older people than of any other age group."

The Task-Centered Approach helped to maintain a sense of dignity, pride and participation within it's process. It gave the client a "You can do it" feeling and followed this up with strong reinforcement of success and further encouragement when they fell short of success. This therapeutic approach did not "belittle" or simplify the clients abilities, helping them to maintain a sense of "achievement" throughout the process, from the accomplishment of each task to final goal completion. It was presented in such a way as to decrease the feeling that they were being "told what to do" in a parental fashion. It was presented at a level which the cleint was:

a) able to achieve success

b) able to participate fully in

c) able to get immediate gratification

d) allowed for a sense of "challenge"

APPENDIX A

1) DEVELOPMENT OF SKILLS IN TASK-CENTERED TREATMENT PROGRAM

2) COMMUNICATION TECHNIQUES

A P P E N D I X A

DEVELOPMENT OF SKILLS IN TASK-CENTERED TREATMENT PROGRAM

Table 12.1 Profile of Practice Skills in Task-Centred Treatment

Note: Underlined words in the skill items on the left-hand side of the page are explained in the underlined words on the right-hand side of the page. The words not underlined are items and explanations that depict level of performance expected at the end of the first quarter or three months; underlined items describe the level expected at the end of the academic year. Numbers in parenthesis are used to identify particular skills.

I. Interviewing	
A. Enables client role induction	Client to be provided with means and opportunity to understand both his and the practitioner's rules, purposes and expectations from treatment and what it will be like.
1. Explains practitioner and client roles and purposes of treatment appropriately	(1) Explains and demonstrates what the practitioner can and will do and the reason for practitioner-client association. Repeats explanations when client gives evidence that his understanding of roles and purposes is unclear
2. Explains procedures appropriately	(2) Explains how treatment will proceed. Repeats explanations of role, purpose, and procedures as needed. Attaches verbal explanations to the treatment activity; for example, when formulating tasks, "Recall that we said we would find ways to reduce this problem. This is what we are doing when we think of tasks."
B. Explores thoroughly and selectively	(3) Asks questions, makes observations, and gathers information to learn what and how client is doing, thinking, feeling; judges directions for movement. Limits information-gathering activity to areas related to the target problem and the development of an assessment of the target problem
C. Obtains necessary facts	(4) Obtains facts about the client's "objective reality" (e.g. address, age, family constellation, job, income or other means of support, marital status, custody of children, school placement and achievement, health)
D. Is disciplined and empathetic	Adopts the preferred professional posture: self-control of preferences and wishes in dealing with clients to avoid exploiting them for personal
1. Disciplines own feelings	(5) reasons; appropriate feeling responses expressed to clients revealing respect and understanding; selectively communicating advocacy of client
2. Demonstrates accurate empathy	(6) interests. Demonstrations of empathy are characterized by accurate knowledge and specific expressions about how this person feels in his plight

II. Initial phase of treatment

A. Identifies appropriate target problems

(7) Identifies to client and in recordings the problem(s) to be forced upon. Identifies the target problem the client wants changed

B. Develops a specification of each target problem in quantifiable terms

(8) Determines the conditions that describe each target problem and the frequency with which each occurs within a stated baseline period. Shares this information with client. The conditions of each target problem and their frequency of occurrence within a stated period of time are sufficiently specific to enable progress or outcome on each problem to be assessed.

C. Sets appropriate goals

(9) Makes a judgement with client on desired, expecable outcome. Works with client to arrive at a desired outcome statement which is feasible and related to the target problems

D. Sets duration and uses to enhance treatment

(10) Specifies the number of treatment interviews which are determined by worker-client agreement by the end of the initial phase
The client is frequently reminded of the number of interviews remaining. The time limits are kept firmly and continuously in mind to intensify effort

E. Determines appropriate priorities with respect to target problems

(11) Lists problems in the order in which they are to be focused upon when they are too numerous to be worked on simultaneously
Priorities are set, taking into account the following: stated wishes of the client; judged urgency of the problem; capability of combining (whenever possible) work on several aspects of the problem or several related problems in order to heighten effect and maintain involvement of significant others at an effective level

F. Arrives at a treatment contract

(12) Summarizes the work in the initial phase by making a verbal or written agreement with the client as to how long treatment will be, what will be worked on, and to what end (duration, target problem, general tasks, goal). Contracts to be altered if a basic change in the agreement occurs

III. Assessment

A. Makes early inclusive assessment

(13) Develops an assessment of the target problem(s) by making connections between the characteristics of the person, his situation, and the problem. Similar to "diagnosis" but without inferences of "medical" or "disease" model.
Takes into account both the influence of the evironment (external factors) and personal characteristics (internal factors)

B.	Revises assessment when necessary	(14) Revises the assessment of the target problem(s) from time to time This is done when new information indicates that a modification will better fit the fact
IV.	Middle phase of treatment	
A.	Concentrates on target problems	(15) Concentrates on actions by client, practitioner, and others to create the desired outcome. Alleviation of target problems, to the degree set forth in the contract, or the contract as altered. When time has prohibited working on all target problems, and if it appears that more time is likely to yield problem alleviation, and client wishes to, the contracted period of time is extended
B.	Reviews problem status in quantifiable terms	(16) Explores to identify changes in the state of the target problem in each interview. States changes in problem status according to the specification of each target problem; that is, obtains the frequency of occurrences of each specifying condition within a stated period of time as in the initial phase of treatment
C.	Generates tasks and task alternatives	(17) Identifies, with the client, an activity or behavior likely to lead to problem reduction Attempts to engage the client in locating several such behaviors
D.	Elicits task agreement	(18) Secures the client's agreement to perform the task
E.	Plans details of task implementation thoroughly	(19) Plans, with the client, when, where, for how long, and with whom the task is to be performed. Does so in detail
F.	Establishes sufficient rationale and incentives	(20) Discusses with the client the potential gains to be had from performing the task Identifies and/or provides the client with rationales and rewards that motivate the client to perform the task
G.	Carries out simulations and guided practice	(21) Engages the client in reheasing or practicing the task or models the task behavior for the client
H.	Analyzes and resolves obstacles	(22) Anticipates, with the client, potential impediments to performing the tasks and plans ways to overcome them. Ascertains retrospectively what obstacles occurred. Plans new or altered tasks to resolve the obstacles, including actions the practitioner will take on the client's behalf.
I.	Summarizes the task specifically	(23) Restates or asks the client to restate the formulated task Includes the details of implementation in this reiteration

J. Reviews task progress in detail

(24) Explores, in interviews following task formulation, to learn what the client did with respect to task performance and what the results were
Does so for all tasks and obtains specific data on progress

V. Work with others - practitioner tasks

A. Consults and involves family appropriately

(25) Secures information from family members
Includes family members in treatment to the extent determined by the target problem and the wishes of the client and family

B. Consults and involves others appropriately

(26) Secures information from others in the social network in which the problem occurs
Includes them in treatment and treatment planning to the extent determined by the target problems and the wishes of the client and others

C. Secures resources

Resources can be classified as either concrete or intangible. Concrete resources include public assistance, homemakers, special education, medical or psychiatric care, visiting nurses, placements, social security benefits, and similar "in-kind" provisions. Intangible resources include counselling, advice, personal support, and the like. Obtaining either kind of resource entails use of the same practice skills. If the resource exists or can be organized by combining several existing resources, it must be procured

1. Consults, requests or orders resources

(27) Confers with agency staff (colleagues, supervisors) to obtain information on types of available resources, procedures for procuring them, conditions for providing them, and evaluation of their usefulness. Asks for and requisitions the particular resource. This is the usual manner of obtaining resources available within the practitioner's agency. Resources from other agencies can sometimes be obtained this way, too
Resources are also obtainable from family members, friends, private-practitioner professionals, and local neighbourhood organizations. Such nonagency resources should be secured by request, not order

2. Negotiates for resources

(28) Arranges conferences between representatives from different agencies and reaches agreements or contracts that cause resources from other agencies to become available. This is done when boundaries between agencies and differences among them in the manner of provision necessitate negotiating for resources. Resources can be purchased from providers when the necessary agreements and funding are available.

3. Provides interagency or intraagency feedback with respect to the provision of resources		Reports back to the provider, interpreting the client's use of the resource, and defining the provider's conditions for use of resource to the client. This step is not always necessary for resources provided routinely within the practitioner's own agency
4. Advocates the client's interest	(30)	Advocates the client's interest if a resource to which he is entitled by law, policy, or custom is not provided. Advocacy is negotiation with a difference; namely, that social pressures are brought to bear to release the desired resource. Advocacy steps of a mild sort are often necessary and should be carried out. However, where power conflicts are apparent so that strong advocacy is likely to involve an agency in an official or public conflict, such steps must be santioned by key administrators.

2) COMMUNICATION TECHNIQUES

I. Communication Techniques

Communication techniques are explained in Table I. Typology of Practitioners' Communication Techniques (Reid and Epstein, 1972, p. 23 and Fortune, 1979, p. 391).

Type of Technique	Description	Examples
1. Exploration	Communication intended to elicit information, including questions and restatements or "echoes" of client's communications.	"What were you able to do on your task?"
2. Structuring	Communication intended to enhance client's functioning in role of client within the interview, including (1) focusing client's communications, (2) structuring the treatment relationship, and (3) stating the practitioner's own intentions.	1. "Let's stick to what happened with your husband for the moment." 2. "This is an area both you and your husband can work with me on." 3. "I'll talk to your doctor about it for you."
3. Direction	Communication intended to guide client's behavior outside the interview, including direct statements, leading questions, and professional opinions.	"Don't you think you should call John." "I think the first step would be to talk this over with your daughter."
4. Encouragement	Communication supporting client's behavior, attitude, or feelings.	"Hey, that's a good idea." "You're able to do that. Look how well you did last time."
5. Overt Understanding	Communication expressing recognition and approval of client's capacities, needs, and feelings, such as expressions of understanding, sympathy, and concern.	"Your getting angry, unhappy, etc. and that is quite understandable." "I know what you mean. It's hard to live alone."

6.	Explanation	Communication intended to enhance client's awareness and understanding of (1) his or her social and physical environment, (2) significant others, and (3) the client's own behavior.	1. "The application procedures at both E.P.H.'s are very much alike." 2. "It seems that your sister doesn't call after speaking to your daughter." "A lot of people get upset when they get bad news. Isn't that what happened to your husband?" 3. "You get in a bad mood every time someone says 'No' to you."
7.	Modeling or role-playing	Communication while demonstrating appropriate behavior or actually engaged in role-playing with the client.	Wife and worker role-play client asking husband to include her in decision about moving to a personal care home. Practitioner's responses while acting as husband.
8.	Other	Communication outside the context of treatment, practitioner self-disclosure, or any other remarks by practitioner that do not fit into previous categories.	"Make yourself comfortable. It's certainly unpleasant weather outside, isn't it?" "I just found out about it myself. It does work."

A P P E N D I X B

1. Problem Assessment Schedule

2. Task Review Schedule

3. Client Questionnaire

4. Closing Interview Schedule

Problem Assessment Schedule

Name of Client(s) _____

Name of Practitioner _____

1. Write below statements of the target problems (to a limit of three) the client most wished to alleviate through treatment, starting with the problem of greatest importance to the client. After each statement indicate approximate length of time client had problem before starting treatment, e.g. 2 weeks, 3 months, a year, 10 years, etc.

   1.

   2.

   3.

2. At what point in treatment was agreement to work on these problems first reached.

When Agreement Was First Reached	Problem		
Interviews 1-2	1	2	3
Interviews 3-4	1	2	3
Interviews 5-6	1	2	3
Interview 7 or later	1	2	3

3. For each problem, indicate the amount and direction of change that occurred by the last treatment interview.

Categories of Change	Problem		
Aggravated	1	2	3
No Change	1	2	3
Slightly Alleviated	1	2	3
Considerably Alleviated	1	2	3
Problem No Longer Present	1	2	3

4. Give brief statements of evidence used for the problem rating given above. Statements for each rating should consist of from one to three sentences setting forth the evidence on which the rating is primarily based. Statements should emphasize evidence for specific changes in client's behavior or situation.

   Problem 1

   (a)

   (b)

   (c)

Problem 2

(a)

(b)

(c)

Problem 3

(a)

(b)

(c)

5. Did client want additional help for any of these problems at termination of task-centred treatment? Indicate which below by number.

1. _____ 3. _____
2. _____ None _____

6. What problems besides those listed in item 1 did client want help for, either during or at the conclusion of treatment? (Write problem statements below. If none, write "none". Add additional numbers and statements as necessary.) Place a check before each of the statements below that were target problems - that is, where there was explicit agreement between practitioner and the client to work on the problem. Rate approximate change in each problem by placing after each statement one of the following symbols: + is alleviation; 0 is no change; and - is aggravation.

7. For which of the problems listed in item 6 did client still want help at the end of the treatment?

None _____ If any, indicate by number from item above _____

Task Review Schedule

Practitioner's Name _____ Case #_____

Task #: _____
Task Statement (begin with client's name):

Prob. # to which related: _____ When task formulated: Sess. #: _____
Date: _____
Who suggested idea for task? Client _____ Practitioner _____ Other _____

Client's Initial Commitment to Task: 1 2 3 4 5 (Low — High)

When task reviewed:
Session #: _____

Progress rating (1-4 or NO)
for each review: _____

Task #: _____
Task Statement (being with client's name):

Prob. # to which related: _____ When task formulated: Sess. # _____
Date: _____
Who suggested idea for task? Client _____ Practitioner _____ Other _____

Client's Initial Commitment to Task: 1 2 3 4 5 (Low — High)

When task reviewed:
Session #: _____

Progress rating (1-4 or NO)
for each review: _____

Task #: _____
Task statement (begin with client's name):

Prob. # to which related: _____ When task formulated: Sess. #: _____
Date: _____
Who suggested idea for task? Client _____ Practitioner _____ Other _____

Client's Initial Commitment to Task: 1 2 3 4 5 (Low — High)

When task reviewed:
Session #: _____

Progress rating (1-4 or NO)
for each review: _____

Task Achievement Scale

RATING

(4) Completely achieved.

This rating applies to tasks that are fully accomplished, e.g. a job has been found, a homemaker secured, financial assistance obtained. It may also be used for tasks that are fully accomplished "for all practical purposes"; if a couple's task was to reduce quarreling a rating of (4) could be given if they reached a point where hostile interchanges occurred infrequently, no longer presented a problem, and they saw no need for further work on the task.

(3) Substantially achieved.

The task is largely accomplished though further action may need to be taken before full accomplishment is realized. Thus, if the task is to improve work performance, significant improvement would merit a rating of (3) even though further improvement would be possible and desireable.

(2) Partially achieved.

Demonstrable progress has been made on the task but considerable work remains to be done. For example, if the task is to obtain a job, a rating of (2) could be given if the client has been actively looking for work and found a job he could take (and might) but was reluctant to. Or this rating would be appropriate for a couple who had made some headway on a shared task of finding things of mutual interest to do together even though they and the caseworker may be dissatisfied with their progress. Specific evidence of task accomplishment is required however. A rating of (2) should not be given just on the basis of positive motivation, good intentions, or expenditure of effort.

(1) Minimally achieved (or not achieved).

This rating is used for task on which no progress has been made or on which progress has been insignificant or uncertain. If a client's task were to locate and enter a suitable vocational training program, a rating of (1) would be given if the client were unable to locate a program, even though much effort had gone into searching for one.

(NO) No opportunity to work on task.

For example, client cannot carry out task in classroom because school is closed by teachers' strike.

Client Questionnaire

We hope you will be able to take a few minutes of your time to complete this questionnaire before leaving the office. The study is designed to help this and other agencies to improve the effectiveness of their case-work and counselling programs.

After you have completed the questionnaire, please place it in the envelope provided, seal it and leave it with the agency's receptionist. Please give us your frank opinion. Absolutely no reference to your name will be made in our use of your responses to the questionnaires.

Thank you for your cooperation.

Name _____

Address _____

Phone No. _____

CHECK ONE RESPONSE FOR EACH QUESTION. IF YOU CHECK "OTHER", WRITE IN YOUR RESPONSE IN THE SPACE PROVIDED.

1. Do you have any personal or family problems now that you think you need further help with?

   ___ yes
   ___ no
   ___ uncertain
   ___ other _____
   _____

2. Consider the one problem that you most wanted the caseworker or counsellor to help you with. How is this problem now compared with how it was when you started treatment here?

   ___ it is no longer present
   ___ it is a lot better
   ___ it is a little better
   ___ it is about the same
   ___ it is worse
   ___ other _____
   _____

3. On the whole, how are you getting along now compared with when you first began treatment here? (check one)

   ___ much better
   ___ a little better
   ___ about the same
   ___ worse
   ___ other _____
   _____

4. The service:

___ was far too brief, it should have continued for a much longer period of time
___ was a little too brief; I could have used a few more sessions
___ lasted about the right length of time
___ went on too long
___ other _____

5. The advice I was given in counselling was:

___ particularly helpful
___ of some help
___ not helpful
___ little or no advice given
___ other _____

6. The encouragement I received for progress I made was:

___ particularly helpful
___ of some help
___ not helpful
___ little or no encouragement given
___ other _____

7. The caseworker's (counsellor's) attempts to help me understand myself or others were:

___ particularly helpful
___ of some help
___ not helpful
___ few such efforts were made
___ other _____

8. The caseworker's (counsellor's) attempt to concentrate on specific goals or tasks for me to work on was:

___ particularly helpful
___ of some help
___ not helpful, I would have liked more freedom to talk about what was on my mind
___ the caseworker (counsellor) did not do this
___ other _____

9. Our agreement at the beginning on how long service was to last:

___ was "a plus" as far as I was concerned
___ was acceptable
___ didn't strike me as a good idea
___ we didn't do this
___ other _____

Closing Interview Schedule

I. Client's Conception of Problems and Tasks

1. What were the most important problems that you and your caseworker worked on? (Number the first three problems in order of their apparent importance to client.)

1a. (For each problem numbered above, determine the amount and direction of change that client thought had occurred by the last treatment interview. Do this by reading back each problem to client and asking him to select appropriate category.)

Categories of Change	Problem		
Aggravated (worse)	1	2	3
No Change	1	2	3
Slightly Alleviated (a little better)	1	2	3
Considerably Alleviated (a lot better)	1	2	3
Problem No Longer Present	1	2	3

2. Do you feel that the caseworker grasped the true nature of your problems as you tried to describe them?

_____Yes _____No _____Uncertain

(If "No" or "Uncertain" probe for reasons for client's feelings.)

3. Did you and your caseworker come to an agreement about what you might try to do to solve these problems?

_____Yes _____No _____Uncertain

4. (If client responded "Yes" to question 3: What did you and your caseworker agree you should try to do?
(Probe for clarifying detail. Before going to next question, ask if there was anything else.)

5. (If client responds with "No" or "Uncertain" to question 3, probe for client's conception of the caseworker's expectations, e.g.: As far as you could tell, what did the caseworker expect you to do to try to solve these problems?)

II. The Client's Assessment of Progress

1. How well were you able to (repeat first task as given by client in response to question 4 or 5). (Probe for details of - and evidence for - task accomplishment.) (Repeat for each task mentioned in 4 or 5)

2. How is your over-all situation now compared with how it was when you first came to Social Service? Is it better, worse or abour the same? (Probe for clarifying details, e.g. Better or worse in which way?)

3. Do you have any personal or family problems now that you think you need help for? (If yes, probe for nature of problems, client's plans, if any, for getting help.)

III. The Client's Assessment of Service

I am going to read you a number of statements describing possible reactions you may have had to casework service. After I read each statement, please tell me whether you would agree or disagree with the statement as it applies to your experience. Please give us your frank opinion.

1. Casework service lasted about the right length of time.
   AGREE DISAGREE

2. My caseworker and I decided to concentrate on one problem at a time.
   AGREE DISAGREE

3. My caseworker gave me too much advice about what to do.
   AGREE DISAGREE

4. I received the kind of help I wanted from Social Service.
   AGREE DISAGREE

5. There were a lot of things on my mind which we did not have time to discuss.
   AGREE DISAGREE

6. I liked the idea of deciding at the beginning how long service was going to last.
   AGREE DISAGREE

7. I am satisfied with that I was able to accomplish as a result of casework service.
   AGREE DISAGREE

8. My caseworker should have given me more advice about what to do.
AGREE DISAGREE

9. Casework service was a little too brief; I could have used a few more sessions.
AGREE DISAGREE

10. The caseworker concentrated too much on me; he (she) should have tried to do more to change the attitude of others or to get me services that I needed.
AGREE DISAGREE

11. The caseworker came through with the kind of help he(she) said he was going to give me when we started.
AGREE DISAGREE

12. Casework service was far too brief; it should have continued for a much longer period of time.
AGREE DISAGREE

13. I felt I understood what my caseworker was trying to do.
AGREE DISAGREE

14. In my last discussion with my caseworker, I got some good ideas about what I might do about problems I still have.
AGREE DISAGREE

15. Too much time was spent trying to help me understand what I was doing wrong.
AGREE DISAGREE

16. I would have had more confidence in my caseworker if he (she) had been older.
AGREE DISAGREE

17. I was confused a lot of the time about what the caseworker was trying to do.
AGREE DISAGREE

18. If I again have personal or family problems, I would turn to Social Service.
AGREE DISAGREE

19. The caseworker seemed to have a lot of confidence that I would be able to work out my problems.
AGREE DISAGREE

20. Casework service lasted too long.
AGREE DISAGREE

21. Social service really did not give me the kind of help I wanted.
AGREE DISAGREE

22. I think my experience with Social Service will help me to handle future problems as they arise.
AGREE DISAGREE

23. On the whole, how would you rate the helpfulness of service?
___ 1. I would have been better off without Social Service contact.
___ 2. I was neither helped nor harmed.
___ 3. I was slightly benefited.
___ 4. I was considerably benefited.
___ 5. I could not have gotten along without the service.

10. If I again have personal or family problems that I need help with I would want to have:

___ the kind of service I have just completed
___ a different kind of service
___ other _____

_____

11. The service:

___ helped with most of the problems that were bothering me
___ helped me with some of the problems that were really bothering me but we did not get to all of them
___ didn't help me much at all
___ other _____

_____

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