CHAPTER 1

Clinical Social Work and Its Commonalities With Cognitive Behavior Therapy

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INTRODUCTION

Social workers are committed to the protection and empowerment of weak populations, of those people who are least powerful. Members of this profession struggle to help their clients improve their physical as well as mental well-being, within a society characterized by great economic inequality and a high potential for vulnerability (Bateman, 2002). During the past two decades, social workers have been facing a sorrowful reality depicted by the emergence of new generations of needy families on the one hand and significant cuts in resources on the other hand. Daily, social workers face the busy and complex world of human behavior in social contexts, a world in which relationships break down, emotions run high, and personal needs go unmet. Some people have problems with which they cannot cope and need intervention to overcome their difficulties or to learn to cope and live with them. Other people are the cause of their own problems and need intervention to change their own destructive behavior toward themselves and others (Howe, 2004).

Broadly, the goals of social work have been defined by the National Association of Social Work as follows: to assist individuals and groups to identify and resolve or minimize problems arising out of disequilibrium between themselves and their environment . . . to prevent the occurrence

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of disequilibrium and . . . to seek out, identify and strengthen the maximum potential in individuals, groups and communities. Social workers must therefore look for patterns and order behind societal changes, human functioning, and human experiences, and they must try to make sense of the people and situations in which they find themselves.

The wish to make the world a better place to live is common to all social workers. However, the view of the root cause of problems and therefore the ensuing focus of intervention and problem resolution differ between social workers. Social workers move between two diverse trends. The first highlights social influences and social processes as the major source of problems and thus as the target of intervention. The second trend views the individual, family, or group as the direct clients of clinical social work.

The first trend upholds that society is responsible for the distress that clients experience. Proponents of this approach explain difficult life situations in terms of society's inability to supply equal opportunities, equal rights, and minimal living standards for weak populations. These social workers hold the inequalities in society accountable for increased client vulnerability (Bateman, 2002). This trend emphasizes the need for social workers to concentrate on social and political advocacy and policy modification as means of changing society in order to help people improve their quality of life. Supporters of this trend also underscore their empowering and protecting roles *vis-à-vis* persons who live in poverty and their roles as advocates to procure social security, debt, and housing rights on behalf of service users (Bateman, 2002; Jones, 2002). While this first trend is indeed a valid, effective way of intervention in social work—it is not the main subject of this book. This book is directed to social workers who belong to the second group and their main interest is in clinical application of the profession.

Proponents of the second trend draw attention to clients themselves as the source of their own problems. This trend attributes problems to clients' ineffective ways of coping with distressing and stressful life conditions. Vulnerability, weakness, and skill deficits are seen as responsible for clients' inadequacies. Consequently, supporters of this trend conduct direct interventions with clients, who may be individuals, couples, families, groups, or systems. These interventions aim to help clients overcome difficulties, cope with stress, and improve their subjective well-being. Professionals who accentuate client interventions must act clearly, competently, and usefully in practical situations; must think theoretically; must retain a deep interest in people; and must wish to understand behavior and relationships, actions and decisions, attitudes and motivations (Howe, 2004). Clinical social workers who espouse direct intervention with clients are continually attempting to construct a unique and respected body of

knowledge concerning the effectiveness of various services for suffering persons.

One of the main deficiencies in social work as an academic profession lies in the fact that it has not succeeded in developing its own theory and unique intervention modes. Rather, its basic theory comprises a mixture of theories taken from sociology, policy making, economy, psychology, psychiatry, and philosophy. From its early days, basic theory in social work leaned on psychodynamic conceptual models and intervention methods. Over the years, changes in society, in social work clients, and in the profession's goals and aims have also necessitated practical and theoretical modifications. Psychoanalysis has declined dramatically as a source of practical knowledge in social work, as it is seen as irrelevant to the dilemmas and conflicts faced by mainstream practitioners in their everyday work (Nathan, 2004). Rather, it has become more of a conceptualization that provides a fundamentally psychosocial knowledge base. Howe (1998) defined social work intervention as "that area of human experience which is created by the interplay between the individual's psychological condition and the social environment" (p. 173). Gradually, social work started to rely more on problem-solving methods, client-focused therapy, family theories, and, more recently, cognitive behavior theories, constructivist theories, and positive psychology developments.

CHANGES AND PROCESSES INFLUENCING SOCIAL WORK

Modern society has brought major changes to people's lives as outcomes of social, political, economic, and technological developments. Social workers today must reckon with multicultural societies, consumerism and communication explosions, personal expectations for empowerment and activism, slashed social welfare budgets, and the frequency and increasing severity of impoverished and multiproblem clients. Over the last decade, prompted by its continual search for effective, applicable modes of intervention, the social work profession has evolved to meet some of these changes head-on. Three main processes can be noted: a shift in the profession's view of clients from passive recipients to active partners, a new demand to focus on diversity that necessitates modifications in intervention strategies, and a mandate to apply evidence-based practice.

The Client's Shift From Passive Recipient to Active Partner

The first process affecting social work has been the radical change in the profession's view of the client's role, which in part stemmed from societal

changes regarding human rights and equality. In the past, adopting the traditional medical model, clinical social workers viewed clients as passive recipients who needed to accept the therapist, the treatment, and the structure of intervention outright. Client responses such as objections, rejection, and noncompliance received central attention in intervention. Over the past decades, this shift in the role of clients has enabled interventionists to look at clients as equal partners and active participants in the intervention process, and the concepts of rejection and objection have been replaced by concepts like learning from clients, learning from success, empowerment, and so forth (Rosenfeld, 1983, 1985).

The mass media explosion has played a major part leading to this shift in client roles. Knowledge that was previously accessible only to professionals is now utterly available to everyone via computer, Internet, television, and radio. Encouraged by the mass communication's appeals for people to "take control of their lives" and to become more assertive, clients nowadays behave more and more as active consumers of their own treatment. This change is apparent in medicine, in which clients are more involved today in deciding how they should be treated, are now entitled to receive diagnoses, and make decisions regarding their wish to live or die, to take the proposed treatment or not. Clients wish to be involved and possess more knowledge than ever before about treatments and methods. They can learn independently about their problems and possible solutions even before they approach professionals, and they may continue to gather knowledge from other sources while they are involved in treatment. They know to ask: "How are you going to treat me? How long will it take? What proof do you have that the intervention will really make a difference?" Aware of the phenomenon of malpractice, they also want to be sure they are putting themselves in the hands of a reliable and effective practitioner.

These developments in client behavior all contribute to the increasing recognition on the part of social workers that clients are capable of making decisions about themselves and their treatment and can become active participants in the process of their own change (Ronen, 1997; Rosenbaum & Ronen, 1998). Modern life has reinforced the idea that people are capable, have strengths, and are entitled to be involved in a process concerning themselves and their own lives. Thus, clients are no longer passive recipients of help but rather active partners in decision making.

This movement toward clients' increased involvement, knowledgability, and activism is expected to continue in the next decades and to render an impact on the social work services offered (Gambrill, 2004). Individuals will probably have growing access to the same knowledge and information as available to professionals (Silagy, 1999). Hence, social workers

must become increasingly expert in direct intervention, in selecting the treatment of choice for clients with diverse needs, and in the ability not only to apply intervention but also to explain treatment decisions satisfactorily to the client and to take responsibility for the outcomes.

Incorporation of Diversity Issues Into Intervention

The second process of change with major implications for the application of clinical social work has been the changing reality of increasingly diverse cultures in the United States and the global community (Anderson & Wiggins-Carter, 2004). A focus on diversity—of any kind—has become an integral part of social work profession standards (Council on Social Work Education, 2002; National Association of Social Work, 1996). In its code of ethics, the National Association of Social Work has added the need to understand culture and its function in human society. Diverse populations, diverse problems, and diverse situations have elicited social work commissions' recognition of diversity as a central concept (Dorfman, Meyer, & Morgan, 2004).

Social workers view themselves as competent to practice with and on behalf of diverse populations (Council on Social Work Education, 2002; National Association of Social Work, 1996). Such competence requires more than just adaptations of existing practice frameworks (Anderson & Wiggins-Carter, 2004). It necessitates an expansion of theory and the learning of new models of practice. To practice with and on behalf of diverse populations, social workers must adhere to a strength paradigm and to concepts that "facilitate the inherent capacity of human beings for maximizing both their autonomy and their independence, as well as their resourcefulness" (National Association of Social Work, 1996, p. 9). The strength perspective encompasses a collation of principals, ideas, and techniques that enable resources and resourcefulness of clients (Saleebey, 1997). Social workers thus should learn direct, structured, skills–directed therapy based on positive psychology, behavioral and cognitive therapies, and the search for empowerment. The empowerment approach (strengths perspective) in social work increases personal and interpersonal or political power and involves the creation of positive perceptions of personal worth; resources and skills; recognition that many of one's views do matter; connections with others; critical analysis; and strategies for social action on behalf of oneself and others.

Along with the strength paradigm that assumes and promotes client competence, two other perspectives have been proposed to facilitate practitioners who need to address diversity: methods and interventions that address the central components of individual and family resiliency (Fraser, 1985) and a focus on solutions rather than on problems (deShazer, 1985).

The Call for Evidence-Based Practice

The third process influencing changes in social work has been the growing call for social workers to apply evidence-based practice. This process has derived from diminished mental health budgetary resources and the ensuing need for intervention efficiency, as well as from accumulating frustration due to the continued suffering of constantly new generations of needy and multiproblem families. From its early stages, even when social work was not yet defined as a profession but rather comprised voluntary action or semiprofessionalism side by side with the need to help people change and cope with problems, social work has emphasized the scientific base underlying intervention. In his book *The Nature and Scope of Social Work*, Cheney (1926) related to social work as "all voluntary efforts to extend benefits which are made in response to a need, are concerned with social relationships, and avail themselves of scientific knowledge and methods" (p. 24) (see details in Chapter 3). Early on, Reynolds (1942) emphasized the need to base social work on a scientific foundation:

> The scientific approach to unsolved problems is the only one which contains any hope of learning to deal with the unknown . . . however, only in recent years, in line with the increasing demand to apply effective interventions, a trend has emerged to ground intervention in theory and to link the treatment's theoretical background to assessment and intervention. (p. 24)

Evidence-based practice has been defined as "the integration of best research evidence with clinical expertise and client values" (Sackett, Straus, Richardson, Rosenberg, & Hanyes, 2000, p. 1). In Chapter 3, Thyer and Myers state that almost all social work practice, dating back for decades, can reasonably be said to have involved clinical expertise and a judicious consideration of value-related issues. They emphasize that evidence-based intervention brings to the table the crucial additional or supplemental voice of giving weight to scientific research, alongside traditional clinical and value-related considerations. In applying evidence-based practice, decision making is transparent, accountable, and based on the best currently available evidence about the effects of particular interventions on the welfare of individuals (Macdonald, 2004).

Myers and Thyer (1997) offered clinicians several ways to facilitate effective interventions. For example, practitioners may use criteria from the Task Force on Promotion and Dissemination of Psychological Procedures (1995), employ stages to categorize empirical validation, base treatments on outcome studies (Chambless, 1996; MacDonald, Sheldon, & Gillespie, 1992), or learn from metaanalyses (Gorey, 1996; Kazdin, 1988).

Howe (2004) emphasized that evidence-based intervention requires social workers to become clearer about their theoretical assumptions and to induce theory from practice and observation. He proposed five key areas for doing so:

1. Observation, as a basis for making assumptions and determining the client's baseline functioning and environment.
2. Description, to help understand the situation in which the observation occurred.
3. Explanation, to link possible influences, relationships, and processes to the occurrence.
4. Prediction of future process, to help make decisions about what might happen.
5. Intervention, to help and change the proposed described situation.

Within this climate of enhancing efficacy, an important contribution of academic schools of social work lies in their shift in focus toward teaching and training students in how to design effective interventions through a clearer and more concrete definition of target problems (Stein & Gambrill, 1977), a greater willingness to pursue goals of a modest scope (Reid, 1978), the institution of baseline and outcome measures (Kazdin, 1988), and the inclusion of all of the aforementioned in social work education and professional training (MacDonald et al., 1992).

In sum, all three recent processes of change in social work—viewing the client as an active equal partner, focusing on diversity, and teaching and training to apply evidence-based practice—have become an integral part of modern social work.

THE BASIC VIEW OF CLINICAL SOCIAL WORK

Clinical social work today operates in a variety of settings in the statutory, voluntary, and private sectors. Social workers apply their practice in hospitals, physicians' clinics, schools, nurseries, prisons, institutions, as well as in a wide variety of primary social work agencies and welfare services. Cree (2004) argued that no clear definition exists concerning how social workers apply interventions to help clients in these varied settings, and that current definitions continue to raise questions about social work and postmodern society. Mostly, an acceptance of the notions that postmodern society is a "risk society" (Beck, 1992) and that social work cannot be separated from society (Cree, 2004) implies that the goals of social work comprise coping with risk and practicing effective means to help clients cope.

Clinical social workers adequately help meet client needs (Wodarski, 1981). Their multitarget and multimethod approaches are directed toward the achievement of positive change and the resolution of human problems (Schinken, 1981). In addition, clinical social workers aim to embrace shaping, educating, and teaching roles, for example, to implement self-help skills or problem-solving models. Another distinctive component of clinical social work is its development of innovative prevention programs to foster clients' ability to cope and manage better in the future (Hardiker & Barker, 1981; Wodarski, 1981).

Clinical social workers have always been interested in helping clients change effectively. The evolution of new intervention modes has permitted the achievement of rapid outcomes on the one hand (Marks, 1987; Ost, Salkovskis, & Hellstrom, 1991) and an increasing emphasis on valuative and comparative studies of treatment efficacy on the other hand (Garfield, 1983; Kazdin, 1982, 1986). The issues of the client's right to effective treatment and the therapist's responsibility to provide that efficacy have started gaining crucial attention in psychotherapy in general, and in social work in particular (Alford & Beck, 1997; Bergin & Garfield, 1994; Giles, 1993).

The importance of empirical study, valid information, and intervention effectiveness has always been accentuated by the social work field's central objectives of increasing accountability, maintaining exemplary ethics and norms, and establishing clear definitions and goals (Gambrill, 1999; Rosen, 1994, 1996; Thyer, 1996). Thyer has emphasized that the contemporary movement toward empirical clinical practice has ample historical precedent, referring to the theme of unifying social work science and practice, which appeared 40 years ago. Social work has been exerting considerable effort to realize its commitment to effective and accountable practice (Rosen, 1994, 1996). Many in the profession believe that effective practice will be enhanced through focused efforts to develop scientifically valid and practice-relevant knowledge for professional decision making.

Until the last decade, only a few interventions based on evidence appeared in Israel. In 1994, Rosen studied the sources of knowledge used to guide Israeli social workers' decisions in actual practice. He found that "value based" normative assessment was the most frequently used rationale in decision-making tasks. Other sources for decision making were theoretical, conceptual, or policy issues. Almost no decisions were made based on empirical outcomes. Thus, according to Rosen's study from a decade ago, practice was generally carried out in Israel on the basis of social workers' beliefs, training, and code of ethics, and only rarely based on valid empirical knowledge.

As previously described, recent processes of change in clinical social work in the United States in general, and in Israel in particular, have been

leading to a shift toward the application of evidence-based practice. Nevertheless, most social work research studies continue to be conducted by individual faculty members from university schools of social work, and some are undertaken by independent research institutes and government-affiliated departments (Auslander, 2000). This situation implies that the main interest for research ordinarily does not originate from the service agencies themselves, and often the researcher is even considered an "outsider" who disrupts the agency's routine and whose presence spurs much complaining from the social work practitioners.

The existing gap between psychotherapy researchers and field clinicians resists closure and even threatens to widen (Greenberg, 1994). Clinicians are personally committed to creating a particular sort of intimate relationship with their clients. Researchers, on the other hand, are personally committed to asking difficult, sometimes provocative questions about those relationships. I believe that the only way to create a meaningful change in this discord and friction would be for local service providers to decide to employ researchers as members of their regular staff and to integrate research evaluation into their basic intervention processes. One of the most important foreseeable changes in social work intervention will be collaboration between researchers and clinicians, who will share a common view that evidence should serve as the basis for practice and that effective intervention applications should be rooted in everyday practice.

Social workers started focusing on planning interventions, in order to seek out the most effective methods for change, and also to evaluating the intervention process and its achievement of goals (Bloom & Fischer, 1982; Gambrill, 1990). Toward this end, social workers should look for short-term, concrete, operational, and effective treatment methods. They should also learn to routinely apply initial assessment tools as well as evaluation methods to research their own treatment outcomes. They need to enhance their awareness that solving a client's specific problem (whether personal or familial) cannot suffice. Rather, a powerful need exists to teach clients specific skills that will enable them to resolve and cope with their own problems in the future. In other words: The client must be taught to become his or her own change agent. Social workers need to shift the weight of their interventions from reliance on therapeutic skills to an approach that is based more on teaching, educating, and training people in skills for helping themselves.

This description sets the stage for understanding the new trends characterizing clinical social work: understanding that clients are equal beings and have the right to intervene in the process of change, focusing on diversity and therefore on strengths and solutions rather than on problems, basing practice on evidence about efficacy, planning and evaluating

treatments, and looking to positive psychology when planning intervention. All of these trends likewise characterize cognitive behavior therapy (CBT).

THE BASICS OF CBT

The dynamic nature of CBT can be understood by reviewing its developments over the last 50 years (Ronen, 2002). Basic behavior theory focused on learning modes. Stimuli, response, and conditioning depicted classical conditioning (Wolpe, 1982), whereas operant conditioning utilized concepts such as behavior, outcomes, extinction, and reinforcement (Skinner, 1938). Social learning employed constructs such as modeling, environment, and observation (Bandura, 1969). Altogether, these constructs pinpointed the role of the environment in conditioning one's behavior and the links between stimuli and responses; behaviors and outcomes; and expectancies, behaviors, and environments.

These main concepts and explanations also manifested themselves in the six thinking rules developed by Kanfer and Schefft (1988) to direct the cognitive behavior therapist in conducting treatment:

1. *Think behavior.* Action should comprise the main dimension on which to focus interchanges in therapy.
2. *Think solution.* Attention should be directed toward determining which problematic situation needs resolving, what is the desirable future, and some indication of how to achieve it.
3. *Think positive.* Focus should be directed toward small changes and positive forces rather than on difficulties, and toward constantly reinforcing positive outcomes.
4. *Think small steps.* The targeting of small gradual changes reduces fears, motivates clients, and helps therapists observe and pinpoint difficulties. An accumulation of many small changes constitutes one final, large, and significant change.
5. *Think flexible.* Therapists should look for disconfirming evidence that points to alternatives. They should try to understand other people's points of view and to adapt treatment to the client's needs.
6. *Think future.* CBT challenges therapists to think toward the future, predicting how their client will cope and how they themselves would like to be different or better in the future.

The addition of cognitive components brought about a major change in the basic behavior model of therapy, creating CBT. As a way of thinking and perceiving human functioning and needs, CBT offers a way of

operating within the environment in order to achieve the most effective means for accomplishing one's aims (Beck et al., 1990; Ronen, 1997, 2002). The cognitive theory of psychopathology and psychotherapy considers cognition as the key to psychological disorders. Cognition is defined as the function that involves inferences about one's experiences, occurrences, and control of future events.

Cognitive behavior theory emphasizes several components. First, as mentioned before, human learning involves cognitive mediational processes. Therefore, thoughts, feelings, and behaviors are causally interrelated. The thought is responsible for information processing relating to the world and to oneself, and that information influences emotions, behaviors, and physiology in reliable, predictable ways. Also, this theory highlights activities such as expectations, self-statements, and attributions, which are seen as important in understanding and predicting psychopathology and psychotherapeutic change.

An important theoretical concept comprises irrational or dysfunctional thought. Human problems derive from persons' irrational, dysfunctional, and inadequate way of thinking (Beck, Rush, Shaw, & Emery, 1979). CBT attributes problems either to thinking style (irrational or distorted) or to deficiencies such as a lack of skills that impedes clients from behaving as they should. Hence, skills acquisition is conceived both as a major, crucial component in human functioning and as an important therapeutic technique.

The underlying theoretical rationale of CBT upholds that human beings' affects and behaviors are largely determined by the way in which they structure the world (Beck, 1963, 1976; Beck, Emery, & Greenberg, 1985). From birth, humans start to develop their personal cognitions—verbal or pictorial "events" in the stream of consciousness—that derive from attitudes or assumptions developed from previous experiences (Alford & Beck, 1997). This personal interpretation creates the human being's personal repertoire of cognitions and reflects individuals' personal schemata toward themselves and the world around them. The schemata evolve from life experiences, personal nature, and environmental components. Personal repertoire and schemata reflect human beings' basic belief systems and manifest themselves in their automatic self-talk. Over the last few years, a wide range of research studies and applications of schema-focused therapy have emerged, as described in detail in Chapter 20.

The addition of constructivist components to CBT highlighted the role of change. Human beings are always in a process of change (Cull & Bondi, 2001). In directing intervention, therapists should therefore consider the fact that clients change and will continue to change in the future. Constructivism also focuses on personal constructs (Mahoney, 1991), emphasizing the role of human beings as architects, with responsibility

for creating their own lives and experiences (Kelly, 1955). People make their own realities by constructing, reconstructing, and construing their life events and by attributing personal meanings to their experiences (Mahoney, 1991, 1993, 1999). Thus, problems do not constitute objective events themselves (e.g., death, depression, sickness) but rather how one subjectively interprets such events and how this specific interpretation gives rise to particular emotions and behaviors (Beck, 1976).

Over the past decades, other developments in CBT have included techniques emphasizing the need for acceptance of problems rather than a focus on overcoming and coping (Hayes, Jacobson, Follette, & Dougher, 1994). In addition, mindfulness techniques have been integrated into the process of intervention (Hayes, Follette, & Linehan, 2004).

Rosenbaum and Ronen (1998) summarized the seven basic, key features of CBT:

1. *Meaning making processes.* These processes help clients develop a new and more suitable way of understanding and accepting their behavior.
2. *Systematic and goal-directed processes.* The therapist plans and executes treatment and designs the therapeutic hour (Beck, 1976), with an emphasis on the need to define problems, goals, expectations, means to achieve these goals, assessment, and evaluation of the process.
3. *Practicing and experiencing.* CBT constitutes not a talking therapy but rather a doing therapy that encompasses practicing and experiencing as central components. Interventions vary and can be verbal or nonverbal, using experiential methods such as role assignments, imagery training, metaphors, writing methods, and so on (Mahoney, 1991; Ronen & Rosenbaum, 1998).
4. *Collaborative effort.* Therapist and client must enter into an alliance and collaborate on joint work in order to achieve the goals of therapy.
5. *Client-focused intervention.* CBT should aim at treating the person, rather than treating the problem. This view focuses on the person as a whole, and concentrates on the client's feelings, thoughts, and way of living, not only on the client's problem.
6. *Facilitating change processes.* This component emphasizes the important role of the therapist in pursuing effective strategies and techniques to help the client change (Rosenbaum & Ronen, 1998).
7. *Empowerment and resourcefulness.* All of the previous features aim to empower clients by training them in self-control skills for self-help and independent functioning.

CBT is not a method that is administered to the client, but rather a method that is designed in collaboration with the client. Therefore, intervention varies from one client to another. No one technique or means is essential for achieving change, but rather the therapist must design an

appropriate intervention that suits each individual client, based on that client's unique nature, hobbies, particular problem, strengths and resources, and motivation for change (Ronen, 1997; Rosenbaum & Ronen, 1998). Therapists maintain a constant state of decision making, always asking themselves what the best intervention is with this specific client, with this specific problem, in this specific situation (Paul, 1967; Ronen, 2001).

Treatment is planned, structured, and goal directed. Yet, no rigid rules predetermine the length of therapy, the frequency of sessions, or the treatment location. These, too, encompass part of the decision-making process regarding the treatment of choice for each client. Treatment may begin with more frequent sessions, which lessen in frequency as the client progresses. Phone calls can provide between-session contact with the client. For example, asking a socially rejected child to call the therapist on each day that he was able to talk with children without them laughing at him may increase the boy's confidence, motivation, and awareness about his ability to carry on a conversation. Therapy generally transpires in the clinic but may make use of outdoor walks or natural settings for exposure exercises, or may shift to a basketball court to promote a child's motivation or practice new skills in a concrete context (Ronen, 2003).

CBT can be applied to various populations such as families, couples, adults, children, individuals, groups, and communities, with an emphasis on the unique nature and needs of each setting (Alford & Beck, 1997; Cigno & Bourn, 1998; Graham, 1998), as can be found in this book. Both verbal and nonverbal therapy can be used to achieve the most effective change possible (Freeman & Boyll, 1992), and some examples of the variety of techniques can be found in the various chapters in this book. Creative indirect techniques can assist therapists in overcoming difficulties in the treatment process, facilitating their clients to surmount obstacles in therapy, and applying more effective treatments to suit their clients' specific life purposes.

The best technique will be the one that is feasible for the therapist to use; suits the client's language, interests, and way of thinking; and enables the client to understand and change the present problem (Ronen, 2001). Decisions about the treatment of choice must be based on assessment of the client's characteristics, the severity of the problem, and the client's ability for change.

Concepts and Components Common to Both Social Work and CBT

Many of the basic concepts underlying social work interventions are shared by CBT. These similarities are not casual. Social work is a practical profession with practically defined goals and concrete techniques, based on structured intervention and goal-directed processes, and emphasizing

the social workers' role as a change agent. CBT aims to resolve the problems of the individual and improve that person's quality of life. This section focuses on several additional concepts that demonstrate similarities between clinical social work and CBT: individualism; rational thinking; clearly defined objects for change; assessment, evaluation, and intervention planning; prediction; developing skills for behavior change; and empowerment.

Individualism

In its early days, social work emphasized the importance of focusing on the individual and on "individualism." Loewenberg (1998) emphasized the importance of individual differences as a notion that should guide social workers in their everyday functioning. Likewise, CBT approaches look for the person behind the problem and the special way in which the problem presents itself in each specific case. CBT focuses on how the person thinks, feels, or acts and what forces maintain his or her behavior. Individual differences also constitute the main concept underlying the approach advocating a focus on cultural diversity in social work. Understanding that every individual is unique, and that every person possesses strengths if only the therapist will look for them, is a common feature in social work as well as in CBT. This issue shifts the focus from diagnosis (e.g., depression) and from generalizations (e.g., depressive people act in a way . . .) to a focus on learning about the individual person and his or her strengths and resources.

Rational Thinking

Rosenfeld (1983) underscored the importance of rational thinking for social workers. He pointed out that the theory of social work stresses the need for awareness of both thoughts and emotions as the main determinants of people's behavior. Rational thinking is also the basis of CBT. Ellis (1973) viewed all problems that people experience as related to irrational thinking, and, therefore, he directed treatment toward changing irrational to rational thought. CBT looks at the person's behavior as an outcome of his or her thinking processes, which affect emotional states and direct the person to take specific actions. Rational thinking, therefore, plays a necessary part of social work as well as CBT.

Clearly Defined Objects for Change

Perlman (1953), Loewenberg (1998), Gambrill (1983, 1990), and others have emphasized that no intervention can be carried out in social work

unless values and targets are very clear, concrete, and well-defined. These three features are at the basis of every cognitive and behavioral intervention, in contrast with the psychodynamic branches of therapy.

Assessment, Evaluation, and Intervention Planning

These components are central features of CBT. Therapy is based on careful assessment, intervention is directly linked to assessment and followed by evaluation. Social workers also recognize the need to evaluate and set criteria for change. One of the unique features of social work is its consistent need for planned intervention in all four systems: the change-agent system, the client system, the target system, and the problem system. Loewenberg (1984) emphasized the need for professionals to use explanation, prediction, practical guidance, and application of practical knowledge. All of these should be accompanied by assessment and evaluation methods to examine the efficacy of interventions.

Prediction

Loewenberg (1998) argued that social work applications should rely on two kinds of prediction: the way the client will act without intervention, and the way intervention might change the nature of the problem. Prediction encompasses an important part of the overall treatment (Bandura, 1969; Kanfer & Schefft, 1988), as a base for choosing the optimal techniques (Gambrill, 1983), and as a means whereby the client takes responsibility for his or her own change (Ronen, 2001).

Developing Skills for Behavior Change

Social work as a profession is built on the notion that theoretical knowledge can be translated into skills and practical know-how in order to achieve change (Beckerman, 1978; Kondrat, 1992). Thus, Schinken (1981) suggested that social workers should translate abstract theory into concrete methods for analyzing and alleviating personal and societal stresses. Skills-directed therapy is also a very important part of CBT in general and with children in particular (Ronen, 1994). For example, see Chapter 13 on children's problem solving and group social skills training. The conceptualization of the nature of the learning process within CBT theories emphasizes each individual's ability to learn and acquire new skills. Like any other type of learning, individual differences determine the amount of time and effort necessary to invest in learning, but there is no question that everyone is capable of learning.

Empowerment

As social work involves weak populations, empowerment constitutes an important interventional goal. Instead of instituting long-term dependent relationships between therapist and client, social workers aim to assist clients to become independent and to help themselves. Likewise, the purpose of CBT theories is to aid individuals, groups, and families to find their own resources, learn to recognize and use their own wisdom, and discover personal methods for self-help. These are expected to lead clients toward greater independence, self-trust, and capability for self-change (Rosenbaum & Ronen, 1998).

Considering the common base shared by social work and CBT, Rosen and Livne (1992) argued that social workers who subscribe to a psychodynamic orientation are more likely to emphasize the unity of personality and to view their own personality, intuition, and spontaneity as critical in treatment, focusing on personal rather than environmental features. They suggested that social workers who adopt a more planned, systematic, and research-oriented approach to treatment are less likely to formulate clients' problems in this way.

BRIDGING THE GAP BETWEEN CLINICAL SOCIAL WORK AND CBT

CBT is based on working toward an understanding of the client and then intervening in how that client anticipates experiences by creating an intervention appropriate for that one human being. Inasmuch as such therapy constitutes a planned, designed process, clinical researchers have given much attention to the construction of the intervention process. The most familiar procedure providing guidelines for conducting the process of intervention comprises Gambrill's 12 steps (Gambrill, Thomas, & Carter, 1971). Gambrill, who is one of the founding figures in behavior therapy, is also a well-known social worker. Although she proposed her intervention procedures many years ago, in the 1970s, they are amazingly relevant today, and I urge all my social work students to learn to use them. These 12 structured phases enable clinical social workers to check and recheck the intervention process, identify their current stage, and clarify what is missing.

1. *Inventory of problem areas.* Aims at collecting information about the whole spectrum of presented problems.
2. *Problem selection and contract.* Raises clients' motivation by collaborating with them and achieving their agreement on problem areas selected for change.

3. *Commitment to cooperate.* Aims to facilitate compliance and motivation by obtaining the client's agreement with the process.
4. *Specification of target behaviors.* Defines and analyzes each behavior to decide what maintains and reinforces the problem.
5. *Baseline assessment of target behavior.* Collects data about the frequency and duration of the problem, to provide a concrete foundation on which to evaluate change.
6. *Identification of problem-controlling conditions.* Identifies the conditions preceding and following the problem's occurrence.
7. *Assessment of environmental resources.* Uncovers possible resources in the client's environment.
8. *Specification of behavioral objectives.* Specifies the behavioral objectives of the modification plan, and elicits the client's terminal behavioral repertoire.
9. *Formulation of a modification plan.* Selects an appropriate technique for applying the most efficient program for change.
10. *Implementation of modification plan.* Modifies behavior and focuses effort on change.
11. *Monitoring of outcomes.* Collects information concerning the effectiveness of intervention.
12. *Maintenance of change.* Works to achieve maintenance and stabilization, to help prevent relapses.

INTEGRATING CBT INTO CLINICAL SOCIAL WORK: LOOKING TOWARD THE FUTURE

Social workers must first address their clients' high-risk, urgent situations, and only then can they free themselves to concentrate on preventive programs. CBT is a treatment of choice not only for decreasing immediate, hazardous problems but also for preventing future difficulties. Practitioners trained in CBT techniques are expected to be able to not only use the acquired skills directly but also to generate and generalize skills for future reference. Hence, one intervention may possibly facilitate the achievement of primary, secondary, and tertiary prevention goals.

Social workers need to look for effective methods for change, and CBT methods are very promising in this respect. CBT is not the only effective method for change but, at least, offers a well-grounded theory, together with clearly defined techniques and suggestions for assessment and evaluation of the change process. CBT has been proven effective for resolving concrete problems as well as for working on future goals. Moreover, inasmuch as CBT is anchored in skills acquisition and learning, it may be viewed as a nonstigmatic way to help normal, regular people.

As educators, teachers, and practitioners, social workers' main roles can be to educate clients for self-help, teach them needed skills, train them in practicing and applying those skills, and then supervise them in generalizing the acquired skills into other areas and problems. By imparting clients with skills and methods through such interventions, social workers can help clients to become their own change agents who are in charge of their self-help processes and who improve the quality of their own lives. CBT training should therefore be recommended as a helpful, effective, and empowering method both for social workers and for their clients.

Social workers practice interventions with different problems spanning a large range of social classes and cultures. It is impossible to design intervention without being familiar with the client's own socioeconomic class, culture, and way of life. The intervention should be adapted to fit the client's familiar way of behaving and only then should the attempt be made to slowly achieve change. Like in a good tennis game, the social worker should learn to meet the ball wherever it arrives and to try and raise it up. Only by so doing can CBT training be adapted to different cultures and problem areas. Concepts and techniques should be designed together with the client, to fit the client's own familiar language, outlook, and lifestyle.

Social workers, schools of social work, agencies, and clients alike need to be sure that social work has something important to offer them. It is time to return to our basic goals and aims. Social workers need to help people help themselves, fulfill their own wishes, and improve their own quality of life.

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