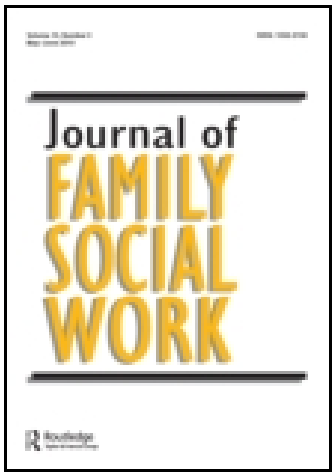

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Solution Based Casework: Case Planning to Reduce Risk

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Solution Based Casework: Case Planning to Reduce Risk

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ABSTRACT. Social workers employed as protective service caseworkers frequently encounter clients who *repeatedly* harm family members. Emerging partnership models for casework have meant better information gained at assessment, however casework practice models have not emphasized collaborative case planning strategies to reduce the risk of recidivism. This paper describes *Solution Based Casework,* a partnership approach to casework that targets high risk behaviors and organizes case planning around relapse prevention. The paper details assessment considerations, particularly when working with individuals and families with multiple, cyclical problems. Focusing on solutions as a strategy to foster partnerships with historically reluctant clients is discussed. Finally, case examples and a case plan are presented to demonstrate how case planning targets dangerous behaviors, reduces the chance of relapse, and creates measurable and accountable outcomes. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com <Website: http://www.haworthpressinc.com>]*

Caseworkers[1] routinely encounter individuals who behave violently and/or neglect the needs of vulnerable children and the elderly. The phenomenon of opening, closing, and reopening files–sometimes over a period of years and even across generations–is widely known. Fami-

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ly caseworkers and family therapists are called upon to work together to prevent risk, yet the two fields do not share a common conceptual roadmap for assessment and case planning. In the latter half of this century, casework practice models have been heavily influenced by physical and mental health treatment models that place a significant emphasis on the assessment and diagnosis of dysfunction (McDaniel, Hepworth, & Doherty, 1992). These models suggest that accurate diagnoses ought to instruct caseworkers and clinicians, i.e., certain diagnoses lead directly to prescribed, corresponding interventions. With this approach, individuals and families have been viewed as service *recipients* rather than capable, *active partners* in the change process. More recently, however, models that emphasize collaboration, individual and environmental change, and solutions (versus cures) have gained acceptance (Berg, 1994; de Shazer, 1991; Kinney, Haapala, Booth, & Leavitt, 1990; Percora, Whittaker, & Maluccio, 1992, Smale, 1995).

Although competency-based, collaborative approaches to family casework have convincingly described the philosophy underpinning collaboration, these models have not yet fully detailed the link between collaboration, targeted case planning, and relapse prevention. Indeed, courts are increasingly wary of making decisions based on general statements of service completion (e.g., ". . . attended x number of sessions at such and such agency"). What is successful completion of casework services? What should be our markers of success? What should courts, therapists, caseworkers, supervisors and others point to to determine safety? Given the frequency with which individuals return to maladaptive behavior (Reid, 1992), a model is needed that (1) is collaborative, (2) offers families, caseworkers and therapists tangible case planning direction, (3) identifies specific high risk behavior in an efficient manner, *and* (4) prepares individuals and families with the skills to *prevent relapse* of dangerous behavior. *Solution Based Casework,* which draws from family developmental theory (Carter & McGoldrick, 1980; Duvall, 1957, 1971), solution-focused therapy (de Shazer, 1985, 1988, 1991; O'Hanlon & Weiner-Davis, 1989), and relapse prevention theory (Lane, 1991; Marlatt, 1985; Pithers, Marques, Gilbat, & Marlatt, 1983), offers a conceptual road map for establishing working partnerships and targeting pertinent behaviors in an effort to prevent problem relapse.[2] Developmental theory is used to anchor case planning in specific everyday life events. Solu-

tion-focused therapy is used for the strength-based interviewing techniques (i.e., searching for exceptions to the problems, anticipating change) that are so helpful in counteracting chronic discouragement. Mental Health providers are also increasingly aware of solution-focused and related constructivist models due to managed care's interest in reducing the length of therapy. Relapse prevention theory is used to focus case plans on specific outcome skills that are known to reduce the likelihood of recidivism. Relapse prevention theory is useful also in that it is the basic approach to several key treatment protocols in mental health (i.e., addiction, sexual offender counseling, and aggression management).

Drawing from these familiar models, *Solution Based Casework* is anchored in the following basic tenets: (1) families encounter common developmental challenges; (2) dangerous behavior occurs within the context of everyday life and, consequently, case planning for prevention must be directly tied to those events; and (3) case planning must target the reinforcement and development of situation-specific relapse prevention skills.

TENET #1: THE COMMONALITY OF CHALLENGES IN FAMILY LIFE

Family development theory and supporting evidence suggest that, although cultural differences certainly exist, families experience fairly predictable life stages and associated tasks (Carter & McGoldrick, 1980, Duvall, 1957, 1971; Germain & Gitterman, 1996). In that sense, families experience similar challenges. It is useful for caseworkers and other professionals to be mindful of these common challenges, e.g., the tension that often exists during hurried morning routines with small children, and the stress single parents encounter when financial pressures mount, diapers need changing, and children become irritable just prior to bedtime. Being mindful of these developmental stressors has at least two advantages: (1) professionals can relate to these stressors, which creates a vehicle to mutual understanding and working partnerships, and (2) many incidents of abuse and neglect are closely tied to developmental stressors, e.g., when closely tracking acts of violence with a given individual, one finds that he is typically abusive in the evening, on the weekends, and particularly at the end of the month when money is tight. This information provides very important

hints toward creating a case plan that targets idiosyncratic, developmentally-informed and relatively predictable problem patterns.

Families who experience marked difficulty in negotiating common developmental stressors often become discouraged as their attempted adaptive solutions too frequently fail to satisfy developmental needs (Terkelson, 1980; White, 1986). Consequently, tension and conflict increases. Not surprisingly, many of these individuals and families eventually become convinced they lack the resources to conquer conflict (White & Epston, 1990). This entrenched and discouraging view of themselves tends to obscure their awareness of their existing and potential solutions (de Shazer, 1988). They may be only vaguely aware of the intrapersonal and interpersonal nature of their responses to daily developmental stressors. As reflected in comments such as "*. . . and then we start all over again . . .*" or "*I was afraid I was doing it again,*" members are cognizant that a pattern exists, but are not confident in their ability to *avoid the pattern, interrupt it* once it starts, or when necessary, *escape it* before harm occurs.

In an effort to assist individuals and families beyond crippling discouragement, *Solution Based Casework* focuses on *exceptions to problems* and on specific, manageable patterned behavior associated with common life tasks. As such, the caseworker needs to answer three assessment questions[3] to keep the problem definition located in the everyday life of the family: (1) *What everyday life task(s) is the family having difficulty with?* (2) *What are the details of the family interaction when they try to accomplish these tasks?* and (3) *What individuals in the family are unable to maintain enough self-control to tolerate the tension in meeting the tasks in question?*

These assessment questions sound easy and logical to front-line workers, yet the investigative responsibility of protective service agencies often predisposes assessment to focus primarily on *whether or not* the neglect, abuse, or out of control behavior has occurred, rather than the more inclusive question of *how* it occurred. Concurrently, investigative workers often feel pressure to collect indications of pathology or dysfunction that can be readily identified by the caseworker, whether or not they are directly related to the conflict in question. Although this information is potentially useful, if the assessment lens is focused primarily on *whether or not* there is evidence of pathology, it will be difficult for the caseworker to maintain a perspective that locates the problem within the developmental challenges the family and its members are facing.

As such, case plans are at risk of simply listing the pathologies identified and assigning a rote, non-tailored treatment package (e.g., Child abuse = parenting classes; presence of alcohol = alcohol counseling; past sexual abuse = victim counseling; domestic violence = perpetrator group). For instance, if a father strikes a child and leaves bruises, caseworkers need to know more than whether or not it occurred, the size and configuration of the bruise, or the father's frequency of attendance in court mandated counseling in order to be reasonably confident of the child's safety. Identification of developmental tasks (e.g., the father struck the adolescent child during a disagreement about acceptable peer relationships), details regarding how all involved respond to the developmental stressor, and most importantly, the specifics around the father's loss of control pattern are each essential components in planning relapse prevention. As such, developmental theory guides the assessment process, provides a palatable explanation of many maladaptive behaviors (thereby reducing defenses), and grounds case planning in tangible, daily events. Consequently, relapse prevention is enhanced as individuals are made aware of factors that contribute to their destructive behavior patterns, and individuals are held accountable to the behaviors that induce harm.

Creating a Partnership to Identify Solutions

The social service profession has been criticized as aloof, assuming an objective posture and emphasizing deficits and pathology (Minuchin, 1993). Indeed, clients who do not accept professionals' perceptions and recommendations are typically labeled resistant and their contribution to the change process is minimized (Berg, 1994). Recently, however, collaboration, subjectivity, and an active, mutually engaging relationship between clients and professionals is re-emerging (Berg, 1994; Lee, 1994; Kemp, Whittaker, & Tracy, 1997; Wood & Middleman, 1989). This shift in the professional relationship reduces contentiousness and facilitates working partnerships.

Solution Based Casework endorses this trend. It is *assumed* the family has attempted to resolve conflict, has too frequently been unsuccessful in those efforts, and has become discouraged. Emphasis is placed on detailing attempted solutions, identifying moments of success, and encouraging the use of underutilized resources. Deficits, though, are not ignored. Instead, they are seen as one aspect of a larger question. Namely, how can *this* family more completely meet

the needs of its members at *this* particular moment in their life cycle? An emphasis on solutions and exceptions to maladaptive behavior reduces defenses and fosters rapport. When fully adopted, this approach allows for meaningful, solution focused conversation, even when faced with contentious situations, such as when it is necessary to separate members in order to ensure safety.

De-pathologizing families and the *intentions* of individuals increases clients' receptivity to explore alternative ways of behaving. Indeed, individuals often are defensive, even before professionals have had an opportunity to begin fostering a working relationship. This is particularly true for families who have had previous involvement with protective services. This contentiousness can be reduced by depicting problems as part of the struggle of negotiating life cycle stages. Destructive behavior, obviously, should not be condoned, but the worker must demonstrate an understanding of the pressures of life and common developmental tasks of families.

When first experimenting with this model, caseworkers may experience a desire to *first* ask numerous questions about the specific abuse or neglect behavior that elicited the referral, rather than thoroughly attempting to understand the *context* (what the family was trying to accomplish prior to the destructive behavior). If the *initial line* of questioning completely revolves around the possible offense, the family and/or certain members will undoubtedly recoil. The solution-focused caseworker anticipates a degree of defensiveness and reduces it by readily normalizing life events and the frustrating feelings associated with them. This is done by normalizing life cycle tasks (e.g., ". . . crying children are very frustrating for most everyone"), but not the dangerous behavior associated with the feelings of frustration. Caseworkers who successfully intervene in this manner create cooperative working relationships with families and are better positioned to gather detailed information and understand risk.

TENET #2: THE IMPORTANCE OF FOCUSING ON EVERYDAY LIFE EVENTS

Recognizing Dominant Patterns in Everyday Life

The process of preventing relapse begins with assisting individuals and families to recognize patterns (interactional sequences) that culmi-

nate in destructive behavior. Many families, when discussing their conflicts, will say *"It just happens,"* or *"All of a sudden (s)he just went off."* They typically do not place the incident in a recognizable sequence of events. These events flow like an uninterrupted experience just beyond their conscious awareness. However, everyday life patterns that end in destructive emotional or physical trauma must remain the focal point of assessment, case planning, case management, and case closure.

There are several benefits of organizing case planning around the everyday life events within which destructive behaviors occur. For instance, the individual who behaves dangerously can more readily recognize how his/her behavior influences, and is influenced by, the family context, and this knowledge informs individual skill development. Further, the family is more apt to receive useable assistance; interventions that emphasizes pertinent and particularly challenging pragmatics of family life. And, finally, since the dangerous behaviors are highlighted as familiar to all involved, service providers are able to more readily measure success in the specific life events that have been a problem in the past.

Searching for Exceptions to Everyday Life Patterns

Discouraged individuals who have repeatedly experienced a sense of failure typically find it difficult to recognize moments when they successfully manage conflict. As such, they may say *"He never tells the truth"* or *"She has always been trouble."* Such expressions clearly do not reflect the entire situation. Professionals can assist individuals and families toward solutions by accepting their rather one-sided view of the problem, while at the same time helping them search for and identify any exceptions to the pattern. Identifying moments when someone didn't lie, didn't create conflict, and handled anger safely gives everyone an opportunity to explore how the exception became possible. What unique characteristics of that moment allowed the maladaptive pattern to be averted? The premise is simple. Since an exception to maladaptive behavior occurred at least once it can occur again when similar conditions are re-created.

For instance, imagine the Smiths who, as they perceive it, *always* argue over finances (an everyday life event that, for these individuals, escalates to violence). Their latest disagreement culminated in a shoving match. She was successful in pushing her husband out of the

house. She then threw their bills, paperwork, and eventually several of his belongings out of the home. He retaliated by throwing rocks, breaking several windows. Meanwhile, their young child stood screaming at the front door. Neighbors became rightly concerned and called police. Working with the caseworker, the couple expressed little hope that anything could be different because they *always* argued over money. When searching for exceptions to a clearly evolved pattern, the caseworker asked them to describe an incident wherein they found themselves in one of those high risk situations, but averted dangerous behavior. The couple agreed that must have occurred and they eventually identified several situations. The conversation then detailed how they avoided danger, which included (1) what the other could do to lessen the tension in those moments; (2) identifying actions that foster escalation; and (3) identifying actions that avoid and interrupt the cycle. Bolstered by this knowledge about their individual and collective patterns, they agreed to more routinely exercise these skills and experiment with other adaptive behaviors. These changes began with a search for exceptions. It must be emphasized here that conjoint work should only occur when it is clearly identified as safe (Jenkins, 1991; Jory, 1997).

TENET #3: FOCUS ON SKILL DEVELOPMENT TO PREVENT RELAPSE

Relapse prevention includes 4 basic steps: (1) recognition of patterns; (2) learning the details of high risk patterns; (3) practicing small steps toward change; and (4) creating a relapse prevention plan. Each of these steps is important in constructing a case plan that is tailored to the idiosyncrasies of individuals and families (and therefore is particularly relevant), is measurable (and therefore creates accountability), and pin points risky behavior (thereby reducing the likelihood of relapse). Further, each of these steps moves clients along in their efforts to master skills that will ensure safety.

Step 1: Recognition of Patterns

As previously described, individuals and families who are engrossed in maladaptive behavior generally have little knowledge of their individual and collective actions, how they contribute to escalat-

ing conflict, and when they are prone to destructive behavior. One may become angry, strike, and then cover his/her transgression without ever recognizing triggering events. Without assistance, some may be unable to recognize gradations in their emotions, or to identify the conditions in which they are prone to violence. A similar cycle can be identified with neglect; the guardian(s) may report constant fatigue and be unable to identify any events, thoughts, or feelings that led to his/her depressed state, let alone identify exceptions to his/her motivation. For instance, it is very useful for a parent who has previously said "It just happens, I have no control over it *(abusive behavior)*," to begin to consider the *who, what, when* and *where* surrounding his/her destructive actions. When clients engage in a conversation that helps them to recognize key sequences, previously unnoticed adaptive and maladaptive behavior becomes obvious. Steps II and III provide a framework for building prevention skills.

Step II: Learning the Details of High Risk Patterns

Since destructive cycles have evolved from non productive efforts to resolve conflict in daily living, it is essential to assist clients in delineating the every day events that led to protective service involvement. Illuminating triggering events has the advantage of obvious relevance to the family, and also begins the process of building accountability. The aim is to thoroughly diagram the vulnerable and explosive moments within the life of the family.

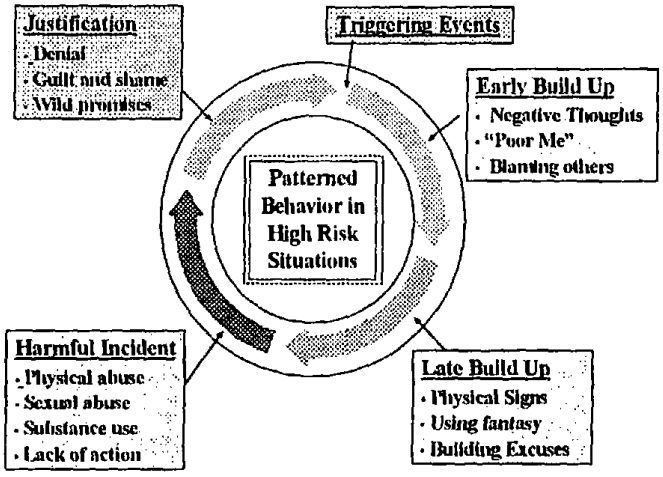
The process of identifying and exposing destructive processes often creates a desire in the family and caseworker to place blame, and transgressors may be expected by staff to admit wrong doing. Indeed, professionals often assume that services can not be productive until perpetrators overtly admit guilt and accept responsibility. It is not without reason that this is assumed; admission of guilt is positively correlated in our experience with a desire for change. However, an admission of wrongful behavior is difficult for anyone, particularly heavily defended (e.g., traumatized) individuals and families. Confessing to a shameful act is a significantly large step. Therefore, intervention need not begin with such a difficult first step. Instead, when professionals and families engage in a disarming, solution-oriented conversation about (1) the challenges in everyday life; (2) specific high risk behavior; and (3) how they can draw on their resources to prevent further conflict, transgressors are more apt to begin to recog-

nize their responsibility, what they can do differently, and to fully engage in the change process.

Entrenched, non productive patterns can be thought of as cyclical in nature (Lane, 1997) and self-perpetuating (Diagram 1). By detailing the heretofore mysterious sequence of events, clients are better positioned to gain mastery over destructive behavior.

A **Triggering Event** (e.g., comment, thought, act of omission) initiates an escalation of tension. The thoughts and emotions that follow triggering events often include a sense of injustice and are frequently self punitive (e.g., "I'll never be loved," "Why does this happen to me?" "It's not fair."). This **Early Build Up** phase typically involves blaming others. In high risk situations, tension often mounts within the individual, as manifested in physical signs (e.g., muscle tension, rapid heart rate), fantasy and the construction of excuses (**Late Build Up**). In problem saturated individuals and families, the release of tension is often manifested in some sort of **Harmful Incident** such as self abuse, aggressive retribution, or as a symbolic act meant to punish both self and others (e.g., sexual promiscuity). Typically, the process includes a **Justification Phase** wherein the individual(s) attempts to exonerate his/her action and avoid responsibility and/or wherein apologies attempt to pacify those involved.

DIAGRAM 1. Patterned Behavior in High Risk Situations



Case Example

A young mother (Ms. Smith) who has hurt her child comes to the attention of social services. The caseworker learns that she has a significant temper problem when she feels that her son is being verbally or physically aggressive toward her. She gets angry at other times but reports being able to manage her anger then. When the caseworker asks her about the sequence of events that led up to the incident in question, they learn that the mother is more at risk when she is exhausted due to lack of sleep (she has an infant daughter), or has been discouraged about finances (near the end of the month) such as when the father of her 4 year old son has not sent his child support payment. As Ms. Smith recalls the events that led to her assaultive behavior, she reports that the evening before the violent event, she waited for the child's father to deliver a child support payment. He never came. She said this **event triggered** in her considerable negative thoughts about the father, herself, and all the things about their 4 year old son that reminded her of his unreliable father. This **early build up** continued until she cried herself to sleep, after drinking wine (something she usually doesn't do unless she's depressed). Her mood continued in the morning, with flashes of anger at her child and even angry thoughts about her infant (i.e., "*Why did I have you?*"). She slapped her infant's bottom for crying when she changed her diaper, and then stomped out of the room angry at herself, leaving the child unattended on the bed. She reports feeling flushed, dizzy, her fists were clenched, she mock pulled at her hair, and she fantasized just running out the door (**late build up**).

Moments later, she heard her baby scream and ran into the room to find her 4 year old son (Sam) trying to diaper the baby, holding a pin in his hand. She flew into him, jerking his arm harshly. The pin accidentally stuck her and she pummeled him with her fists. She grabbed the baby and ran crying to her mother's home nearby. The incident was reported and the offending mother initially minimized what occurred. She publicly **justified** the bruises as accidental, yet privately promised herself she would never behave in that manner again. She agreed with the worker that, overall, mornings are her *most difficult time, particularly when she is tired, when she drinks the night before, and especially at the end of the month when money is tight* (**high risk situations**).

While the caseworker has assessed significant environmental stressors for this mother (e.g., unreliable child support), and will work with

her on these concerns, the worker recognizes that these stressors can come and go and ultimately mother will need to master her temper under such high risk situations. In assisting individuals and families who struggle to safely negotiate tasks, it is essential that triggering events, early build up, late build up and justification are identified. Detailing these processes can reduce recidivism since clients are better positioned to (1) recognize risky situations; (2) recognize early warning signals; and (3) intervene before emotional intensity decreases their ability to choose safe alternatives.

Assessment questions that assume change will occur are empowering and generally create a willingness to discuss the sequential details of maladaptive patterns. For instance, individuals are apt to participate in a conversation about productive solutions when the question posed to them is "*When you have dealt with similar conflict in a manner that you feel good about, what exactly did you do?*" Or, "*If this problem you have with temper disappeared one day, how would similar situations be handled? What exactly would you do?*" There are countless versions of questions that assume competence, anticipate change and forecast positive outcomes. Two types of change-anticipating questions are (1) questions that offer a *scale* by which to measure difference and (2) questions that offer a comparison between one *time* and another.

Scaling Questions

Scaling questions illuminate small increments of change by encouraging individuals to plot their experience on a continuum (de Shazer, 1988; O'Hanlon & Weiner-Davis, 1989). For instance, asking a depressed client to rate his/her current degree of depression using a scale of 1 to 10 (with 1 being extreme depression and 10 being the happiest moment of his/her life) can begin a conversation that exposes even slight differences between depressed and non depressed states. For instance, his/her response might be "I'm about a three." His/her response could be followed with, "Describe everything that's different when you're slightly higher, say a 4." This information provides essential clues to individual and systemic patterns, creates a window into idiosyncratic solutions and informs case planning. Table 1 includes further examples of scaling questions.

TABLE 1. Questions That Anticipate Change

Scaling Questions	Time-Oriented Questions
• On a scale of 1 to 10, with 1 being the lowest and 10 being the highest: • How would you rate your self-control today? "4" How would you rate it back when you started working on it? "2" What keeps you from slipping back to a 2? Where do you think you'll be in three months from now? "6" What will you be doing differently when you are not quite a six, say a five? • Describe what you are doing on a day when you are feeling very upbeat . . . say a seven or an eight? • How much change does your wife see in you, what might she rate you if asked? "5" What would you rate yourself? "6" What does she not see that you do? What will you have to do to let her see that you are at a 6 now? • Describe what your husband would be doing on a day that you solved your problem at about a level 6?	• If you woke up in the morning and the problem was miraculously solved, what would be different? What is the first thing you would notice about yourself? How would you know that a miracle had occurred? • Imagine you are an old person sitting on your front porch, thinking back about this difficult period of your life, what will you say was the turning point? • Let's say I never met you until one year from now, when all this will be behind you, what would be my first impression of you? • How have you improved over the previous generation in this area, what have you done to keep from repeating their mistakes? • As these changes continue in your family, what will be different about your family in one month (one year) from now? • When will your family of origin first notice you have changed? What will they see?

Time-Oriented Questions

Time-oriented questions tease out positive change, motivational values, possible goals, and potential first steps of change. The discouraging present can be sidestepped to a promising future. As was the case in the popular movie "Back to the Future," the caseworker can take the client to the future and from that perspective have the client look back and advise themselves on what direction to head and what initial steps to take. Besides help with recognizing patterns, the purpose of all anticipatory questions is to build a context of hope and encouragement; an antidote to the stagnating experience of being overwhelmed by a problem that seems insurmountable. Table 1 provides further examples of time-oriented questions.

Step III: Developing Skills to Avoid, Interrupt or Escape High Risk Situations

As mentioned, early recognition of contextual and internal signals of impending danger is an essential skill of preventing relapse. One must recognize when he/she is nearing a dangerous moment in order to hamper its occurrence. Individuals who have frequently not recognized those signals benefit significantly when professionals assist

them in developing that skill. For instance, a father who has been physically violent toward his teenage son needs to *recognize* his high risk situation(s) and determine how he will prevent his out of control behavior. At the same time, the son, although not responsible for his father's violent act, needs to recognize how his provocative behavior (e.g., non-verbal posturing, cursing in the midst of a high risk situation) is not helpful. The idea is not to encourage family members to lay low in order to pacify an aggressive member, but to identify what each member can reasonably do to ensure safety.

A particular key to the safe management of stressful, high risk life events is the ability of members to *intervene early in their cycle.* Casework offers the natural practice field for such efforts. This may take different forms. Early on, it may take the form of a de-briefing after a cycle gets out of hand. For instance, assume a father received a notice that his electricity was being shut off. Discouraged by this, that evening he drank heavily, something he usually only did when away from home with his friends. He fell asleep on the couch while he was supposed to be watching his child. His 5 year old son was reported by a neighbor to be "across the road in an empty lot playing alone for over an hour after dark." The worker and the father identified the following early warning signals: (1) *negative thoughts*: "I've had enough of this. There's no way I'll ever get caught up. I need a beer"; and (2) *emotions*: "I guess I was pretty down. I've been trying, but I can't ever seem to get the bills paid." This father felt terrible about putting his son at risk, but he did not see himself as a neglectful parent. He did not view his drinking as a problem and was a poor candidate for abstention goals. He was, however, able to join the caseworker in developing a plan to identify when he was at risk for misusing alcohol, and to identify associated early warning signals.

Individuals who can routinely recognize early warning signals in a safe manner are better able to develop strategies that *avoid high risk* or that failing, are able to *interrupt their pattern* effectively. Since all problems can not be avoided, and some are too difficult to interrupt, successful individuals also need plans to *escape* (leave safely) when all other options have failed. *Solution Based Casework* emphasizes these prevention skills and incorporates them routinely in case planning.

Avoiding High Risk Situations

By avoiding high risk situations, individuals and families enter fewer dangerous sequences and are, therefore, less frequently at risk.

This requires the development of alternatives to entrenched routines and detailed knowledge about high risk situations. For instance, when one recognizes that he/she is most apt to return to violent behavior after having visited the local bar, the local bar must be identified as a high risk situation and a plan for avoiding that situation needs to be created. Although one may initially be unclear about how that will be accomplished, it is often encouraging to realize that problematic/high risk situations can be more narrowly defined and subject to remedy.

Interrupting High Risk Situations

Safety also depends on a pre-determined plan once in the midst of a maladaptive sequence (i.e., when plans to avoid high risk situations have faltered). This skill is critical and probably the most difficult to apply since it assumes emotions have already begun to escalate. However, when families are prepared–when they discuss ahead of time how to intervene in high risk situations–they can agree to a strategy that will interrupt the cycle. If an interruption plan is not identified proactively, behaviors can be misinterpreted and safe de-escalation of conflict is less likely. One couple with a history of angry outbursts decided that when they found themselves in an argument over their in-laws (an old high risk situation), either one could call attention to the escalating cycle by stating "I/we need to calm down." This simple statement was powerful for this couple because they recognized it as an important part of their plan to prevent reoccurrence of abuse toward their child (previous arguments led to one of the parents assaulting the child). They had previously come to a mutual understanding about its importance in their lives and the lives of their children. An agreement of this nature obviously does not guarantee safety, yet is an important skill that interrupts destructive processes. The couple identified this solution strategy when asked, "When have you started an argument but then did something that kept it from escalating?"

Escaping High Risk Situations

Since even the best plans can fail, it is essential that family members prepare for those moments when behaviors suggest emerging loss of control and interruption seems unlikely. In these situations, the thrust of the plan is safety and avoidance of otherwise imminent re-

lapse. This may involve leaving the situation or a variety of customized contingencies. Escape plans are usually the first strategies put into place.

With each of these situations, the caseworker plays an important role in helping individuals and families create, practice and refine a relapse prevention plan. Each episode informs plan revision. For instance, if the intervention plan (eye glasses upside down) doesn't interrupt the escalating sequence, the worker can collect detailed pattern information. Typically, the conflict was allowed to brew and, consequently, escalated. Or, individuals may not have readily recognized warning signals, may have allowed their emotions and thoughts to dissuade preventive actions, or external conditions may have been overwhelming. Assume, for instance, that an adult daughter of a middle stage Alzheimer's patient had been cooking for her mother after spending a sleepless night worrying about her teenage son. Let's further assume that she overlooked both the high risk situation and her early warning signals of frustration, and in a fit of anger threw a dish across the kitchen into the wall. At that moment, despite the danger in leaving her mother unattended briefly, she recognized this as an emergency and fled to her neighbors for help. Her neighbors, who had agreed to be a part of the escape plan, then immediately provided care for the elderly mother.

Although the incident was potentially dangerous, the key players had effectively acted on their emergency plan and their efforts were at least a measured success (i.e., no one was hurt). Obviously, families cannot expect conflict to be completely eliminated. Rather, they must focus on reducing the intensity and duration of conflict so that destructive behavior is eliminated.

Step IV: Creating a Plan That Stays Focused on Solutions

Case plans that are written in client language and that emphasize everyday life events and skill development (i.e., recognition of high risk events; plans to intervene early; plans to avoid, interrupt, and escape risky situations) increase safety and reduce relapse because they (1) incorporate crucial behaviors that are completely relevant to the individuals involved, and (2) because individuals are held accountable to behaviors that create harm. Case planning, therefore, should

target specific skill development in everyday life. Indeed, *Solution Based Casework* advocates that protective services in dangerous behavior cases should not be terminated until key family members know and show evidence of competency in the skills listed in Table 2.

Solution Based Casework does not choose between focusing on individual behavior or family systems issues, regardless of the behavior in question, the severity of the situation, or the presumed availability of participants. Although there are several circumstances that create or require a separation of family members, or that demand intensive preparatory work by individuals (e.g., domestic violence, sexual abuse), assessment and case planning must always seek to focus individual skill development on the specific high risk situations that occur in family life. As such, all case plans should have goals and objectives at both the family and individual level. Family goals are based on developmental tasks associated with the dangerous situations, whereas individual goals emphasize skills necessary to successfully participate in tasks *without harming anyone involved.*

Case Example

Recall the young mother (Ms. Smith) who repeatedly struck her 4 year old son. When asking the mother about details of the event, the worker discovered that most of the tension occurred in the morning during the work week. This was not surprising given the common, every-

TABLE 2. Knowledge Needed Prior to Termination of Services

What will I know about my high risk behavior by the end of treatment?
• Typical situations and or moods that lead to my loss of control.
• Physical cues and trigger actions that are my early warning signals.
• Thoughts or beliefs that have kept me from asking for help prior to losing control.
• Everyday situations with my *friends* that are high risk for me to lose control.
• Everyday situations with my *family* that are high risk for me to lose control.
• Thoughts and feelings that I have during these high-risk situations.
• Skills in self-control and self-respect that I have always had but not always used.
• My strategies for avoiding high risk situations that lead to loss of control.
• My strategies for intervening once I start a loss of control pattern.
• My strategies for avoiding relapse in an emergency.
• What I've done to arrange external monitoring of my relapse prevention plan.
• My plan for taking care of myself and celebrating progress as I grow.

day challenges faced by young families. The worker also discovered that Ms. Smith was particularly vulnerable (1) at the end of the month, especially when the support check was not delivered; (2) when she was exhausted due to lack of sleep; and (3) when she felt like her son was being aggressive toward her. Given this information, the case plan targeted the morning routine (family level objective) and the emotional pattern that culminated in Ms. Smith's angry behavior (individual level objective). The worker and Ms. Smith set the case plan goal as "family members will live safely together" and created family and individual level objectives. Table 3 provides an example of one family level and one individual level objective used in this case.

Exceptions to maladaptive behavior do occur, and it is important to identify those exceptions and include them in the case plan. For instance, the worker asked Ms. Smith: "*Tell me about a time when you were close to losing your temper, but something happened to avoid it–what happened?*" Ms. Smith said that one morning her son was refusing to get dressed and she found herself becoming more and more frustrated. "*I started to force him to put his clothes on, but I realized it was only going to get worse. So, I told him that he wouldn't get a movie that night unless he put his shirt on. But I can't always cool myself down like that.*" This skill, interrupting the escalation by using a logical consequence to manage her son's behavior, was included in the family level task, (i.e., *"Ms. Smith will use logical consequences when Sam refuses to follow the morning routine plan").* The worker also was able to help Ms. Smith recognize one of her warning signals by going back over the incident in more detail (i.e., *"What were you feeling or thinking when you realized the situation was getting worse?"*). The worker then asked Ms. Smith to record this signal and to talk to her therapist about how to use the information as part of her self-control plan.

Reinforcing Client Progress

Reinforcing change has long been a part of effective casework. Working from a solution-based approach encourages the caseworker to immediately notice and reinforce small increments of change. Whether it is acknowledging a client's fortitude in resisting the influence of an old problem pattern, or certifying expertise in defeating a current problem that has plagued a family for some time, the caseworker moves quickly to claim a solution skill before old patterns

TABLE 3. Partial Case Plan

OBJECTIVES	TASKS
Family Level Objective Will use the "*Get our family through the morning plan.*"	1 ☐ Ms. Smith and her therapist will develop a "*Get our family through the morning plan*" by (date). (Copy of plan to be attached).* 2 ☐ Ms. Smith will discuss the morning plan with her son and explain the rewards and consequences by (date). 3 ☐ Ms. Smith will track their family progress by logging on a calendar daily. Ms. Smith will share this log with Ms. Jones (therapist) on a weekly basis. 4 ☐ Ms. Smith will discuss her morning plan with her mother and neighbor and arrange for emergency support when necessary. A plan will be completed by (date) and shared with Mr. Brown (worker) at that time.
Individual Level Objective Ms. Smith will use her "*Keep my cool at all costs plan*" to prevent further harm to family members.	1 ☐ Ms. Smith and Ms. Jones (therapist) will create a *"Keep cool at all costs plan"* to prevent loss of control by (date). The plan will be shared with Mr. Brown (worker) by (date). (*Copy of plan to be attached*).* 2 ☐ By (date), Ms. Smith will demonstrate, through use of her "keep cool plan," the following: • recognition of high risk situations • recognition of early warning signals • plan to intervene early in risky situations • plan to avoid risky situations • plan to intervene in risky situations • plan to escape risky situations 3 ☐ Ms. Smith, Mr. Brown, and Ms. Jones will identify Ms. Smith's existing skills by (date). 4 ☐ Ms. Smith, assisted by Ms. Jones, will document her progress with "keeping cool" by maintaining a log of her self-control in the mornings. This will begin (date) and continue through (date).

*Attachments are detailed plans, tailored to each everyday family life task. The plan maps out how the issue at hand (e.g., morning routine) will be safely managed. These family plans are specific and therefore measurable.

emerge to re-discourage members. Since conflict is viewed as normal in this model, the management of conflict is acknowledged and celebrated. The existence of a difficult family situation does not overly concern a solution-based caseworker, but how the family members handled the situation is of utmost concern. Was there any difference in this event that would indicate further skill growth? Did someone rec-

ognize early warning signals and attempt to leave or alter the situation? Did the argument stop short of the intensity of the last argument? Did anyone attempt to intervene in ways that had been discussed? These and countless other questions regarding how the family members managed their high risk situation help to identify, acknowledge and reinforce incremental changes.

SUMMARY

If relapse prevention is to be successful, family protective casework must focus on specific events and family member's ability to control their behavior in response to those events. Because families are constantly developing, and therefore changing their organization to meet their needs, the caseworker assumes a proactive role in assisting this adaptation process. It is not unusual for social service clients to become problem saturated to the extent that they not only have the original problems in everyday living to solve, but have the further burden of the effects of their unsuccessful problem resolution. Their sense of helplessness is compounded by their involvement in the judicial system and governmental institutions. Approaching such clients from a solution-based model instills a sense of hope within the context of a collaborative, pragmatic professional relationship.

The effectiveness of this relationship is best measured by the cognitive and behavioral skills learned to prevent reoccurrence of the presenting problem. At the family environmental level, these skills focus on re-organizing everyday family routines to better meet the developmental needs of the family. At the individual level, the skills targeted include identifying situations that are high risk, learning the details of personal patterns when in high risk situations, and then developing strategies to avoid, interrupt, or escape those problem patterns before they result in harm to a family member. The *Solution Based Casework* model provides a coherent map for caseworker and therapist to work collaboratively on the mutual task of helping a family prevent further acts of abuse or neglect.

NOTES

1. The term casework is used in this article to describe all activities of a line family service caseworker in protective services. In most states, the everyday practice of a worker's job is a mixture of case management and casework practice. With increasingly heavy caseloads, it is acknowledged the balance has shifted for many to case management.

2. The *Solution Based Casework* model was developed in close cooperation with the Family Services Division of the Department for Social Services, Commonwealth of Kentucky.

3. This is not to say that there are *only three* questions necessary to assess risk, they are simply meant to provide the context for insuring that data is located within the context of family life. Risk factors must still be covered (i.e., Criminal history, substance abuse, serial relationships).

REFERENCES

Berg, I.K., (1994). *Family based services: A solution-focused approach.* New York: W.W. Norton.

Carter, E.A., & McGoldrick, M. (1980). *The family life cycle: A framework for family therapy.* New York: Gardner Press.

de Shazer, S. (1985). *Keys to solution in brief therapy.* New York: Norton.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: Norton.

de Shazer, S. (1991). *Putting difference to work.* New York: W.W. Norton.

de Shazer, S., Berg, I.K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W.C., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process, 25,* 207-221.

Duvall, E.M. (1971). *Family development (4th ed.).* Philadelphia: J.B. Lippincott.

Germanin, C.B., & Gitterman, A. (1996). *The life model of social work practice: Advances in theory and practice* (2nd ed.). New York: Columbia University Press.

Gerstein, D.N., & Lewin, L.S. (1990). Treating drug problems. *The New England Journal of Medicine, 323*(12), 844-899.

Hoffman, L. (1990). Constructing realities: An art of lenses. *Family Process, 29,* 1-12.

Jenkins, A. (1991). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive.* Adelaide: Dulwich Centre Publications.

Jory, B. (1997). Intimate justice: Confronting issues of accountability, respect, and freedom in treatment for abuse and violence. *Journal of Marital and Family Therapy, 23*(4), 399-419.

Kinney, J.M., Haapala, D.A., Booth, C., & Leavitt, S. (1990). The Homebuilders model. In J.K. Whittaker, J.M. Kinney, E. Tracy, & C. Booth (Eds.), *Reaching high risk Families: Intensive family preservation services in human services* (pp. 31-64). Hawthorne, NY: Aldine de Gruyter.

Lane, S. (1991). The sexual abuse cycle. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offending.* Lexington, Mass: Lexington Books.

Lee, J.A.B. (1994). *The empowerment approach to social work practice.* New York: Columbia University Press.

Marlatt, G.A., & Gordon, J.R. (1985). *Relapse prevention.* New York: Guilford Press.

McDaniel, S.H., Hepworth, J., & Doherty, W.J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems.* New York: Basic Books Incorporated.

Minuchin, S. (1993). *Family healing: Tales of hope and renewal from family therapy.* New York: Free Press.

Nagayama, H., & Gordon, C. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology, 63*(5), 802-810.

O'Hanlon, W., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy.* New York: Norton.

Pecora, P.J., Whittaker, J.K., & Maluccio, A.N. (1992). *The child welfare challenge: policy, practice, and research.* New York: Aldine de Gruyter.

Pithers, W. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic gain and enhancing external supervision. In W.L. Marshall, D.R. Laws, & H.E. Barbee (Eds.), *Handbook of Sexual Assault: Issues, Theories and Treatments of the Offender.* New York: Plenum.

Pithers, W., Marques, J., Gilbat, C., & Marlatt, A. (1983). Relapse prevention with Sexual Agressives. In J. Green & I. Stuart (Eds.), *Sexual aggressor.* New York: Van Nostrand Reinhold.

Reid, W.J. (1992). *Task strategies: An empirical approach to clinical social work.* New York: Columbia University Press.

Rice, M.E., & Harris, G.T. (1995). Violent recidivism: Assessing predictive validity. *Journal of Consulting and Clinical Psychology, 63*(5), 737-749.

Smale, G. (1995). Integrating community and individual practice: A new paradigm for practice. In P. Adams & K. Newlson (Eds.) *Reinventing human services.* New York: Aldine de Gruyter.

Terkelson, K. (1980). Toward a theory of the family life cycle, In E. Carter (ed.), *The family life cycle.* New York: Gardiner Press.

Tolman, R.M., & Weisz, A. (1995). Coordinated community intervention for domestic violence: The effects of arrest and prosecution on recidivism of violence. *Crime and Delinquency, 41*(4), 481-495.

White, M. (1988). The process of questioning: A therapy of literary merit? *Dulwich Center Newsletter,* Winter, 8-14.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: W.W. Norton.

Wood, G.G., & Middleman, R.R. (1989). *The structural approach to direct practice in social work.* New York: Columbia University Press.