

The Social Work Supervisor as Teacher of Educational Methods and Skills

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ABSTRACT. In social work supervision and field instruction, insufficient attention has been devoted to the use of educational methods and skills to enhance client coping. This paper discusses the supervisory teaching of social workers on the uses of educational and guiding methods and skills to improve their clients' efforts to problem solve and to manage their feelings. [*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>*]

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Social worker supervisors and field instructors teach a wide repertoire of professional methods and skills. While many professional methods and skills have been conceptualized by various practice texts (Germain & Gitterman 1996; Shulman 1999; Woods & Hollis 1990), insufficient attention has been devoted to the use of educational methods and skills to enhance client coping. This paper discusses the supervisory teaching of social workers on the uses of educational and guiding methods and skills to improve their clients efforts to problem solve and to manage their feelings.

EDUCATIONAL AND GUIDING SKILLS

Clients experience stress when they perceive a discrepancy between their needs and problems and their ability to deal with them. The extent and

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intensity of their stress depends on several interrelated factors: (1) the complexity and chronicity of their needs/problems; (2) the meanings these needs/problems have for the individual, family or group; (3) the perception of personal and environmental resources to deal with their needs/problems; and (4) the level of fit between the individual, family, or group's perceived needs/problems and available environmental resources. Facilitating a greater congruence between people's needs and environmental resources and helping people to deal with and gain greater control over their challenges and problems are essential to feelings of well-being.

Owing to difficult life circumstances, many clients lack requisite coping skills. Some are unable to deal with a problem simply because they lack basic information or are misinformed. Others are immobilized and can not partialize the problem(s) and take action. They are too overwhelmed by life events or by the oppressiveness of the environment to engage in problem solving tasks. Still others have difficulty because they are unaware of their own dysfunctional and possibly self-destructive behavior patterns. They adapt to racism, sexism, ageism, or homophobia by turning their rage against themselves or family, friends, and neighbors. They remain stuck in a mire of helplessness.

Social workers often require supervisory assistance in helping their clients with the problem-solving aspects of coping. Successful coping calls for the ability to: (1) identify the stressor(s); (2) evaluate its impact; (3) deal with attendant emotions; and (4) delineate and choose among potential alternative responses. Supervisors can make available to their workers a repertoire of professional educational interventions which they can use to influence, encourage, and mobilize their clients' coping strategies and skills (Gitterman, 1988). They include:

1. *Providing relevant information:* Supervisors can assist their workers in providing relevant information to their clients. By providing clients with relevant information, social workers offer essential tools for improved coping. Many social work skills enable clients to elaborate and clarify their concerns. The information flows principally from the client to the worker. Clients, however, also expect relevant information from the worker, that is, for information to flow both ways. When this expectation is not realized, clients often become frustrated. Informing clients about their entitlements, or available resources in the community, or the impact of oppression on their daily lives raises consciousness and provides data essential for coping.

2. *Clarifying misinformation:* Misinformation can be a greater problem than the lack of information. Distress may be induced or intensified by being misinformed. Adolescents who, for example, believe "crack" is non-addicting "until you use it a few times" or that "withdrawal" method of birth control prevents pregnancy can be seriously handicapped by such beliefs.

Misinformation needs to yield to accurate information. Thus, by clarifying misinformation, the social worker might well enhance the possibilities for adaptive problem solving.

3. *Providing advice*: Beginning social workers and students are often uncertain about if and/or when they should provide advice to their clients. When clients confide their problems and needs to professionals, they often expect some practical advice about what to do. Research findings suggest that clients frequently are more satisfied when advice is offered and less so when little advice is given (Maluccio, 1979; Elliot, Barker, Caskey & Pistrang, 1982). Offering advice, therefore, can be an important educational intervention. Advice may encourage a client to try a new behavior (e.g., “If you feel the nurse is too rough with you, tell her softly that she is hurting you and could she please take blood from the other arm . . .”). Advice can also be offered to discourage self-defeating behavior (e.g., “If you continue to pull out your I.V., the nurses may bind your arms”). Social workers often require supervisory assistance in determining the appropriateness and timing of advice interventions.

A practice principle might be beneficial for supervisors to share with their workers. Namely, the directness of the advice is determined by three factors: (1) the stressor(s)’s severity; (2) the potential consequences of the stressor(s); and (3) the client’s level of functioning. The stressor(s)’s severity, potential consequences, and level of client functioning determines how direct the advice should be, ranging from “suggesting” to “urging” to “warning” to “insisting.” For example, if a client faces eviction or a medical emergency and denies the imminent danger, such stressors must be immediately addressed through the more intense modes of advice giving. In contrast, if, for another example, parents declare their child to be the cause of family problems, the worker should be extremely cautious about immediately redefining it as a marital issue. Premature advice may mobilize the couple’s defenses. Trust and credibility must be in place before a fixed system can become more flexible and receptive to this sort of advice. Under these circumstances, beginning with the person(s)’s definition of the life issue minimizes defensiveness and resistance.

In relation to a client’s level of functioning, the more directive advice is usually helpful with anxious and cognitively impaired clients. In offering advice, we have to be familiar with clients’ situations; careful not to impose our own values and coping styles. The advice must be sensitive to what a client is really requesting and not reflect the practitioner’s own need to demonstrate helpfulness.

4. *Offering a hypothesis*: In helping clients to explain and explore their concerns, supervisors can help a social worker to occasionally offer a hypothesis. In offering a hypothesis, the social worker poses an explanatory state-

ment that is intended to clarify the client's feelings, behaviors, and situation. By patterning available data, the clinician presents a possible new definition or perspective of the situation for the client to consider (e.g., "I am concerned that you're upset about being a diabetic, about the injections, and special diet, and this is being expressed in disappointment and annoyance with your family") Interpretations seem to be more effective with neurotic and less so with psychotic clients (Orlinsky & Howard, 1986, p. 324).

5. *Providing feedback*: A somewhat similar educational intervention is providing the client with feedback in which practitioners share their own reactions to the client. People are usually unaware of how they are perceived by others. By sharing one's own reactions to a client, the worker provides invaluable feedback. When the feedback is offered out of caring and concern rather than frustration and anger, the response is more likely to be received and considered. A worker might decide to share her/his feelings at a particular moment (e.g., "Right now, I am feeling overwhelmed. When I try to say something you run right by me, pushing me away."). To be most helpful, the clinician's reaction is concrete, behavioral and is expressed calmly and caringly.

Timing affects how a client receives the interpretation or feedback. The worker must gain trust and sufficient data about a client's defense and coping systems before touching upon a potentially painful subject. Insights ventured prematurely distance clients from workers. The best time for offering a hypothesis and providing feedback is when clients virtually and in their own way show or hint at their own awareness and insight.

6. *Inviting client reactions*: Generally, a worker should follow offering advice, interpretative and feedback interventions by inviting clients' reactions (e.g., "What's your reaction to what I suggested?"). At times, a client will respond directly to whether the advice, interpretation, or feedback was helpful or unhelpful. Other times, the response will be more qualified (e.g., "I guess you're right" or "Yes, but . . ."). The worker reaches for hesitation, lack of clarity and negative reactions.

7. *Specifying action tasks*: In seeking information and advice from workers, clients frequently want to know what they should do about their problems. They often require assistance in specifying behavioral actions, i.e., what to do next. By specifying action tasks, the worker helps clients to mobilize and utilize their coping skill so that they will be able to deal more effectively with their familial and social environments. For example, with a mother facing a mastectomy and concerned about her children's reactions, at the appropriate time the worker might say something such as, "Let's decide when and where you want to tell the children, and how and what you want to tell them." The more active and specific the task formulation, the more likely it will be put into action. Research suggest that the more clients are involved

in specifying and selecting their tasks, the more likely there will be progress (Reid, 1978).

8. *Preparing to carry out action tasks:* In addition to involving clients in making specific the actions to be taken, they need to be helped in planning such actions. Actual “homework” assignments (e.g., “During the week, how about if each one of you writes down what you think the kids should be told about the surgery . . .”) and role play (e.g., “I’ll be your child—let’s rehearse what you will try to say.”) are often helpful and practical techniques for preparing clients to carry out agreed-upon tasks. These concrete steps also prepare clients to anticipate and handle related situations (e.g., children remaining silent, or refusing to listen, asking personal questions). After completing preparatory planning, the worker summarizes and reviews the specific agreed upon strategies.

LEARNING STYLES AND TEACHING METHODS

In teaching coping skills, the supervisor/field instructor attends to the different ways their workers process information and learn and, in turn, teach them to attend to their clients learning styles. Some people will learn primarily by taking action. Others will learn primarily by visualizing and organizing perceptions into patterns and images. Still others will learn primarily by abstracting and conceptualizing (Brunner, 1966). To enhance learning, supervisors must use teaching methods which are responsive to workers’ different learning styles rather than impose their own most comfortable way of learning and teaching. By role modeling effective teaching, supervisors/field instructors help workers/students to be creative in their practice.

For workers (as well as clients) who learn primarily by action, role play is an extremely useful method for helping people to take action in their own behalf. For example, through supervisory role play a worker might be helped to use role play to prepare a hospitalized patient for a conversation with her intimidating physician. Role modeling and coaching can be used to demonstrate effective communication skills, i.e., specifically what and how to say; role reversal can be used to help the patient to examine the physician’s as well as his/her own experience and reactions. By mirroring the social worker in the role play, the worker can learn to use role mirroring to help the patient in a role play, that is the social worker can demonstrate how the patient may be perceived by the physician. And finally, by role re-creation and dramatization, the patient can examine the actual meeting with the doctor, analyzing and evaluating his/her conversation with the physician.

Other action methods available to supervisors include: psycho and socio-drama, sculpting, relaxation exercises, art, music, and activities (Duffy, 1994; Glassman & Kates, 1993; Hepworth, Rooney, & Larsen, 1997; Lynn &

Nisivoccia, 1995; Papp, 1980; Waite, 1993; Whittaker, 1985). With children and cognitively impaired clients, supervisors can encourage their workers to use games. Games help people to have fun while they problem solve and develop social skills (Middleman, 1970, 1980; Rabin et. al., 1985; LeCroy, 1987). Activities diminish pressure and facilitate comfort in interaction. Essentially, for some clients, talking while doing is much easier than “simply” talking. We tend to underestimate how much activities themselves can help people problem solve and manage their feelings. Action can, indeed, speak louder than prescriptive instruction or directive discussion.

For workers (as well as clients) who learn primarily by *visualizing and organizing perceptions* into patterns and images, various graphic presentations are available to the supervisor and clinician. These visual presentations illuminate heretofore unrealized patterns of relationships and behavior. Eco-maps, for example, capture the complexity of clients transactions with their environments (Hartman, 1994), and social network maps and grids examine a client’s social relationships and linkages (Swenson, 1979; Richman, Rosenfeld, & Hardy, 1993; Tracy & Whittaker, 1990). Similarly, ego-grams reveal communication styles between people (Dussy, 1977), and genograms elucidate and trace the family tree, covering several generations (Hartman, 1994).

The Jo-Hari window provides a design for a person’s life awareness, comparing the person’s self-awareness with others’ perceptions (Polsky, 1971), and the socio-graph depicts friendship patterns in a group. Similarly, charts can be used to sort out ambivalent thoughts and feelings, and force field diagrams to identify available environmental supports and restraints (Brager & Holloway, 1978; Germain & Gitterman, 1996). Goal attainment scales help social workers and clients to partialize tasks and to monitor their progress (Kiresuk & Sherman, 1968; Mattaini, 1995; Rock, 1987). And, finally, self-administered scales provide useful information and facilitate planning and action (Hudson, 1992). For visual learners, these graphic presentations enhance understanding and thus problem-solving abilities.

For workers (as well as clients) who learn primarily by *abstracting and conceptualizing*, structured discussions provide them with an opportunity to explore concerns and test their ideas. How the supervisor asks questions and teaches his/her worker to ask questions has a profound affect on the quality of their respective conversations. Different types of questions can be asked which in turn invite different type of answers. These distinct type of questions include those that solicit: (1) facts and clarification (“When did you meet with your client last?”); (2) inferences and explanations (“What happened to your client when she lost her job?”); (3) elaboration and syntheses (“What went into your decision to advocate for her entitlement?”); (4) evaluative judgments (“How did she change from when you first met her?”); and (5) opinions (“What might the client have contributed to the present marital

conflict?”). By skillfully formulating questions, supervisors role model and teach their workers to explore their clients’ concerns, test their ideas as they are being formed and shaped, and increase their cognitive skills.

When supervisors ask questions, they must wait for answers. And when workers respond, their responses need to be valued. A climate of acceptance and support must be established for workers to feel safe in risking themselves. Workers are more likely to internalize what they experience in supervision rather than what they are told to do—that is more is “caught” than “taught.”

Supervisors can also teach workers to offer their clients brief and informal exposition of formulations and ideas. Concepts can increase people’s problem solving abilities by helping them to look at their situations in new ways. Four patterned transactional scripts (i.e., “I’m O.K., You’re O.K.”; “I’m O.K., You’re not O.K.”; “I’m not O.K., You’re O.K.”; and “I’m not O.K., You’re not O.K.”) might be used, for example, with the spouse of an abusing alcoholic to examine his/her feelings of “not being O.K.” and victim role (Harris, 1967; Steiner, 1971). Similarly, Berne’s (1961) analysis of people’s transactions (i.e., child, adult, parent ego states) and games people play (Berne, 1964) (i.e., “Yes . . . but,” “Kick me,” “Now I’ve got you, you S.O.B.”) symbolically pattern clients’ communications and transactions.

Supervisors can introduce workers to other formulations to help their clients carry out action in their own behalf. Providing a client an established sequence for assertive behavior provides a tool for gaining greater confidence and mastery over one’s environment. Thus, teaching a patient and family, for example, to be more assertive with a physician can dramatically affect coping and even carry over to other role relationships. A client may be taught the following assertiveness sequence: “Dr. Young, when you run in and out of my room without talking to me (describe the behavior one wishes to change), I begin to feel helpless, get depressed, stop taking my medication, became convinced I will never leave the hospital (present the associated feelings and thoughts). Please take a few minutes to sit down and to talk to me (identify the requested behavioral change). I will be less upset and become a more cooperative patient” (describe the positive consequence of the behavioral change (Bower & Bower, 1979; Germain & Gitterman, 1996; Gitterman & Miller, 1989; Hepworth, Rooney, & Larsen, 1997).

And, as a final example, workers can be taught to teach their clients specific steps in a problem-solving sequence: (1) delay immediate, impulsive action (i.e., “stop and think,” “hold it”); (2) formulate and define problems (i.e., search for alternative definitions); (3) develop strategies to deal with problem (i.e., general direction and specific tactics); (4) evaluate strategies (i.e., feasibility, possible and unexpected outcomes); and (5) select and carry out specific action (D’Zurilla & Goldfried, 1971; Hepworth, Rooney, & Larsen, 1997). These formulations provide clients with the tools for working

on life's problems and managing the associated feelings. These as well as other formulation and ideas have to be presented simply and without jargon.

While most people have a primary and dominant learning style, i.e., active, visual and symbolic, all three modes are usually mastered to different degrees. Thus, the supervisor must help the clinician to be flexible, creative and attuned to different levels of client comfort and receptivity. By improving clients' problem solving skills and management of emotions, social workers help them to gain greater control and mastery over their lives. And by acquiring greater control and mastery over their lives, social workers help clients to begin to recognize their inherent self power and begin to make use of it.

CONCLUSION

Educational interventions are rarely used alone, but rather in combination with various other methods and skills. They have to be placed within the context of contemporary practice issues. As our profession assumes increasing responsibility for accountability, one of the consequences has been a preoccupation with practice outcomes; another has been a tendency in the field to evaluate professional competence and skills primarily on the basis of outcomes specified as a priori. The client's progress or lack of progress is attributed to the worker's skills or lack of skills. This is dangerous as it may lead us to want to work only with motivated clients. This ends/means confusion negates the reality of what happens in the helping process, i.e., a worker trying to be helpful, and a client deciding whether and how to use or not use the help from this particular person at this particular time.

The worker's behaviors may be skillful and, yet, the client may not progress or possibly even regress; the worker's behaviors may be unskillful and, yet, the client may progress. Professional methods and skills have to be evaluated on their own terms, as well as in relation to specific outcomes. Clients make progress because, in spite of, and without our help. That is why lawyers who lose may be justly praised for their fine work in a lost case and physicians do well but their patient died. In all cases, the question or issue is, did they do well or the right thing in the circumstances and considering the state of the art and available options. And, similarly in social work, the behavior of helping has to be separated from the behavior of using help.

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