6 Recruiting Assistance to Enhance Personal Well-Being

This, the final chapter in part II, discusses CB interventions that assist vulnerable populations in recruiting assistance and in obtaining information from potential helpers and other community resources to achieve goals related to enhancing personal well-being. The goals include enhancing social and emotional support, meeting medical and emergency needs, performing routine or daily activities, and attaining individually defined goals. These goals are particularly relevant for females with low income, sexual and racial/ethnic minorities, the elderly, and individuals with disabilities. These groups commonly lack access to potential helpers and other community resources that can provide social, emotional, and other types of support and the assistance needed to meet medical, emergency, and daily needs, and to achieve personal goals. Vulnerable populations frequently experience environmental stressors, such as discrimination, segregation, and lack of economic resources, which can create high levels of stress. Individual characteristics, including physical, cognitive, and mental health limitations, all can interfere with effective communication, establishing supportive relationships, and learning help-seeking skills.

As the interventions in this chapter suggest, learning skills to recruit assistance and to obtain information from potential helpers and other community resources can assist vulnerable clients in satisfying their own needs and desires, in gaining greater control over their environment, in seeking relevant information about their medical and psychiatric treatment, and in setting and achieving their own goals. At the end of this chapter, a critical discussion of the interventions is provided, including practice and research implications.

ENHANCING SOCIAL AND EMOTIONAL SUPPORT

The CB interventions discussed now are designed to enhance the social and emotional support of pregnant adolescents or parenting adolescent mothers, women with low income, and lesbians. Several interventions discussed in chapter 4 that assist students with disabilities in decreasing loneliness and in building peer networks also are relevant here, but the evaluations of the inter-

ventions did not directly measure enhancing social and emotional support. For this reason, these interventions are not discussed again in this chapter.

Several types and combinations of CB interventions that enhance social and emotional support and related outcomes for vulnerable clients are described in this section. Interventions include group and individual SST, providing sources of information and community resources, prompting, reinforcement, homework assignments, and cognitive restructuring. Other CB interventions, such as teaching various coping strategies (e.g., self-talk, identifying and engaging in positive activities), also are used to reduce depression and stress and to enhance other measures of well-being. The interventions were evaluated using quasi-experimental, single-system, pretest–-posttest, and multiple-baseline designs.

Poor, Minority Pregnant Adolescents or Parenting Adolescent Mothers

A CB program for enhancing the social support and psychological well-being of predominately poor, minority pregnant or parenting adolescents was developed during the mid-1980s by Richard Barth and his colleagues (Barth & Maxwell, 1985; Barth & Schinke, 1984; Barth, Schinke, & Maxwell, 1985). The components of the program are based on research identifying the characteristics and experiences of adolescent mothers. Studies indicate that adolescent mothers frequently experience multiple sources of stress, including poverty, social isolation, biological changes, and family conflict. Adolescent mothers also commonly lack the cognitive and behavioral skills for building, accessing, and maintaining the social support networks that can mitigate the adverse influence of the stressors on their parenting and mental health.

In addition to research findings, information gathered from students in parenting programs and responses to questionnaires identified stressful situations and coping skills relevant to the adolescents. A second sample of parenting adolescents then evaluated the stressful situations based on their frequency, difficulty, and future likelihood of occurring. Problem situations were related to child care, conflicts at home and with partners, and engaging in important activities, such as attending school and finding employment. These problem situations guided the choice of the specific examples used in the SST and the homework assignments, as well as the coping and social skills targeted by the program. The skills fall into four main categories: coping with unwanted advice or criticism, refusing unwanted requests, handling significant others' offensive behavior, and decreasing personal distress.

During the group intervention, facilitators use SST to teach the adolescents specific coping and social skills. These skills include nonverbal behavior, help seeking, negotiation and comprising, problem solving, identifying and using positive cognitions, coping with depression, and dealing with crit-

icism and stress while remaining calm. Examples of strategies for coping with depression are identifying and engaging in positive activities and identifying and drawing on members of the adolescents' social support networks. For successfully handling criticism and stress, adolescents are taught to identify and use self-talk during stressful exchanges and to reinforce or acknowledge when they remain calm. Examples of self-talk are "Hang in there, you're staying calm" and "That was all right. I said my mind and I didn't give up or get too upset" (Barth & Schinke, 1984, pp. 528–529). Group facilitators also provide the group members with a handout prompting them to identify members of their social support networks who might be able to provide various types of support (see Barth & Schinke, 1984, p. 529, for the handout). To assist the adolescents in meeting their various needs, group leaders encourage them to identify, discuss, and access a wide range of available resources beyond immediate family, such as extended kin, peers, and neighbors, and to evaluate the personal costs of using the resources. Group members also identify potential social supports to assist with specific problems, such as obtaining transportation. Quizzes and homework assignments are given to encourage the adolescents to use the skills in their homes and communities.

The adolescents (N = 79) involved in the program's evaluation were attending alternative high schools and volunteered to join the treatment or comparison group. After intervention, the adolescents participating in the group intervention had stronger social support networks compared with the comparison group. The treatment gain was maintained at the four-month follow-up, as indicated by three of the four social support measures, including the "Asking for Aid Scale." The adolescents also reported satisfaction with the program and its benefits.

Women with Low Income

Women with low income also are at risk of experiencing low levels of social support. Despite their greater need, these women have fewer social contacts and receive lower levels of material, emotional, and social support compared with women with more economic resources. This lack of support, in turn, can contribute to negative outcomes, such as psychological distress and impaired parenting practices (Belle, 1982; Klebanov, Brooks-Gunn, & Duncan, 1994). More than thirty years ago, Miller and Miller (1970) developed a reinforcement intervention to increase the attendance of women with low income at self-help groups. The developers of the intervention realized the difficulties many women with low income have in attending self-help and related groups even when the groups can provide benefits, such as social support. They therefore used positive reinforcement to increase the attendance of these women at self-help group meetings.

Practitioners assisting women with low-income in enhancing their social, emotional, and even material support might find this intervention applicable for two reasons. First, the self-help meetings can provide support for their members. For example, in one of the group's activities, the group leader invites the women to identify personal problems, after which group members discuss and offer solutions for the problems. Second, the reinforcers that the consulting practitioner provides for attendance are related to material and community resources. For example, reinforcers include concrete goods (e.g., kitchen appliances and utensils, furniture, clothing, toys), which can be solicited from higher-income neighborhoods, services (e.g., assistance in negotiating a welfare benefit grievance, locating housing, negotiating housing improvements with a landlord, resolving legal problems), and information (e.g., on obtaining benefits from social service agencies). Attendance at the meetings (N = 52) increased dramatically from an average of three participants before intervention to an average of fifteen after reinforcement. Attendance at the self-help meetings also was associated with participation in other self-help activities.

A multicomponent behavioral intervention also can be implemented in self-help or mutual-aid groups to enhance the social support of low-income women (Paine, Suarez-Balcazar, Fawcett, & Borck-Jameson, 1992). This intervention was designed to assist a mutual-aid group, which was led by a low-income agency's nonprofessional staff person, in achieving the group's goals by enhancing the skills of the group leader. The goals include providing and receiving support and encouraging and assisting one another in finding solutions to common life problems. Examples of problems include coping with an alcoholic, abusive spouse, living on a limited income, and finding suitable day care and employment.

The intervention is conducted using a self-help group leader's handbook that develops leadership skills for the types of support measured by the Self-Help Behavioral Assessment Instrument. The instrument was developed through a relevant literature review, an analysis of audiotapes of the mutual-aid group meetings, and consultation with experts in the area of self-help and social support. The types of support identified include sharing personal problems, providing empathetic responses, and discussing possible solutions to problems. Leadership skills, such as coping with difficult situations (e.g., members who frequently come late) and opening and closing group meetings, also are targeted in the handbook. The handbook, which was developed in collaboration with the mutual-aid group leaders, is not meant to be prescriptive. Instead, the handbook encourages group leaders and members to choose the elements that they find helpful (for information on acquiring the Self-Help Behavioral Assessment Instrument and *The Self-Help Group Leaders Handbook*, see Research and Training Center on Indepen-

dent Living in "Additional Readings and Resources" at the end of this chapter).

During the training sessions, the practitioner uses SST to teach the group leader the content of the handbook, which focuses on the identified support behaviors and leadership skills. In a typical session, the group leader reads the relevant chapter, answers exercises and study guide questions, and practices the skills through role play, which is followed by the practitioner providing performance feedback. The leadership skills are then practiced in a mock mutual-aid group. Comparing pretraining and posttraining observations demonstrated increases in the group members' disclosures of personal concerns and a variety of support behaviors (e.g., providing alternatives, general information, and statements of support) during the mutual-aid meetings after intervention. Ratings of two experts on the assistance and support group members provided to one another during the self-help meetings also increased after intervention. Other social validity measures indicated that the group leader was highly satisfied with the importance, usefulness, and ease of the intervention. However, the intervention appeared to have no effect on member satisfaction with the group meetings.

One of the goals of the survival skills workshop developed by Thurston and her colleagues (Thurston, 1990; Thurston, Dasta, & Greenwood, 1984) for low-income, urban, and primarily minority women is to enhance the participants' social support. The workshop is conducted by peer trainers using SST and prepared materials. Skill areas, which were identified as necessary for advancing educational and employment goals, were chosen through a survey of urban women and professionals working with low-income women and through analysis of requests for assistance from a local community action agency. Examples of the identified skill areas, which are the focus of the workshop, include assertiveness, child management, self-advocacy, coping with crises, employment, and obtaining community resources. The interventions, such as role playing and group discussion, maximize opportunities for the women to interact, engage in supportive social interactions, and form relationships that will continue after workshop completion. The women also are given materials, such as informational handouts, resource lists, and worksheets, to increase their awareness and use of various community and personal supports. Transfer of the skills to the women's natural environments is accomplished through the assignment of weekly homework related to the workshop content and the women's own goals. An example of a goal is identifying and engaging in an assertive response to a specific difficult situation (for additional information on the survival skills workshop, see Survival Skills Education & Development in "Additional Readings and Resources" at the end of this chapter).

The workshop was evaluated using pretraining and posttraining interviews and scores on a survival skills knowledge test and by group members

providing evidence of completing weekly homework assignments. The results of fourteen workshops involving more than 200 women demonstrated an increase in the women's survival skill knowledge test scores after intervention. Almost 50% of the women provided evidence supporting their performance of the identified behaviors. The women also reported applying the workshop information to handle current problems, an enhanced capacity for meeting their future goals, and an increase in their social interactions. The women's ratings of their satisfaction with the program and the workshop's materials, relevance, and impact on their ability to handle current problems and attain future goals were high (ranging from 4.4 to 4.6 on a five-point scale).

Lesbians

Safren and Rogers (2001) reported a case study using CB interventions to assist Anne, a 24-year-old white woman experiencing difficulties with attention and concentration, which resulted in several job losses during the previous three years. Anne's problems appeared to stem from her inability to cope with the realization that she was a lesbian. As part of Anne's treatment, the therapist used CB methods to assist her in the coming-out process, in reducing her anxiety, and in increasing her social support.

During the beginning stages of therapy, Anne articulated her concerns, negative judgments, and mixed beliefs and feelings about lesbians. Anne feared lesbians, yet she wanted to identify with them. To assist Anne in resolving her ambivalent beliefs and emotions, the therapist used cognitive restructuring. After the therapist asked Anne to write down her automatic thoughts about lesbians in general and what it would mean for her to be a lesbian, Anne was able to identify several negative beliefs she held about lesbians (e.g., they are angry, man-hating, unhappy) and negative beliefs about herself as a lesbian (e.g., she couldn't have children, she would be estranged from her family, she always would be lonely). Anne also was frightened to admit that she was "one of them." The therapist assisted Anne in finding evidence for alternative statements and beliefs, and together they developed a homework assignment in which Anne would test her automatic thought that "lesbians are angry." Anne agreed to go to a local lesbian bookstore, where she interacted with lesbians and read literature depicting images of lesbians inconsistent with Anne's automatic thoughts. In between sessions, Anne also recorded her thoughts about lesbians and her sexual orientation in order to identify her negative beliefs about herself and other lesbians. Anne then learned to examine the evidence for these beliefs and to identify more functional alternative beliefs.

After Anne made progress in changing her automatic thoughts and beliefs about life as a lesbian, the therapist used cognitive restructuring to assist

Anne in identifying and changing the thoughts that prevented her from frequenting places where she could meet other lesbians. After building a small group of close friends and acquaintances, Anne became increasingly anxious over her desire to come out to her family. After exploring with Anne the reason for the timing of her decision and the pros and cons of coming out, the therapist had Anne make a list of the people to whom she wanted to share her sexual identity and needed the therapist's assistance to do so. The therapist then rehearsed with Anne her disclosure. They began with the persons causing Anne the least amount of anxiety (e.g., her sister) and progressed to her mother, the person causing her the most anxiety. When treatment ended, Anne was experiencing less anxiety and depression about her sexual orientation and other aspects of her life. Anne also was much more comfortable with her lesbian identity, had a social support system in the lesbian community, and was able to come out to the persons important to her.

MEETING MEDICAL AND EMERGENCY NEEDS

The CB methods discussed now are designed for adult clients with a chronic health condition, mental retardation, and severe mental illness, and the elderly. The interventions are based on an important assumption. That is, in order for individuals with disabilities and the elderly to be fully and successfully integrated into the community, they must possess the necessary skills to recruit assistance for handling emergencies and for obtaining information about their medical and/or psychiatric treatment. The interventions that enhance vulnerable clients' ability to meet their medical and emergency needs include individual and group SST, problem solving, prompting strategies, reinforcement, and homework assignments. Two of the interventions were evaluated using experimental designs (Brown & Munford, 1983; Dow, Verdi, & Sacco, 1991). With the exception of the first group intervention (which was not evaluated), the remaining interventions were evaluated using single-system, multiple-baseline, and pretest-posttest designs.

Adults with Chronic Disease

This CB group intervention is designed for adults with type 1 diabetes, a condition usually diagnosed during childhood in which the body cannot produce the insulin necessary for it to convert sugar, starches, and other food into energy (Petrides et al., 1995). The intervention assists adults with type 1 diabetes in coping more effectively in social situations involving their chronic health condition. The practitioner begins by assisting the clients in determining the amount of health information that is appropriate to share, depending on the person involved (e.g., intimate friend, colleague, work supervisor, stranger) and the social context (e.g., residence, work, store).

The clients then learn to identify persons who can assist them, to identify appropriate information and explanations to provide to potential helpers, and to ask for specific assistance in a variety of contexts. For example, group members identify potential helpers when they require a glucagon injection for severe hypoglycemia (low blood sugar) or food for an insulin reaction at their place of employment. Based on the particular individual and context, the clients discuss and develop strategies, modify them, and practice the skills in role plays. Unfortunately, the effectiveness of the intervention was not evaluated. The intervention is described here because practitioners might find it applicable to clients with many different types of chronic health problems or disabilities.

Adults with Mental Retardation

Risley and Cuvo (1980) designed this behavioral intervention, which involves prompting and reinforcement strategies, to teach adults with mental retardation to make emergency telephone calls to the fire station, police, and doctor. In developing the intervention, the researchers used a variety of techniques to identify and then modify the specific steps required to reach four subgoals related to seeking emergency assistance by phone. The techniques included observing a skilled individual with mental retardation perform the behaviors, obtaining relevant information and feedback from a telephone company business consultant and local fire and police departments, and observing a training film on using the telephone. The four subgoals are as follows.

1. Make a decision on whom to call.
2. Find the telephone number of the emergency person in a directory.
3. Dial the number.
4. Provide the necessary information.

The intervention uses a specially designed telephone directory accommodating the clients' special learning needs. The directory contains a page for each emergency service provider, which displays a picture of the relevant person (e.g., fireman, policeman, or doctor), a printed occupation, and a telephone number. Pictures of emergency situations for each type of emergency, such as a kitchen stove on fire for a fire emergency, also are used during training. During the intervention, the practitioner presents the clients with one of the pictures, asks the clients whom they would call on the telephone if the event in the picture occurred, and prompts the clients to use the telephone and telephone directory. If the client does not respond or responds incorrectly, the practitioner uses a verbal prompt, for example, "Lift the telephone off the hook and listen for the dial tone." If the task is not successfully performed, the practitioner uses verbal instruction plus model-

ing, for example, “Let me show you. See how I picked up the receiver and listened for the dial tone? Now you try it.” If necessary, the practitioner uses physical guidance, and praise is given for correct responses. To provide feedback and additional reinforcement, the practitioner also constructs a poster board “thermometer” depicting the identified steps of emergency calling. After each step is performed correctly, the clients move a ribbon up the thermometer and “win the game” when the ribbon reaches the top. The multiple-baseline design across the three clients participating in the evaluation demonstrated that they all learned to successfully make emergency calls in the three types of situations. The skills were maintained one to two weeks later.

Adults with Severe Mental Illness

The SST program discussed in the previous chapter (Brown & Munford, 1983), which teaches inpatients with chronic schizophrenia a variety of social skills, also teaches the patients relevant skills to access information about their medication needs. For example, the patients are taught to set up an appointment with a busy doctor to discuss the side effects of their medication. The patients practice the skills on the ward, as well as in the community. Self-reports and role plays indicated that the SST group performed better than individuals in a traditional rehabilitation program in making appointments and discussing medication issues with their physicians.

Two of the training modules developed at the UCLA CRTRP—Medication Self-Management and Symptom Self-Management—assist clients diagnosed with severe mental illness in successfully coping with problems related to medication issues (see chapter 4 for a discussion of the basic components of the training modules and for ordering information). Examples of skills practitioners teach clients in the Medication Self-Management module include obtaining information about their psychiatric medications, identifying side effects and methods to alleviate them, and negotiating medication issues with health-care providers. Examples of skills taught in the Symptom Self-Management module include identifying and managing warning signs of relapse, for example, developing an emergency plan and monitoring relapse signs with assistance from others.

Based on the Medication Self-Management module, Dow et al. (1991) evaluated a group Medication Communication Skills Program (MCSP) for psychiatric inpatients with a variety of diagnoses (primarily schizophrenia, major depression, and bipolar disorder). In implementing the MCSP program, group facilitators use SST to teach the patients a variety of nonverbal (e.g., eye contact and voice volume) and verbal (e.g., making specific requests and asking medication-related questions) communication skills. Group facilitators also teach group members additional skills for identifying

and using resources to improve patient-physician communication. The skills include making phone calls, arranging transportation to the physician's office, and recording side effects. To enhance generalization of the skills, the patients role-play the skills with staff members from another unit and ask their unit physician medication-related questions. For example, the patients ask their physician to describe common side effects and options to alleviate them. Group members also learn the problem-solving component of the modular training, and group facilitators initiate a discussion on methods to cope with problematic patient-physician situations. The situations include a physician refusing to address medication side effects, a physician missing a scheduled appointment, and a patient running out of medication and having no available funds. Finally, group facilitators elicit and discuss problematic situations that patients experience with their own physicians.

Psychiatric inpatients (N = 48) were randomly assigned to the MCSP group or to a medication education group. Psychiatrists found that the MCSP group engaged in longer conversations and asked more specific medication-related questions, as compared with the comparison group. Ratings of the MCSP group on assertiveness in seeking treatment-related information and acquiring information about a newly prescribed medication, exhibiting appropriate social skills and eye contact, and compliance with their medication regime also were higher.

The Elderly

Ruben (1987) based this group SST on research indicating that elderly persons frequently have inaccurate or incomplete knowledge of their prescribed medications, because they fail to adequately question their physicians and pharmacists. Failure to obtain this information contributes to medication errors and dissatisfaction with physicians. Although the intervention was designed for elderly women residing in the community and receiving antidepressant medication, it could be applied to elderly individuals receiving any type of medication. The intervention involves a practitioner using group SST to teach group members relevant questions to ask their pharmacists and physicians. A simple recording form listing specific questions and statements is used during the training (see Ruben, 1987, pp. 9–10). An example question follows.

> I have a few questions to ask you about one of my medicines. The name of my medicine is ________. What is the medicine for? It says on the label ________. What does this mean? What side-effect does the medicine have?

The group members practice using the form during a telephone conversation with another group member, and during three telephone calls to local

area pharmacists, and then generalize the skills by calling local physicians. As indicated by the preintervention and postintervention measures, the group members ($N = 20$) increased their ability to obtain information on their medications from local pharmacists and physicians after intervention.

The case study of a 65-year-old widowed female with a psychiatric diagnosis of major depression and a visual impairment, discussed in chapter 4, also used SST to teach the client to recruit assistance from others (Donohue, Acierno, Van Hasselt, & Hersen, 1995). An example of a scenario used for role playing in the area of asking someone for transportation to a doctor's appointment follows from Donohue, Acierno, Hersen, and Van Hasselt (1995).

> You have an important appointment with your eye doctor. You were supposed to get a ride with a relative, but the relative is sick and can't take you. Just then, your phone rings, and it's a friend. You want to ask this person to take you to the doctor. The person says to you: "Hello, ________, how are you?" (pp. 389–390)

The SST resulted in the client increasing her requests for such assistance.

PERFORMING ROUTINE OR DAILY ACTIVITIES

Individuals with some types of disabilities commonly are unable to perform routine or daily activities without assistance from others. CB interventions that empower vulnerable clients by teaching them skills to obtain the necessary assistance from others when it is needed are discussed here. The interventions teach children and youths with mental retardation, learning disabilities, and/or multiple types of disabilities to recruit others to assist them in completing class assignments and engaging in routine activities within school settings. Behavioral interventions that teach adults with physical disabilities and the elderly to recruit help to perform routine activities also are discussed.

The CB strategies presented here are combined in a variety of ways to form unique intervention packages. The strategies include SST (including assertiveness training), identifying and changing cognitions related to anger control and self-efficacy, relaxation techniques, think-aloud strategies, prompting, reinforcement, homework assignments, and general case instruction. With one exception (Glueckauf & Quittner, 1992), all of the interventions were evaluated using single-system, multiple-baseline, or multiple-probe designs.

Adults with Physical Disabilities and Visual Impairments

This group assertiveness skills program is designed to teach adult wheelchair users with a variety of physical disabilities, including spinal cord injuries,

multiple sclerosis, and cerebral palsy, to achieve goals related to asserting their needs (Glueckauf & Quittner, 1992). Among the multiple goals of the program are to (1) appropriately use assertion skills in situations such as obtaining information about wheelchair accessibility and requesting assistance from a stranger (evaluated by role plays); (2) decrease social anxiety caused by a variety of wheelchair-related activities, such as asking for assistance to mount a curb (measured by a social discomfort scale); and (3) increase the inclination to perform wheelchair-related activities (evaluated by self-report). Therapists use SST techniques to teach the relevant assertive skills. The techniques include discussions and role plays of structured vignettes and audio-visual and therapist modeling. Other interventions involve discussing the previous and the next week's homework assignments (i.e., practicing the skills in natural settings and relevant readings), identifying and changing cognitions related to anger control and self-efficacy, teaching relaxation techniques, and implementing individual assertiveness goals. Although no significant differences between pretest and posttest scores were found in the wait-list control group, the assertion training group significantly increased performance on the three outcome measures (N = 34 whites). With the exception of the role-play test, the treatment group maintained the gains six months later.

Practitioners also can teach assertive skills to adults with visual impairments to increase their help-seeking behavior (Everhart, Luzader, & Tullos, 1980). In this intervention, the group facilitator incorporates SST into an interactive group format. The group members set group objectives, such as requesting assistance outside of the rehabilitation center, telling a bus or cab driver where they want to go, and asking for assistance to find items in a store. Group members also identify three personal goals. In subsequent sessions, the successes and failures of attempting to accomplish the personal goals are shared, and some experiences are role played. All group members (N = 8) participating in the group intervention at a rehabilitation center for the blind passed an evaluation of their performance on role-play situations based on the group goals. Staff at the center also reported positive changes in all but one group member, and five of the clients reported that the group was helpful. However, no baselines of the behaviors were taken to assess whether the group members increased their help-seeking behaviors.

An intervention developed by Dattilo and Camarata (1991), which uses behavioral techniques to teach the use of an augmentative communication system (Touch Talker) to increase the conversational skills of young adults with severe motor and speech problems, was discussed in chapter 4. One of the results of the evaluation is applicable to this chapter as well. That is, the frequency with which the clients signaled their care providers for assistance increased after intervention.

Individuals with Learning, Cognitive, and Developmental Disabilities

Mental retardation. This intervention teaches elementary school students with mild to moderate mental retardation the skills for recruiting their teachers' assistance and feedback on class assignments when attending a general education classroom (Craft, Alber, & Heward, 1998). The behavioral program consists of three components. First, the practitioner uses SST to teach the students to recruit teacher assistance. A think-aloud technique is used to model the recruiting skills, for example, "OK, I'm done with half of my work. Now I'll look to see if the teacher is busy. She's free. I'll raise my hand." After discussing circumstances appropriate for seeking teacher assistance (e.g., when the students do not understand the assignment and the teacher is available), the practitioner teaches the students appropriate recruiting behaviors. The behaviors include the students raising their hands two or three times per class period or walking to the teacher's desk. If other students are at the desk, the students are taught to wait in line until the teacher recognizes them. At that time, the students make a statement (e.g., "I don't understand this question," "I'm finished") or ask a question (e.g., "Can you help me, please?").

Second, the practitioner prompts the students to recruit before entering the general education classroom each morning. The practitioner also draws three small boxes at the top of the students' classroom assignments (e.g., a spelling worksheet) and instructs them to check one of the boxes each time they recruit and to stop recruiting when all three boxes are checked. Finally, at the end of the school day, the practitioner reviews the students' progress. The practitioner prompts the students if they do not recruit and provides inexpensive reinforcers (e.g., a sticker, pencil) if they do recruit. Prompts and artificial reinforcers are gradually phased out, and a social reinforcer (teacher praise) is used as appropriate.

The evaluation (a multiple-baseline design across four students) demonstrated that after intervention all of the students increased their recruiting behavior, as well as the percentages of completed and correct worksheet items. After intervention, the general education teacher provided feedback more frequently and reported that the students appropriately asked for assistance. All four students reported accomplishing more work when they recruited and feeling good and happy when they received praise from their classroom teacher. Maintenance of the skills and outcomes were measured for only five class periods.

Learning disabilities. Teachers in regular classrooms frequently have insufficient time to provide all of the assistance required by students with special needs. As this intervention demonstrates, teaching students to recruit peer assistance can supplement teacher assistance (Wolford, Heward, &

Alber, 2001). This behavioral intervention teaches junior high school students with LD to recruit peers with no disabilities to assist them in completing class assignments during cooperative learning group (CLG) activities in a general education classroom. A special education teacher, who is trained to carry out the intervention, discusses with the students appropriate times to ask for help. Examples of the times are when the student begins the assignment and does not understand the directions, has completed approximately one-half of the assignment, and completes the assignment. The teacher then uses SST to teach each student the following help-seeking behaviors.

1 The student gets the peer's attention by lightly tapping him or her on the arm or back, and saying, ''Excuse me'' and/or saying the peer's first name.
2 If the peer does not respond within five seconds, the student attempts to get the peer's attention by repeating the behaviors.
3 The student asks the peer questions that are likely to generate positive attention or a relevant response, for example, ''Did I answer this question right?'' ''Can you give me some help with this question?'' or ''Can you tell me how I am doing so far?''
4 After the peer responds, the student thanks the peer.

The teacher also provides students with a cue card listing the recruiting steps and encourages them, if necessary, to refer to the card during the CLG. At the end of the school day, the teacher reviews the recruiting behaviors and reinforces the students with inexpensive items for appropriately recruiting. These activities are gradually discontinued.

The multiple-baseline design across four students (each CLG consisted of one student with LD and three peers with no disabilities) demonstrated that the students increased their recruiting responses, instructional feedback and praise from peers, and the number and accuracy of their completed language arts assignments after intervention. The recruiting behaviors also transferred to another classroom. During the maintenance phase, the rate of recruiting responses decreased but remained far above baselines and within the desired range. Qualitative information gathered from students, peers, and teachers generally indicated satisfaction with the students' help-seeking behaviors and the effectiveness of the intervention in teaching the students with LD to appropriately seek assistance from peers.

Individuals with Multiple Disabilities

General case instruction (i.e., using multiple examples of help-seeking situations, prompts, and reinforcers) also can teach help-seeking behaviors to individuals with mental retardation and multiple physical impairments (Chadsey-Rusch et al., 1993). This intervention is designed for clients who

encounter daily situations in which they need assistance and have the ability to either sign or ask for assistance but rarely initiate requests for help without being prompted by someone else. The intervention is implemented in situations in natural settings where the clients need assistance to engage in a variety of tasks. Examples of tasks include accessing food, operating drinking fountains, opening doors, and walking in school (e.g., in the cafeteria, classroom, and hallway) and in community settings (e.g., vocational training and work sites and shopping malls).

During the general case instruction, the practitioner sets up five opportunities a day for each client to request help. An example is giving a client an unopened bag of chips in a school cafeteria. The practitioner waits for the client to ask for or sign "help" or to attempt to help himself or herself. If the client requests assistance, the practitioner assists him or her. If the client does not request the required assistance, the practitioner gives a verbal or sign prompt to the client to request help. After the client responds with a help request, the practitioner reinforces the response with assistance. The spontaneous help-request behaviors of two of the three female adolescent students participating in the evaluation increased after intervention (a multiple-probe design across participants was used). For the two students who improved, their gains in help-seeking behavior generalized to novel situations, and the skills were maintained for five to eight weeks.

The Elderly

A case study discussed in chapter 4 and in the previous section of this chapter also demonstrates the use of SST to increase the help-seeking behavior of a 65-year-old widowed female client with major depression and a visual impairment (Donohue, Acierno, Van Hasselt, & Hersen, 1995). An example of a role-play scenario for requesting assistance follows from Donohue, Acierno, Hersen, and Van Hasselt (1995).

> You are walking to your apartment from the parking lot. You have just finished talking with a friend for a long time, and you have forgotten how to get home. In addition, you are having a tough time walking because of some uneven pavement in the parking lot. Just then you hear someone walk by and you want to ask this person to take your arm and guide you to your apartment. The person says to you, "You look like you're lost." (p. 408)

ATTAINING INDIVIDUALLY DEFINED GOALS

Three similar SST programs were developed by Fabricio Balcazar and his colleagues to teach vulnerable youths skills to recruit assistance from poten-

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tial helpers to attain their personal goals. Although some of the interventions discussed in the previous two chapters provide for clients defining their own goals, the programs discussed here are unique. In addition to establishing their own goals, the youths learn specific skills to recruit potential helpers to achieve the goals, and goal attainment is evaluated. Students with physical disabilities, African American students, and institutionalized youths with emotional or behavioral disorders, or LD participated in the evaluations of the interventions. The first of the three interventions is described in more detail, followed by briefer descriptions of the remaining two interventions (see Balcazar, Garrate-Serafini, & Keys, 1999, in ''Additional Readings and Resources'' at the end of this chapter to obtain information on the interventions).

Adults with Physical Disabilities and Sensory Impairments

This SST program teaches adults with seeing, hearing, and mobility impairments to recruit assistance to achieve their personal goals (Balcazar, Fawcett, & Seekins, 1991). The interventions were based on a situational analysis that identified the contexts in which help-recruiting behaviors for individuals with disabilities were most likely to occur. The analysis used information obtained from interviewing experts on and individuals with physical disabilities and reviewing relevant literature. Examples of the identified situations include asking for assistance to clarify goals, to obtain referrals, to remove obstacles that might impede goal attainment, and to secure information about available opportunities, and asking for advice. Role-play scenes were prepared based on these identified situations. The researchers identified the help-recruiting skills targeted for intervention by reviewing relevant literature, by interviewing individuals with physical disabilities, and by asking individuals experienced in working with individuals with disabilities to evaluate a videotape depicting simulated help-recruiting situations. Table 6.1 presents the twenty-five help-recruiting skills targeted for intervention.

Practitioners teach the identified skills to clients individually using a prepared training manual. The practitioner begins by reviewing the lesson content, which includes definitions of the responses used during conversations with potential helpers and examples of these conversations. Clients then complete written exercises requiring them to list relevant responses. The clients practice the skills using role-play exercises, while the practitioner provides performance feedback and social reinforcers as appropriate. The clients also establish personal goals related to health, education, and social relationships and meet with relevant individuals in the community or in educational settings (e.g., professors and graduate students in a university) to request help to achieve their goals. Examples of short-term goals include

Table 6.1. List of Help-Recruiting Skills

Opening Statements

1. Greet and introduce yourself.
2. Make a comment to initiate an informal conversation.
3. Mention the person who referred you (if applicable).
4. State your general goal.
5. State your situation.
6. State your strengths and abilities.

Making a request

7. Describe what you have done.
8. State your personal resources and experiences.
9. State the specific request.
10. State the potential benefits of the assistance.
11. Request confirmation of your goal.

Handling refusals to your request

12. Ask the helper what he/she would do in your situation.

If the helper has a suggestion:

13. State whether the suggestion is compatible with your goal.
14. State the feasibility of the suggestion.
15. State whether you will follow the suggestion.

If you decide to follow a suggestion, or the helper agrees to assist you:

16. Ask when, where, or how the assistance will take place.

If you decide not to follow a suggestion:

17. Ask for additional advice.

If no additional advice is provided:

18. Make a different request.
19. Ask for a referral.
20. Ask how the referred person might help.
21. Ask for permission to use the helper's name when talking to the referral.

Closing statements

22. State your appreciation for the helper's time and assistance.
23. Summarize your understanding of the agreements.
24. State your enjoyment of the meeting.
25. Make a final closing statement.

Note. From "Teaching People with Disabilities to Recruit Help to Attain Personal Goals," by F. E. Balcazar, S. B. Fawcett, and T. Seekins, 1991, *Rehabilitation Psychology*, *36*, p. 34. Copyright 1991 by the Division of Rehabilitation Psychology of the American Psychological Association. Reprinted with permission.

locating note takers for a class, finding summer employment, and obtaining needed equipment to practice wheelchair racing.

Preintervention and postintervention ratings of the role-play exercises by helping professionals experienced in working with individuals with disabilities indicated that performances of the recruiting skills were significantly higher after intervention for all four college students participating in the evaluation. Ratings of the quality of the students' videotaped meetings with

potential helpers (professors and graduate students in the universities the students were attending) were higher after intervention. Of the twenty goals proposed by the students, 75% of the goals were attained; 47% of the attained goals were attained with better than expected results. The size of the participants' social support networks, including individuals who provided material aid, advice, positive feedback, physical assistance, and social support, significantly increased from baseline to four months after intervention. The participants' ratings of their satisfaction with the intervention (mean of 6.5 on a seven-point scale) indicated that they were highly satisfied.

African American Youths

Other vulnerable populations also can have difficulties in accessing adequate social resources. For minority racial/ethnic populations, discrimination, disproportionate economic disadvantage, and residential and educational segregation all can limit access to social support networks that could assist them in achieving personal goals. Based on this research, Balcazar, Majors et al. (1991) developed a SST program to teach African American high school seniors attending inner-city schools to recruit help to attain their educational and personal goals. Techniques similar to those described in the previous intervention were used to identify typical situations that African American students can experience in requesting assistance from others, as well as to identify effective skills involved in the help-seeking process.

As does the previous behavioral program, this program divides a typical meeting with a potential helper into four main phases, including thirty identified skills for opening the meeting, making a request, handling rejections and suggestions, and closing the meeting. Practitioners instruct the students to write observable goal statements by starting the goal with the word "to." This word is then followed by an action verb clearly specifying one main result when the goal is accomplished. Examples of goals include "to find a summer job," "to apply for scholarships to attend college," and "to learn to use a word processor." A training manual with procedures similar to those described in the previous intervention is used to teach the students the identified skills for requesting assistance to attain their established goals. An African American consultant reviewed the manual's training examples and language to ensure that they were appropriate for the youths' age and culture. During the group sessions, the practitioner and students role-play the help-seeking situations identified for each lesson. An example of a situation follows.

> You have been thinking about what classes you will be taking during your first semester in college. You would like to get an idea from someone with

experience. Tell me who you might ask for help and approach me as if I am that person. (Balcazar, Majors, et al., 1991, p. 448)

Preintervention and postintervention ratings of the role-play performance of the three students involved in the evaluation demonstrated significant increases in their help-seeking behaviors after training. Evaluation of in vivo help-seeking behaviors, in which each student met with a different minority professional before and after intervention (e.g., two students aspiring to be accountants requested assistance from an accountant and bank vice president), also demonstrated significant improvements in the identified skills. Student reports of their goal attainment also were positive. Of the twelve goals proposed by the students, ten of the goals were attained at or above expected levels of success three months after intervention. None of the established goals resulted in an unfavorable outcome, but two goals were achieved with less than expected success. All three students entered college the fall semester following the completion of the project.

Youths with Behavioral/Emotional Disorders and Learning Disabilities

Balcazar and his colleagues (Balcazar, Keys, & Garate-Serafini, 1995) developed a similar SST program to teach youths with emotional/behavioral disorders, mild mental retardation, or LD to set "transitional" goals and to recruit potential helpers to assist in attaining their goals. The youths who participated in the evaluation were separated from their families by court order, attended a residential school for students with severe behavioral/emotional problems, and were expected to transition into the community in the near future. The main phases of the help-recruiting process (opening the meeting, making a request, the person agrees to help or handling rejections, and closing the meeting), the help-seeking skills, and the role-play scenarios were identified using a similar process as described in the first help-seeking intervention.

Practitioners conduct SST in groups with the use of a training manual containing content divided into two phases (samples of lesson plans are provided in the article). In the first phase, practitioners teach the youths to identify personal strengths; to set personal transitional goals in the areas of education, employment, social life, and independent living; and to develop a plan of action while identifying potential helpers. In the second phase, practitioners teach help-recruiting skills using instructional content similar to that described in the first help-recruiting intervention. During the SST, situations involving problem areas such as inquiring about and applying for jobs and colleges, seeking information on financial aid and scholarships, locating health care, and increasing community involvement and social relationships are role played. In addition to practicing prepared role-play

situations, the youths suggest and role-play situations based on their personal experiences with vocational, educational, and independent living problems.

Pretraining and posttraining role-play assessments and evaluations of the male youths' (two African Americans; four whites) actual help-seeking interviews demonstrated increases and improvements in their help-seeking skills. Of the seventeen goals set by the youths, 65% were achieved, and 23% were still in progress at the end of the evaluation. The size of the participants' social networks, including individuals who provided assistance in at least one of seven areas, also increased. The youths' ratings indicated satisfaction with the training and content of the materials (5.2 and 4.5, respectively, on a seven-point scale). One year after intervention, five of the six students were employed or were in vocational training with jobs funded by rehabilitation services.

ANALYSIS AND CRITIQUE FOR PRACTICE AND RESEARCH

This final chapter in part II discussed CB strategies that empower vulnerable populations, including women with low incomes, racial/ethnic minorities, lesbians, elderly individuals, and children, youths, and adults with disabilities, by teaching them to recruit assistance and obtain information to achieve four main goals. The goals include (1) enhancing social and emotional support, such as receiving empathy and advice, information, and assistance to resolve common life problems; (2) meeting emergency and medical needs, such as learning skills to receive emergency assistance, obtaining information on medications, negotiating medication needs and problems, and keeping appointments with medical providers; (3) performing routine and daily activities, such as completing school assignments, mounting curbs, operating drinking fountains, and having personal needs addressed by care providers; and (4) attaining individually defined goals, such as locating note takers for a college class, applying for scholarships to attend college, and obtaining employment.

Results of the evaluations of these interventions suggest that a range and different combinations of CB strategies can be used individually or in groups to achieve the identified goals. The interventions include SST, PST, prompting strategies, reinforcement, providing sources of information and community support cognitive restructuring, homework assignments, relaxation techniques, think-aloud strategies, and general case instruction. The following sections discuss these interventions more critically and suggest implications for practice and future research.

Effectiveness and Additional Applications

As was the case in the previous two chapters, evaluations of these CB interventions have a number of limitations. The interventions primarily were con-

ducted with volunteers, frequently used single-system and multiple-baseline designs instead of random assignment, combined CB interventions in different ways, and involved a small number of participants with specific characteristics. Therefore, determinations of which CB interventions, or combinations of interventions, are effective for achieving particular goals for specific clients are far from conclusive and require further research. Despite the limitations of current research and cautions regarding the applicability of the evaluation results to other individuals or groups (e.g., Paine et al., 1992, found that the leadership training that was effective in increasing supportive interactions in a low-income woman's mutual-aid group was not effective for a group of individuals with multiple sclerosis), many of the interventions might be applicable to other vulnerable populations desiring to achieve similar goals.

The CB interventions that assist individuals in enhancing emotional and social support were conducted with low-income racial/ethnic minority females, but similar interventions also might apply to other vulnerable groups. The groups could include racial/ethnic minority males, sexual minorities, the elderly, and clients with physical, learning, or sensory impairments. Practitioners could implement the group SST that teaches adults with diabetes to recruit assistance for medical or other emergencies in a variety of settings (e.g., hospitals, rehabilitation centers, nursing and group homes, mental health clinics). The SST also might be used to assist clients experiencing other chronic health problems or disabilities in requesting needed assistance. The interventions designed to teach clients with severe mental illness to obtain information about their medications and psychiatric condition, to discuss and negotiate their medications, and to obtain resources to keep medical appointments also appear to be relevant to youths and adults with other types of disabilities and chronic medical problems.

In addition to teaching students with physical and developmental disabilities to recruit others to assist them in performing school work and other routine tasks, practitioners might use similar behavioral methods in other settings and with other vulnerable clients. For example, practitioners could use SST to teach students from low-income and some racial/ethnic minority backgrounds, who tend to perform less well academically compared with higher-income and white students, to recruit assistance in completing homework assignments and in acquiring related resources in the school, residential, and other community settings. The behavioral interventions designed to teach African American youths and students with disabilities to establish personal goals and to recruit others to assist them in achieving their goals might be applicable when individual assessment for any vulnerable client reveals that an inadequate social network, or a lack of social skills for accessing an existing social network, is impeding goal attainment. Practitioners also could use similar interventions for other racial/ethnic and sexual minorities, low-income clients, and females.

Similar SST programs also might be relevant for some recent immigrant groups. In the United States, individuals are expected to be assertive in identifying and recruiting others to help achieve their personal goals. However, individuals from other ethnic groups (e.g., Asians and Latinos) might expect that others will automatically provide support, because their culture emphasizes interdependence. Finally, practitioners might find that the SST program developed for vulnerable youths transitioning from a residential setting to independent living is applicable to clients making other kinds of transitions. Examples include child welfare clients (who are disproportionately poor and African American) transitioning from a group or foster care home to independent living and patients being discharged from rehabilitation centers, long-term care facilities, and psychiatric hospitals into the community.

Freedom, Control, and Social Justice

The previously discussed CB interventions demonstrate several methods that practitioners and future researchers might use to enhance individual freedom, control, and input into the intervention process. For example, in the case study of Anne, cognitive restructuring was used to assist her in the coming-out process. By examining, challenging, and changing the thoughts that were causing her difficulties, Anne was able to control the intervention process, and ultimately her own thoughts and behavior. By offering interventions, such as the content of the leadership training for the low-income mutual-aid group, as suggestions, practitioners and researchers can recognize the need for group leaders and members to use their own strengths and to maintain their autonomy. Similar to the studies discussed in the previous two chapters, the interventions examined in this chapter use a variety of prompting strategies that recognize and build on client strengths. Practitioners also can provide opportunities for client input into the intervention process by asking clients to identify their own goals, high-risk situations, social supports, and unique self-talk. Additional examples of individualizing the CB procedures are discussed in the next two sections.

CB interventions that teach clients to monitor their own psychiatric symptoms, to make emergency plans, and to seek assistance for personal problems, emergencies, school work, and performing routine activities in the home, school, and community, enhance clients' freedom and control. After acquiring such skills, vulnerable clients do not have to wait for someone to notice and assist them. The clients themselves are in control of when, whom, and how to ask for the needed assistance. Clients who learn to ask relevant questions about their medications can make informed decisions about their medical and psychiatric treatment. Vulnerable youths who learn skills to recruit assistance and obtain information from community sources can exert

greater control over their environment, satisfy their own needs and desires, and achieve their personal goals.

The interventions assist vulnerable groups in obtaining resources, assistance, and information to achieve their own goals; to enhance their social support, academic work, and performance of daily routines; and to meet their medical and emergency needs. These outcomes are consistent with a social justice perspective. Finally, if achieving these goals results in successful integration of vulnerable groups into the community, this also is consistent with the value of social justice.

Social Validity

Socially relevant goals and results. The interventions discussed in this chapter demonstrate several methods that practitioners and researchers can use to establish the social validity of their instrumental and ultimate treatment goals. An example is identifying supporting research, such as establishing the importance of social support to the well-being of adolescent mothers and of learning relevant skills to recruit assistance to handle emergencies and obtain needed resources and information. Acquiring the latter skills also can enhance successful integration of vulnerable groups into schools and communities. Surveying individuals with similar characteristics as the clients (e.g., low-income women) and professionals with relevant experience (e.g., those working with individuals with disabilities) also can identify socially relevant skills. Analyzing interactions in the context in which the behaviors are to be performed is another method to identify skills for which socially valid intervention goals are established. An example is reviewing audiotapes of mutual-aid group meetings to determine supportive behaviors. Creating opportunities for clients to establish and work toward their personal goals also should enhance the acceptability, desirability, and importance of the intervention goals. An example of an intervention goal that might be less socially valid is increasing attendance at self-help group meetings without establishing a goal related to gaining some benefit from the meetings.

With few exceptions (e.g., Petrides et al., 1995), the evaluations of the interventions provide evidence that the interventions can assist clients in accessing or increasing social resources that most people likely would consider socially relevant. The social resources include acquiring assistance from others to complete class work assignments, perform other daily/routine activities, resolve personal problems, learn knowledge related to medications and medical treatment, achieve personal goals, and increase social support networks. In other studies where measuring the client's actual use of the skills to obtain social resources would be difficult (e.g., accessing police, fire, or medical services to assist with emergencies), evidence was

provided that participants learned the relevant social skills. However, whether increases or improvements in other outcomes (e.g., size of social support networks, likelihood scales, survival skills tests, skills exhibited in role plays) were actually meaningful or relevant to the participants' lives is not always clear.

Practitioners and researchers might adopt additional methods from the previously described interventions to establish the social validity of their intervention results. Examples include surveying and interviewing clients and relevant others (e.g., teachers, peers) to determine their satisfaction with the intervention gains. Experts and others involved in the interventions can assess the quality of the acquired skills and ultimate outcomes (e.g., help-seeking skills and supportive behaviors in natural settings). Determining increases in the percentage of completed and correct class assignments for students with disabilities who increase their help-seeking behavior is another example of a socially relevant measure. Finally, clients can evaluate the success of their goal achievement. With the exception of an evaluation of whether striving to attain personal goals resulted in unfavorable outcomes for African American youths, none of the evaluations of the interventions reported assessing negative outcomes as a result of the interventions.

Socially relevant intervention procedures. As was the case with the interventions discussed in the previous two chapters, functional assessments were not completed before implementation of any of the interventions described in this chapter. If antecedent conditions such as physical or other barriers (e.g., access to transportation, a telephone, the necessary economic resources), depression or anxiety, or negative perceptions of anticipated outcomes exist, even socially skilled clients would be less likely to access community supports, potential helpers, and other resources. This suggests the need for practitioners and researchers to conduct functional assessments to ensure that their interventions are socially relevant, that is, that the interventions address the maintaining conditions of identified behaviors, such as recruiting skills.

Various rationales were provided for the selection of intervention materials, such as role-play situations and the responses that participants learned and practiced. For example, the interventions developed by Balcazar and Barth and their colleagues used detailed and extensive contextual analyses (based on Goldfried & D'Zurilla, 1969) to ensure that the content of the interventions was sensitive to the participants' characteristics and situations. Practitioners and researchers might use other techniques, such as incorporating relevant literature and surveying or interviewing clients themselves, individuals with similar characteristics as the clients (e.g., physical disabilities, racial minority status, gender, age, income), and relevant professionals and experts to develop and modify intervention materials to ensure their

social appropriateness. The intervention described by Petrides et al. (1995) uses strategies that are particularly sensitive to the social context in which individuals with type 1 diabetes might share information and use help-recruiting behaviors to seek emergency medical assistance. Assessing the satisfaction of clients and involved others with the intervention procedures and materials is another method that practitioners and researchers can use to determine whether their interventions are socially valid.

The previously discussed interventions also suggest a variety of methods that practitioners and researchers might use to individualize treatment, which also should enhance the acceptability and applicability of their interventions. Examples include teaching clients to identify their own high-risk situations, unique self-talk to assist them in handling high-stress situations, and positive activities to combat depression. Clients identify members of their own social support networks to assist them in a variety of ways, complete homework assignments relevant to their unique problems, practice skills necessary to achieve their individual goals, and choose among a variety of reinforcers.

In addition to the special accommodations discussed in the previous two chapters (e.g., Touch Talker), the interventions presented in this chapter suggest additional accommodations and adaptations that practitioners and researchers might use to enhance the acceptability and feasibility of their interventions. Using specially constructed emergency telephone directories adapted to the cognitive abilities of clients with mental retardation is an example. Teaching and prompting students with learning and developmental problems to keep track of recruiting their teacher's assistance by marking boxes on their class assignments and providing cue cards to assist students with LD in remembering the steps of recruiting peer assistance are yet other examples. The absence of reports of special accommodations or adaptations for participants in some interventions, such as teaching relaxation techniques to wheelchair users with physical disabilities, is surprising.

Maintenance and generalization. Evaluations of the interventions previously discussed frequently neglected to determine whether gains in social skills or ultimate outcomes were maintained after formal intervention ended. If maintenance of intervention gains was measured, it usually was measured for a short period (e.g., a few weeks). As discussed in the two subsequent chapter summaries, practitioners and researchers must realize that for many reasons the acquired skills, or the use of the skills, will not always be maintained or transfer to other settings, individuals, and contexts. The reasons include adverse experiences with others (e.g., medical providers or members of social support networks), worsening of physical or psychiatric conditions, and changes in social support networks. For example, individuals who had provided some type of support or information might no longer be avail-

able, or a student might be assigned a new classroom teacher or learning group. Reinforcing attendance of women with low income in self-help groups might not result in long-term attendance if the women do not receive emotional support and/or assistance from group members or other impediments, such as lack of transportation or child care, are not addressed.

The research evaluating the interventions frequently, but not always, examined whether the intervention gains transferred to environments outside of the intervention setting. As already noted, determining whether skills used infrequently, such as seeking police, fire, and medical emergency services, generalize to actual emergencies is very difficult. Even when researchers evaluated the transfer of intervention gains to natural settings, they frequently neglected to assess whether the gains transferred to multiple settings, individuals, and contexts. For example, the acquired skills of students with mental retardation to recruit their teacher's assistance and feedback on class assignments were evaluated on only one type of assignment, in one class, and with one teacher. The college students with disabilities recruited assistance for attaining their individual goals only from college personnel. If the client's goal is to transfer the acquired skills to other materials, settings, situations, and/or individuals, then the acquired skills must be assessed under those circumstances. And, when necessary, practitioners and researchers must use the same or develop additional strategies to enhance generalization of the skills.

To assist clients in maintaining and transferring their intervention gains, practitioners and researchers might adopt the techniques used in the interventions discussed in this chapter. For example, clients can complete homework assignments in a variety of natural settings and practice the identified skills, such as medication-related information-seeking and negotiation skills, with multiple individuals, including relevant individuals in natural settings (e.g., physicians and pharmacists). Clients can practice problem-solving exercises to identify and develop methods to cope with problematic situations, such as between themselves and their physician. Multiple situations can be set up across multiple natural settings for clients to practice help-seeking skills, and clients can be taught strategies to cope with rejection when recruiting assistance from potential helpers. Phasing out prompts and artificial reinforcers also might enhance maintenance and generalization of the skills. However, none the interventions (as was the case with most of the interventions discussed in the two previous chapters) involved significant others to coordinate intervention between the treatment and other settings (e.g., between the school and home). This analysis suggests the need for practitioners to assess and, when necessary, resolve barriers that interfere with the transfer and maintenance of intervention gains before closing a case. Researchers also need to continue to evaluate effective methods to

enhance maintenance and transfer of intervention gains to multiple materials, settings, individuals, and situations.

The three chapters of part II discussed CB interventions that practitioners can use to assist vulnerable clients in accessing and increasing a variety of social resources. Although research has provided some evidence for the effectiveness of all but a few of the interventions, many of the interventions and evaluations have limitations that continue to present challenges for practitioners and researchers. The limitations are related to the research design, applicability of the findings to similar or other vulnerable clients, and establishment of socially valid intervention methods, goals, and results. The challenges include identifying and providing special accommodations and adaptations for the special needs of vulnerable clients, individualizing assessment and treatment, and maintaining and transferring the treatment gains to other relevant materials, settings, contexts, and individuals. Despite these challenges, part II provides a rich source of interventions and information for practitioners to use to assist vulnerable clients in accessing and increasing their social resources and for researchers interested in developing and evaluating CB interventions to achieve related outcomes.

Part III contains three chapters discussing CB interventions that empower vulnerable populations by assisting them in acquiring, maintaining, and increasing their economic resources. The specific goals are securing employment by learning job-seeking skills; maintaining and advancing in employment by increasing on-the-job productivity, work quality, and relevant social skills; and acquiring economic-related resources from public benefits programs and private sources.

ADDITIONAL READINGS AND RESOURCES

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