SOCIAL WORK TREATMENT

INTERLOCKING THEORETICAL APPROACHES

SIXTH EDITION

edited by
Francis J. Turner

OXFORD

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For my sisters Patricia and Cecil, both members of religious orders and missionaries, one as a teacher in a distant town in Eastern Canada and the other as a midwife in various parts of rural Guiana, Brazil, and the Philippines. Through their professional activities, each taught me much about our responsibilities as social workers to seek to understand the complexity and inherent differences in our clients and, so doing, learn to appreciate how to build on such differences as we seek to effect change in their bio-psychosocial realities.

Foreword to the Sixth Edition

It is with great pleasure that I write this foreword to the sixth edition of *Social Work Treatment: Interlocking Theoretical Approaches*, edited by Francis J. Turner. The first edition of this book appeared in 1974—a very different time in the history of social work practice. Over the years and in subsequent editions, some of the theories covered remain, some have fallen away, others have been added—but all have evolved. In his characteristic manner, in this volume, Professor Turner has brought together seasoned and well-recognized experts in the field and emerging scholars, blending experience and history with the work of future leaders in our field.

While it is not my remit, I feel obligated to take the writing of this foreword as an opportunity to reflect on the vast contributions that Francis J. Turner has made to the discipline of social work and social work education over his long, illustrious, and remarkably productive career. Professor Turner began his social work career in child welfare in 1951, having obtained a BA and BTh from the University of Western Ontario, returning to complete his BSW and MSW at the University of Ottawa, and later his DSW at Columbia University (1963). His academic career has included appointments as chair of schools of social work at Memorial University of Newfoundland and York University; Dean of Social Work at Wilfrid Laurier University on two separate occasions 20 years apart; and Vice-President, Academic, and Executive Vice-President at Laurentian University. In addition, he has been a visiting professor and lecturer at universities worldwide, including Case Western, Hunter College (City University of New York), and Oxford University. These many appointments underline Turner's deep and abiding commitment to social work education, a commitment that is further evidenced by the broad use of his books in social work programs across the world. These books, including *Social Work Treatment, Social Work Diagnosis, Social Work Practice*, and *Canadian Social Welfare*, have shaped the learning experiences of five decades of social work students and, ultimately, the field of social work. His work as editor-in-chief of the *International Journal of Social Work* demonstrates the manner in which his influence has reached far beyond the boundaries of North America. This work has also reflected profound changes in the environment in which social workers work.

Professor Turner began his career in social work just four years after the first social worker was hired by the Toronto Lunatic Asylum (subsequently named "the Toronto Psychiatric Hospital" and then "Centre for Addiction and Mental Health"). At that time, phenothiazines, major tranquilizers for the treatment of psychoses, were invented, provoking an abrupt shift in mental health treatment (Regehr & Glancy, 2010). In 1957, the first community-based mental health center was established in Burnaby, British Columbia; and in 1959, the Ontario Ministry of Health drafted the first proposal for community-based treatment, including the provision of psychiatric beds in general hospitals. This marked the beginning of the deinstitutionalization movement, and between 1965 and 1981, the number of beds in provincial psychiatric hospitals across Canada dropped by 70%—unfortunately resulting in psychiatric ghettos and a rapid rise in the number of individuals suffering from major mental illnesses in the jail system (Regehr & Kanani, 2010). Social work practice in mental health has thus evolved,

responding to the lived experiences of individuals wherever they are.

In 1952, the American Psychiatric Association published the first edition of *The Diagnostic and Statistical Manual for Mental Disorders* (DSM-I), identifying two categories of disorders: those associated with brain tissue (e.g., dementia), and psychogenic disorders without a clear physical cause (e.g., psychosis). Now in its fifth edition (DSM-5), the DSM has seen many changes over the years, including the introduction of homosexuality as a mental disorder in the second edition, and as a result of outcry, the change to Ego-Dystonic Homosexuality in DSM-III. Over the years, at first thought revolutionary and then understood to be damaging, theories and concepts such as the "schizophrenogenic mother" have come and gone from mental health social work practice (Regehr & Glancy, 2014). In the 1970s, the return of soldiers from the Vietnam war whose horrifying experiences left them scarred, and the growing awareness of rape and its aftermath, resulted in recognition of post-traumatic stress disorder (PTSD) and its inclusion in DSM-III (Regehr & Glancy, 2014). Trauma-informed care is now a central element of social work practice.

In the world of health care, since Turner entered social work, AIDS emerged as a domestic epidemic. First identified by the Centers for Disease Control and Prevention (CDC) as a rare lung disease in June 1981, by the end of that same year, 270 cases of severe immune deficiency were reported among gay men, 121 of whom had died (aids.gov, 2016), and fear spread throughout the community. By 2016, a decade-long clinical trial determined that antiretroviral therapy is highly effective, not only in prolonging life, but also in preventing sexual transmission of HIV (aids.gov, 2016). Stigma associated with the disease continues to be addressed by social workers in policy, community, and hospital-based practices.

In 1967, the first successful human heart transplant was performed by Christiaan Barnard in South Africa. Now organ transplants are routine operations, and social workers are engaged in working with donor families and recipients and their families (Anthony et al., 2014). The major challenge has become, not survival, but securing sufficient donated organs (Regehr, Kanani, McFadden, & Saini, 2015), and as laboratories throughout the world work to grow human organ tissue, social work interventions will shift again.

In 1950, the life expectancy for men in the United States was 65.6 and for women was 71.1; in 2015, it was 76.4 and 81.2, respectively (CDC, 2016). As the aging population has grown, social work has responded, establishing the field of gerontological social work, focusing on issue of elder justice, caregiver well-being, and healthy aging.

In 1955, Rosa Parks was arrested in Montgomery, Alabama, for refusing to give up her seat in the bus, sparking the Montgomery bus boycott led by Martin Luther King, Jr., and the civil rights movement. Nine years later, the Civil Rights Act of 1964 was enacted, prohibiting discrimination in public places and providing for the integration of schools. Then, following the march on Selma, the Voting Rights Act of 1965 was enacted, outlawing discriminatory voting practices against African Americans brought into force after the Civil War (ourdocuments.gov, 2016). Our students today remind us through Black Lives Matter protests that racism and systemic discrimination continue to exist and that social work must continuously challenge our theories and our practices. Such views can be found in the theories covered in this book.

Child welfare social work has also seen enormous shifts in the past 65 years. In the 1960s, the consequences of, first child abuse (the battered child syndrome), and later, child sexual abuse, expanded and enforced the mandate of child welfare agencies to protect children, in part because of public outrage over the issue. Removal of children from their homes was a relatively informal process, affording little protection for vulnerable families, particularly Aboriginal Canadians and African Americans. As a result, in the 1970s, the child protection system came under public scrutiny, and the legislative balance shifted to favoring the "least restrictive" actions. Then, in the 1990s, public scrutiny turned to deaths of children who were known to child welfare services, and social workers and the agencies where they worked were held to be liable (Regehr et al., 2015). Child welfare social work

practice has thus changed over the decades and continues to change as society as a whole balances the needs and rights of families with those of vulnerable children.

The legislative framework governing the social work profession has also changed, and in Canada, Turner has had a profound effect on these changes. In 1964, he was a founding member of the Ontario Association of Social Workers; he served as president of the Canadian Association of Social Workers (CASW) and received both the CASW Distinguished Service Award and the Outstanding National Service Award. Noting that Ontario was one of the last jurisdictions in North America where social workers were not regulated, Turner chaired the Project Legislation Committee, whose advocacy led to Canada's Social Work and Social Service Act of 1998. In advocating for social work as a profession, he simultaneously sought to ensure protection of the public by ensuring that those who serve them adhere to the highest professional standards and accountability.

Over the course of Turner's career, he has witnessed profound changes in society and profound changes in our profession. His advocacy and scholarly work have both reflected these changes and shaped the profession. His books have presented generations of social work students with the most current challenges, theories, and research in social work—informing their thinking and future practices. I have had the privilege of writing chapters in five different books edited by Professor Turner—including the fifth edition of *Social Work Treatment*. I am deeply honored to have been invited to write the foreword for this most recent book, and have relished the opportunity to reflect on where we have come as a profession over the years of his illustrious career.

Cheryl Regehr

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Preface

Fifty years is a long time! Within the scope of the last fifty years, this book has gone through five editions, with the present one being the sixth. The process began at a time in our profession's history when the continuance of a search for a single theory for social work practice was over. Rather, the profession had come to the realization that a "psycho-social" thrust of social work better fitted the profession, at least in this part of the world.

As our profession expanded in scope and in recognition, so too did an appreciation of the importance and richness of many aspects of social sciences; hence the growth and interest in the application of the various schools of psychotherapy to our profession expanded. Now our interest lay in the adoption of knowledge and skills of the various schools of thought to social work treatment, practice, and relevant research. Thus the body of both the psychological and the social thought systems became the theoretical bases from which the profession presented its credentials to the world of teaching, practice, and research. One educational factor that influenced this development was the reality that the profession, because of a variety of important sociological factors, had moved into the university world on a wider scale. This meant that many students were registered in the academic structure at both the master's and doctoral levels. Only later did social work education move into the baccalaureate and community-college levels.

From the earliest days, social work education included a strong interest and commitment to the research challenges at a university level. The wealth of social work research and the impact of teaching and practice have been and continue to be dramatic, as reflected in this volume. It has created a rich setting for research and its subsequent publication.

One of the ongoing challenges to our profession was, and continues to be, how to get important research and practice findings into the hands of practitioners and academics in a convenient and effective way. A format we have found useful is to address the development and plans for this volume and its various editions by inviting colleagues (each of whom is a recognized spokesperson for one of the 38 theories discussed in this edition) to present an updated summary of a particular practice theory, which includes a current reference list of relevant material related to a specific theory.

This process has led to our publishing a set of six editions, each of which updated the prior editions, in a format that has been found useful and helpful to teaching practitioners and researchers although initially we thought that one of the goals of the earlier editions was to encapsulate the full range of theories in use in practice.

Clearly, the practice world has come to appreciate the complications and inherited challenges of social work practice. Although in an earlier day we presented groups of theories in a scholarly comparative manner, we have now become more comfortable in also seeing them as groups of therapeutic resources. That is, we are learning to present groups such as this volume as a discussion of resources on which a practitioner can draw. Each theory is viewed as a neutral resource that may or may not be drawn upon in a particular case.

To date, we have not found a way to evaluate our cluster of 38 theories and their differential use in different situations. How we might do this is a challenge the profession faces. In the meantime, we shall begin to gather data as to how and where the profession finds use for each theory by encouraging practitioners to share their experiences with us.

Francis J. Turner

Acknowledgments

On each occasion that I engage in the process of writing the traditional paragraph of acknowledgements, I am humbled by an awareness of the many persons who have assisted in the multiple tasks of bringing the book to fruition. I suspect that this network is much broader than I am aware of. Over the years, my family has been consistently supportive of my publishing activities, albeit from the distances that their lives have taken them. Joanne plays a much more direct role in recent projects.

I am most pleased that Oxford University Press has recognized the need for a sixth edition and has been most helpful through the editing process. I am most grateful for the support and assistance of Dr. Dan Andreae and Dr. Alex Polgar, and the research support of York University.

Finding and assembling the group of contributors was a challenging process, and the collegial help of the group as it developed served to make the process manageable and functional. Throughout, my research assistant, Carlos Pereira, played a major role in planning and implementing the required and constantly changing strategy that eventually brought the book to fruition. To him and to all, I am grateful.

Toronto, February, 2016

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Social Work Treatment

I

Attachment Theory and Social Work Treatment

Timothy Page

History and Development of the Theory

Origins

Attachment theory was originally created in the mid-20th century by the British psychiatrist John Bowlby, director of the Department for Children and Parents at the Tavistock Clinic in London.[1] The first public presentation of attachment theory occurred in three seminal lectures Bowlby gave to the British Psychoanalytical Society in London, one each year, from 1957 to 1959 (Bretherton, 1992). His audience was the child psychiatry establishment of that era, including such notable figures as Anna Freud, Melanie Klein, and Donald Winnicott, and their view of human development and psychotherapy was firmly rooted in Freudian psychoanalytic theory.

The classical psychoanalytic model of human development was based on a concept of psycho-sexual drive energy as its primary motivating force (Greenberg & Mitchell, 1983). In the Freudian view, the process of buildup and discharge of psycho-sexual drive energy creates internal fantasies that ultimately are responsible for the emergence of personality, social relationships, and virtually every other aspect of human development. This so-called "hydraulic model" of motivational drive was based on ideas taken from 19th-century physics concerning the process of accumulation and discharge of energy within closed systems, the goal of which is a state of relative quiescence. In the classical Freudian theories of development and psychoanalytic treatment, internally created fantasies are even more important to the

course of human growth and development than the child's actual experience.

Bowlby's attachment theory diverged from Freudian theory in many important ways, none more so than in his emphasis on the importance of actual experience to human development (Bowlby, 1982). In Bowlby's view, the quality of interactions between infant and caregiver(s), beginning at birth, motivated specifically by the child's needs for safety and protection, is central to life span development. Reaction from the Psychoanalytical Society, including his own mentors, to his attachment papers was immediately condemnatory because of his explicit rejection of core tenets of Freudian theory. Although he remained a member of the Society for the rest of his life, he never formally presented a paper there again (Bretherton, 1992).

A New Model of Instinct

In attachment theory, Bowlby replaced the Freudian notion of instinct as psycho-sexual drive, and the hydraulic model's relative emphasis on internally derived motivation, with a model conceptualizing instinct as an interaction of organism and environment. Taking language primarily from the field of cybernetics and adapting this to studies in ethology and human development, Bowlby saw instinctive behavior in terms of "control systems." He saw the expression of an intrinsic need as goal-directed behavior in a relational context. Modification of the behavior occurs through feedback from the environment, especially the quality of response from the relational partner involved, a process he referred to as "goal-correction." Bowlby integrated the control systems model with the term "behavioral system," which he borrowed from ethology, to explain the basic processes governing instinct-based social behavior in humans (Stevenson-Hinde, 2007). He discussed the hunting behavior of a falcon in flight and a frightened infant's seeking of his caregiver as analogous to the way the power steering mechanism works on a car (Bowlby, 1982). In each of these cases, there is a goal the object is directed to, and behavior is modified or corrected as information is fed back about its progress toward the goal—be it the hunt, the turning of the wheel, or the comfort-seeking of the infant. By conceptualizing "instinct" as an interaction of inherited predispositions and environmental response, he laid an important theoretical foundation: What we consider to be the "normative" parameters of human experience must include considerable diversity and variation.

The influence of the field of ethology on Bowlby's work is reflected in the comprehensive analyses and syntheses of scores of diverse studies, particularly primate studies, he used to establish attachment theory within the larger theory of Darwinian evolution. Attachment theory has been called a "major middle-level" evolutionary theory (Simpson & Belsky, 2008) because of its foundation in and refinement of Darwinian theory. Evolutionary theory became increasingly established as the dominant paradigm of the natural sciences in the 20th century, though it had not, until Bowlby, had a significant place in our understanding of human psychosocial development. One of the great achievements, therefore, of Bowlby's attachment theory is that it represented the first time that a major theory of human psychosocial development became integrated into the dominant paradigm of modern biological sciences.

Attachment Behavior

Among the ethological researchers of his time, Bowlby was profoundly influenced by the now-classic studies of Konrad Lorenz (1935) on "imprinting" in ducks and geese, and Harry Harlow (1958) on infant rhesus monkey behavior toward wire adult models. This and other ethological research inspired Bowlby to see that the formation of social bonds in these species was not dependent on feeding, an insight he then applied to human development. In doing so, he explicitly rejected the views of Freudian and behavioral theories alike, which posited that the formation of social bonds between human children and their caregivers is secondary to the oral gratification associated with feeding. If social bonds form independently of feeding and not secondary to pleasure, however, he had to explain what their larger purpose was.

Bowlby's main interest was the formation, beginning in infancy, of the behaviors that collectively compose the attachment behavioral system. He saw in the development of

attachment behavior powerful relational themes influencing the entire life course. Much as the neonate responds to tactile stimulation of the lips and hard palate with grasping and sucking, Bowlby proposed, the infant also responds to conditions of vulnerability such as fear, pain, cold, hunger, fatigue, and illness, with an array of behaviors that result in the maintenance of *proximity* to the caregiver. Around the age of six months, the early behaviors of crying, clinging, smiling, visually following the caregiver, signaling, and, later, movement toward the caregiver become increasingly organized into the attachment behavioral system (Bowlby, 1982). The attachment system becomes activated in conditions of vulnerability, including distance and separations from caregivers. The caregiver's response to the infant's activated attachment behavior amounts to, in control systems terminology, the "feeding back" of information to the infant, and it produces, under favorable conditions, calming and a growing sense of security. Proximity-seeking directed to a specific caregiver is the fundamental component of attachment behavior, whose proximate purpose is to calm feelings of insecurity, and whose ultimate, evolutionary function is to ensure the survival of the infant and species (Bowlby, 1982).

The term "attachment figure" is applied to the specific caregivers to whom, by virtue of their protective role for the child, children direct their attachment behavior. Attachment relationships typically involve parents, and may include other relatives such as grandparents, aunts, uncles, and older siblings, or close relationships with non-family members. Attachments—the internalized bonds that form in attachment relationships—reflect specific dyadic qualities and interactive histories, yet are considered characteristics of the child. An attachment bond involves, is indeed defined by, the child's affective tie to a specific attachment figure, not the attachment figure's bond to the child. The term "attachment" is therefore not used in the colloquial sense of "connection" and specifically refers to an emotional bond experienced by a relatively more vulnerable person in relation to a relatively stronger one. Most children, fortunately, have multiple attachment bonds, each specific to the relational history with the individual attachment figure. Bowlby (1982) believed that, despite the presence of multiple attachments, children organize attachment relationships in some form of hierarchy, with one preferred attachment figure, usually the mother, above others, a principle he referred to as the "monotropy" of attachment bonds.

Attachment, Fear, and Exploration

The attachment behavioral system functions in direct relation to two other major behavioral systems within the child (Bowlby, 1982), the fear/wariness and exploratory behavioral systems, representing, respectively, the instinct to withdraw from frightening circumstances and the instinct to explore novel situations. Bowlby proposed that the attachment and fear/wariness behavioral systems operate in close, but not absolute, synchrony. Very frequently, but not always, Bowlby argued, attachment behavior is activated by fear-inducing conditions that simultaneously activate withdrawal from the feared object. Attachment behavior may also be activated, however, according to Bowlby, in conditions not directly associated with an instinct to withdraw, such as fatigue and illness. The exploratory behavioral system, in contrast to the fear/wariness system, plays a role fully equal in importance to the attachment system in determining how attachment behavior ultimately becomes expressed and, thus, how the attachment bond is formed. A natural, instinctive desire to explore the social and physical environment is normally activated in conditions where the child is relatively stress-free. Through this process, the child learns about the world, taking in new information and developing perceptual, analytical, and motor skills that provide opportunities for the child's development of mastery and autonomy.

Inevitably, however, the child experiences depletion in energy or becomes distressed by encounters with unfamiliar objects or events, or from the separation from an attachment figure, all of which produce feelings of vulnerability, activating the attachment behavioral system. In this way, exploratory and attachment systems are regarded as polar dimensions of a larger process, whereby the activation of one normally involves the relative deactivation of the other. In order for the child to be

able to explore the world with confidence, s/he must be able to trust in the availability of the "secure base" of the attachment relationship, as described by Ainsworth (Ainsworth & Bowlby, 1991), from which the child ventures outward, and to which the child can return, as a "safe haven" for care and protection when needed. The way in which the attachment figure accurately perceives and responds to the child's alternating needs for exploration and attachment will determine the nature of the attachment bond that the child will form with the attachment figure. As Ainsworth (1989) later demonstrated, the transactions associated with exploration and proximity-seeking provide the infant with opportunities to learn an array of communication and social skills that become a foundation for social relatedness in ever-widening social spheres as the infant matures into childhood. Essential relational styles involving the communication of needs, and the expectations of others' responses to expressions of need, are therefore first learned in infancy in the first attachment relationships.

Bowlby's emphasis on predictable functions of behavioral systems led some critics in the Psychoanalytical Society to label him a "behaviorist" (Bretherton, 1992), referring to the mechanistic competing theory of the day, "behaviorism," or "social learning theory." Although, to a great extent, attachment theory is compatible with and can subsume important tenets of behaviorism, it is profoundly different from it in several ways. First, as discussed above, attachment theory contains a theory of instinctive motivation for safety and protection. Behaviorism, in contrast, has no theory of instinctive motivation beyond the pursuit of pleasure. Ainsworth and Bowlby repeatedly emphasized the dangers of employing a behaviorist model to understand children's distress when in need of their caregivers. According to behaviorism, children's expressed distress is presumed to be learned behavior. Learning theory predicts that when parents respond to fussy or distressed behavior with comfort, the behavior will be reinforced and is thus likely to continue, and the child is thereby in danger of developing "dependency" or insufficient autonomy. The risk to children of this approach is that it ignores their intrinsic needs for safety, comfort, and protection, and that to withhold comfort from them risks creating long-standing anxiety and emotional insecurity. Autonomy, from the attachment viewpoint, is enabled, not through withholding comfort, but through security-enhancing behavior, including ample provision of comfort when needed.

Cognition and Development

Bowlby's interest in the development of attachment in children led him to theorize that the attachment behavioral system had to operate as part of the central nervous system circuitry, in which memory systems play a crucial role. Through repeated experiences with an attachment figure in times of distress, the child learns, and begins to make generalizations, about the responsiveness and reliability of the caregiving environment. These early experiences become increasingly organized in memory in structures Bowlby (1973, 1982) referred to as "internal working models," a term first used by the philosopher and cognitive psychologist Kenneth Craik. Bowlby preferred this term to more static representations of cognitive structures, because it communicates a sense of patterned responses to the social environment and, at the same time, the capacity for ongoing revision, based on learning from new social experiences. Internal working models, thus, can account for continuity of individual development as well as individual change. Internal working models become increasingly established and resistant to major revisions as the child grows, however. (The conceptualization of stability and change in cognition is one of several areas where Bowlby [1973] acknowledged the influence of Piaget on his thinking.) According to Bowlby, the primary adaptive function of internal working models is to provide the developing child with the capacity to predict the likely responses of potentially protective figures in situations where the child experiences vulnerability. Expectations of responsive care from others derive from and further promote emotional security, an attribute that can facilitate the building of positive relationships and provide a buffer against future negative interpersonal experiences (Bretherton, 2005).

The process of organizing internal working models of attachment relationships is theorized

to begin at the approximate age at which the formation of "object permanence," in the Piagetian sense, begins for most children. The cognitive capacity of object permanence is, therefore, thought to have a functional role in the development of internal working models (Bowlby, 1980). From this initial period of approximately age six months until approximately 18 months, Bowlby viewed the child's development of internal working models as embryonic. At the latter age, the child, under favorable conditions, is able to apply the representation of attachment figure in a new capacity. From the approximate age of 18 months to three years, the child's internal working model of attachment figure becomes increasingly available for the purpose of executing increasingly complex behavioral plans, especially those that involve venturing farther away from the caregiver. The child is now able to *use* the internal representation of the caregiver to make predictions concerning his/her availability (Bowlby, 1980). As most children approach the end of their third year, the internal representation of the caregiver begins to carry with it the security-providing functions that, for the infant, were previously associated only with the actual presence of the attachment figure.

The young child's developing capacities to organize memories into internal working models is a central element in what Bowlby referred to as the four major "phases in the development of attachment" (1980, p. 265). The first of these begins at birth and lasts for the next approximately eight to 12 weeks. This first phase is actually a phase of non-attachment, or pre-attachment, in which the infant's orientation to caregivers and communication signals occurs with "limited discrimination of figure." That is, in these early weeks, the infant has not yet achieved the capacity to discriminate among individuals beyond olfactory and auditory stimuli. In the second phase, lasting from approximately 12 weeks to six months, the infant's visual capacities to discriminate among individuals emerge, with obvious abilities to orient and respond to them, particularly primary caregivers. The third phase, which lasts from approximately six months to three years, is characterized by the capacity to differentiate known caregivers from strangers, with the emergence of "stranger wariness" and, simultaneously, "clear-cut" attachment behavior directed toward caregivers. In the fourth phase, the toddler, now in his/her third year, increasingly uses "goal-corrected systems" involving internal working models of caregivers and him/herself to achieve the experience of proximity to the caregiver. These new cognitive capacities eventually allow the child to develop sophisticated abilities to gain insight into the caregiver's feelings and motives, further refining the child's ability to construct models and interactive plans of the relationship.

While an approximate developmental chronology is useful for tracking these changes, it is important to note that Bowlby disliked the use of "watershed"-type age-markers. He saw the development of internal working models as a gradual life process, which changes qualitatively over time and is susceptible to revision. At the same time, however, according to theory, it is the formation of internal working models in infancy that accounts for the enduring quality of early attachment relationships throughout life (Bowlby, 1982).

Internal Working Models, Adversity, and Defensive Processes

In optimal conditions, attachment figures respond adequately and consistently to children's experiences of vulnerability. A child forms internal working models of attachment figures as reliable and trustworthy when these conditions are present. When a child consistently encounters behavior by an attachment figure that does not adequately address conditions of vulnerability, however, the child is likely to form conflicting internal working models of the same attachment figure: a conscious one that preserves a sense of the parent as trustworthy, and one that is defensively excluded from consciousness containing the information regarding the parent's inadequacy (Bowlby, 1973). If the mental representations of the untrustworthy parent were integrated into the child's conscious internal working model, according to Bowlby, the resultant experience of threat and persistent insecurity would be overwhelming to the child. In order to preserve some sense of safety and security, therefore, the child maintains an

illusory mental model of a reliable and responsive parent.

The formation of the internal working model of self reflects an appraisal process: A small child makes appraisals of him/herself inferred from the nature of responses received from attachment figures. Internal working models of self and attachment figures are, thus, likely to be *complementary* (Bowlby, 1973). In non-optimal circumstances, where an attachment figure has not consistently responded to the child in reassuring ways, the internal working model of the child's self is likely to take on qualities of inadequacy. An unloved child will appraise him/herself as unlovable.

Effects of Prolonged Separations from Caregivers

One central, organizing idea of attachment theory that propelled much of Bowlby's work and set him apart from most psychoanalysts of his day is that children's intense reactions to prolonged separations from, or loss of, their primary caregivers provide direct and observable evidence for the existence of attachment bonds (Bowlby, 1982). Classical psychoanalytic theory discounted the experience of mourning in young children as a result of its emphasis on internal vs. actual experience. Prolonged separations from or loss of attachment figures during the critical period for the formation of attachment, six to 36 months, and the quality of the subsequent care children receive, may have profound developmental effects across the life span.

Bowlby incorporated a stage theory of children's reactions to prolonged separations, first developed by social worker James Robertson, a colleague of Bowlby's at Tavistock. Robertson proposed, based on filmed observations he made of children separated from their parents in hospitals (1952), as well as observations he and his wife, Joyce, made of their foster children, that young children normally react to prolonged separations from their attachment figures in phases characterized by protest, despair, and lastly (if the separation is not addressed) detachment. In the first stage, the child exhibits a high level of anger, uncooperative behavior, searching, and anxiety, the function of which is, according to Bowlby, to challenge and eliminate interpersonal barriers standing in the way of reunion with the attachment figure. The protest of this stage is thus connected to the activation of attachment behavior, whose expression may take different affective forms; it is designed to accomplish proximity to the missing attachment figure.

The next stage, despair, begins after the young child's protest at the separation has gone unanswered by the attachment figure. Depending on circumstances, this stage may begin after a period of days or weeks following the separation. At this stage, sadness and withdrawal are common features, though typically still intermingled with anxiety and/or anger.

In the final stage, if the attachment figure has failed to appear for the child and no substitutes are available, a virtual shutdown of the systems responsible for the child's attachment behavior begins, and the child detaches emotionally from significant others. The longer that separation from the attachment figure continues, under circumstances where no substitute caregivers are available, the greater the risk for a progression into detachment and despair.

Bowlby's theory of grief and mourning, influenced by the work of Colin Murray Parkes (Bowlby, 1960, 1980), involves a normative progression through four major phases of adjustment: (a) numbing and shock; (b) yearning and searching, accompanied by anger and disbelief; (c) disorganization and despair, including the dismantling of internal working models of the relationships; and (d) reorganization and redefinition. This theory proved to be very influential on the work of others in the field, including that of Kubler-Ross (1969).

Conditions in the grieving child's life may or may not promote the child's successful reorganization of internal equilibrium. Often, the most important variable affecting this process is the way in which significant adults in the child's life react to the loss themselves and how they appraise and respond to the child's needs at this time. According to Bowlby, the most basic and, perhaps, the single most helpful thing a significant adult in the child's life can do to promote the child's successful grieving of a lost figure is

to permit and encourage the child to express, uncensored, the emotions associated with the loss (Bowlby, 1980). In this way, the risk to the child of developing a rigid, defensive exclusion of the emotions associated with the loss and with the actual relationship with the lost figure is minimized. The ability of significant adults to provide a child with opportunities for grieving necessarily depends on their own capacity to accept and express the range of emotions associated with the loss.

When conditions do not favor a person's successful resolution of loss, characteristics of "disordered mourning" are likely to appear. Among the manifestations of disordered mourning discussed by Bowlby are: Chronic mourning, when the resolution of the loss is not effected, and the person remains "stuck" in earlier phases of searching/yearning or disorganization/despair; and the absence of grief, when the experience of the loss is largely defensively excluded from conscious awareness. Bowlby describes several types of symptoms associated with children's reactions to loss, which fall generally under these two major rubrics, including the following: fear that a surviving parent will die; fear of the child's own death; hopes for death as a way to be reunited with the lost figure (this is especially likely for children who do not perceive death as irreversible); persisting blame, of self or of others, or guilt; aggression and destructive outbursts (Bowlby believed that virtually all children who react in this way have a hidden sense of guilt for the loss); compulsive care-giving; compulsive self-reliance; euphoria and depersonalization; and the development of symptoms similar to those the lost person had (Bowlby, 1980).

In Bowlby's view, psychological defense, separation anxiety/reaction, and grief and mourning are interrelated processes, functioning as part of one larger process involving initial activation and subsequent deactivation of attachment behavior for a missing, lost, or unresponsive attachment figure; thus the meaning and function of these processes were recast as expressions of attachment behavior (1973). He also emphasized that the course taken in childhood in reaction to separation or loss may well affect a person throughout the entire life span, depending to a great extent on the way in which attachment behavior was expressed in the relationship and the nature of response received from the caregiving environment.

The Contributions to Attachment Theory of Mary Ainsworth and Colleagues

Bowlby's crowning achievement was the construction of an elegant, new developmental framework. In contrast, he participated less in empirical research. The application of attachment theory to empirical research was left by and large to his colleagues and followers, beginning, most notably, with Mary Ainsworth, an American developmental psychologist and colleague of Bowlby's at the Tavistock Clinic. Ainsworth conducted the first major empirical studies of attachment, beginning with work she did in rural Uganda (Ainsworth, 1963) and later in Baltimore (Ainsworth, Blehar, Waters, & Wall, 1978). Her interest in children's emotional security went back to her days as a doctoral student in Toronto, where her dissertation, completed in 1940, incorporated the "security theory" of her mentor, William Blatz (Ainsworth & Marvin, 1995).

Ainsworth's research utilized primarily observations of mother–child interactions, which became a major part of her enduring legacy, the inspiration for which she credited Robertson's observations of children in hospital settings. In their Baltimore study, Ainsworth and colleagues created a major innovation in observational research methods, the "Strange Situation Procedure," a laboratory assessment containing several progressive steps designed to observe firsthand how infants react to separations from their mothers. Significant associations were found between home observations of the quality of mother–child interactions and attachment patterns observed in the Strange Situation, suggesting that the laboratory observations were valid indicators of interactive behavioral patterns between mother and child, and probably represented enduring dyadic relationship qualities.

In brief, the Strange Situation Procedure consists of the following seven episodes:

1. The caregiver and infant enter a small room containing several toys, and the infant is allowed to play and explore as desired;
2. A "stranger"/assistant enters the room and sits quietly at first, then engages in conversation with the caregiver;
3. Caregiver leaves the room, leaving the infant alone with the assistant, who freely interacts with the child;
4. The caregiver returns, and the assistant leaves the room;
5. The caregiver departs, leaving the infant alone;
6. The stranger returns to the room;
7. The caregiver returns to the room, and the assistant leaves.

Each of the major episodes lasts three minutes, unless curtailed because of infant distress.

In her Baltimore study, Ainsworth's subjects (n = 106) were collected over four separate projects; all were white and middle-class. Observations of the infants' responses to absences from and, especially, reunions with the mother were recorded by scoring numerous types of infant behavior in interaction with their mothers. On the basis of these observations, Ainsworth created three main categories (composed of eight subgroups) of attachment security: Insecure-avoidant (A); secure (B); and insecure-ambivalent (resistant) (C). Avoidant babies tended to display little attachment behavior and little emotion, in general, toward their mothers. They typically avoided their mothers upon their return by turning their backs or snubbing maternal overtures toward them. Secure babies showed clear distress and attachment behavior toward their mothers during separations. When reunited with mothers, they approached and sought contact, and after a period of comforting, returned to exploration. These babies were distinguished from the other groups by their ability to regain emotional equilibrium and regulation after reassuring contact with the mother. Ambivalent babies tended to approach the mother upon her return but remained dissatisfied and angry, not soothed, by her presence.

Ainsworth's findings supported and elucidated several important aspects of Bowlby's theory of attachment, especially the notion that attachment behavior will look different for children depending on their life experiences. Consistent with theory, the three main categories of attachment security were primarily distinguished by patterned activation or deactivation of attachment behavior and the qualities of synchronous interaction of parent and child. In Bowlby's original terms, the attachment relationship provides the infant with an interpersonal system of regulation, which eventually leads to the child's own physiological regulatory capacities (1982). Ainsworth's classification system identified specific variations in how this goal is accomplished. Parents of securely attached babies, in contrast to those of insecurely attached children, were notable for their *sensitivity* and *responsiveness* toward their children. They were expert at understanding their children's needs for them, with great insight into the child's point of view, and had the necessary personal resources to be able to respond to them according to their needs.

The Strange Situation Procedure (SSP) was important, first, because it provided a standard behavioral measure of attachment for infants up to approximately two years of age (it is typically used for infants between the ages of 12 and 18 months). (Two of Ainsworth's students, Jude Cassidy and Robert Marvin, adapted the original SSP for use with preschool children up to age five [Cassidy & Marvin, 1992].) It also came to be viewed as, essentially, a "shortcut" in the assessment of parent and child interaction that normally would be done in the naturalistic setting of the home (Ainsworth & Marvin, 1995). Assessment in the SSP, then, has become a standard to which other measures of attachment, especially those taking place later in childhood, are compared. In some ways, Ainsworth regretted that the classifications derived from Strange Situation assessments had become essentially synonymous with attachment, and presumed by many to be sufficient for understanding attachment behavior in parent–child dyads. She advocated all her life that behavioral scientists study children by observing them in their natural environments, especially their homes (Ainsworth & Marvin, 1995), which she

regarded as essential to capturing a full understanding of attachment relationships.

As researchers around the world began to use the SSP, providing validation in varied settings, it became apparent to many that a significant minority of children were difficult to classify according to the Ainsworth tripartite system, especially those in high-risk samples. Mary Main, another of Ainsworth's former students, and her colleagues ultimately discovered consistencies in behavioral profiles for many of these children, resulting in a fourth category of attachment behavior, the Disorganized/Disoriented category (Main & Solomon, 1990). Characteristics observed in the SSP reunion behavior of children assigned to this group are immobilization and disorientation upon the mother's return, contradiction in physical movements, and, inferred from the contradictory physical movements, contradictions in intended, or planned, behavior. The disorganized/disoriented attachment pattern is considered a more severe adaptation to inadequate caregiving circumstances, distinguished by the absence of any coherent strategy for engagement and interaction. As such, it is considered a "non-organized" attachment strategy, compared to the original three categories identified by Ainsworth. Even though the avoidant and ambivalent patterns are insecure attachment strategies, they are at least organized strategies; that is, predictable patterns of interaction that function to maintain contact with attachment figures, however limited. In contrast, the young child with disorganized attachment is disoriented, without a predictable means of engagement with attachment figures. Disorganized attachment has been shown to be prevalent among maltreated children (as high as 82% reported in Carlson, Cicchetti, Barnett, & Braunwald, 1989). As the child matures, however, many do develop patterned interactions with their caregivers, but not in the sense of reliance on them. By the age of six, role-reversed, controlling interactive patterns, of punitive or caretaking dimensions, have been observed among many children classified in infancy as insecure-disorganized (Main & Cassidy, 1988). These behavioral adaptations, of course, are not oriented to the child's needs, and they are not typically stable or predictable, since they tend to occur in the context of a maltreating relationship.

Ainsworth stressed the importance of recognizing secure and insecure attachments as variations, or individual patterns, of attachment bonds and not, except in relatively rare circumstances, as equivalent to the presence or absence of attachments per se. Insecure children by and large have attachments to their caregivers that are equal in intensity to those of secure children. Child welfare workers and foster parents see this every day of their professional lives, in the protest and activated attachment behavior in children who have been seriously maltreated. When such behavior is not seen for what it is, the anxious, insecure child who has been separated from a parent will often be misunderstood and perceived simply as having a behavior problem.

Another major innovation in the development of attachment theory and research was marked with the publication of a seminal paper by Main, Kaplan, and Cassidy (1985), which brought attention to the study of the *representational* dimension of attachment. Following Bowlby's theory of internal working models, Main, Kaplan, and Cassidy argued that attachment organization could be assessed beyond infancy with evidence of organized memories, the internally represented dimension, of attachment-relevant experience. This approach to measurement is critical for the study of attachment in older children and adults, since attachment behavior becomes attenuated as the child matures, and observational measures lose their utility.

A major innovation to arise from this line of research was created by Mary Main and colleagues, the Adult Attachment Interview (AAI), to which Main applied her background in psycholinguistics with her knowledge of attachment in infancy gained from her years in Ainsworth's infant laboratory (Main, 1999a). The major innovation of the AAI was the discovery that the assessment of attachment organization in adulthood could be accomplished primarily on the basis of nonverbal discourse qualities, particularly the *coherence* of discourse, moderation in affective expression, and sense of objectivity regarding important events. Coherence of discourse involves qualities such as consistency, flow, truthfulness, and richness of supporting

memories offered in responses, as well as the succinctness, completion, relevance, and clarity of responses (Hesse, 2008). The AAI questions focus on the respondent's history of care received as a child, especially major events relevant to safety and protection. Attachment classifications are identified based on the discourse qualities revealed in the telling of this personal narrative. Four main adult attachment classifications are used, reflecting the four similar classifications used for infants: Secure/autonomous; dismissing (avoidant); preoccupied (ambivalent); and unresolved/disorganized. The process of recall in the interview activates feelings associated with early attachment-related events, as well as the respondent's characteristic style of making sense of and coping with these. The degree to which the respondent has access to the memory systems involved is an important indicator of the extent of past emotional pain and defenses employed to address this. Dismissing adults tend to have difficulties accessing the often-intense affect associated with these memories, coping to a great extent by relying on emotional distance. Preoccupied adults tend towards the reverse, with relatively greater access to affectively charged memories, to the point of being overwhelmed with intense and unfocused emotion, with relatively weak abilities to use synthesized memories to gain a more dispassionate and balanced perception of past events. The unresolved/disorganized classification is characterized by evidence of lack of resolution of past trauma or major loss (Hesse, 2008). Numerous studies over the past 20-plus years attest to the reliability and validity of the AAI as a measure of attachment organization in adulthood (see Hesse, 2008, for a review).

Concurrent linkages between infant SSP classifications and parents' AAI classifications have been found in several studies, with moderately strong effect sizes. Hesse (2008) reports four U.S. samples, involving a total of over 200 subjects where high, though not absolute, concordances between SSP and AAI classifications have been found for individuals longitudinally, across their life spans. The AAI has also been used, most impressively, to prospectively predict attachment security in dyads. AAI classifications of mothers assessed in their third trimester of pregnancy have been found to predict their infants' attachment classification to them when the children were 12 months old (Fonagy, Steele, & Steele, 1991). The AAI has led to a new understanding of the significance of discourse qualities in speech and has spawned a new generation of interview protocols that reflect these insights (Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002; Zeanah & Benoit, 1995).

Current Research

Since the publication of the first volume of Bowlby's *Attachment and Loss* trilogy in 1969, attachment research has grown exponentially. A cursory search of indexed databases shows applications of attachment theory in all major areas of human development and therapeutic intervention and across all major related disciplines. Attachment theory is regarded, according to the eminent developmental scholar Michael Rutter, as the leading theory of the development of early social behavior in childhood (Rutter & Rutter, 1993).

The body of evidence, including major longitudinal studies of attachment in different countries, has confirmed the major tenets of Bowlby's theory: that it is universal, transmitted across generations, relatively enduring, predictive of major developmental sequelae, yet subject to environmental influence across the life span. Due to space limitations, a sampling of selected topics, with perhaps particular relevance to social workers, is presented here.

Attachment Across the Life Span

Several longitudinal studies have now shown strong consistencies in attachment security from infancy, into childhood, and adulthood. Many developmentally relevant correlates of secure attachment have been discovered across the life span. In this very large body of research, attachment security assessed in infancy has been shown to predict supportive social networks, including peer relationships, ego resilience, emotion regulation, positive self-concept, conscience development and pro-social behavior, emotion understanding, and empathic responsiveness in childhood (see Thompson, 2008, for a review). In short,

secure attachment is regarded as an essential developmental foundation that is the basis for the acquisition of critical social skills that determine social and emotional functioning beyond infancy and across the life span.

Developments in representational assessments have enabled researchers to advance the study of attachment into early and middle childhood. Among these, the Attachment Story Completion Task (ASCT; Bretherton, Ridgeway, & Cassidy, 1990) and the MacArthur Story–Stem Battery (MSSB; Bretherton, Oppenheim, Buchsbaum, Emde, & the MacArthur Narrative Group, 1990) are based on Bowlby's theory that attachment experience becomes organized, and increasingly relied upon, via internal working models. Children aged four to seven are presented short story "stems" depicting everyday stressors (e.g., the parents go away for an overnight trip and the grandmother babysits), enacted with basic family doll figures and props. In response, the children create spontaneous narratives, which researchers videotape and code for themes of interest, such as enactments of caregiving, conflict, attachment behavior, and coherence. A growing body of story-completion task literature has demonstrated that children's story-stem responses are significantly correlated with indices of attachment security, including infant SSP classifications and mothers' AAI classifications (Bretherton, 2005), and a variety of other measures of social and emotional well-being, including pro-social behavior with peers, anxiety, maltreatment history, and mothers' depression (Emde, Wolf, & Oppenheim, 2003; Page, 2001). Story-stem responses have also been used as a dependent variable following a parenting intervention, showing change in children's perceptions of their parents (Toth, Maughan, Todd Manly, Spagnola, & Cicchetti, 2002), as well as a measure of perceptions of mother–child interactive qualities associated with observed behavior in the home (Dubois-Comtois & Moss, 2008).

Attachment has also been increasingly studied beyond childhood, into adolescence and adulthood, a subject that Ainsworth was particularly interested in and wrote about in the latter part of her career (1989). This emerging empirical literature began with Hazan and Shaver's (1987) discovery of attachment-oriented interactive styles in romantically involved young adults that were conceptually consistent with Ainsworth's original attachment categories. Subsequent findings from two prospective longitudinal studies have found that attachment security in infancy indirectly predicts the quality of romantic relationships in early adulthood, via a developmental pathway through childhood peer relationships (Berlin, Cassidy, & Appleyard, 2008).

Social Ecology/Social Systems

Attachment theory is an "ecological theory," taking into account biology and individual, micro-system interdependence, as well as larger system influences, external to the family, on the development of emotional security in children (see Belsky, 2005). At its core, attachment is a dynamic concept. The behavioral systems governing its operation are in constant interaction, in states of relative activation and deactivation, with overarching system goals of balance and regulation characterizing their optimal functioning. The infant develops within a dyadic, mutually regulatory, interactive system that promotes and eventually leads to the achievement of more internalized management of regulatory capacities (Bowlby, 1982).

Attachment patterns tend to be transmitted intergenerationally, though not absolutely; that is, children tend to develop the same basic attachment type as their attachment figures (Bretherton & Munholland, 2008), but various forces operating in the social ecology affect this process. Attachment type thus represents a learned coping strategy. Since attachment type is specific to a given dyadic relationship, a child may have different attachments within the family, depending on the attachment figure. How children synthesize their attachment experiences into a dominant attachment interpersonal style is likely to be influenced by their primary attachment figure, though as yet little is known about this process.

Attachment and Developmental Psychopathology

Attachment theory has proven to be useful in understanding the developmental

consequences of risk, resilience, and trauma for children, including the emergence of psychopathology. Bowlby (1973) adapted the concept of the "developmental pathway" from the biological sciences to explain how early events, especially those affecting attachment security, can come to influence later development, not necessarily linearly, but in interaction with various other events and circumstances the growing child encounters in the environment over the years.

Attachment insecurity has been shown to be associated with specific forms of psychopathology, but these relationships are complex and determined by other risks encountered in the child's social ecology, including child characteristics (primarily biologically inherited characteristics), insensitive parental practices, and family-level risks (DeKlyen & Greenberg, 2008), among which poverty has a dominating influence. The evidence thus far is consistent with theory: Organized insecure attachments (avoidance and ambivalence) are moderate risk factors for the development of some forms of psychopathology (e.g., affective disorders, conduct disorders; DeKlyen & Greenberg, 2008), whereas disorganized/disoriented attachment presents significantly stronger risks, in particular for conduct, affective, self-injurious, and dissociative disorders (Sroufe, 2005).

Trauma and Child Welfare Services

Attachment theory has contributed to significant innovations in thinking about the needs of maltreated children in foster care systems, and children who are exposed to chronic extreme distress, such as family violence. Seen from an attachment perspective, traumatic events are damaging to children first and foremost because they threaten a child's sense of safety and protection. Kisiel et al. (2014) used attachment theory to inform a "developmental trauma framework," applying this to an examination of the impact of complex trauma in maltreated children in the child welfare system. Their major finding was that children exposed to the combination of trauma engendered by family violence and nonviolent trauma involving attachment-related risk were nine times more likely to experience trauma-related symptoms and functional impairments than children with either form of trauma alone.

A child whose attachment figure inflicts abuse and trauma faces an unresolvable dilemma: Attachment behavior is instinctively activated toward the very source of this distress, a desire for proximity with the person who presents the most immediate threat. This dilemma is the heart of disorganized attachment, and its confused and contradictory behavioral strategies are familiar to every child welfare worker and foster parent, as well as many adult victims of domestic violence, and are a powerful influence in the emergence of the psychopathology associated with disorganized attachment.

Recovery from trauma must begin with the reestablishment of confidence in the safety and protection of the caregiving environment. Attachment theory has been instrumental in demonstrating that children need to have protective adults, including adoptive and foster parents, make emotional investments in them, as opposed to guarding against emotional commitment as a way to protect the child (and themselves) from the pain of potential or eventual separation (Dozier & Rutter, 2008).

Reactive Attachment Disorder

The psychiatric literature has been influenced by attachment theory, particularly in the mental disorder known as "reactive attachment disorder" (RAD). The 2013 revision of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) reorganized the diagnostic criteria for RAD by separating out the criteria for a related disorder—disinhibited social engagement disorder—whose tie to attachment experience is still not well understood. The new conceptualization of RAD, on the other hand, is tied more explicitly to attachment processes, characterized by the absence of selective attachments and extreme neglect of care. Evidence for RAD must appear before age five years and persist for at least 12 months. Children with RAD typically exhibit extreme emotional withdrawal and compromised capacities for emotion regulation involving various emotional states (e.g., sadness, fear, anger). Attachment disorders, thus, are not simply insecure attachments, and

must be thought of as extreme disruptions or deprivations in attachment, associated with the most profound of developmental risks.

The Neurobiology of Attachment

The study of the brain physiology associated with attachment processes has recently witnessed a significant expansion, revising our understanding of the biological foundation of attachment and related developmental processes. When young children experience separations from caregivers, for example, stress-response systems are activated involving the neuroendocrine system, particularly the hypothalamic-pituitary-adrenal (HPA) axis (Cassidy, Ehrlich, & Sherman, 2014; Sheridan & Nelson, 2009). When caregivers provide soothing to their young children, re-regulation of the child's stress response system occurs. The neuropeptide oxytocin, found throughout the brain and body, interacts with the HPA axis and dopamine receptors to facilitate regulatory processes (Feldman, 2014). The extent to which caregivers and their children achieve mutual coordination in behavioral interactions—the "biobehavioral synchrony" of caregiver and child of gaze, touch, proximity, and vocalization—is highly correlated with oxytocin levels in both (Feldman, 2014). Evidence from studies across mammalian species shows that distress related to separation from a caregiver, and the instinctive calls of protest that result from this, are associated with decreases in the secretion of oxytocin and opioids as well as increases in stress-related hormones (Panksepp et al., 2014). Pleasure associated with reunion with that caregiver involves the dopamine reward system. Neurochemical dysregulation associated with prolonged states of separation distress and the absence of pleasure specifically associated with reunion with a loved one, particularly a caregiver, have been shown to have important roles in the development of depression (Panksepp et al., 2014).

Recent applications of neuroimaging have shown that mothers tend to respond differentially to pictures of their own and of other infants' faces. Pictures of their own infants tend to differentially activate the cortico-ventral basal ganglia circuit, specifically the orbitofrontal cortex, which is involved in affective appraisals of people, and sub-cortical reward regions (Bretherton & Munholland, 2016). Strathearn (2011) showed that visual depictions of their children affected the release of oxytocin and dopamine reward systems in mothers differently, depending on the mothers' attachment security. Compared to securely attached mothers (as assessed with the AAI), insecure/dismissing mothers were significantly less likely to activate the ventral striatum, a component of the cortico-ventral basal ganglia circuit, and mesocorticolimbic reward pathways, regions of the brain associated with oxytocin and dopamine production. Recent evidence has also been provided for specific neurobiological processes involved in the formation of attachment-related internal working models. Specific brain regions, particularly the hippocampus, have been shown through neuroimaging studies to process memory storage and retrieval, as well as simulations of future interactive behavioral scenarios based on learned experience, thus identifying specific brain functions that appear to provide a neuroanatomical explanation for Bowlby's original formulation of internal working models (Bretherton & Munholland, 2016).

The advancement of neurobiological research in attachment extends Bowlby's original formulation of attachment as a physiological process and product of evolutionary selection that is shaped through learning. Expansion of our understanding of the neurophysiology underlying attachment will further illuminate explanations for the intergenerational transmission of interactive qualities involving care and responsiveness, as well as linkages to psychopathology associated with prolonged periods of dysregulated attachment processes.

Pseudoscience

It is important to note, finally, that attachment theory has been seriously misapplied, at the expense of children's lives, by some proponents of so-called attachment therapies. In perhaps the most notorious of these cases, a 10-year-old girl was smothered to death by ersatz "therapists" practicing "holding therapy" (Mercer, Sarner, & Rosa, 2003), a dangerous treatment without evidentiary basis that does not derive in any logical way from attachment theory (O'Connor & Zeanah, 2003). It

is imperative that social workers and other human services professionals have accurate information about what attachment is and is not, and that their practice be consistent with developmental knowledge and evidence-based approaches.

Current Status and Relevance in the Social Work Profession

Attachment scholarship has been the province primarily of developmental psychologists, ever since Mary Ainsworth's pioneering studies in the 1960s. Social work has been comparatively late in integrating attachment theory into its research and practice, especially in the United States, but this is changing quickly. The fifth edition of *Social Work Treatment* in 2011 marked the first time that attachment theory was included among its chapters. Contributions by social work scholars toward integrating attachment theory into social work practice now appear across a wide range of topics, including: theory development (McMillen, 1992; Sable, 1979); as a theory of placement change in foster care (Tucker & MacKenzie, 2012); practice roles (Howe, 1995); clinical supervision (Bennett, 2008; Bennett & Deal, 2009); assessment and intervention with foster children and/or foster parents (Fish, & Chapman, 2004; Schofield & Beek, 2005); parental visitation in child welfare (Haight, Kagle, & Black, 2003); adoption (Howe, 2001); narrative assessments with young children (Page, 2001); childbearing motivations (Warren, Sable, & Csizmadia, 2008); risk for disruptive behavior problems in childhood (Keller, Spieker, & Gilchrist, 2005); treatment for reactive attachment disorder (Drisko & Zilberstein, 2008); eating disorders (Barth, 2008); parenting assessments (Farnfield, 2008; Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002; Lewis, 1999; Rosenblum, Zeanah, McDonough, & Muzik, 2004); adolescent parents (Hans & Thullen, 2009); and intervention with couples (Solomon, 2009) and parents (Page & Cain, 2009), among others. Special issues of the *Clinical Social Work Journal* and *Child and Adolescent Social Work Journal* in 2008 and 2009, respectively, were dedicated to addressing applications of attachment theory to clinical social work practice. Haight and Taylor's (2007) text for social work courses on human behavior in the social environment was the first to use attachment theory as a major organizing framework, and stands in marked contrast to the cursory treatment attachment theory gets, if it is mentioned, in most other human behavior texts in social work courses. Bennett and Nelson's edited volume (2011) on applications of attachment theory to clinical interventions with adults is particularly noteworthy.

Assessment and Intervention

Attachment theory has proven to be a very fertile theoretical foundation for psychotherapeutic interventions for people across the life span, a topic that was of special concern to Bowlby (1988). According to Bowlby, a therapist should be sensitive to the primacy of safety and protection in the developmental experience of the client. Interpretations and analysis of the client's relational experience, including within the therapeutic relationship, should be based on an understanding of the centrality of the expression of attachment behavior in social experience and with regard to the creation of personal identity. Psychotherapy from an attachment perspective provides the conditions in which the client can "explore his representational models of himself and his attachment figures with a view to reappraising and restructuring them in the light of the new understanding he acquires and the new experiences he has in the therapeutic relationship" (Bowlby, 1988, p. 138). The integration of attachment theory in psychotherapy brings a heightened understanding of the characteristic ways in which needs for safety and protection are expressed in current relationships, including defensive strategies, and the extent to which these behaviors represent attempts to cope with unresponsive attachment figures, learned early in life. Discussions of clients' perceptions of the therapeutic relationship should include sensitivity to the client's regard for the therapist as an attachment figure, and the actual limitations of this role.

Attachment theory has been particularly effective in structuring and guiding direct

dyadic psychotherapy with young children and their caregivers to address problems in parenting and children's emotional and behavioral dysregulation. Standardized intervention protocols such as Parent–Child Interaction Therapy (PCIT; Eyberg et al., 2001) and Child–Parent Psychotherapy (CPP; Lieberman & VanHorn, 2009) and its variants (e.g., Toth et al., 2002) emphasize building parental capacities for sensitivity and responsiveness, active imagination about the child's internal perceptual experience, and attention to the child's specific attachment-related needs in the relationship. Multiple Family Group Intervention (MFGI; Keiley, 2002) utilizes similar principles to provide an attachment-based treatment for adolescents with conduct disorder in a group setting with their parents.

Attachment theory has provided a particular impetus to psychotherapeutic interventions for parents using videotape. The SSP validated the use of attachment ratings based on laboratory observations. By extension, psychotherapists realized that videotaped interactional sequences had great utility for clinical intervention, particularly when using attachment theory to understand relationship qualities and identify focal points for intervention. Several evidence-based attachment-related interventions using videotapes of child–caregiver interactions have been created, most notably: Interaction Guidance (McDonough, 2005); the Seeing Is Believing component of Steps Toward Enjoyable, Effective Parenting (STEEP; Egeland & Erickson, 2004); Video-feedback Intervention to promote Positive Parenting (VIPP; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2007); the Circle of Security (Hoffman, Marvin, Cooper, & Powell, 2006); Attachment and Biobehavioral Catch-up (ABC; Bernard et al., 2012); Promoting First Relationships (PFR; Spieker, Oxford, Kelly, Nelson, & Fleming, 2012); Group Attachment-Based Intervention (GABI; Steele et al., 2014); and a variation of VIPP for maltreated children (Moss et al. 2011). Each of these interventions emphasizes the importance of strengthening caregiver capacities for "mentalisation" (Fonagy, Steele, Steele, Moran, & Higgitt, 1991), or the capacity to reflect upon and be curious about the child's mental states and perceptual experience, and sensitive responsiveness to children. Strengthening these capacities, according to Fonagy and colleagues, has broad implications for the well-being of the relationship: As the caregiver strengthens her or his mentalizing capacities and sensitivity, s/he further strengthens observational skills and, in so doing, more firmly defines relationship boundaries and empathic attunement to the child. This reinforces his/her knowledge of and confidence in the role of caregiver. Caregivers who are confident in their roles are more likely to communicate a sense of security to their children and, in this process, facilitate the child's physiological, emotional, and behavioral regulation and, ultimately, emotional security.

Specific services for maltreated children and their caregivers have become another major area where attachment theory has been effectively employed to structure and guide interventions. Four notable studies utilizing randomized control trials compared attachment-based interventions with parent–child dyads to more routine child welfare family services. Three of these (Bernard et al., 2012; Moss et al., 2011; and Spieker et al., 2012) drew their inspiration to a great extent from the VIPP model, which is also notable for its relatively short duration (approximately 10 sessions). Toth and colleagues' intervention, Preschool Parent Psychotherapy (PPP; 2002) was longer (approximately 32 sessions over 12 months) but focused on similar parenting qualities. All interventions demonstrated improvements in their targeted outcomes, including parental sensitivity and child attachment qualities.

There is a particular imperative for social workers, including social work educators, to be thoroughly grounded in attachment theory and research. As a profession, we have a unique responsibility to provide services to the most vulnerable of our society's children in our child welfare systems. Making the best-informed decisions about the well-being of these children requires thorough knowledge of the processes through which children form attachments to their caregivers. It is a professional imperative, therefore, that we understand these issues in depth and keep abreast of the current state of knowledge in the field.

A Case Example

This case involves Jerri, a 21-year-old mother, who was reported to Child Protective Services for inadequate supervision of her son, Brian (both names are pseudonyms). At age two, Brian was found wandering alone along a busy highway, the latest of several incidents when he had been found wandering outside unsupervised, necessitating police involvement. After a brief stay in kinship foster care, Brian was returned to Jerri's custody, and Jerri was referred for parenting services. Jerri worked an afternoon/night shift as a nursing home attendant, often up to 16 hours, and child care was inconsistently provided. At the time of this intervention, Jerri had been a client of the child welfare system for two years. In childhood, she had been severely emotionally and sexually abused by her father. She had attained a ninth-grade education (she dropped out in tenth grade), and had been diagnosed with dyslexia.

The parenting service provided was the Circle of Security® (Hoffman et al., 2006; Marvin, Cooper, Hoffman, & Powell, 2002; Page & Cain, 2009), a small group intervention for six to eight participants based on attachment principles. Children's interactions with caregivers are presented as representing the two principal behavioral systems discussed by Bowlby—attachment and exploration—integrated as continuous and alternating dimensions of one interactive circle. Empathic understanding and responsiveness toward children's alternating needs for exploration and attachment are taught primarily through videotape-review sessions where participants watch themselves in interaction with their children. The video segments are selected from pre-intervention assessments by group leaders to illustrate key relationship qualities as identified in treatment plans. Each participant receives three review sessions.

Assessments included attachment ratings for child and mother provided by the SSP (parent attachment was assessed with Marvin's Caregiver Behavior Scales, rated by the author, Robert Marvin [Britner, Marvin, & Pianta, 2005]; child attachment classifications were also provided by Robert Marvin). Parent insightfulness ("the parent's capacity to invoke motives that underlie the child's behavior"; Oppenheim & Koren-Karie, 2002) was also assessed using an attachment-inspired interview, the Insightfulness Assessment (IA; rated by its authors, David Oppenheim and Nina Koren-Karie). All assessments were rated independently. Jerri and Brian were assessed at the pre-test observation with disorganized attachment, and Jerri was assessed with the most problematic of three classes of insightfulness, corresponding to disorganized attachment (Oppenheim & Koren-Karie, 2002). The intervention was led by this author.

The following dialogue was taken from Jerri's second tape-review session. Second tape-review sessions are designed to focus on the most profound problems in the relationship, conceptualized as the parent's difficulties in responding to the child's expressions of exploration, or attachment, or both. For Jerri, as for parents in other dyads rated with disorganized attachment, the major relationship difficulties typically involved inconsistent responsiveness to *both* the child's exploration and attachment. In the following excerpt, we see Jerri's frustration and irritation with Brian's anxiety and need for her, which were often activated when she came home from work feeling emotionally and physically depleted. The therapeutic challenge was to reframe Brian's behavior so Jerri could understand it as activated attachment behavior.

Jerri: You know, when I work, he is usually up at six o'clock in the morning waiting for me to get home. . . . He is very demanding in the morning time. He is like, "I don't want to go to school, I want to stay home with you," and I am like, "You can't stay here, you have to go to school, so we are going to sit here and watch TV." . . . It is very aggravating at times, only from exhaustion, because you know I am so exhausted sometimes. . . .

Later in this session, a short video clip was shown to Jerri of her interaction with Brian in the SSP, showing her reunion with him after a brief separation, to illustrate and explain Brian's attachment behavior directed toward her:

Group Leader 1: So this first clip, you have been out of the room, and we are looking at how he is responding to you when you return. What are we seeing?

Jerri: Going back to his mom.

Group Leader 2: He made a beeline for you.

Jerri: Yeah, he does that all the time. It's like he can smell me when I walk in the door, whether he sees me or not, he knows when I walk in the door. Sometimes I try to sneak, he's in his room, so I try to shower before he comes out, and he's like, "Mama, let me in." He knows, he knows.

Group Leader 1: This kind of behavior has been studied a lot. That behavior has been identified in every mammal on the planet. When there has been a separation, you see the exact same thing. I am imagining that, it can kind of feel aggravating at times, but it is also important to see that it's normal.

Jerri: Oh yeah, as much as it aggravates me when he runs up to me, my back is killing me and he goes, "Hold me," there is nothing I like better than when he runs up to me and hugs me and kisses me and holds me and I don't want to let go.

Group Leader 1: Right. He just wants to be near you. . . .

Later, Jerri reflected on her conflict over wanting Brian to be more autonomous and for her to have more emotional "space," yet at the same time fearing separation from him, the loss of his love, and her own abandonment.

Jerri [*discussion turned to anticipation of Brian's visits with his father*]: I am so jealous. I want him to be all mine. I don't like to have to share him. I had him by myself this whole while, so I don't want to share him with anybody. I don't want to know that he could love somebody else more than he loves me. . . . Man, they grow up so fast. You want them to be able to do their own little thing, but once they do it, it sucks. The older they get, the less they act like they need you to be there.

Later in this session, Jerri reflected further:

Jerri: Most of my [anxiety] comes on when I feel that threat that he is going to be taken away from me or he is going to love someone more than me. I guess my mother did this to me, she was the same way. If we ever acted like we had more fun at my father's, she would be like, "You had more fun with him than you did with me."

Group Leader 1: You put your finger on the idea that . . . you feel anxious about being separated. It is important to look at where that leaves him. He gets a little confused. Keep in mind, when you are in that situation, "Is he feeling like he needs to soothe me or am I being the 'bigger, stronger, wiser, and kind' person?" [*a phrase used in the intervention to refer to the authoritative role*]

Jerri: I think it is good for your children to feel like they help you as much as you help them. I think it is good for him to feel needed. Even though I hate when I feel that way, it only takes a second of his wonderful personality to make me better . . . as soon as I notice that he notices that I feel that way and he is like, "Give me a hug, let's lay down mama," I automatically perk up and smile and everything is okay. He doesn't realize that I am dying inside.

In this passage, we see tendencies toward role-reversal, indicating Jerri's strong, unmet needs for her own nurture, a characteristic commonly associated with disorganized attachment and child maltreatment. Jerri's primary treatment goal was to become more empathic in recognizing and responding to Brian's need for proximity to and comfort from her and, in the process, to maintain a nurturing and authoritative parental role. At the same time, she had to learn to cope with her own anxiety about his normally developing autonomy and separateness from her. The intervention thus focused on challenges she faced in responding to "both sides" of the attachment-exploration circle.

Several sessions later, during her third and final tape review, Jerri reflected on how her discomfort at Brian's expressions of attachment typically evoked a circular set of responses, wherein she became irritated and withdrew, which elicited stronger attachment behavior and frustration for him. This sort of interchange typically involved hostility and coercion.

Jerri: He does that. He knows right when I am at the boiling point, I am just right there, don't mess with me, then he is like, he likes to go a couple feet over the edge there.

Group Leader 1: What might that be about?

Jerri: Testing.

Group Leader 1: What might a child be needing when you are almost going to boil over?

Jerri: I think he is just, because when I am to the point where I have just had enough, I am distant. . . . Sometimes when you are distant, a lot of children experience this, it doesn't, sometimes doesn't matter good or bad, they want attention.

By conceptualizing Jerri's struggles with her son in terms of an integrated circle of expression of exploration and attachment needs, Jerri was able to reframe Brian's neediness for her, and she was able to respond empathically to his need. This facilitated her growing capacity to reflect on and cope with her own anxieties about separation and abandonment, and her occupation of the authoritative parental role. She very obviously and deliberately began to change her behavior toward Brian to be more nurturing when

she perceived him to be anxious and needing her, and more supportive when she perceived him to need autonomy.

At the post-test assessments, approximately six months after the pre-test, Jerri and Brian were rated with secure attachment, and Jerri's Insightfulness Assessment revealed a Positively Insightful rating, which corresponds to secure attachment. Anecdotal follow-up with them in subsequent years has shown that they continue to do well, and Jerri consistently regards the Circle of Security intervention as having provided a positive turning point in her relationship with her son.

Research Challenges Still Lying Ahead

Growth in the field of attachment research has given rise to many new questions about its applicability across many dimensions of the human experience (see Main, 1999b, for a discussion of research challenges). A sampling of these issues is presented here.

Cultural Variation

Several cross-cultural studies have shown that attachment is a universal human phenomenon (van IJzendoorn & Sagi-Schwartz, 2008) but that frequencies within attachment patterns appear to vary with culture. Larger numbers of people have been identified, for example, as insecure-ambivalent in Mediterranean countries compared to U.S. and northern European samples. The extent to which attachment patterns are shaped by culture, and the mechanisms through which this occurs, are not yet well understood.

Instinctive Inheritance and the Brain

Attachment theory locates attachment behavior among other instinctive behaviors, whose functions ultimately promote species survival. It is still unclear how other instinct-based behavioral systems such as, for example, social dominance hierarchies and mating behavior, may interact and influence or be influenced by the attachment behavioral system. Much more study is needed of the brain functions responsible for these behaviors.

Measurement

The best-known systems for measuring attachment quality are the categorical systems derived from Strange Situation classifications (secure, insecure-avoidant, insecure-ambivalent, insecure-disorganized). Other approaches to the measurement of attachment quality have used dimensional systems, placing variations on a continuum or continua of dimensions of central characteristics, such as security versus insecurity. It is not yet known what the "best" way for conceptualizing differences in attachment quality will prove to be.

Research Applications to Social Work Practice

The needs for new knowledge concerning applications of attachment theory to social work practice are too numerous to include here, spanning virtually every practice area. Little is yet known, for example, about how children who have been exposed to extreme adversity in their caregiving environments form healthy attachments later in childhood, so-called second attachments, as in the case of placement in foster homes. Other important practice areas in need of more research include: assessments with children, especially adapting representational measures to clinical settings; adult interviewing, using the insights of research with the AAI on the significance of discourse qualities to attachment organization; and education for parents and foster parents, applying our developmental, knowledge about the significance of attachment to development to problems in parenting. Opportunities abound for social work researchers interested in furthering these and other fields of inquiry.

Attachment scholarship, beginning with Bowlby nearly 60 years ago, has profoundly changed our understanding of the human needs for care and protection in close relationships. Although the field of social work has been relatively late in understanding and integrating this new knowledge, we are now being transformed by it, in many different areas of practice. This is a very promising development: The quality of social work services, especially for children and families, depends on our mastery of the most current scientific

knowledge of human behavior, among which attachment theory must be regarded as a foundational pillar.

Note

1. Significant portions of this chapter appeared in Page, T. & Norwood, R. (2007). Attachment theory and the social work curriculum. *Advances in Social Work, 8*(1), 30–48.

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2

Chaos Theory and Social Work Treatment

Sandra Loucks Campbell

Chaos Theory

A theory emerging from modern mathematics, chaos theory posits that system disorganization is ever-present and that we are in a chaotic social reality from which we can emerge as creative new entities.

Who could argue that chaos exists in our new world? Nowhere is this as true as in the settings where social workers find themselves. Multilayered practice contexts are chaotic, and when the levels of complexity increase, the pressure is also increased on workers who are already grappling with increasing numbers of people needing help, new management models, and declining government dollars. In this world, the old ways of working in traditional hierarchies are not working, and social and health service networks are reaching the breaking point. Social workers are finding it increasingly difficult to cope with the new demands and heavier workload imposed by these advancements. The people served by social workers suffer as a result.

Despite our search for order and control in all facets of our lives, unpredictability remains (Tarnas, 1991). And it is out of that unpredictability that chaos theory, sometimes called "complexity theory," has emerged. As a species, we both create and exist in a state of disequilibrium and unpredictability—chaos. The theory of chaos presents an interesting contradiction, not only to our human tendency to seek control, but also to the work of Isaac Newton (1729) and of Max Weber (1947). This relatively new theory suggests a novel lens for social workers as they work with individuals, families, groups, organizations, and communities—a challenge to social workers. In this chapter, I will describe chaos theory and its origins, and present ideas for the applications it evokes for social workers in the 21st century.

Background of Chaos Theory

Chaos theory developed in an era ripe for change and new ideas. It was time for movement away from the absolutes of the industrial and modern age.

In 1687, Isaac Newton developed and described the Laws of Thermodynamics in his *Principia Mathematica*, a publication acclaimed by scientists for generations. In this important touchstone for the science of the natural world, Newton postulated that energy is neither created nor destroyed, and that disorder does not decrease. In other words, he believed that entropy, a measure of the disorganization in a system, was ever-increasing in the natural world (Barber, 2001). His assertion that disorder could be predicted to be ever-present and on the rise served to impose order on the natural world. The world could be seen as predictable.

We might claim similarity between this Newtonian thinking and the work of Max Weber, wherein the latter described bureaucracy as an "organization of offices" (1947, p. 331) hierarchically developed by the assignment of precise roles and sanctions. During the Industrial Age, from circa 1830 to 1970, the metaphor of the machine dominated. Humans understood a whole by learning about its parts and sought order through enhanced knowledge of a hierarchy of parts or functions, and we accepted that, over time, most matter moves toward deterioration. Both the laws of the natural world (Newton, 1729; Kuhn, 1962) and the principles of Weber's bureaucracy in 1947 define and value similar principles: determinism, stability, orderliness, uniformity, and equilibrium (Prigogine & Stengers, 1984).

But that predictable world has changed. Taken together, the computer age, financial crises and cutbacks, organizational restructuring, and the ongoing quest for information propel all of us, with astonishing speed, into a new social reality (Greenwood & Lachman, 1996; Peters, 1987). As we move away from the certainty of modernity, chaos theorists present an alternate view, an idea that might be called a contradiction of Newton's work. Chaos theory suggests we take a further look at our quest for the precision, balance, and control, lauded in Newton's natural world and in the organizational world of Weber. A new metaphor might be useful for social workers during such immense change.

Developers

Chaos theory, primarily a theory of physics and mathematics, originated with Prigogine and Stengers (1984) and was augmented by Mandelbrot (1983) and Lorenz (1963). This relatively new theory hypothesizes that creative new entities emerge from chaos (Gleick, 1987; Prigogine & Stengers, 1984). Chaos makes space for complex systems, allowing for the simultaneous existence of order and disorder, complexity and simplicity, and other dualities. Theorists describe a flow of energy through a system that is "self-organizing" (Zimmerman, 1996). As its creators describe the theory's essential premise, that creativity emerges from chaos, they also point to the initial development of chaos itself. Readers are asked to consider an evolving, erratic, and incredibly complex situation. Far from the homeostasis and balance suggested by traditional systems theory, a vibrant tension exists—at the margin of chaos. It is at the margins, at this point of division, of "bifurcation," that chaos is set into full motion and creativity surfaces—a new entity emerges. Out of tension comes a new beginning (Gleick, 1987; Prigogine & Stengers, 1984).

Within chaos theory, we have access to two supplementary but fascinating ideas. The first one, the "butterfly effect," was described by Lorenz (1963) while studying weather patterns. He noticed that even a small change in initial computerized weather conditions could create huge weather changes in his models over time (Gleick, 1987). This challenging idea allows us to pose the question "Can the breeze from the flap of a butterfly's wing in Brazil cause a tornado in Texas?" (Lorenz, 1972, as cited in Hudson, 2000). He began to discuss this "butterfly effect" as the "sensitive dependence on initial conditions" (as quoted in Gleick, 1987, p. 23).

The second supplementary concept, also closely related to chaos theory, was developed and given shape by Mandelbrot (1983)—the "fractal." Mandelbrot's contribution, demonstrated in his famous Mandelbrot Set, gives a pictorial representation of an interesting phenomenon. Here he defined and gave structure

to the fractal. This complex, irregular, and almost mathematical form, said to "give form to chaos," is similarly variable and random on all scales. Repeating their random forms at macro and micro levels, fractals have been described as "exposing the geometric nature of chaos" (Mandelbrot, 1983). The "butterfly" and the "fractal" will be discussed in relation to social work later in the chapter.

The principles of Weber's bureaucracy and Newton's laws of the natural world identify and value similar principles noted earlier, including stability, uniformity, predictability, and balance (Kuhn, 1962; Prigogine & Stengers, 1984; Weber, 1947). The chaotic system's basic elements, as defined by its creators (nonlinearity, numerous parts with no causal relationship, a network of feedback loops, unpredictability, a flow of energy toward self-organization, an openness of the system to the environment), offer us a new vision of reality (Gleick, 1987; Prigogine & Stengers, 1984).

Why Pair Chaos Theory with Social Work?

Certainly, in the scientific world of Newton, the concepts of chaos theory hold fast. This thinking may lead to a more complete understanding of science, itself an open system embedded in society, with feedback loops of learning and expanding knowledge. In his classic book *The Structure of Scientific Revolutions*, Thomas Kuhn posited that "anomalous experiences . . . by evoking crisis, prepare the way for a new theory" (Kuhn, 1962, p. 146). But can this theory be applied to social work and the settings in which we work?

Since its conceptual origin in the 1980s, chaos theory has found its way into social work literature and practice. With the potential to provide a new frame for practice, chaos expands our expertise with systems theory and builds on our experience as agents of change (Hudson, 2000; Woehle, 2007). Although some social work authors attempt to integrate mathematical and physical origins of chaos theory with social work, this chapter takes a big-picture view. Here, we apply the overarching ideas and the metaphor of chaos to human systems and social work practice.

Most human beings know intuitively that chaos is a part of being human. When we compare our nature and that of human organizations, we can see "the systems through which we administer ourselves, have become estranged from the social relations by which we define ourselves" (Sossin, 1994, p. 367). The seeming compatibility between the central tenets of chaos theory and the nature of humans, and the contexts we live in, builds on our understanding of systems theory. Human beings may actually thrive in chaotic situations and settings. In our complex world, fast-paced social changes, disorder, and nonlinear relationships coexist with our search for control—in street gangs, in large corporations, and in health and social service organizations. Chaos theory offers help in understanding human relationships and organizations, but it also demands that we abandon our obsession with control. Our new ability to see the boundary between the control that exists prior to the "bifurcation" point and the creativity that can be released when we abandon that control offers the key.

Yet, the organizations of today's social work practice resemble the bureaucracies defined by Weber in 1947. As with the machine metaphor of the industrial age, we try to understand the entirety by understanding component parts. We have sought order and control through a hierarchy of functions or roles, and we have been on the alert for deterioration (Prigogine & Stengers, 1984). Ever-watchful internal and external agents assess for risk, ready to move to control when disorder erupts.

Like the impact of a butterfly wing, a small change will lead to creativity only as we accept and learn to live with chaos. In the 20th century, we built myriad mechanisms of control into our interpersonal relationships, in our organizations and in our research methodologies. In families, we seek to ensure a family structure that is healthy, not dysfunctional (as defined by the perhaps white, professional social worker). We structure groups according to our own educated stance, built through our enmeshment in the Western educational and professional systems of which we are a part. In organizations, we present the idea that the goals of strategic five-year plans are attainable, even in a chaotic world. We bureaucratize our health and social

services in an attempt, as predicted by Weber, to ensure control at each and every level. We might ask whether these strategies actually reach the intended goals. This machine-like control described and applied from Newton's time to today might be questioned. Chaos theory presents an interesting counter-thesis to our previously held views about gaining control in chaotic families, in interpersonal relationships, and through our bureaucratization of social and health services.

As we practice social work in this new century, technological advances, rapid and intensified change, and globalization have catapulted the natural world, its people, and its human organizations into a new reality. Here, cutbacks, restructuring, the ongoing quest for information occurring at breakneck speed, and the ever-occurring crises and change have become the norm (Greenwood & Lachman, 1996; Peters, 1987).

Against this backdrop of change, chaos theory's fundamental premise that creative new entities or ideas arise from chaos (Gleick, 1987) is a direct contradiction of the stability and order held as fundamental conditions essential to the machine metaphor, to Newton's natural laws, and to the built bureaucracy proposed by Weber. The creators of this new theory have described its *non–machine-like* elements: nonlinearity, multiple components, a labyrinth of feedback spirals, an energy that organizes itself, and openness to the environment. And, likewise, social work principles engage and reflect nonlinear thinking, complex systems, communication feedback systems, the environment, human systems, a vision of both sides of an issue, and an openness to change. This theory seems ideally suited to social work.

Authors and Practioners of Chaos Theory

Since the genesis of chaos theory, social work and other authors have analyzed and applied the ideas of chaos in many forums. Some claim that chaos theory validates what social workers have always known intuitively, that "things are not that simple or deterministic" (Bolland & Atherton, 1999, p. 370). Stating that "the human mind is naturally creative," Lee (2008) argues for social workers to build an environment that will foster creativity. As an example, he outlined a model (2008) to foster creativity and growth that involved changing perspectives of transition, of developing meaningful goals, of doing something new to see what happens, and of modifying thoughts and actions based on the actual outcome. Bolland and Atherton (1999), in their writing about practice and research, also point to chaos theory as a useful frame of reference for thinking about complexities.

Several social work authors have discussed change in relation to chaos. Some use chaos thinking to frame social work counseling, itself a change process, to build on general systems theory and to present a new perspective on change (Halmi, 2003; Hudson, 2000; Woehle, 2007). Bussolari and Goodell (2009), discussing the applicability of chaos theory to life-transitions counseling, contend that instability and lack of control are normal experiences during a life transition and argue that incorporating postmodern thought, specifically, teaching clients to construct new stories to fit within a context of growth rather than disorder, would be helpful. Woehle (2007) provided detail about the relationship between change and chaos by comparing four processes of change: (1) an entropic/equilibric process, (2) a homeostatic/equilibric process, (3) a complex change process at the edge of chaos, and (4) a chaotic change process. His findings suggest that chaos theory extends entropic and homeostatic processes beyond ecosystems theory while providing a new view of client outcomes. Other authors build on the relationship between change and chaos while applying the theory to social work practice in very specific ways. Halmi, for example (2003), contends that this new understanding of change could lead to the development of specific interventions at the micro-level of practice, noting that brief therapists, for example, hold assumptions and beliefs consistent with ideas basic to chaos theory.

Stevens and Hassett (2007) and Stevens and Cox (2008) discussed the application of chaos theory, sometimes called "complexity," in child-protection practice specifically. Stevens and Cox asserted that current applications of linear thinking and processes, which tend to be static and narrow, may oversimplify

assessment, hypothesis building, and intervention, leaving service providers with a false sense of security about their accuracy. In their study of child welfare, Stevens and Cox suggested that social workers develop assessments that incorporate a systemic view. This broad view could point to the use of techniques and interventions that would enhance workers' understanding of complex adaptive systems in child protection, including their own professional involvement in the system, and account for unanticipated events. Stephens and Hassett used chaos theory to frame risk and risk assessment in child welfare. They argued that a linear approach of cause and effect can lead to cause-and-blame explanations for harm to children (e.g., too few visits by the social worker). They suggest a complexity-based model using a nonlinear spatial analysis approach to focus on processes and interactions of systems at macro-levels rather than on procedures and tasks. This model seeks to identify the boundaries of instability in an effort to provide effective interventions.

Other authors have applied chaos theory to group processes. In describing a participatory-action research project, Traver reported that the "act of centralizing empowerment of multicultural groups becomes a process that moves towards complexity" (2005, p. 3) and is best understood through a chaos lens. She used chaos theory to frame the characteristic uncertainty in the lives of immigrants and refugees in her meso/macro-level qualitative study. The concept of bifurcation led Traver to better understand and explain crisis points in the lives and interaction of researchers with study participants and helped demonstrate complexity and uncertainty in the system. "This project, in a state of constant change, seemed to be an embodiment of the participants' unpredictable lives" (2005, p. 16). In their study of turn-taking in a youth group therapy session, the use of chaos thinking and nonlinear dynamics led Pincus and Guastello (2005) to see strong correlations between turn-taking in groups and control, closeness, and conflict in groups. They found the existence of coherent yet complex patterns of interaction, consistent with their other studies and with the fractals of chaos.

Bolland and Atherton (1999) argued the chaos theory framework provides, not only an alternative to cause-and-effect thinking, but also a basis on which social workers can clarify their understanding of how people are connected with the environment as well as better understand the complexities of clients' varying perceptions of reality. Ramsay (2003) compared 11 traditional and transformative concepts of social work in an effort to modernize the working definition of "social work" for the next century. He suggested that use of the idea of equilibrium (balance and stability) to indicate healthy social functioning should be replaced with the postmodern understanding, based on Prigogine's discoveries, that far-from-equilibrium states are ideal for one's health and well-being as they permit flexibility and adaptation to change in one's environment.

Brenda Zimmerman (1993) and others applied chaos theory to organizational dynamics (Nonaka, 1988; Tetenbaum, 1998). She proposed that the chaos lens enhances understanding of organizational change in this time of unparalleled societal change and postulated that, although an organization may appear disorganized, there may be an order, not always visible, beneath the surface (Zimmerman, 1996). She recommended that executive officers view management in an evolving system, or set of systems, not as managing change, but as managing "changeability" (Zimmerman, 1996, p. 16).

Several authors have commented on the limitations of chaos theory as currently applied in social work venues. Hudson (2000) observed that, for the application of the theory to social work to move beyond conceptual aspects, additional research and skill development will be needed. He asserted that the theory does not offer exclusively good news to the field of social work, suggesting that, in accepting the existence of chaotic processes within social systems, the theory makes it difficult to predict therapeutic or other outcomes. However, since chaos theory is helpful in predicting overall trends, processes, and change in a client's life, it can be used to plan interventions. Woehle (2007) also recommended that the field of social work benefit from additional research to understand and apply chaos theory at the levels possible.

Application Concepts

Chaos theory pushes us as social workers to advance our work in a number of ways. We are challenged to stretch our imagination as we look at the systems we work in, and at the systems in which our clients live. We are drawn to notice flourishing interactions with co-workers and with clients as we work together in thriving networks of communication feedback loops. These somewhat covert challenges to our profession ensure an ongoing emergence of novel social work interventions from this new theory, chaos. However, if we truly engage with chaos, the future outcomes may be unpredictable. In fact, our need to control, even if only to satisfy the naysayers, may be our undoing in this venture. If we are truly to accept chaos theory and its basic premise, we will need to resist the temptation to seize control. We may be asked to consider the impact of randomness, the consequences of giving up control, and the true meaning of creativity in social work practice. This section of the chapter provides a few basic examples as a starting point for readers who wish to "think chaos" in their practice.

Micro Practice

As we listen to an individual's story, how do we respond? Do we look at the client's complex, perhaps chaotic world, through a lens of acceptance? Do we ask ourselves if this client will find the creativity, the new way of being, that will emerge from the edge of his or her chaotic world? Or are we intent on working with our clients to control chaos and build predictable systems into their world? Rather than imposing the order and calmness that could activate a move toward entropy, we might look for indicators that foreshadow an emerging novel approach in the individual's life. Can the social worker help the client move toward a new, creative reality?

Consider this example. You meet with a young woman who tells a story of her life bouncing around the country as her parents changed locations through her childhood. She reports attending 12 different schools through her childhood. Now she finds herself unable to settle into a consistent life, wandering around from one home to another, from one job to another, and from one friend to another. She reports that her friends and family suggest she is a failure because she is not building solid roots from which to grow. You might find yourself wishing to assist her in settling into a friendly neighborhood and a solid job so she can find some peace. Yet, as you trace her history with her, listening without imposing your own life goals and priorities, you may discover an excitement in her as she moves from place to place, finding different parts of herself in each location and job. Perhaps you could support her in her movement—perhaps reframing the pattern as a "treasure hunt," an "adventure." As she moves and grows, she may find the treasure, she may find her future. And her future may emerge from her scattered early years, capturing a positive essence from each experience. She may need a worker with a chaos lens, a worker who can see the energy bursting forth, the creative potential, that could emerge from her chaotic experiences.

Fractals

Social workers often observe and analyze patterns in the lives of their clients. Fractals allow us to build our expertise in this kind of analysis. In the previous example, we can see fractals in the foreground of the story, between the lines of the case, the "same degree of irregularity on all scales" (Gleick, 1987, p. 98; Mandelbrot, 1975) in the life of this young woman. Her relationships, homes, schools, and jobs share the same patterns, irregular but similarly irregular. Perhaps in the future, these degrees of irregularity will merge into colorful, repeating patterns of rich experience. That experience may give this client exactly what she needs to build a life of creativity and richness.

Butterfly

In the example, we can see the "butterfly rising" as the young woman, emerging from her first meeting with the liberating social worker, feels, perhaps for the first time in many years, accepted and supported in her chaotic life. She begins to wonder if there might be some hope for her to retain the lifestyle she has secretly enjoyed, where she may finally find her treasure. The small change, the support of a social

worker, could lead to a transformational shift in her life.

Meso Practice

During an era of lawsuits and demands for accountability in a world of flourishing technology and burgeoning information, healthcare teams are increasingly influenced by the governing policies and standards under which they function. In fact, government and insurance regulations, demands for efficiency (Stein, 2001), and concerns about liabilities can easily slip onto center stage, taking the spotlight off quality care.

The chaotic environment of a layered bureaucracy is complicated further by its interdisciplinary nature and increasing costs. When cuts to available funds lead to lower staff levels, workers are stressed to the limit. Managers seek control through high-level planning, restructuring, smaller staff teams, through streamlined meetings and processes, enhanced documentation requirements, and demands for uniformity. Social workers are further stressed as fewer team members do more work to serve more people. Staff shortages can also lead to essential interdisciplinary team meetings being cancelled or shortened, or conversely, team meetings may be held with some disciplines unable to attend due to their workload. In a setting where teamwork has been determined to be vital to the overall success of an institution, cancelled meetings can pose a problem (Wituk et al., 2002).

Interdisciplinary groups, with members often wearing their discipline on their sleeve, can slide into a situation of restrained conflict, where some members seek control of the agenda, primarily to gain control of their own mandate and workload. When meetings are cut and team members each work in isolation, there can be an atmosphere that encourages individual workers to hunker down, do the work, go home, recover, return to work, and hunker down again . . . and on it goes. Efforts by managers to impose control may actually backfire. Some might claim this pattern of work leads, not to a controlled environment, but to chaos.

Weber's bureaucracy and Newton's linear thinking, along with the temptation to control, are easily spotted in healthcare settings. Here, uniformity, black-and-white choices, and controlled risk are sought; variability, changeability, creativity, and chaos are to be avoided. In a complex environment where managers find it difficult to impose control, chaos thinkers might question whether the current model is, indeed, the best path to success in interdisciplinary health care.

Workers comfortable with change who can manage and work through challenges may have skills to work through chaos rather than trying to block it. We might question what would happen if teams worked together—interdisciplinary teams flying in evolving formation through the chaos together (Zimmerman, 1996). A team member thinking about chaos may propose the enhancement of interdisciplinarity rather than its diminishment. This social worker could wonder whether creative solutions would surface from teams' meeting more often, not less. Chaos thinking suggests that a novel approach might develop, not in sporadic small-team meetings, but rather from meeting together more often, sometimes spontaneously, brainstorming new solutions and enhancing team support of each other in the work.

Rather than imagining isolated workers hunkering down and doing the work, consider the image of workers spending time together, providing mutual support, helping each other, having breakfast together, and watching the edge of chaos. This unified team, riding the wave and welcoming change, using trial-and-error strategies, brainstorming for new creative ideas, might learn to manage and work through ongoing "changeability" (Zimmerman, 1996, p. 16). Teams might move from cutting meeting times and numbers of staff to natural and unstructured, but joint, decision-making about programs, client needs, staffing, and budgets. Instead of isolating themselves from each other, team members will come closer together. Members of cohesive teams in an organization with open budget documents may offer, for example, to take a week off without pay so someone else can earn more. True team members could build solid cross-disciplinary relationships, having each other's back, like a family pulls together when faced with adversity. Managers need only to trust the creativity and competence of the team.

Fractals

Social workers often identify and use parallel processes in their work with clients where their therapeutic relationship with a client has qualities similar to those of the client's relationships with others in his or her life, *or* when the social worker's relationship with the client bears similarities to the social worker's relationship with his or her own supervisor. In clinical practice, I have observed similarities, and perhaps parallel processes, arising at different levels between client and worker, client and family, and worker and environment. One day, working in a long-term care healthcare setting, while listening to nurses talking about their bosses, I was surprised to hear the nurses using the same words about their bosses as I had heard their patients use about their nurses. This observation led, finally, to the development of a research project using the fractals of chaos as a base metaphor of analysis of layers of parallel levels of decision-making power in a long-term care facility (Campbell, 2003).

Butterfly

Perhaps one unit's small interdisciplinary team can develop competencies riding the crest of change while keeping the rigidities of the larger bureaucratic system at bay. The principle of the butterfly effect would suggest that this small area of competency could grow and develop to surprising levels. Perhaps individual workers or teams could build transforming change in a second team, rotating through the facility, spreading and teaching a new, chaotic way to think about the work.

Macro Practice

Consider the implications of replacing the firm bounds of a traditional organization with the more flexible boundaries suggested by chaos. In such a system, managers would need to trust that a more open process would unfold to produce something better, through employee creativity. Such an evolution would be maintained by manager and worker commitment rather than by the power of those in charge (Helgesen, 1990). Supervisors would encourage staff to take responsibility for the organization's credibility. Traditional management methods (reengineering, quality control, strategic planning, and others) impose control and view equilibrium and stability as signs of success (Zimmerman, 1996). Chaotic management strategies make trust, not control, the essential element.

In traditional organizations, management has sought order from the top down. Management by objectives, strategic planning, and hierarchical flowcharts have often been the result in these ordered and machine-like, non-chaotic systems. But they may quash creative potential along the way. Chaos theory, on the other hand, fits with and explains some of the uncertainty and randomness of organizations (Zimmerman, 1996). In "chaotic" organizations, the valued worker learns quickly and is comfortable with ambiguity and chaos (Tetenbaum, 1998). Work becomes de-bureaucratized (Peters, 1987). Though the system with fewer barriers of control is much less predictable, many more options become possible (Peters, 1987; Zimmerman, 1994). As we begin to see the connecting relationships and the suppressed energy, we will be free to let go of control and release creativity. Like fractals, the assets of the organization (employee creativity, adaptability, and novel ideas) will exist at all levels (Zimmerman, 1996).

If the true state of our natural and human world does allow for coexistence of order and disorder, irregularity and stability, simplicity and complexity, closed systems and open systems, perhaps organizations can accommodate a similar duality. During crises, when decisions to downsize and make rapid change are questioned, bureaucratic managers often try to regain control through rational processes and planning. Managers who follow chaos principles, on the other hand, would manage through the crisis, giving staff the autonomy, freedom, and the power to develop their potential (Prigogine & Stengers, 1984; Tetenbaum, 1998; Zimmerman, 1996). While organizational boundaries may appear rigid and closed, there are few truly closed systems, even in the scientific world. Most organizations are, underneath all the mechanisms of control, open and creative. They exchange energy with the environment—compatible with the systems described by chaos theorists. The chaotic terms "edge of chaos," "far from equilibrium," and its point of dynamic tension could well apply

to a social or health system undergoing change (Prigogine & Stengers, 1984, pp. 178, 231).

Fractals

While working in long-term healthcare settings in Canada, I began to wonder about power, particularly about the flow of power through the organization. Here we have some of the most powerful people, titled scientists and top-level bureaucrats, working in one of the largest organizations in the Canadian government. These powerful people provide service to some of the most powerless service recipients—frail elders living with cognitive impairment. I wondered whether the power I could see was held at the top, or whether the power at the top actually emanated from the powerlessness at the bottom. In a related study, I used chaos theory and fractals to define a research question about parallel processes of decision-making power in long-term-care organizations. I found that similar levels of perceived decision-making power, or lack of decision-making power, existed at all organizational levels: care recipients, frontline workers, middle managers, senior managers, and the chief executive officer. None of these groups or individuals believed they had any decision-making power. I began to see that, like fractals, the power in human relationships and organizations at one level might be parallel to the processes and relationships at other levels (Campbell, 2003).

Butterfly

You can see the "butterfly" emerge in organizations with "the impact of a simple memo as it flows through an organization, demonstrating Lorenz's butterfly effect" (Campbell, 2003, p. 53) as the note moves from desk to desk with escalating impact. A carefully worded memo can sometimes create the transformational shift of the metaphorical butterfly.

Social Work Research

Our compliance with deterministic thinking in our work can be seen in vestiges of Weber's bureaucracy, in our use of the medical model, and in our preference for pure scientific quantitative research methods while excluding qualitative methods. Yet social workers have always worked at the edge of systems—where clients meet contexts. We work with life's complexity at individual, family, small group, organization, and community levels. Although complying with the dominant linearity in some ways, social workers can also be found encouraging flexibility and openness in spite of our maintenance of the status quo thinking of the day. We call ourselves agents of change. But can "traditional positivist methodology" truly reflect social work realities accurately (Halmi, 1999, 243)?

Perhaps we need to consider a more fundamental change, such as that emerging from the "disciplines of nonlinear dynamics—chaos and complexity" (Warren et al., 1998, p. 357). The creative thought of chaos theory could not only deepen our understanding of family or system complexity, but also give comfort with the uncertainty we face (Bolland & Altherton, 1999). Although the word "chaos" can be frightening, this way of thinking may accurately reflect the deeply embedded complexity in human dynamics we have struggled to understand over the years. Bolland and Altherton state that social workers "have intuitively know(n) all along—things are not that simple or deterministic." (1999, p. 370) The creative response suggested by chaos theory may also be exactly what is needed as researchers attempt to shed light on an increasingly complex world at the intersection of client and context and at the intersection of the scientific model and qualitative methods.

Fractals

As we consider the levels of social work practice identified—micro, meso, macro, and research, we have a more complete picture of the fractal. At each level of practice, we can describe the connection and the parallels between levels. We can see patterns of irregularity recurring, but like the fractal, the patterns may not be immediately obvious.

Butterfly

The butterfly might be seen in qualitative practice as researchers doggedly repeat data collection and analysis processes until they reach "theoretical saturation" when new findings no

longer emerge (Punch, 1998, Fig. 7.1). Here, the researcher moves forward to the next step having exhausted the study's capacity to find new data. Like the breeze from the wing of the butterfly, the next step may hold the transformational shift in findings essential in our complex social reality.

Future Possibilities

The opportunities for social workers to develop our profession from a base of chaos are virtually limitless. Social work authors have applied this theory to change. Social workers are change agents. It is here, where client meets context and where change happens, that social workers do their best work. When we consider our professional goals, to intervene and advocate for clients in an atmosphere of respect, chaos theory can play a central role. To maximize the possibilities for our profession, we will need to engage in further research; develop chaos-based interventions at the micro, meso, macro, and research levels; and find ways to prove their worth, despite the unpredictability essential to chaos.

Conclusion

Chaos theory provides space for an open, interrelated world where randomness happens, where disorder and order coexist, and where, in the midst of disorder, we can find creative new entities. The pressure defined at the borders of disorder or chaos, the creativity that is thought to follow that pressure, and the subsequent settling back into equilibrium all can be related to human beings and their relationships. As a fluttering memo creates hushed conversation at water coolers, and as stressed, overworked workers try to help their clients, chaos is everywhere. Social workers work for change in and with systems, where the individual meets the context (Gray & Webb, 2009). Chaos theory, a theory based in concepts of change, is ideally suited for our profession.

Social work has long been thought to be part science and part art (Martinez-Brawley & Zorita, 1998). Chaos theory, with its emphasis on non-linearity, creativity, and unrestrained human capacity, takes us, with renewed energy, to the "art" of social work. Here, we can find our way back to fundamental social work principles and processes. We can revisit the relationship between multiple parts of a system in an open environment. We can call for "feedback loops" of communication in our work. And we can look beyond modernity and postulate new ideas about parallel processes metaphorically pictured in the fractals of Mandelbrot. The unbridled energy in the client system and the possibility of working simultaneously with dualities at all levels of practice opens the doors of social workers who want to develop the "art" of social work.

Here we can question whether the idea of an "edge of chaos" (Gleick, 1987; Prigogine & Stengers, 1984) may be a useful way to challenge conventional views of individuals, families, groups, and organizations. We can consider whether the "butterfly effect" might help the social worker leap from his or her traditional social work role in an ineffective system to a changed role working to create the broad impact, the transformation, imagined by Lorenz (1963). We can visualize new connections in the social work milieu of overlapping relationships, perhaps parallels or "fractals," for use in this world of contradiction and complexity—the 21st century.

Chaos thinking will help us understand and adapt as we take a broad view of multiple intersection points between person and context. It calls us to expand our already well-developed understanding of layers of contextual reality exponentially and invites us to consider that all doors are open. In a profession that prides itself on being contextually competent, chaos theory may call our bluff.

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3

Client-Centered Theory and the Person-Centered Approach: Values-Based, Evidence-Supported

William S. Rowe

Client-Centered

Built on the work of Carl Rogers (and now called "person-centered"), "client-centered" theory emphasizes and builds on a person's self-actualizing techniques to achieve individual or collective life goals

I had ventured in the fifth edition of *Social Work Treatment* that client-centered theory and the person-centered approach might better be described at this point as "values-based, evidence-supported" practice. It is becoming increasingly clear that many of the principles underlying Carl Rogers's client-centered theory and person-centered approach are essential elements in delivering effective evidence-based interventions that have become standards of practice in a variety of service arenas. Silberschatz and George (2007) noted that many of the ideas are pertinent to current intensely debated issues such as the role of techniques in therapy, therapeutic relationships, therapeutic alliances, and empirical research in psychotherapy. LaCombe (2008) cited a 2006 survey asking counselors, "Over the last 25 years which figures have most influenced your practice?" Of the 2,598 who responded, they overwhelmingly said "Carl Rogers."

Rogers passed away in 1987 after a rich and varied life that saw the development, expansion, and globalization of his theories. Prior to his death, he had continued to test and develop his theories by applying them to some of the more complex social dilemmas and exploring areas of convergence with other significant thinkers in psychology and human behavior (Rogers, 1986). Even though the parallels with social work thinking and social work activity remain constant, the vast majority of literature in person-centered theory and practice is now developed and expanded outside of social work and, indeed, for the most part, outside of the United States. Some examples include new applications in pastoral care (Snodgrass, 2007) and nursing (Green, 2006) and expansions in Brazil (da Silva, 2005) and

Japan (Shimizu, 2010) Others have incorporated person-centered principles into evidence-based practices such as solution-focused brief therapy (Cepeda & Davenport, 2006) and motivational interviewing (Miller & Rollnick, 2014).

Many of the tenets of client-centered theory have been hallmarks of the social work profession since its beginnings. The term "client" as opposed to "patient" was in popular use by social workers long before the field of psychology embraced client-centered theories. In addition, the values espoused by client-centered theorists were established and accepted by the earliest of social workers, including Octavia Hill and Mary Richmond (1917). Today, the principles of client-centered theory can be seen in patient-centered medical practice, student-centered learning, and even customer-centered business practices.

The fact that most of the theory and research in the client-centered approach has developed outside of the social work profession is somewhat of a historical anomaly. Carl Rogers developed many of the original principles of client-centered theory via the influence and observation of social work practitioners (Rogers, 1980). The following pages present the historical origins and basic principles of client-centered theory, explore its confluence with and divergence from social work practice, and reflect on new developments in and uses for person-centered theory.

Historical Origins

Client-centered theory and Carl Rogers have been all but synonymous for over four decades. When an individual is so central to a thought system, biographical data tend to illuminate the theory as well as the person (Seeman, 1990). What is unique about Rogers's influence on client-centered theory is that, even though he was its parent and chief proponent, his force was derived more from the integration and organization of existing concepts than from the generation of new ideas. This may account for the lack of authoritative rigidity and dogma that is characteristic of client-centered theory.

Therefore, the persons and ideas that shaped Rogers's early development also influenced the formulation of client-centered theory. Rogers's ideas were both an expression of and a reaction to the suburban, upper-middle-class Protestant family he was born to in 1902. His experience on the family farm, which they moved to when he was 14, led to an interest in agriculture and to scientific methodology and empiricism, which later became an important feature of client-centered theory (Rogers, 1961b). However, after studying agriculture at the University of Wisconsin, Rogers decided to pursue a career in the ministry and attended the Union Theological Seminary (UTS) in New York City.

Rogers later applied the liberal religious outlook that he found at UTS to client-centered theory by stressing the importance of individuality, trust in feeling and intuition, and non-authoritarian relationships (Sollod, 1978). Even though Rogers was at UTS for a short time, he helped organize a study group that was reminiscent of later "encounter groups."

After deciding that the ministry was too constrictive for his own professional growth and development, Rogers elected to pursue an M.A. in education and psychology at Columbia University. It was here that Rogers was significantly influenced by the pragmatic philosophy of John Dewey and the educational wisdom of William Kilpatrick. Kilpatrick, as a leader of the progressive education movement, stressed learner-focused education and redefined education as a process of continuous growth (Kilpatrick, 1937). The connection between Kilpatrick's ideas and what was later articulated as client-centered theory is by no means coincidental.

Rogers began his professional career as a psychologist at the Rochester Child Guidance Clinic while continuing to work on his doctorate at Columbia. The academic and professional isolation he experienced in Rochester allowed him to develop his approach to working with clients in a relatively unencumbered manner. In this pragmatic creative environment, Rogers first became interested in effective therapeutic methods as opposed to psychological ideologies. After attending a two-day seminar led by Otto Rank, he found that his practice was similar to that of the Rankians. Rogers learned even more about Rank's theories from a social worker at the Rochester Clinic who had been

trained at the Philadelphia School of Social Work (Rogers, 1980).

In 1939, Rogers published *The Clinical Treatment of the Problem Child*, a book that drew heavily on the work of Jessie Taft and relationship therapy. Many aspects of Rankian-based relationship therapy, as expressed in this book, show up later as tenets of client-centered theory. Among these are an emphasis on present experiences and circumstances, a positive valuation of the expression of feelings, a focus on individual growth and will, and a devaluation of the authority relationship in therapy. Relationship therapy continued to be developed in psychology by Rank, Taft, and Patterson, and in social work by the "functional school" led by Taft, Virginia Robinson, and Ruth Smalley (1967). In "relationship therapy," Rogers found the practical affirmation of the progressive educational concepts that he had embraced earlier. There can be no mistaking the similarity between client-centered theory and the following description of the therapist attitude by Taft (1951):

> It is not so easy as it sounds to learn to ignore content and to go through it to the fundamental attitude and emotions behind it, but it is possible, if one has no need for the patient to be or feel one thing rather than another and then is free to perceive and accept what is happening even if it means rejection of the therapeutic goal. The analyst in this view has no goal, has no right to one. He is passive in the sense that he tries to keep his own ends out of the situation to the extent of being willing to leave even the "cure" so-called, to the will of the patient.

Rogers's definition and articulation of the essential elements of the counseling and psychotherapy he had practiced for a decade began at Ohio State University, where he received an appointment in 1940. In the same year, he attended a symposium at Teachers College at Columbia that was presided over by Goodwin Watson, who at the time was attempting to discover the essential elements of effective therapy. The model of therapy articulated by Watson at this time was similar to the non-directive model that was to be the basis for Rogers's ideas in *Counseling and Psychotherapy*. Rogers identified this as an emerging viewpoint for which there was a "sizable core of agreement" (1942).

During his tenure at Ohio State University, Rogers reaffirmed his earlier commitment to empiricism. In his own work and the work he did with his graduate students, he attempted to operationalize and study the process of psychotherapy. The recording and analysis of interviews and outcome research were significant innovations for the time. Those activities brought Rogers's ideas into the mainstream of psychology.

In 1945, Rogers accepted an invitation to head a new counseling center at the University of Chicago. The 12 years he spent there resulted in his wide recognition as a leading therapist, theorist, teacher, and researcher. This period also signaled the shift from the theoretical period described as non-directive to the period described as reflective or client-centered. It was during this period that interest in Rogers's ideas developed in an ever-widening circle. As Rogers described it later, "To me, as I try to understand the phenomenon, it seems that without knowing it I had expressed an idea whose time had come. It is as though a pond had become utterly still so that a pebble dropped into it sent ripples out farther and farther and farther having an influence that could not be understood by looking at the pebble" (1980, p. 49). Theoreticians and practitioners from various fields, who gravitated to the principles that Rogers espoused, advanced client-centered theories in their own disciplines. Rogers's flexibility and non-authoritarian stance helped characterize him as the benign parent of client-centered theory in a variety of areas to be described later in this chapter.

In 1957, Rogers moved to the University of Wisconsin, where he helped bridge the gap between psychology and psychiatry through the completion of his work on schizophrenics and the loosening of the psychiatric monopoly on the practice of psychotherapy.

In 1964, Rogers moved to California, where he was able to fully develop the work with encounter groups that he had begun in Chicago. In 1968, Rogers and several staff members left to found the Center for Studies of the Person at La Jolla, California. Through the center, Rogers was able to apply the person-centered approach to perplexing problems in Northern Ireland; South Africa; Warsaw, Poland; Venezuela,

and many other areas. With the publication of *Carl Rogers on Personal Power* (1977) and *A Way of Being* (1980), Rogers moved person-centered theory into the realm of politics and philosophy.

Rogers continued to be an extraordinary philosopher and scientist up to his death in 1987. He attended the Evolution of Psychotherapy Conference at Phoenix, Arizona, in 1986, where he presented a paper that compared his person-centered theory with the work of Kohut and Erikson (Rogers, 1986). This author was fortunate to take part in some "conversation" and "demonstration" sessions that illustrated Rogers's personification of the theories he had developed and espoused. In his 80s, Rogers retained the clarity, honesty, personal warmth, and therapeutic effectiveness that had set the standard for an entire field of psychology. Even after Rogers's passing, person-centered theories continue to be debated and advanced in the literature, in terms of both fundamental theory (Moreira, 1993; Purton, 1989) and practical application (Lambert, 1986; Quinn, 1993; Silberschatz & George, 2007).

Principal Proponents of Client-Centered Theory

Counseling and Clinical Psychology

By far, client-centered theory has had its greatest impact on the field of counseling and clinical psychology. From the outset, it was clear that this approach represented a third force in American psychology. Many therapists embraced it as a desirable alternative to orthodox analysis or rigid behaviorism. The term "client," as opposed to "patient" or "subject," suggested the person's active, voluntary, and responsible participation.

The process, or "how to," of psychotherapy was described for the first time, allowing students to study and become proficient in observable counseling skills. A second attractive feature for counselors was the attention to the expression of positive humanistic values in a pragmatic approach to therapy. Finally, the continuing concern with effectiveness and outcome in the client-centered approach added to the credibility of the worker.

Many of the individuals who were influenced by Rogers and client-centered theory developed orientations of their own. Eugene Gendlin (1978) furthered the concept of "focusing" as a significant tool for change. Robert Carkhuff (1969), along with Bernard Berenson (Carkhuff & Berenson, 1977) and C. B. Truax (Truax & Carkhuff,1967), advanced the client-centered principles in greater depth and with greater precision. Greenberg, Rice, and Elliot (1993) and Rice and Greenberg (1984) also advanced the notion of "process-experiential," which remains closely aligned with the person-centered approach. Numerous others have incorporated the essential elements of client-centered theory, which is likely to ensure that it will continue to be a major component of the theoretical base of both counseling and clinical psychology.

Psychiatry

Rogers was for some time engaged in a struggle to get the field of psychiatry to recognize the value of client-centered theory to psychotherapy. Psychiatry to that point had retained a virtual stranglehold on the practice of psychotherapy. It was not until the results of his work with schizophrenics were published that psychiatry as a whole began to recognize the value of his approach (Gendlin, 1962; Rogers 1961a). Currently, client-centered theory is an accepted, if not widely practiced, orientation in psychiatry. Even though recent studies have reaffirmed the effectiveness of Rogerian counseling with patients diagnosed as paranoid schizophrenic (Gerwood, 1993), the approach does not appear to have been developed or expanded in psychiatry. After Rogers turned his attention to working with "nonpathologica1" clients in untraditional or unstructured settings, psychiatry as a whole appeared to lose interest in this form of counseling.

Some encounter group principles are still utilized in psychiatric settings in group psychotherapy and therapeutic communities. But as psychiatry has increased its concern with the organic etiology of the more severe psychological impairments, there has been a diminishing interest in client-centered theory and much greater emphasis on psychopharmacology.

Coincidently, a body of literature has surfaced in family medicine and general practice that is referred to as "patient-centered" (Stewart, Weston, Brown, McWhinney, McWilliam, & Freeman, 1995). The parallels are obvious, and physicians appear to be embracing the concepts as they are increasingly faced with a diverse patient body that is informed, empowered, and demanding a more equal helping relationship.

Administration and Leadership

The whole field of administration and leadership training has been noticeably affected by client-centered theory. Client-centered principles found easy application in conflict resolution, organizational behavior, and employer–employee relations. Many of the practices were utilized and expanded by those involved with the National Training Laboratories in Bethel, Maine, and the numerous Training Groups and sensitivity training sessions that were organized to help groups work more effectively and meaningfully (Lewin, 1951; Maslow, 1971). Helen MacGregor's "Y theory" and Abraham Maslow's "Z theory" of management both clearly reflect the application of client-centered principles to this area (Maslow, 1971).

These ideas have lost some of their allure in today's highly competitive workplace, which is increasingly less concerned with the person as an entity than with a set of skills that serve the corporate purpose and can be discarded when necessary. As people adapt to the modern workplace, their need for personal fulfillment, interrelatedness, and community building is likely to be expressed in a different form. Hence, there may be an even greater role for person-centered theory in the workplace of the future.

Social Work

Client-centered theory was highly acceptable to social workers from its inception. This is partly due to the fact that, in its infancy, client-centered theory was more or less a conceptualization of many of the practices of relationship therapy, which was the central force of the functional school of social casework. Many of the values that are expressed in client-centered theory are fundamental to social work practice.

Rogers found himself closely aligned with the social work profession in the early part of his career, and in fact held offices in social work organizations at both the local and national levels while in Rochester, New York (Rogers, 1961b). In the 1940s, Rogers and client-centered theory became identified with the field of psychology. Since social work had become entangled in the debate between the diagnostic and functional schools of casework, client-centered theory as a separate entity received less attention. Many of the principles of client-centered theory continued to be applied by social workers, but relatively little of this was reported or researched.

In the 1950s and 1960s, the profession turned its attention to the development of a unified theory of social work based on the person–environment continuum. Client-centered theory to this point had appeared too person-centered to be of much use in this effort. Barrett-Lennard's description of client-centered theory and its usefulness in social work practice theory was the first major reference in social work literature to Rogers's contribution (Barrett-Lennard, 1979).

In the 1970s, an increased concern with effectiveness and accountability sent theorists and investigators in search of methods that could be demonstrated and evaluated. As a result, there was a resurgence of interest in client-centered theory and its utility in social work, since it was one of the few demonstrably effective treatment approaches. It was followed up by investigations into the value of client-centered principles in training social workers (Keefe, 1976; Larsen, 1975; Rowe, 1981; Wallman, 1980). Today, most interpersonal skills training takes place in the undergraduate curriculum, and it is increasingly difficult to differentiate client-centered principles from good basic interviewing skills. At this point, practice skills texts utilize client-centered theory and practice, but as part of a set of generic or eclectic skills that are framed in a social work context. Recent contributions to the literature by Greene (2008), Shulman (1979), and Brodley (2006) have demonstrated the practical utility and generally positive application of person-centered approaches. Social work educators continue to incorporate some of the

person-centered ideas related to complex social and political problems into the macro and international spheres of the curriculum.

Theoretical Perspectives and Basic Concepts

Theory Building

As noted earlier, Rogers was more a coordinator than a generator of the principles that are associated with person-centered theory. Because he essentially followed a deductive reasoning process in his early investigations, his personality theory emerged *ex post facto*.

Epistemologically, his work is best described by the term "humanistic phenomenology" (Nye, 1975). Rogers's "humanism" is related to his belief that humans are essentially growth-oriented, forward-moving, and concerned with fulfilling their basic potentials. He assumes that basic human nature is positive, and that if individuals are not forced into socially constructed molds but are accepted for what they are, they will turn out "good" and live in ways that enhance both themselves and society.

Phenomenology is concerned with the individual's perceptions in determining reality. Rogers believes that knowledge of these perceptions of reality can help explain human behavior. Objective reality is less important than our perception of reality, which is the main determinant of our behavior. The phenomenological approach guided Rogers's approach to both therapy and research as he struggled with the difficulty of perceiving reality through another person's eyes.

As a scientist, Rogers sees determinism as "the very foundation stone of science" (Rogers, 1969); hence, he is committed to objective study and evolution. He sees this approach as incomplete in fostering an understanding of the "inner human experience" and embraces freedom as critical to effective personal and interpersonal functioning.

Basic (Key) Concepts

Rogers gave a detailed presentation of his theories of therapy, personality, and interpersonal relationships in volume three of *Psychology: A Study of a Science (*1959). The following are nine propositions that outline the personality theory underlying this approach:

1. "All individuals exist in a continually changing world of experience of which they are the center." The "phenomenal field," as it is sometimes called, includes all that the individual experiences. Only the individual can completely and genuinely perceive his experience of the world.
2. "Individuals react to their phenomenal field as they experience and perceive it." The perceptual field is reality for the individual. Individuals will react to reality as they perceive it, rather than as it may be perceived by others.
3. "The organism has one basic tendency and striving to actualize, maintain and enhance the experiencing organism." Rogers suggests that all organic and psychological needs may be described as partial aspects of this one fundamental need.
4. "Behavior is basically the goal-directed attempt of individuals to satisfy their needs as experienced in their phenomenal field as perceived." Reality for any given individual is that individual's perception of reality, whether or not it has been confirmed. There is no absolute reality that takes precedence over an individual's perceptions.
5. "The best vantage point for understanding behavior is from the internal frame of reference of the individual." This includes the full range of sensations, perceptions, meanings, and memories available to the conscious mind. Accurate empathy is required to achieve this understanding.
6. "Most ways of behaving adopted by the individual are consistent with the individual's concept of self." The concept of self is basic to client-centered theory. Self-concept is an organized internal view consisting of the individual's perceptions of himself alone, himself in relation to others, and himself in relation to his environment and to the values attached to these perceptions. Self-concept is seen as an ever-evolving entity.
7. "The incongruence that often occurs between an individual's conscious wishes and his behavior is the result of a split between the

individual's self-concept and his experiences." As the individual gains an awareness of self, he develops a need for positive regard and positive self-regard. When the individual feels loved or not loved by significant others, he develops positive or negative self-regard.

8. "When there is incongruence between the individual's self-concept and experiences with others, a state of anxiety results." This anxiety is often the result of the incongruence between the ideal and real self. To lower an individual's anxiety, the self-concept must become more congruent with the individual's actual experiences.
9. "The fully functioning individual is open to all experiences, exhibiting no defensiveness." Such a person fully accepts himself and can exhibit unconditional positive regard for others. The self-concept is congruent with the experiences, and the individual is able to assert his basic actualizing tendency.

With regard to motivation, Rogers believed the organism to be an active initiator that exhibits a directional tendency (Rogers, 1977). He agreed with White's description of motivation as more than simple stasis: "Even when its primary needs are satisfied and its homeostatic chores are done, an organism is alive, active and up to something" (White, 1959). Rogers affirmed that there is a central source of energy in the organism that is concerned with enhancement as well as maintenance (Rogers, 1977).

The following are some of the most significant assumptions of Rogers's personality theory from the perspective of therapy:

We behave in accordance with our perception of reality. In light of this, in order to understand the client's problem, we must fully understand how she perceives it.

We are motivated by an innate primary drive to self-actualization. The individual will automatically develop her potential under favorable conditions. These conditions can be established in therapy and the stance of the therapist must, as a result, be nondirective.

The individual has a basic need for love and acceptance. This translates into a focus on relationship and the communication of empathy, respect, and authenticity by the therapist.

The individual's self-concept is dependent upon the nature of the acceptance and respect she experiences from others. The client's self-concept can be changed by her experiencing unconditional positive regard in therapy.

Values

The valuing process has been discussed at some length in client-centered theory. Rogers hypothesized that "there is an organismic commonality of value directions" and that "these common value directions are of such kinds as to enhance the development of the individual himself or others in his community and to make for the survival and evolution of his species" (Rogers, 1964). This positive and hopeful view of human beings is by and large acceptable to a profession like social work that is dedicated to the enhancement of social relationships and functioning.

In addition to being concerned with the "organismic valuing process," client-centered theory professes both general and specific attitudinal values. In its early stages, client-centered theory was essentially neutral regarding values. Over the years, it has progressed to the point where person-centered or humanistic values are asserted (Carkhuff & Berenson, 1967). These include the following (Boy & Pine, 1982; Rogers, 1964, 1977):

1. The counselor who intends to be of service to a client must value the client's integral worth as a person.
2. Responsible action occurs within the context of respect for the dignity and worth of others.
3. The counselor who values the client has a fundamental respect for the client's freedom to know, shape, and determine personal attitudes and behavior.
4. The client possesses free will; she can be the determiner of a personal destiny.
5. A person's free functioning not only tends toward development of the self, but also includes a responsibility to other persons.
6. The client enhances the self by fulfilling obligations to herself and others.
7. The client begins to relate to others with a sense of personal responsibility and ethical behavior.
8. Love and peace are basic strivings and must be advanced during one's lifetime.

These values are universally expressed and professed in social work. A belief in the fundamental dignity and worth of an individual is similar to values 1 and 2. Social work's commitment to self-determination is captured in 3 and 4. The importance of social responsibility and reciprocity has also become a more broadly accepted value (Compton & Gallaway, 1979; Siporin, 1975) and is reflected in 5, 6, and 7. Number 8 (a commitment to the advancement of love and peace) is a value that few social workers would reject, although it is not articulated and asserted by the mainstream in the profession as yet.

The major values of the person-centered approach appear to be closely aligned with those expressed in social work. This is partly because of the similarity of historical roots, but it is also due to the cross-cultural, time-tested effectiveness of these values. In other words, they appear to be functional as well as philosophical.

Sociocultural Sensitivity

Person-centered theory, especially that characterized by Rogers's early work, has come under criticism for placing too much emphasis on individualism and independence, although dependency on family, friends, and authority figures is considered appropriate and necessary in many cultures (Usher, 1989). Rogers recognized the importance of a client's natural support systems and traditional healing methods in his later writings, and others have managed to find significant points of convergence in cross-cultural settings (Hayashi et al., 1992). It is notable that person-centered theory has received more attention and generated more interest in multicultural settings outside of North America in the past decade than in its historical stronghold.

Treatment

The basic goal of client-centered therapy is to release an already existing capacity for self-actualization in a potentially competent individual. The underlying assumptions are as follows:

1. The individual has the capacity to guide, regulate, direct, and control himself, providing certain conditions exist.
2. The individual has the potential to understand what is in his life that is related to his distress and anxiety.
3. The individual has the potential to reorganize himself in such a way as not only to eliminate his distress and anxiety, but also to experience self-fulfillment and happiness.

In 1957, Rogers postulated the following elements that he believed were necessary and sufficient for a positive outcome in therapy:

1. The therapist is genuine and congruent in the relationship.
2. The therapist experiences unconditional positive regard toward the client.
3. The therapist experiences empathic understanding of the client's internal frame of reference.
4. The client perceives these conditions at least to a minimal degree.

These "core conditions," as they came to be known, have been linked with positive outcomes in therapy for a wide variety of clients in various settings (Carkhuff, 1971; Carkhuff & Berenson, 1967; Truax & Mitchell, 1971). Additional dimensions of the therapist, such as concreteness, confrontation, self-disclosure, and immediacy, have been recognized as important (Carkhuff, 1969). Quinn (1993) has argued for an expansion of the concept of "genuineness" to include a developmental-interactional component, and Natiello (1987) has suggested that the therapist's personal power is so crucial that it should be treated as a fourth condition. The process of therapy and counseling in the client-centered approach is basically the following:

1. The therapist and client establish a mutual counseling contract.
2. The therapist presents an attitude in the relationship characterized by the core conditions.
3. The client's greatest capacity for problem-solving is released because he is free from the anxiety and doubts that were blocking his potential.

It is difficult to make a comprehensive statement about person-centered therapy because, true

to its basic philosophy, it has been changing, evolving, and actualizing since its inception. Table 3.1, adapted from David Cole (1982) and J. T. Hart (1970), illustrates some of the major points associated with those changes over the past 40 years.

The person-centered developments referred to in the table are more indicative of Rogers's orientation since 1970. Some proponents of person-centered theory have continued to develop and refine the microlevel counseling aspects. Carkhuff and his associates have developed specific training programs in which the novice counselor first learns how to discriminate between high-level responses (understanding and direction) and low-level responses (little understanding or direction). Second, the student counselor learns how to communicate high levels of accurate empathy, authenticity, and positive regard. The following dialogue exemplifies this process:

Client: I don't know if I'm right or wrong feeling the way I do, but I find myself withdrawing from people. I don't seem to socialize and play their stupid little games any more.

Counselor's response (Low level): Friendships like this are precarious at best.

(Medium level): You're really down because they won't let you be yourself.

(High level): You feel really bad because you can't be yourself and you want to be. The first thing you might do is spend a little time exploring who you are without them.

Client: Sometimes I question my adequacy raising three boys, especially the baby. Well, I call him the baby because he's the last. I can't have any more, so I know I kept him a baby longer than the others. He won't let anyone else do things for him. Only Mommy!

Counselor's response (Low level): Could you tell me, have you talked with your husband about this?

(Medium level): You feel concern because your son is so demanding.

(High level): You're disappointed in yourself because you haven't helped him develop fully and you really

Table 3.1 The Development of Client-Centered Therapy

Therapy	Therapist Goals	Therapist Roles
Nondirective cognitive orientation (insight) 1940–1950	1. Create an atmosphere of permission and acceptance 2. Help client clarify thoughts and feelings rather than interpret for him 3. Help client increase knowledge of self	1. Passive, nonjudgmental listening 2. Empathic 3. Nonconfronting 4. Nonsharing of self 5. Feedback objective, rephrasing, repeating, clarifying
Client-centered or reflective emotional orientation (self-concept) 1950–1957	1. Develop the conditions necessary and sufficient for constructive personality change 2. Communicate to client: • empathy • unconditional positive regard • genuineness	1. Active listening 2. Accurate, emphatic 3. Nonconfronting 4. Sharing of self 5. Noninterpretive 6. Feedback, subjective indicating how therapist believes client feels
Experimental existential/ encounter orientation (humanistic) 1957–1970	1. Establishing therapeutic relationship 2. Reflecting client experiencing 3. Expressing therapist experiencing 4. Client as a unique individual and as a group member	1. Active listening 2. Accurate empathy 3. Confronting 4. Sharing an authentic friendship 5. Interpreting, if appropriate 6. Feedback is subjective prizing, loving, caring
Person-centered • Community • Institution • Political orientation (militant humanism) 1970 to present	Humanize and facilitate the actualization of communities, institutions, and political systems	1. Apply effective components of person-centered approach to such organizations 2. Assert humanistic values 3. Quiet revolutionary

want to. Now a first step might be to design a little program for you and for him (Carkhuff, 1976).

Person-centered theory can no longer be described or evaluated in a singular fashion. So many individuals and groups have embraced the approach that the underlying philosophy and principles are evident even in approaches that are not specifically identified as "client-centered." For the beginning counselor or therapist, person-centered theory still appears to offer a comprehensive approach. In a refinement of this approach, Angelo Boy and Gerald Pine offered the following reasons for utilizing person-centered theory in counseling (Boy & Pine, 1982):

- Possesses a positive philosophy of the person
- Articulates propositions regarding human personality and behavior
- Possesses achievable human goals for the client
- Possesses a definition of the counselor's role within the counseling relationship
- Has research evidence supporting its effectiveness
- Is comprehensive and can be applied beyond the one-to-one counseling relationship
- Is clear and precise regarding application
- Has an expansive intellectual and attitudinal substance
- Focuses on the client as a person rather than on the client's problem
- Focuses on the attitudes of the counselor rather than on techniques
- Provides the counselor with a systematic response pattern
- Provides flexibility for the counselor to go beyond reflection of feelings
- Can be individualized to the particular needs of a client
- Enables client behavior to change in a natural sequence of events
- Can draw from the process components of other theories of counseling and human development

Not surprisingly, person-centered theory is most often identified with the "person" end of the person–environment continuum. The concept of self is so important to Rogers's view of personality that it is often referred to as "self-psychology" or "self-theory."

Rogers viewed human nature as growth-oriented and positive and believed that maladaptation is generally more a problem in the environment than in the person. In most cases, client-centered therapy is predicated on the belief that the client's innate self-actualizing tendencies will flourish if the conditions are right. This view recognizes the importance of the environment and places the locus of change in that area. Essentially, the environment should be altered or adjusted to suit humans, rather than the reverse.

This view has received limited acceptance in social work. Most social work approaches afford equal importance to both aspects of the person–environment continuum, at least in theory. In practice, a great deal of social work activity is directed toward helping the individual adjust to society. Person-centered theory is at odds with both of these.

Social Work with Individuals

Person-centered theory has found both acceptance and expression in social work with individuals, or "social casework." Person-centered theory is most closely aligned with the functional approach to social casework, although there are areas of convergence with and divergence from the other major approaches. This is understandable given Rogers's involvement with social work and the functional school in the 1930s.

Psychosocial History. The place of a psychosocial history in casework, firmly established by Mary Richmond (1917), for the most part has been broadly accepted by the profession. Person-centered theory has historically placed little emphasis on this aspect of the helping process. In applying the person-centered approach narrowly, workers would concern themselves with history-taking only to the degree the client was willing. A broader interpretation of person-centered theory would also promote history-taking, since a full appreciation and credible acceptance of the client can be better realized when the worker is cognizant of both the past and the present. History-taking is one of the areas that has become more acceptable to person-centered therapists in its more eclectic form.

Diagnosis. Another area of traditional divergence has been the place of diagnosis in casework. Person-centered theory has been

fundamentally opposed to diagnostic classification. This theory's belief in the uniqueness of the person disallows the categorization, classification, and dehumanized labeling of individuals. Diagnosis has been and continues to be an important concept in social casework (Hollis, 1972; Turner, 1968, 1974), where it is generally viewed as a dynamic and functional process. Smalley's approach, in which the worker and client are both fully considered in the diagnosis, is most reminiscent of the person-centered approach.

Rogers and others have demonstrated that the person-centered approach is effective with a variety of diagnostic categories, including schizophrenics and psychotics (Gerwood, 1993; Rogers, 1980; Rogers et al., 1967). This research, coupled with the person-centered philosophy, has established some of the rationale for rejecting the concept of diagnosis. The person-centered approach in social work need not reject this concept wholly, and may indeed discover that person-centered theory applied within the diagnostic framework can increase its effectiveness. This latter approach would undoubtedly be more acceptable to social caseworkers.

The Helping Interview. By far the greatest contribution person-centered theory has made to social casework has been the helping interview. Most approaches to social casework recognize the utility of the "core conditions of helping." These conditions of communicating accurate empathy, authenticity, and positive regard in the helping interview have been demonstrated as effective by Truax, Carkhuff, and Mitchell. In the 1970s, social work educators introduced training in the core conditions to the social work curriculum (Fischer, 1978; Hammond et al., 1978; Wells, 1975). Silberschatz and George (2007) further suggest that these necessary and sufficient conditions of therapeutic personality change are still pertinent to many of the major techniques commonly used in counseling. Clearly the core conditions appear to be a good base from which to begin skill development in the helping interview. In order to be more broadly useful and acceptable to social caseworkers, they need to be expanded and adapted to fit the wide variety of situations and circumstances.

Case Example

Brian is a client who has reportedly suffered from low self-esteem and feelings of anxiety for several years. According to Brian, these issues have intensified recently and he's not sure why.

Brian: "Today has been an awful day. I have always felt like less of a person compared to everyone else, but recently it seems as though things have gotten worse and I don't know why."

Therapist: "I understand that you feel bad. This is a very difficult time for you and I wonder if it feels a little scary to be unsure of what is wrong."

Brian: "It is scary, because I don't like to feel as if I'm not in control of myself. Also, sometimes I feel like there is no one around me who understands how I feel, or they just think my feelings are wrong. I mean my family gets mad that I don't talk to them enough, but how can I open up to them when they won't understand me?"

Therapist: "Currently, things seem so overwhelming to you and you feel that you have no one in your personal life who understands what you're going through, so you can't see the point of sharing your feelings with them."

Brian: "Yes, they just don't get it. Maybe I'm just not worth the trouble of listening to."

Therapist: "Well, I believe that you are worth listening to. I am glad to see you when you come for sessions and share your thoughts and feelings. I also believe that you are able to make your own decisions about who you want to speak to and when."

Brian: "You are confident in my ability to make my own decisions. I am afraid that I will ruin my life, but you aren't afraid of that for me."

Therapist: "You are a competent person who is capable of determining the correct choices for your life."

Brian: "Well, I think if I try to look at my life more positively than negatively I will be better off. If I think more positively, then I will start to speak and act in more positive ways, which will lead to a much happier and more positive life. That's all I want, and now I believe that I actually deserve it and can achieve it."

Therapist: "I feel so proud of you and the bravery you have shown while in therapy. I am honored to have shared in your personal journey and growth."

Using a client-centered therapy approach provided the ability for Brian to decide what to talk about and

when, without direction, judgment, or interpretation by his therapist. The therapist's unconditional positive regard, empathy, and congruence allowed Brian to feel more comfortable expressing himself without any worries. This gave him the opportunity for plenty of self-exploration and personal growth. His therapist's confidence in him empowered Brian to take back the control in his life that he felt he was losing and to be more open in his personal relationships.

Social Work with Families

Person-centered principles have had a wide impact on the whole area of work with children and families. Rogers (1939), in his doctoral dissertation and his first book, focused on therapy with children and found it necessary to include the entire family.

A few years after Rogers published *Counseling and Psychotherapy* (1942), Virginia Axline (1947) presented a work that drew from his nondirective principles and from the relationship therapy orientation of Taft (1951) and Allen (1942). Axline's approach to nondirective play therapy included the basic principles of acceptance, relationship, freedom of expression, and freedom of behavior. Others, like Clark Moustakas (1953), expanded and developed these principles to help make the person-centered approach a significant force in child therapy.

By the late 1950s, therapists were increasingly including parents and family members in the counseling context and applying person-centered principles to work with families. Guerney described a process of filial therapy in which parents were taught person-centered skills so they could deal with their children themselves (Guerney, 1964Guerney, Guerney, & Andronico, 1970). Some explored the development of self-concept in families (Van der Veen et al., 1964), while others used person-centered principles in working with couples (Rogers, 1972).

While the person-centered approach to working with families has by and large been found useful and philosophically acceptable by social workers, it has essentially been overshadowed by concurrent developments in the application of systems theory to both family work and social work. These two schools of thought appear to be fundamentally divergent in terms of basic assumptions, but some have attempted to establish a dialogue between the two. For example, O'Leary (1989) has written: "Family members need to be received as subjects while being encouraged to face their reality as part of a system with patterns not entirely in their consciousness or control. They need to be acknowledged as mysteries as well as confronted with the limits and unacknowledged potential in their interpersonal living."

Social Work with Groups

Group work in the person-centered tradition has received sporadic acceptance in social work circles. Social work had a rich history in group work long before person-centered principles were applied to this area. The major application of person-centered principles to group work has been in the form of the encounter group or T-group, as developed by Rogers (1970). The encounter group began in the 1940s at the University of Chicago with Rogers, and in Bethel, Maine, with Kurt Lewin. Rogers viewed the intensive group experience as an important vehicle for therapeutic growth and attitudinal change, whereas Lewin focused on the improvement of human relations and interpersonal interaction.

Rogers (1970) noted the following as central to the process of change in intensive group experience:

Climate of safety
Expression of immediate feelings and reactions
Mutual trust
Change in attitudes and behavior
Understanding and openness
Feedback
Innovation, change, and risk
Transfer of learning to other situations

Many of the above are seen as essential elements of mutual aid in social group work (Shulman, 1979). Also, the following description of the goals of the therapist leader (Beck, 1974) are

not incompatible with the orientation of many social group workers:

1. The facilitation of group members to take responsibility for themselves in whatever way is realistically possible
2. The clarification and solution of problems and conflicts by a process of self-understanding and the development of an empathic understanding of others
3. Recognition of the client as she is and recognition of her reality as she sees it
4. Attempts to offer an attitude that is nonjudgmental in order to facilitate exploratory and self-reflective behavior in the client
5. Recognition of the significance of maintaining as high a degree as possible of clarity about the leader's own views, feelings, and reactions while he is in the therapeutic relationship.

The expression of the core conditions by group leaders has been shown to have a positive impact on increasing client self-exploration (O'Hare, 1979).

Given the therapeutic aim of encounter groups and their focus on the individual in group, they are most readily identified with the remedial model of social group work. However, many of the underlying principles and some of the techniques are more reminiscent of the reciprocal model of social group work. Some aspects, such as adherence to democratic principles, are aligned with social group work in general. Recently, some researchers have argued that there may be points of compatibility between structuring group process and nondirectiveness (Coughlan & McIlduff, 1990). This opens the door for a much wider use of person-centered group work with, for example, low-functioning or involuntary clients (Foreman, 1988; Patterson, 1990).

Social Work with Communities

The more recent developments in person-centered theory have included an interest and involvement in the concept of community. Rogers applied the fundamental principles of person-centered theory to both community concerns and community development.

Much of this was initiated at the Center for Studies of the Person in workshops and learning laboratories. Some concurrent efforts continued at the University of Chicago, where Gendlin and others established a therapeutic community called Changes, which was based on person-centered principles (Rogers, 1980). The experiments in community have included work with a wide variety of neighborhoods, cultures, religions, and political situations.

In the tradition of the person-centered orientation, writers have first concerned themselves with establishing propositions that describe the basic assumptions concerning communities. Barrett-Lennard (1979) has postulated that "a well functioning community would be an open system in interface with other systems . . . continually in process . . . and characterized by an organismic egalitarianism." William Rogers (1974) suggests that, from the person-centered viewpoint, "individuals seek a community of belonging, understanding and mutual support that will enhance the actualization of life," and that "persons within a community are potentially better able to understand and articulate the identity and hopes of that community than are persons from outside." William Rogers moves to the next phase by considering the necessary steps in the process of social change. Some of the person-centered principles contained in his approach are:

The importance of listening deeply to the needs and concerns of individuals and groups within the constituent communities
The facilitation of community self-perception
The recognition and encouragement of indigenous leadership
The facilitation of the communication among divergent groups
The identification of community goals

In work with communities, person-centered theory is most clearly aligned with the principles of locality development. The person-centered approach to community development articulated by William Rogers is both astute and pragmatic. As such, it is generally more acceptable to social workers than the more esoteric, unstructured offerings developed at such places as the Center for Studies of the Person and Changes. Many community workers in

social work find the community-building techniques developed and experimented with in the person-centered approach to be useful in conjunction with their own theories. To this end, the person-centered approach affords an important laboratory for exploring different aspects of community building. Curiously, it is possible that the person-centered approach as it has evolved may be too value-laden and prescriptive for most social work community organizers to embrace.

Social Work Administration

For many years, Rogers viewed the tenets of person-centered theory as applicable to all human interaction. In *Carl Rogers on Personal Power* (1977), he described how these features have been successfully applied to agencies and organizations. Rogers provided examples of how person-centered approaches resulted in greater productivity, as well as greater career and personal satisfaction. In this approach, leadership is characterized by influence and impact, rather than power and control. The person-centered administrator, where possible, gives autonomy to persons and groups, stimulates independence, facilitates learning, delegates responsibility, encourages self-evaluation, and finds rewards in the development and achievements of others (Rogers, 1977).

Person-centered theories of administration did not originate with Rogers, but were articulated in administration circles since the early part of this century (Schatz, 1970). The major contribution of Rogers has once again been the operationalization and application of the concepts within an organized framework.

Social workers have found many aspects of person-centered administration to be compatible with their values. There has been a great deal of interest in and experimentation with participatory management approaches (McMahon, 1981; Schatz, 1970) and equality-based supervisory practices (Mandell, 1973). Rogers's approach to administration, with its antiauthoritarianism, is limited in its broad application in social work. As they are applied and refined, however, the principles may mature into an acceptable, coherent, and functional administrative orientation.

Empirical Base

Investigators received a new impetus from the study of client-centered theory. Rogers's personal commitment to empiricism and to outcome-and-evaluation research opened new avenues in research that had previously not been considered. Rogers's objective observations of the subjective experience of counselors and clients through hypothesizing and testing were clearly innovative. While his initial interest was in the systematic description of the process of psychotherapy, his attention later turned to effectiveness and outcome measures, and finally, to attempts to substantiate his theoretical postulates.

John Shlien and Fred Zimring (1970) identified four stages in the development of research methods and directives in client-centered theory. In stage 1, the emphasis was on the client in the context of therapy. In stage 2, the emphasis expanded to cover the phenomenological aspects of perception and personality. In stage 3, the emphasis shifted to the study of the therapist, and in stage 4, all three elements merged into a process conception of psychotherapy. An extraordinary number of studies have been generated in all of these areas. Although many support the original claims, some challenge both the original assumptions and the external validity of some of the findings. Investigators such as Charles B. Truax and Robert Carkhuff further refined, expanded, and substantiated the basic principles of client-centered theory.

The research on the core conditions of therapy is especially notable. There is considerable agreement across a number of professions, including psychology, psychiatry, social work, and nursing, that the core conditions are demonstrably linked with effective counseling practices. As such, the core conditions remain one of the only substantive elements of effective counseling, and are supported by numerous studies.

With the possible exception of behavior therapy, no other approach has had such an intensive research orientation. This is in part attributable to the fact that, unlike most schools of therapy, client-centered theory was developed primarily in the university setting. As Rogers (1960) remarked, "Client-centered therapy will at least

be remembered for its willingness to take a square look at the facts," and this emphasis has been embraced by most of those associated with the client-centered orientation. The methods employed in client-centered research appear to be particularly adaptable to the needs of social work research. The stages of development in client-centered research are closely aligned with social work concerns.

The first level of development in client-centered research was the recording of cases, the definition of concepts, the development of objective measures of the concepts, the application of the concepts, and the establishment of relationships among the concepts. This is similar to attempts in social work research to quantify and evaluate practice, as in Larry Shulman's study on casework skill (1978). It is widely acknowledged that much of what is considered to be practice wisdom in social work would be better understood and utilized if it were subjected to this kind of rigor (Siporin, 1975).

Another stage of research in client-centered theory that is directly useful to social work is outcomes research. Numerous effectiveness and outcome studies have been done using creative investigative techniques such as the Q-sort. Social work researchers are increasingly concerned with the same issues in light of increased demands for accountability. As social workers become better able to define and operationalize their objectives, these research techniques have proven useful.

In the past decade, social work research has increased significantly and social workers have expanded their repertoire of research methods. Heuristic models and qualitative research methods are finding increasing use in social work, and their congruence with the empirical base in person-centered theory is clear (Barrineau & Bozarth, 1989). As direct practice becomes more eclectic in nature, the challenge is to establish how person-centered approaches are more or less useful, under what conditions, and with what particular disorders or needs (Lambert, 1986). A good example of this is seen in a recent work by Joseph (2004) where he looks at the practical applications of client-centered therapy for posttraumatic stress disorder (PTSD) and posttraumatic growth. While most of the major texts on PTSD make no reference whatsoever to client-centered therapy, Joseph suggests that PTSD symptoms may simply be another way of talking about what Rogers described as the breakdown and disorganization of the self-structure. He points out that the person-centered approach forces us view recovery from PTSD in terms of positive movement toward posttraumatic growth.

Prospectus

There are numerous areas of convergence and compatibility between person-centered theory and social work practice. Given the similarities in philosophy and practice, it is in some ways curious that person-centered theory is not more accepted by the profession. For example, not long ago, Howard Goldstein (1983) published an article, "Starting Where the Client Is," in which he competently articulated the value of his longstanding social work adage. It is odd that he made only passing reference to Rogers and person-centered theory, considering the amount of theory and research available to support his thesis. Rogers presents what many believe is a naive and one-sided view of human nature.

Many social workers support this positive view of humanity in theory, but decades of practice with some of the more disturbing problems in society (poverty, child abuse and neglect, family violence) diminish enthusiasm for such beliefs. Much of person-centered theory was developed in controlled university settings, whereas the social worker's practice environment is often far more unpredictable. Much of the work done in the past decade has advanced the use of person-centered methods with difficult-to-serve clients (Gerwood, 1993; Patterson, 1990; Murphy,2009) and should help to bridge this gap. Those who have advanced the work of Martin Luther King Jr. and use his ideas and methods to work with both perpetrators and victims of terror, gang violence, and even genocide readily trace their techniques and approaches to Rogerian values and philosophy. This is especially clear in the wide acceptance of Kingian Nonviolence Conflict Reconciliation strategies and programs. (LaFayette & Jehnsen,1995).

Most of the research validating the concepts takes the expressions of the clients at face value and gives little attention to unconscious processes. Many social workers firmly believe in the importance of understanding unconscious motivations and have experienced the usefulness of this understanding in both assessment and intervention. Some of the theory-bridging begun by Rogers (1986) and furthered by others (Purton, 1989; Quinn, 1993; Kolden, et al,2011) will allow for more convergence on these issues in the future.

Another area of divergence between person-centered theory and social work pertains to the concept of authority. Rogers took an extreme position against authority and saw it as an essentially destructive component of relationships. While many social workers deemphasize authority, the major concern is more often how to make positive use of it, as opposed to simply denying its existence. Not all person-centered therapists are as adamant about this issue as Rogers was, and some of the more recent contributors have included rather than rejected the concept of authority relationships (Boy & Pine, 1982; Coughlan & McIlduff, 1990; O'Leary, 1989).

The development of person-centered theory in many ways has been a microcosm of the development of the social work profession. Both began with the worker–client interaction and progressed to include groups, families, organizations, communities, and political systems. Person-centered theory has matured along with social work theory to the point where Orlov (1990) made reference to "person-centered politics," a concept that would have been unthinkable a short time ago. Solomon (1990), in a work entitled "Carl Rogers's Efforts for World Peace," demonstrated advances in the application of person-centered theory that have significant ramifications for international work.

Many social work students, upon their introduction to person-centered concepts, dismiss them as simplistic and unsophisticated. It is only when workers have had significant experience that they are in a position to rediscover person-centered theory, with its many layers of depth and meaning. Miriam Polster captured this well when she referred to Rogers's work as "informed simplicity," not unlike a Picasso painting (Zeig, 1987, p. 198).

The term "person-centered" is highly appropriate for both theory and practice in a profession that has traditionally attempted to encompass both science and compassion. In essence, both the emphasis on the person and the research practices of person-centered theory are valuable to social work. In the past few years evidence-based practice has taken a central role in social work practice and social work education. At first glance it may appear that the ordered protocols inherent in evidence-based practice appear to be at odds with many of the fundamental tenets of client-centered theory as articulated by Rogers and as practiced by Rogerians. Actually, virtually all of Rogers's early work was based on observation and experimentation at a time when others were using mostly post-report information often gathered from the therapists themselves. As noted at the beginning of the chapter client-centered theory might better be described at this point as values-based, evidence-supported practice. Overall it is essential that, as professional boundaries become less distinct and multidisciplinary practice becomes more the norm, we re-embrace person-centered theory and all that it has to offer in its old and new forms.

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Annotated Listing of Key References

Boy, A. V., & Pine, G. J. (1982). *Person-centered counseling: A renewal*. Boston: Allyn and Bacon. The authors focus on the current application of person-centered theory to individual and group counseling. Boy and Pine recognize the shift of most person-centered authors to applications in teaching, administration, community building, race relations, and conflict resolution. They offer a refinement of the original person-centered counseling principles and renewed possibilities for individual and group application. In addition, Boy and Pine critically discuss the counseling concerns of personality theory, values, accountability, evaluation, and counselor education.

Carkhuff, R. R., & Berenson, B. G. (1977). *Beyond counseling and therapy* (2nd ed.). New York: Holt, Rinehart and Winston. Carkhuff and Berenson have significantly advanced person-centered theory through both clinical and research efforts. This book supplies a comprehensive statement of the research and clinical observations that support their view of the person-centered model of helping. The authors compare the person-centered approach with other major helping theories and show the rationale for their particular beliefs. In addition, the philosophy, values, and content of a training approach for counselors are outlined.

Fischer, J. (1978). *Effective casework practice*. New York: McGraw-Hill. Fischer presents an approach to casework that bridges the gap between research and practice. He describes an eclectic approach that consists of empirically validated helping models. Fischer's "integrative model" includes components of behavior modification, cognitive procedures, and the core conditions of helping. A model for training and learning the core conditions is presented. Fisher's book represents one of the few significant references to person-centered theory in social work literature.

Greenberg, L. S., Rice, L., & Elliot, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.

Rice, L., & Greenberg, L. (Eds.). (1984). *Patterns of change: An intensive analysis of psychotherapeutic process*. New York: Guilford Press.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin. This is a classic work that helped establish Rogers and person-centered theory as a major force in American psychology. Rogers articulates the culmination of three

decades of theory development, clinical practice, and clinical research as a cohesive approach to helping and personal growth. As such, it is an excellent first reading for individuals interested in the person-centered approach.

Rogers, C. R. (1977). *Carl Rogers on personal power.* New York: Dell. Rogers describes the impact of the person-centered approach on relationships, education, administration, and political systems. He reiterates the theoretical foundation of this approach and shows how it translates into a base for political activity and what he terms the "quiet revolution." Rogers details the principles of the person-centered approach and describes a number of examples of these principles in practice, in the workplace, and in the political arena. In conclusion, Rogers offers some humanistic alternatives to polarized conflict and entrenched political structures.

Websites

Association for the Development of the Person-Centered Approach: http://www.adpca.org.

World Association for Person Centered & Experiential Psychotherapy & Counseling: http://pce-world.org

Classics in the History of Psychology, by Christopher D. Green: http://psychclassics.yorku.ca/Rogers/personality.htm.

Carl Rogers Biography: http://www.nrogers.com/carlrogersbio.html

Sofia University—Transpersonal Pioneers: http://www.sofia.edu/content/transpersonal-pioneers-carl-rogers

Person-Centered Counseling: http://www.person-centered-counseling.com/index.htm.

Personality Theories, by Dr. C. George Boeree: http://webspace.ship.edu/cgboer/rogers.html.

4

Cognitive Behavior Theory and Social Work Treatment

Ray J. Thomlison and Barbara Thomlison

The treatment of social, emotional, and behavioral problems of children, adolescents, and adults has developed remarkably in the past decades. Reviews of the evidence have consistently found that cognitive behavioral treatments produce lasting favorable changes for many problems. The purpose of this chapter on cognitive behavior therapy (CBT) is to provide the reader with an overview of this approach to social work practice. This overview is placed within the context of the development of CBT on the base of the late 1960s clinical approach known as "behavior modification." Since the earlier editions of this book (Turner, 1996), considerable change is noted in the evolution of behavior modification to behavior therapy, and then to the current concept of CBT. In large part, this has been driven by advances in research, practice, and training, and driven by the importance of increased accountability. These transitions reflect, to some degree, the movement from the early emphasis by the behaviorists on the need for clients and clinicians to focus on observable behavior. While this principle served to discipline the clinicians and provide a systematic basis for the early clinical research models, it gave way to pressures to broaden and unify various contributing elements of the impact on behavior of cognitive and affective factors. Essentially, behavior modification, behavior therapy, and CBT are similar in that they share an emphasis on client behavior as the focus for therapy. CBT, however, refers to the inclusion of thoughts and beliefs in the determination of clients' problems and their alleviation. The idea behind CBT is that if you

can change the way you think, you can change the way you feel.

A second purpose of this chapter is to acquaint the reader with a brief overview of the history of CBT. Numerous researchers and clinicians have influenced the development of CBT. To have a basic knowledge of this history is essential because it provides the clinician with a necessary understanding of the rationale for why this approach has departed from the more traditional psychotherapy approaches. In essence, CBT emerged from a commitment to the empirical study of human behavior and, specifically, conditions under which problem behaviors or maladaptive behaviors and responses are maintained, and then altered or changed. Learning new, more adaptive behaviors will lead to more rewarding behaviors. There is no single definition of CBT, as it encompasses a broad array of techniques that are based in the behavioral conditioning theories, learning theory, and cognitive theory. One factor does separate CBT from the earlier traditional psychotherapies, which is that the focus of clinical treatment is on the present. In terms of intervention, therefore, the conditions for change are viewed as being actions taken by the clients themselves and, where possible, by persons in the client's environment.

A third purpose of this chapter is to illustrate some common applications of behavior modification, behavior therapy, and CBT. Also, the authors hope to demonstrate the compatibility and applicability of CBT to social work treatment and to inspire social workers to integrate these approaches into their treatment model.

Development of Cognitive Behavior Therapy

The development of behavior therapy over the past decades has been referred to as the "Three Waves of Behavior Therapy" (Hayes, 2004; Moran, 2008). Briefly, these "waves" or groupings are divided into the early behavior-modification therapies, including the contingency management, stimulus control, exposure, and modeling approaches. The second wave reflects the major influences of cognitive theories of Aaron Beck (1976), Albert Ellis (1989), and Donald Meichenbaum (1977). Specifically, this second wave includes the cognitive approaches of rational emotive therapy, cognitive therapy, problem solving, thought stopping, and stress inoculation. The third wave, which remains somewhat controversial and challenging to the very roots of behavior therapy, comprises the three more recent therapies, identified as acceptance and commitment therapy, dialectical behavior therapy, and mindfulness-based cognitive therapy. These three therapies, as their names suggest, share the assumption that, by focusing less on painful thoughts, feelings, and experiences and accept their discomfort, one can live life by committing to important values and alternative ways of achieving one's life goals. Acceptance and mindfulness are important elements in Buddhism, in respect to the experiencing one's life situation without judgment and evaluation.

In the recent, fifth edition of their book *Contemporary Behavior Therapy,* Spiegler and Guevremont (2010) offer a succinct description of the third wave or generation of behavior therapies:

> Acceptance and commitment therapy (ACT) posits that psychological inflexibility—a narrowing of options for behaving—is at the core of psychological suffering and is maintained by six interrelated processes: (1) cognitive fusion (taking thoughts literally rather than seeing them as just thoughts); (2) attachment to the conceptualized self (how we view ourselves); (3) experiential avoidance (escape from or avoidance of unpleasant thoughts and feelings); (4) disconnection from the present moment; (5) unclear personal values, and (6) inaction with respect to values (failure to act in accord with what is personally important). These six sources of psychological inflexibility are treated in ACT to foster psychological flexibility. (p. 415)

Included in this third wave of behavior therapy is dialectical behavior therapy, developed by Marsha Linehan (1993). This therapy mode involves a relatively structured form of both individual and group therapy, and, consistent with ACT, it merges the core conditions of acceptance and change with acceptance. This approach was developed for the treatment of borderline personality disorders. The approach evolved in her work with suicidal patients, who

she concluded were overwhelmed by change expectations but who also felt their problems to be ignored by acceptance theory. The synthesis of both a structured skills training approach and acceptance of the self, she argued, provides a more effective outcome to therapy.

The third-wave applications continue to the broader field of CBT as social workers become more familiar with the theory and practice of these approaches. Importantly the efficacy of these approaches continue demonstrate impressive clinical results (Leahy, 2008; Ost, 2008). "Behavior therapy"[1] refers to the systematic application of techniques intended to facilitate behavioral changes that are based principally, but not exclusively, on the conditioning theories of learning. It is more appropriate to refer to "the behavior therapies" rather than to imply that a single method of behavior therapy exists. Behavior therapy is, however, characterized by multiple theories and techniques much like other therapies, such as psychotherapy, marital therapy, and family therapy.

Behavioral practice can trace its beginnings to the first quarter of this century in the works of Ivan Pavlov associated with respondent or classical conditioning; Thorndike, Hull, Watson, and Skinner associated with operant conditioning; and Bandura noted for contributions of social learning theory (Franks, Wilson, Kendall, & Foreyt, 1990). The contributions of Pavlov and Skinner are well documented in both the behavioral and social work literature.

Pavlov's studies of the salivation reflex of dogs are familiar to most students of human behavior. The basic experimental procedure for the learning process involved placing food within the view of the dog. Salivation was elicited, and the relationship between the unconditioned stimulus (food) and the unconditioned response (salivation) was established. An arbitrary event (stimulus)—for example, a ringing bell—was then established to occur at the same time as the presentation of the food. Over a number of such pairings, the bell (the conditioned stimulus) took on the power to elicit the response of salivation (the conditioned response). This behavioral learning process is referred to as "respondent conditioning" and remains as a foundational theoretical explanation for a variety of anxiety and phobic disorders in contemporary behavior therapy (Thomlison, 1984b).

Skinner's contribution to behavior therapy was initially motivated by a different set of objectives than those of Pavlov. Skinner was dedicated to the objective of the scientific study of human behavior. While he did not deny the possibilities of the internal mechanisms postulated by other theorists, he argued that human behavior could only be empirically investigated through the measurement of observable behavior. Underlying his approach was the belief that, if we are to use the methods of science in the field of human affairs, we must assume that behavior is lawful and determined. We must expect to discover that what an individual does is the result of specifiable conditions, and that once these conditions have been discovered, one can anticipate and to some extent determine one's actions (Skinner, 1953, p. 6). It is necessary to understand that this commitment to science set relatively stringent requirements on the pursuit of knowledge within the behavioral school, not least of which was the need to develop techniques of measurement compatible with the exploration of human behavior.

True to his commitment, Skinner evolved one of the most empirically based theories of human behavior and set the foundation for contemporary behavior therapy. At the heart of this Skinnerian theory was the concept of "reinforcement." Operant behavior (voluntary behavior) emitted by an individual could be increased in frequency of occurrence if such behavior was positively or negatively reinforced. Alternatively, the frequency of occurrence of a behavior could be decreased by either administering punishment or withholding reinforcement; this latter process being referred to as "extinction." In other words, the essence of the Skinnerian or operant model of conceptualizing human behavior relied heavily upon an understanding of the environmental (behavioral) events that preceded and/or followed the behavior(s) under scrutiny. This theoretical explanation of human behavior-acquisition has been refined and elaborated on as a result of clinical experience and research. Importantly, however, the interaction of behavior and its prior and consequent events remains

the foundation of most contemporary behavior therapy.

In addition, cognitive behavioral approaches are also regarded as part of the behavioral paradigm, and are illustrated by the contributions of Beck (1976), Ellis (1989), and Meichenbaum (1977). Cognitive approaches developed directly from behavior theory, but they are considered distinct ideas, and therefore are discussed in a separate chapter, "Cognitive Theory and Social Work Treatment," in this book.

It was not until the late 1960s that behavioral approaches appeared in social work, at the same time that psychodynamic theories were under attack. Much of the impetus and contemporary development of behavior therapy to social work is represented by the practice and research contributions of Bruce Thyer (1987a; 1988; 1989; 1990; 1991; 1992). Other significant initial social work contributors are Ray Thomlison (1972; 1981; 1982; 1984a; 1984b) for the applications of behavior theory to marital problems and phobic disorders, and its effectiveness for clinical social work practice; Richard Stuart (1971; 1977) in the development of behavior theory to deal with delinquency, marital problems, and weight management; Sheldon Rose (1981) for behavior therapy conducted in groups; and Eileen Gambrill (1977; 1983; 1994) for her work with clinical problems.

Criticisms of the Cognitive Behavioral Approach

Before proceeding with an overview of the cognitive behavioral approach and its application to problematic conditions and behaviors, several comments are in order regarding critiques leveled at the model by some clinicians. There have always been some questions raised about behavioral therapy, both within and outside the behavioral schools of thought, regarding the place of human psychological or cognitive processes. Given recognition of the increased interest in the role of cognition in shaping behavior, the debate regarding the place of cognitions in behavior therapy has centered on several assertions by traditional behaviorists. Some theorists, such as Skinner (1988) and Wolpe (1989), argued that behavior therapy was sidetracked by the inclusion of cognitively based techniques and principles. They proposed that a reliance on cognitions in behavior therapy led to a general abandonment of individualized behavior analysis in favor of treating classes of problems. Behaviorism is based upon the idea that behavior is measurable, and that behavior can be changed through the application of various behavioral principles such as classical and operant conditioning. It was thought that the empirical nature of behavior therapy was eroded through the inclusion of feelings and thoughts that were inaccessible to direct, external observation. Furthermore, some argue, analyses of research data comparing behavior therapy outcomes to those of cognitive and/or cognitive-behavioral therapy indicate that, in general, outcomes have not been improved through the addition of cognitive components to behavior therapy (Sweet & Loizeaux, 1991; Wolpe, 1989). For example, Sweet and Loizeaux (1991) reported that 83% of the 40 clinical outcome studies used in their analysis demonstrated that "no more beneficial outcome was achieved by adding therapy modules that specifically attended to cognitive-semantic variables" (p. 176). However, the efficacy of treatment methods tended to vary according to the type of problem. When follow-up versus immediate post-treatment results were considered, cognitive-behavior interventions seemed to offer longer-lasting results. The acceptance of CBT by so many clinicians is also due to the shorter-term treatment compared to other therapies. In CBT, clients see their therapist for an average of 10–16 sessions. In today's managed care world, time is money.

Another criticism concerns the focus of CBT. CBT focuses on changing flawed thought processes, as well as the behavior caused by these thoughts. If you change the way you think, then you will behave differently. It is "based on the assumption that a re-organization of one's self-statements will result in a corresponding re-organization of one's behavior" (Corey, 2009, p. 275). On the surface, it may sound simple, but simply being told that a view doesn't accurately reflect reality doesn't actually make individuals feel any better, and they may continue to worry and behave in the same way. But to suggest that a cognitive behavioral therapist merely tells the client something is wrong is to unfairly undermine the approach.

In CBT, active client participation is essential. The client and therapist, through the relationship, must work together to identify faulty thought processes and goals and then help their clients attain a more positive and healthy way of thinking about these things. Some criticize these therapists as assuming too much of an authority role, which, for many clients, is not helpful. From this perspective, some people may also feel that the therapist can be "leading" in their questioning and somewhat directive in terms of their recommendations. For clients who are comfortable with introspection and self-exploration, the basic theoretical approach of cognitive therapy may not be good match. Clients who are less comfortable with any of these approaches, or whose distress is of a more general interpersonal nature—such that it cannot easily be framed in terms of interplay between thoughts, emotions, and behaviors within a given environment—may be less well served by cognitive therapy. Currently, cognitive and cognitive-behavioral therapy is the most investigated treatment for clients suffering from depression, anxiety, panic, and obsessive-compulsive disorder. Whatever the final resolution of this debate, there is no doubt that a cognitively based behavior therapy has developed, one that is quite compatible with social work practice.

Areas of Well-Developed Cognitive Behavioral Practice

Social work clinicians need to take a close look at the support for the efficacy of CBT. An impressive and extensive research base exists for CBT, which includes over 120 randomized controlled clinical trials between 1986 and 1993 (Hollon & Beck, 1994), and 325 outcome studies on cognitive behavioral interventions for numerous disorders and problem behaviors (Butler, Chapman, Forman, & Beck, 2006). In 16 high-quality meta-analyses of a review of CBT for different disorders, CBT was identified as effective, and it was strongly suggested that across many disorders the effects are maintained for substantial periods beyond treatment termination (Butler, Chapman, Forman, & Beck, 2006). The research continues on outcome studies and on the treatment protocols and less focus placed on further research of a given disorder. The advances in CBT treatment of psychological disorders from the perspective of evidence-based practice has developed technology or procedures of behavior change that necessarily differs from disorder to disorder with more or less proven effectiveness. Furthermore, considerable clinical skill is required to apply this technology most effectively (Barlow, 2014, p. xi).

Much of the social work literature supporting the relative success of various therapies depends on anecdotal material from the case reports of social workers. Many of these accounts are unidimensional, and relatively few are based on empirical findings, with before-and-after measures, or with clear relationships established between the therapeutic intervention and client change. The cognitive behavior therapies have, on the other hand, a built-in opportunity for data collection by both social workers and clients. Behavioral procedures involve the systematic application of specific techniques intended to facilitate observable behavior change. Measurement of change is therefore an integral part of CBT. This emphasis on problem assessment and concrete indicators of progress has led to the extensive development and use of standardized measures. One example of a widely utilized behavioral measure is the Achenbach Child Behavior Checklist (Achenbach, 1991). Behavior therapy has championed the use of single-system research design (Gambrill, 1994; Hersen, 1990; Thyer & Thyer, 1992), as well as studies in group outcome research (Barrios, 1990; Kazdin, 1989).

Individual Cognitive Behavioral Therapy for Problems

Many cognitive behavioral interventions have been developed and are available to clinicians with treatment manuals for working with children and adults. These offer a highly desirable opportunity for improving social work clinical practice. Treatment manuals in which interventions are illustrated on a step-by-step basis are standardized treatments that have been empirically validated for use with precisely defined populations and problems

under clearly defined conditions. Social workers can find cognitive behavior interventions in the *Handbook of Child and Adolescent Treatment Manuals* (LeCroy, 2007), *Handbook of Prevention and Intervention Programs for Adolescent Girls* (LeCroy & Mann, 2007), and *Cognitive-Behavioral Methods for Social Workers: A Workbook* (Corcoran, 2006). This maturity and richness in empirical literature is the result of decades of clinical application of cognitive behavioral interventions and rigorous research. For example, large effect sizes have been found for CBT for unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, posttraumatic stress disorder (PTSD), childhood depressive and anxiety disorders, and internalizing and externalizing behaviors (Butler, Chapman, Forman, & Beck, 2006). Strong moderate effect sizes were found using CBT for marital distress, anger, childhood somatic disorders, and chronic pain had effect size in the moderate range (Butler, Chapman, Forman, & Beck, 2006). These findings are consistent across reviews of CBT.

The development of cognitive behavioral interventions as applied to a wider, more specific spectrum of disorders and challenging and problematic behaviors is needed. For example, CBT applications for substance abuse, bipolar disorder, personality disorders, and anorexia nervosa are among the areas receiving recent empirical attention. Evaluation of the long-term effects of CBT and the continuous evaluation of the effects of CBT compared to alternative treatments is needed. It should be noted that, for some problems, behavior therapy is routinely and effectively used in conjunction with pharmacotherapy (e.g., adult depression, attention deficit hyperactivity disorder [ADHD], obsessive-compulsive disorder [OCD]). Figure 4.1 shows selected problems and research studies identifying evidence-based practices for CBT in producing individual change with a wide range of problems.

Couples and Families: Cognitive Behavioral Therapy for Problems

Couple and family counseling are two other areas where social workers frequently utilize a behavioral approach. Jacobson (1992) asserts that cognitive behavioral interventions are the most effective in reducing marital distress. Communication, conflict-management, and problem-solving-skills building are the most common behavioral interventions used. Behavioral procedures have been demonstrated to be effective with a multitude of problems and circumstances, with diverse populations and settings. Indeed, behavioral social work treatments have been found to be superior to other treatment modalities (Shadish & Baldwin, 2005). More recently, approaches focused on couples and families, detailing the use of cognitive behavioral techniques, have been provided by Dattilio (2010). Among the strengths of this approach is the recognition of family interaction, system influences, and the need for joint interviews, elements long recognized by social workers to be essential in working with couples and families.

Group Cognitive Behavioral Therapy for Problems

Cognitive behavior approaches to group work have a recognized place in social work, primarily due to the excellent research of Rose (1981; 2004), Gambrill (1983), Tolman and Molidor (1994), and others (Gambrill, 1983) who have used the behavioral approach successfully with a variety of groups including adults and children (Finkelhor, Ormrod, Turner, & Hamby, 2005; Gamble, Elder, & Lashley, 1989; Tallant, Rose, & Tolman, 1989; Thyer, 1987b; Van der Ploeg-Stapert & Van der Ploeg, 1986). Group work often focuses on teaching assertive behaviors and other interpersonal skills. It has been used extensively in the treatment of depression, eating disorders, parent and child skills training, and addictions. Tolman and Molidor

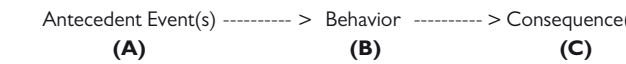

Figure 4.1 Generalized Cognitive Behavioral Paradigm

(1994) reviewed group work within social work practice throughout the 1980s. They noted that 69% of the articles reviewed had a cognitive-behavioral orientation. Child social skills training and other behavior problems of children and adolescents were the most frequently targeted fields of social work practice research reviewed that utilized cognitive behavioral group work (Jenson & Howard, 1990; LeCroy, 2007; Zimpfer, 1992).

Community Behavioral Practice

Finally, applications of behavior therapy principles to community practice have been somewhat more limited, but they have not been ignored. Importantly, however, there are numerous examples of community projects based on behavioral principles reported in the literature (Mattaini, 1993; Mattaini & McGuire, 2006; O'Donnell & Tharpe, 1990; Rothman & Thyer, 1984). Areas such as community violence or natural disasters are stressful conditions that may result in a PTSD reaction. The behavioral interventions employed are the same as those utilized for individual change (for example, modeling, feedback, contingency management). Some of the problem areas addressed through behavioral community practice have been increasing the level and quality of community participation, as well as decreasing undesirable and increasing prosocial community practices (Guide to Community Preventive Services, 2009; Mattaini & McGuire, 2006).

The current evidence overall shows CBT as efficacious for many problems compared to other treatments and relative to other approaches, with wide variety of mental health disorders and behavioral problems. Clearly, more research is needed comparing CBT with other forms of therapy. Several gaps in our knowledge and research are noted in the literature. These gaps include the maintenance and generalization of the behavioral changes. "Maintenance" refers to the durability of the behavioral change over time, whereas "generalization" refers to behavioral change in contexts different from the one in which the intervention took place. Strategies to enhance both maintenance and generalization need to become part of any behavioral change program and to be validated through empirical research (Gambrill, 1994; Kendall, 1989; Whisman, 1990). Identifying critical variables that predict which clients will benefit from which intervention procedures can be advanced by, not only looking at the clients for whom a specific behavioral procedure is effective, but also considering the clients who fail to improve from the treatment (Goldfried & Castonguay, 1993; Steketee & Chambless, 1992). The quality of efficacy and prediction research will improve if a number of common methodological problems are addressed, particularly if limitations of the meta-analytic approach are considered in the statistical analyses of the randomized clinical studies (Chambless, 2002).

Central Premises of Cognitive Behavioral Treatment Programs

Cognitive behavioral treatment is grounded on several interrelated theoretical perspectives and underlying assumptions. First, behavioral approaches to change are based on the general view that problems can be understood within a behavioral context, and that all behaviors can be changed. Therefore, problem behaviors can be replaced with more positive adaptive behaviors, as well as by improving communication and problem-solving skills. Second, cognitions (i.e., beliefs and attitudes) play a significant role in shaping behaviors. Therefore, behavioral changes should be accompanied by cognitive shifts that support long-term, adaptive change. Finally, effecting positive, meaningful behavioral and cognitive changes requires a systematic approach. Effective cognitive behavioral treatments are contingent on accurate assessment and planned intervention strategies tailored to the specific individual, with systematic, ongoing evaluation of the change. The assumptions in the following sections are central to cognitive behavioral interventions.

Assumption 1: Problem Behaviors Can Be Identified and Changed

All behavior is assumed to be learned and can be both defined and changed. It is first important to identify the problem targeted for intervention. "The problem" is formulated as

the undesirable behavior, which can be understood through systematic exploration and modified through specific behavioral techniques. Thus, personal and social problems are translated into behavior that is *observable, measurable, and changeable*. Understanding the mechanisms that reinforce behaviors is an essential early step in assessing the problem. These *contingencies of reinforcement* are identified as targets of intervention. Change occurs through rearranging contingencies of reinforcement—that is, altering what happens before and after the specified behavior. Behaviorists believe that behavioral change is brought about through changes in reinforcement by significant others in the person's environment, or environmental transactions, as well as by an enhanced perception of the self that comes from acquiring new behavior. CBT acknowledges that there is a large number of both *reinforcing and aversive events* that can be operative in any given behavioral exchange. Identifying current and alternative stimuli is essential. By changing the contingencies of reinforcement, the behavior that needs to be changed can be extinguished, or other behavior can be conditioned to replace it. The learning and changing of behavior can be understood using social learning theory. Specific approaches to using social learning theory are described later in this chapter.

Assumption 2: Cognitions Shape Behaviors

In its broadest definition, "cognition" incorporates many of the elements of human thought processes characteristically of concern to social work. Such a broad definition would include the processes by which information (input) from the environment is translated, considered, integrated, stored, retrieved, and eventually produced as some form of personal activity (output). Simply stated, how one thinks about one's experiences shapes one's experiences. Therefore, the process of examining one's attitudes, beliefs, and values is relevant for practitioners to understand, not only how clients view their own behaviors and environment, but also potential deterrents and/or motivators for change. Cognitive-behavioral practitioners have selected and explored certain cognitive elements in behavior change. The following elements of cognitive theory are used in modifying behavior:

1. *Information processing*: the acquisition, storage, and utilization of information; encompassing attention, perception, language, and memory;
2. *Beliefs and belief systems*: ideas, attitudes, and expectations about self, others, and experience;
3. *Self statements*: private monologues that influence behavior and feelings; and
4. *Problem-solving and coping*: conceptual and symbolic processes involved in arriving at effective responses to deal with problematic situation. (Schwartz, 1982, p. 269).

CBT incorporates both the behavior and cognition in the assessment and targeted intervention of cognitive processes to effect long-term behavioral change.

Assumption 3: Effecting Behavioral Change Requires a Systematic Approach

Behavioral approaches to assessment, intervention, implementation, and evaluation share a number of characteristics with the basic social work problem-solving process. Foremost, the plan for change must include a systematic process of intervention that begins with a thorough assessment of the problem and ongoing assessment of effectiveness of the intervention. In general, the goals of cognitive behavioral social work treatment are increasing desirable behaviors and reducing undesirable behaviors in order that those affected by the circumstances can improve their day-to-day and moment-to-moment functioning. As with all social work practice, *relationship* skills form the foundation to work with client systems. The basic behavioral assessment method is used to analyze the client's problem and assist in a plan of change through development of appropriate behavioral change goals. The selection of a specific intervention is based on the assessment process during which presenting problems are translated into observable behaviors. Then, specific behavior techniques and strategies to be followed are

detailed in a treatment contract to address the client's problems and circumstances.

Conducting a behavioral assessment requires a focus on the here-and-now of the problem, as well as current environmental factors related to the problem behavior. Also, a clear description of the intervention is provided, along with concrete ways to measure progress. Building on client strengths while developing new skills and increasing their knowledge-base is another characteristic of behavioral intervention. Generally, the etiology of the behavior is not investigated, nor is the provision of a diagnostic label pursued. Both of these factors are deemed stigmatizing and uninformative when considering behavioral change. Nevertheless, much of the behavioral research literature utilizes diagnostic labels (for example, agoraphobia, attention deficit disorder, and PTSD) in the description of the problem behavior under investigation. This has resulted from the integration of behavior-assessment methods with traditional psychiatric diagnostic classifications. This practice has been criticized as promoting a neglect of individual differences between clients (Gambrill, 1994; Wolpe, 1989) and potentially masking outcome differences between types of intervention (Eifert, Evans, & McKendrick, 1990).

Social Learning Theory and the A-B-C Paradigm

A classic perspective of behavioral change is the "A-B-C paradigm," which is based on social learning theory. This theory assumes that behavior is learned within social contexts and thus should be changed within the social environment. Social learning theory identifies three major elements: target behaviors, antecedents, and consequences (Bandura, 1976).

1. *Target behaviors* are the behaviors that are the focus of the behavioral analysis. These are often identified during the period of assessment as undesirable, problematic, or the behavior that needs to be changed.
2. *Antecedents and consequences* are the incidents, behaviors, or environmental events that precede or follow the problematic or target behaviors, respectively. They are often identified as the controlling or maintaining conditions for the problem behaviors. For instance, an antecedent may incite a behavior to occur, while a consequence may deter the behavior from occurring again.

These events serve as the focus of the behavioral assessment. The interaction of these three elements is described as the A-B-C behavior therapy paradigm and is represented in Table 4.1.

It must be noted that this paradigm serves to label one exchange in an ongoing sequence of exchanges between individuals. In order for the social worker to determine the antecedents and consequences, a decision as to the problem or target behavior must first be made. With this target behavior in mind, the social worker then identifies the events or behaviors that precede or follow the target behavior. This identification process is usually done by direct observation by the social worker or by client self-report. This process is known as *behavioral analysis* and is considered essential to effective behavior therapy.

To illustrate the application of this social learning paradigm in a behavior therapy assessment and change program, a common parent–child behavioral exchange is as follows: Mr. S. complains that his child, Josh, will "never do what he is told." One of the concerns is that Josh will not come to the dinner table when he is called. The presenting situation, as explained by Mr. S., is shown in Table 4.2.

In order to assess the behavior further, it is generally necessary to examine the nature of the consequences that might be provided for Josh. Behavioral consequences differ in terms of their quality and purpose. Some are of a positive (pleasing) nature, while others are of a negative (displeasing) variety. The former category is referred to as *positive consequences,* which are employed to increase the occurrence of a behavior. The latter category is usually referred to as *punishments* and are frequently observed when a parent attempts to prevent the recurrence of an undesired behavior by spanking the child; that is, using physical punishment. While the use of physical punishment as a consequence is acknowledged as a means of decreasing the frequency of a behavior, it is viewed by behavioral social workers as an unacceptable means of altering behavior. In addition to humanitarian

Table 4.1 Empirically Supported Behavioral Treatment Problems

Problem Area	Empirical Research*
Addictions	Acierno, Donohue, & Kogan, 1994; Goldapple & Montgomery, 1993; Hall, Hall, & Ginsberg, 1990; Lipsey & Wilson, 1993; Peyrot, Yen, & Baldassano, 1994; Polansky & Horan, 1993; Sobell, Sobell, & Nirenberg, 1988
Anxiety disorders	Acierno, Hersen, & Van Hasselt, 1993; Beck & Zebb, 1994; Butler, Chapman, Forman, & Beck, 2006; Emmelkamp & Gerlsma, 1994; Lipsey & Wilson, 1993; Mitte, 2005; Rachmann, 1993; Van Oppen, De Haan, Van Balkom, Spinhoven, Hoogdin, & Van Dyck, 1995
Attention deficit hyperactivity	Fabiano, Pelham, Coles, Chronis-Tuscano, O'Connor, & Gnagy, 2009
Autism	Celiberti & Harris, 1993; Ducharme, Lucas, & Pontes, 1994; McEachin, Smith, & Lovaas, 1993; Reichow & Wolery, 2009; Scheibman, Koegel, Charlop, & Egel, 1990
Child maltreatment	Centers for Disease Control, 2009; Gambrill, 1983; Finkelhor & Berliner, 1995; Gaudin, 1993; Lundahl, Nimer, & Parsons, 2006; Meadowcroft, Thomlison, & Chamberlain, 1994; Wekerle & Wolfe, 1993; Wolfe, 1990; Wolfe & Wekerle, 1993
Conduct disorders	Bramlett, Wodarski, & Thyer, 1991; Christophersen & Finney, 1993; Dumas, 1989; Kazdin, 1990; Lochman & Lenhart, 1993; Maag & Kotlash, 1994; Magen & Rose, 1994; Raines & Foy, 1994
Couple problems	Granvold, 1994; Epstein, Baucom, & Rankin, 1993; Halford, Sanders, & Behrens, 1994; Hahlweg & Markman, 1988; Lipsey & Wilson, 1993; Montang & Wilson, 1992; O'Farrell, 1994; Thomlison, 1984a
Depression	Beach, Whisman, & O'Leary, 1994; Frame & Cooper, 1993; Hoberman & Clarke, 1993; Norman & Lowry, 1995; Rohde, Lewinsohn, & Seeley, 1994
Developmental disabilities	Butler, Chapman, Forman, & Beck, 2006; Feldman, 1994; Hile & Derochers, 1993; Kirkham, 1993; Nixon & Singer, 1993; Thomlison, 1981; Underwood & Thyer, 1990
Eating disorders	Garner & Rosen, 1990; Isreal, 1990; Kennedy, Katz, Neitzert, Ralevski, & Mendlowitz, 1995; Lipsey & Wilson, 1993; Morin, Winter, Besalel, & Azrin, 1987; Saunders & Saunders, 1993; Wilson, 1994
Family violence	Edleson & Syers, 1990, 1991; Faulkner, Stoltenberg, Cogen, Nolder, & Shooter, 1992; Peled & Edleson, 1992; Tolman & Bennett, 1990
Gerontology	Fisher & Carstensen, 1990; Hersen & Van Hasselt, 1992; Nicholson & Blanchard, 1993; Widner & Zeichner, 1993
Juvenile delinquency	Bank, Marlowe, Reid, Patterson, & Weinrott, 1991; Hagan & King, 1992; Lipsey & Wilson, 1993; Meadowcroft, Thomlison, & Chamberlain, 1994; Zimpfer, 1992
Obsessive compulsive disorder	Franklin & Foa, 2014; Watson & Rees, 2008
Pain management	Biederman & Schefft, 1994; Gamsa, 1994; Holroyd & Penzien, 1994; Lipsey & Wilson, 1993; Subramanian, 1991, 1994
Phobic disorders	Donohue, Van Hasselt, & Hersen, 1994; King, 1993; Newman, Hofman, Trabert, Roth, & Taylor, 1994; Turner, Beidel, & Cooley-Quille, 1995
Post-traumatic stress	Butler, Chapman, Forman, & Beck, 2006; Caddell & Drabman, 1993; Corrigan, 1991; Mitte, 2005; Monson, Resnick, & Rizvi, 2014; Richards, Lovell, & Marks, 1994; Roberts, Kitchiner, Kenardy, & Bisson, 2009; Saigh, 1992
Psychosis	Liberman, Kopelowicz, & Young, 1994; Lipsey & Wilson, 1993; Morrison & Sayers, 1993; Scotti, McMorrow, & Trawitzki, 1993; Tarrier, Beckett, Harwood, Baker, Yusupoff, & Ugarteburu, 1993
Sexual deviance	Camp & Thyer, 1993; Hanson, Steffy, & Gauthier, 1993; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Kaplan, Morales, & Becker, 1993; Marques, Day, Nelson, & West, 1994
Sleep disturbances	Lichstein & Riedel, 1994; Minde, Popiel, Leos, & Falkner, 1993
Stress management	Dubbert, 1995; Lipsey & Wilson, 1993
Substance abuse	Dutra, Stathopoulou, Basden, Leyro, & Powers, & Ottow, 2008; Powers, Vedel, & Emmelkamp, 2008

*When possible, review articles and research directly applicable to social work practice were selected.

Table 4.2 Application of the A-B-C Paradigm

	Antecedents (A)	Behavior (B)	Consequences (C)
Behavioral Analysis of Presenting Situation	Mr. S. calls Josh several times to the table. There is an escalation of threats and yelling when Josh does not immediately respond.	Josh ignores his father's first requests but eventually presents himself angrily at the table and begins to eat.	Father is silent and appears angry.
Behavior Change Contract	Mr. S. makes one verbal request in a pleasant tone for Josh to come to the table.	Josh comes to the table when called.	When Josh arrives at the table as requested, Mr. S. verbally praises Josh and places a check mark on Josh's tally sheet. If Josh chooses not to respond to his father's request, Mr. S. will begin eating alone, ignoring Josh's absence. Josh will forego the opportunity for his father's praise and tangible, positive acknowledgement for this dinner time.

reasons, physical punishment is generally considered unacceptable because in many instances it suppresses a behavior without providing an alternative, more desirable behavior. Behavior therapy requires that any agreed behavioral change must be defined in terms that are recognized to be desirable and to be increased in frequency by the participants. This requires that all parties to a behavioral change contract define what behaviors are desired, not simply what is undesired. This is often a difficult requirement, as it is almost always easier to tell someone to stop doing something that is undesirable than it is to them to engage in a desired behavioral alternative. The use of positive consequences to increase desirable behavior is the strength of the social learning approach to behavior therapy. The research strongly supports the use of positive consequences as a means of facilitating desired behavior. However, it is not always easy to put this principle into practice. For example, Mr. S. may feel that, if Josh would do what he was told, then all would be okay, but until Josh changes, Mr. S. feels he cannot give Josh any positive messages or praise. Unfortunately, Josh and his father have reached a stalemate wherein, even if they agree that change is desirable, it is difficult because they are into a *coercive exchange* (Patterson & Reid, 1970).

Attempting to control another person's behavior by command and threat is familiar to most of us. In many instances, however, it has the effect demonstrated by Josh and his father. The commands and threats escalate until finally the child complies in order to terminate the threats and/or yelling. By the time the child obeys the parent's command, the parent has become agitated enough to lose any motivation to acknowledge, in positive terms, the child's compliance. This coercive process, then, can be conceptualized using Skinner's notion of a *negative reinforcement process*—this is the termination of a behavior (threats) upon occurrence of the desired behavior (compliance); and *extinction process*—that is, the withholding of a positive reinforcer upon the occurrence of the desired behavior (compliance); as well as a *positive reinforcement process*—that is, Mr. S. achieves what he set out to get (compliance).

In other words, when Josh cooperated as he was asked to do—for example, sat down at the table—his father chose to ignore his compliant behavior. On the other hand, Mr. S. achieved his objective and to some degree was positively

reinforced, except for the feelings of frustration and anger. The difficulty is that one person (Josh) is being negatively reinforced, and the other (Mr. S.) is being positively reinforced. This behavioral exchange will therefore be strengthened and can be predicted to increase in frequency unless an alternative exchange can be identified and practiced by both.

In order to help Josh and his father alter their undesirable interaction, the social worker will need to help by devising a program by which the father can give a clear cue or instruction to Josh and award positive consequences to Josh if he complies by arriving at the dinner table at the desired time. Intervention requires that a target behavior for desired change be clearly identified. In this case, such a target might be labeled as "Josh's coming to the table when called." New antecedents or instructions would be identified, as well as new consequences for this new target behavior. An agreement to change might well be formalized as a contractual statement detailing the new behavioral target, its antecedents, and its consequences (see Table 4.2, "Application of the A-B-C Paradigm").

This brief example serves to demonstrate the basic procedures of assessment and intervention in accordance with the A-B-C paradigm. While the overall behavior therapy program would require a more detailed assessment and a more comprehensive intervention strategy, behavior, and its controlling antecedents and consequences, remains the focus of this approach.

Behavioral Social Work Practice

The most common behavior therapy techniques social workers use include:

1. Cognitive behavioral procedures such as cognitive restructuring, self-instructional training, thought stopping, and stress-inoculation training;
2. Assertiveness training; improves communication skills in personal, work, and other relations in how one expresses rights, requests, opinions, and feelings, honestly, and directly through body language and self-awareness;
3. Systematic desensitization; and variants of this procedure such as eye movement desensitization, procedures involving strong anxiety evocation (e.g., flooding, paradoxical intention), operant-conditioning methods (e.g., extinction, positive or negative reinforcement); and
4. Aversion therapy; inducing dislike of the problem behavior, but a method that is less respected, although historically used in addiction and paraphilias.

Each of these approaches requires a more extensive discussion than is possible here. Books on behavior theory and practice will provide descriptions of the application of these procedures and their effectiveness (Corcoran, 2006; Franks, Wilson, Kendall, & Foreyt, 1990; Granvold, 1994; LeCroy, 2007; Sundel & Sundel, 1993; Thomlison, 1984b, 1986; Thyer, 1992; Wolpe, 1990). The choice of a specific intervention method should be based on a careful assessment of client need and the empirically determined effectiveness of a procedure to meet that need (see Table 4.1, "Empirically Supported Behavioral Treatment Problems").

Cognitive Behavioral Assessment and Intervention

Behavior therapy provides a planned, systematic approach to social work intervention. Indeed, there are specific stages through which all behavior therapy must proceed. While there is a range of activities that are specific to each of the different behavior therapy approaches, there is also a basic set of general procedures that serve as a framework. It is important to remember, however, that this framework is essentially a summary of a behavior therapy approach and is based primarily on the social learning paradigm. The procedural outline is based on the authors' practice and research with married couples, children, and families. Since much of clinical social work practice is carried out in the context of the family, the outline is presented as an approach to working with the family system.

Beyond the procedural steps identified here, it is important to emphasize that behavioral social workers strongly believe that it is important to build a positive therapeutic relationship early in the client's contact with the client system and actively involve the client as much as possible in each step of the assessment

and intervention. The importance of this relationship building is not to be underestimated, as it establishes trust, rapport, and the necessary support for the analysis and management of problem behavior. Once the client system is engaged through the relationship, behavioral procedures can occur. A behavioral assessment to determine the client's problems is the next step.

Assessment

Social workers will use procedures during a behavioral assessment. The goal is to define as clearly as possible the problems or events targeted for change, and the desired outcome.

1. *Compilation of the problematic behavior inventory.*
   (a) Begin by asking one member of the family group to identify the perceived problems that have resulted in the meeting.
   (b) Clarify these perceived problems by asking for behaviorally specific examples. Most perceived problems can be translated into statements of "who does what to whom" within what context.
   (c) As each family member offers their perception of the problem, there is a high probability that the ensuing discussion will stimulate disagreements among family members. It is important to observe who disagrees with whom, and over what behavioral statements. Therefore, these interchanges must be allowed to occur; however, they can become counterproductive to the objective of the assessment, and you must reconcile discrepancies. When this occurs, the social worker should intervene, requesting the family members to terminate the debate, yet acknowledging that differences of opinion are expected. Assure all family members that their perceptions of the problems are important and that each member will have an opportunity to present personal views.
2. *Identify priority behavioral problems and their maintaining conditions.*
   (a) Attempt to identify the antecedent events of at least the behaviors that arouse the most intense feelings among family members. Antecedent events are the conditions that exist immediately prior to the occurrence of the target behavior; e.g., what other members of the family are doing or not doing prior to the occurrence of an undesired behavior.
   (b) Identify the consequences of the problem behaviors that elicit the more intense family feelings. Identify the consequences of the events that occur after a target behavior; e.g., what other family members do after one of the problem behaviors has occurred.
3. *Identify the contingencies existent for the provision of consequences.* That is, what rules appear to govern the conditions under which these consequences are provided? For example, find out when a child is reprimanded versus when he is not, or when privileges are withdrawn versus when they are not.
4. *Observe and record behavioral exchanges.* Identify recurrent behavior patterns in the exchanges among the family members. These behaviors will include coercive exchanges, shouting, avoidance responses, excessive demands, etc.
5. *Secure a commitment from each member of the family system, ensuring that they wish to work toward change.* This commitment should clearly explicate: (a) that they will work as a unit on these family problems, and (b) that they, as individuals, will work toward behavioral change. At this point in the assessment procedure, the social worker should be able to demonstrate to the family the interconnections of their individual behaviors in that, when one individual behaves, all family members must respond in the same manner; that is, behaviors do not occur in isolation. For example, when the adolescent youth repeatedly violates her curfew, the resultant parent–youth conflict affects all members of the family.
6. *Begin to identify possible behavior targets for change.* The target behaviors should be desirable behaviors with the objective of increasing their frequency of occurrence. This identification is often assisted by asking

each family member to answer two questions: "How could you behave differently to make this a happier family?" "How would you like to see others behave to make this a happier family?"

Homework Assignments

These questions may be given as homework assignments, with the instructions that each family member provide as many answers as possible to each question. The social worker should point out to the family members that this assignment is a challenge, as it requires the identification of desired behaviors. Individuals are more often accustomed to identifying what behaviors they do *not* like to see, rather than those they prefer. Homework is used to reinforce the new thinking and behaviors that are introduced during the session.

7. On the basis of the family's homework assignment, discuss possible appropriate behavioral targets for change.
   (a) Select behaviors that are to be accelerated in frequency in order to maximize the opportunities for positive consequences.
   (b) Select behaviors that appear to be most relevant to enhancing this family's definition of its own happiness.
   (c) Strive to select behaviors that are incompatible with the occurrence of undesirable (problematic) behaviors.
   (d) For each child, select at least one behavior that is low-risk for change. A *low-risk behavioral target* is one that be easily attained by the child and one that, if performed by the child without positive reinforcement (a violation of the change contract), will not jeopardize the growing trust of the child. An example of a child's low-risk target behavior change might be combing her hair in the morning, or cleaning up after dinner each evening.
   (e) Attempt to select behaviors that are commonly identified among family members; e.g., mealtime behavior, family get-together, tidying-up cooperation, playtime with siblings or peers.
   (f) Remember that a behavior must be *observable* to all; therefore, it is necessary to explicate the indicators of some behaviors in order to minimize debates over whether the behavior has actually occurred. For many parents, the behavior of cleaning up the child's room is a desired behavior-change objective. Interestingly, what appears to be a very clear behavior has a great deal of opportunity for individual interpretation. It is therefore necessary to pinpoint such behaviors as picking up clothes, placing them in the appropriate locations, making the bed, placing trash in appropriate containers, and so on.
8. *Commitment for change*. Allow time for all family members to present their concerns and their support for the target behaviors. Certain behavior choices will elicit strong feelings from some family members. *Negotiation* must take place before selected behaviors are settled upon and must always take place within the spirit of the agreement, acceptance, or commitment for change. If one or more family member wishes to reevaluate this commitment in light of the selected targets for change, then this request must be honored. Such reevaluation may have to take place within the context of the consequences of no change; that is, all persons have a right not to be required not to change. There are, however, certain consequences for not changing. What are they for the individual and the family?
9. *Record baseline data/information*. When target behaviors have been agreed upon, set the conditions for a baseline measure.
   (a) Before instructing the family to change, request that the parents monitor the frequency of occurrence of the target behaviors. This will allow for some "before =" or baseline behavior frequency measures. These measures should be recorded and can be used at a later date to assess the ongoing behavioral change within the family.
   (b) Appoint the parents as the monitors of the behavior targets. Give the parents a tally sheet and instructions to record the frequency of occurrence of each target behavior.

10. *Behavioral intervention is compatible with the assessment in progress.* Throughout the assessment phase, the social worker may identify problems with an individual or the couple that require specific attention. On occasion, the assessment period indicates that the change process should be focused on the couple rather than on the child. With the couple's agreement, the intervention may be temporarily suspended in light of the recognized need to concentrate on the couple's problems.

Intervention

The intervention or implementation phase of a behavioral therapy program is marked by the identification of new contingencies between identified behaviors and their consequences. To this point, the focus has been on the appropriate targeting of behaviors for change. At the time a program for change is to be implemented, a *contingency contract* might be formulated in order to facilitate a systematic, cooperative effort by the family in facilitating change.

1. Clearly identify the target behaviors that have been agreed upon as the focus for change.
2. Establish new antecedent events for each of these target behaviors.
3. Establish new consequences that are to be provided for each occurrence or nonoccurrence of a targeted behavior.
4. Formulate a written contract specifying the following conditions:
   (a) The target behaviors for change and their pinpointed elements.
   (b) New antecedents. If these are to be instructions, then specify by whom these instructions are to be given.
   (c) New positive consequences that might include the tangible *check marks and/or tokens* provided upon behavioral occurrence, as well a *social reinforcer* such as affection and praise.
   (d) Specify what is to happen if there is a violation of the contract; that is, if a behavior does not occur, or an undesired behavior occurs, then it must be clear what others in the family are to do. For example, if a target behavior focuses on "good dinner time behavior" and one or more of the children violate this agreement, then all family members must be clear about what is to happen when unacceptable behavior occurs at the dinner table.
   (e) Specify the positive consequences that are to act as *bonus reinforcers*, particularly when certain behavioral objectives are accomplished. For example, it is often helpful to include special privileges, such as family outings, as bonus reinforcers for a designated behavioral achievement; such as a target behavior that occurs at the desired level for a period of one week or more.
   (f) Specify the persons in the family unit who are to be responsible for *recording* the frequency of behavioral occurrences. This is usually one or both of the parents. These *tally records* are important in communicating to the family members the degree and intensity of change.
   (g) Contracts may be written in various ways, but they must all contain the condition: Who does what to whom, under what conditions! Many different examples of contracts may be found in the literature.
5. After a program has been implemented, it is necessary to follow up with a series of telephone calls to ensure that the program is being implemented. In addition, these telephone calls provide the opportunity for members of the family, particularly the parents, to ask any questions that might have arisen as a result of implementing the program for change. These calls need not take long and should be limited only to the pragmatics of the program implementation. Any conflict among family members reported at this time should be directed back to the family for resolution. If resolution is not possible, the persons in charge of recording should make note of the nature of the conflict and the context in which it occurs. This will be dealt with at the next meeting with the social worker.
6. Difficulties in implementing the program are inevitable. These problems usually pertain to such things as tally recording, differences in target behavior definitions, and lack of cooperation by certain family

members. In order to deal with these problems, the social worker must remember that the contract is the reference point. Once it is agreed to, all problems arising with the behavioral changes must relate to the original document. Changes in the contract must be negotiated by all members of the family. Remember that all problems related to the implementation of and adherence to a contract for family interactional modification may eventually have to be related back to the original commitment for change agreed to by the family during the assessment period.

7. Each interview with the family after implementation should begin with an examination of the tally recording provided by the family members. Where change is evident in these data, the social worker must provide positive reinforcement by acknowledging the change and the hard work of all family members.
8. Discussion must then shift to focusing on problems arising between sessions. These discussions may flow to more general aspects of the family's functioning, and special techniques such as *role playing, modeling*, and *behavioral rehearsal* may be introduced in an effort to assist the family in dealing with these problems.
9. Since much of the family's energy goes into *problem-solving activity* and *conflict resolution*, the social worker must spend time on these areas of family life. One of the advantages of having required the family to negotiate a contingency contract is that they have experienced a process of successful problem-solving and negotiation. Examples derived from that process can be utilized in the ongoing problem-solving and conflict-resolution training.
10. Where the *monitoring of change* has indicated that little if any change is taking place, it is necessary to examine certain aspects of the program design. Depending on the area in which the program is failing, it will be necessary to consider changes in target behavior, consequences, and violations of the contract. It is often necessary to assess whether people are in fact following through on the requirements of the contract. For example, it might be that a parent has agreed to read a bedtime story for successful achievement of a behavioral objective during the day, but fails to deliver.
11. When target behaviors have been achieved at the desired level of frequency, it is time to identify new behaviors for change, or move toward termination of the behavioral therapy program.

Evaluation for Maintenance of Change

1. Together with the family system, evaluate the progress in relation to the objectives of the contract.
2. If the decision is to terminate, then set the conditions for behavioral maintenance.
3. Behavioral maintenance requires the social worker to review with the family the basic learning principles identified during the modification of the target behaviors, such as giving positive consequences versus punishment.
4. Instruct the family to continue the tally recording over the next four weeks but without the regularly scheduled appointments.
5. Set up an appointment for four weeks from the last interview for termination and follow-up.

Follow-up

The follow-up interview should be an assessment interview related to whether or not the behavioral changes have been maintained. If these changes have not been maintained at a level consistent with the expectations of the social worker and/or the family, it will be necessary to reinstitute the program structure. If, on the other hand, the social worker and family think that the behavioral changes have been maintained within desired parameters, then termination may take place. Termination, of course, does allow for the family to contact the social worker at any point in the future where they feel the need.

From the perspective of clinical evaluation, it is important that the social worker analyze the results of the behavioral change program. Furthermore, it is helpful for the social worker to assess the maintenance of change by contacting

the family members at a three-month and a six-month interval to ascertain the degree to which the behavioral changes have been maintained.

Implementation Considerations in Cognitive Behavioral Interventions

It is widely acknowledged that CBT reliably produces desirable effects, but does it work with everyone? Examples of designated evidence-based cognitive behavior therapeutic interventions include applications to anxiety (Butler, Chapman, Forman, & Beck, 2006; Mitte, 2005a, 2005b); attention-hyperactivity (Fabiano, Pelham, Coles, Chronis-Tuscano, O'Connor, & Gnagy, 2009); depression (Butler, et al. 2006); substance abuse (Powers, Vedel, & Emmelkamp, 2008); obsessive compulsive disorder (Watson & Rees, 2008); schizophrenia (Zimmermann, Favrod, Trieu, & Pomini, 2005); phobias (Mitte, 2005); couples (Shadish & Baldwin, 2005), and others. For a more complete review, the reader is directed to Dobson and Dobson (2009).

During the past two decades, one of the most important areas of behavioral practice to emerge has been that of dealing with parenting, parent training, and child management and skill acquisition. Using the basic A-B-C paradigm, many childhood problems have been reconceptualized as behavioral problems resulting from interactional exchanges between children and parents. By systematically altering these exchanges in the context of behavior therapy, it has repeatedly been demonstrated that both parental and child behavior can be altered toward desired objectives (Dangel, Yu, Slot, & Fashimpar, 1994; Graziano & Diament, 1992; Sundel & Sundel, 1993). Typical child problems addressed using behavioral techniques include noncompliance, chore completion, enuresis, eating disorders, interrupting, fire-setting, sleep problems and bedtime anxieties, and hyperactivity (Butterfield & Cobb, 1994). Conduct disorders or antisocial behaviors in children have received considerable clinical and research attention in the past decade. Behavioral techniques have been demonstrated as effective in changing these behaviors (Christophersen & Finney, 1993; Doren, 1993; Jensen & Howard, 1990; Kazdin, 1990). It has been estimated that 3–5% of school-age children have attention deficit-hyperactivity disorder (ADHD), which has been identified as a risk factor in conduct disturbance and antisocial behavior (DuPaul, Guevremont, & Barkley, 1991). Social workers encounter these children and adolescents within the program contexts of child welfare, treatment foster care, juvenile incarceration, therapeutic day programs, residential and school-based programs (Centers for Disease Control and Prevention [CDC], 2009; Meadowcroft, Thomlison, & Chamberlain, 1994).

Home-based interventions with families and children are the preferred intervention setting for many child- and parent-related problems (CDC, 2009). The focus is on family interaction supported by the social learning model. Maltreatment or risk of maltreatment of children by primary caretakers has become a focus of in-home intervention. Problem-solving and skills training for parents usually includes child-management skills, anger management, and addressing parents' issues involving substance abuse, communication difficulties, and social isolation (CDC, 2009; Gambrill, 1994; Hodges, 1994; Kaminski, Valle, Filene, & Boyle, 2008).

Since the late 1950s, the treatment of choice for many professionals working with anxiety and phobic-disordered clients has been Joseph Wolpe's (1990) "systematic desensitization." Clients suffering from the inhibitory effects of phobic disorders have been the subjects of a great deal of effective intervention by behavioral social workers. Combined with the basic systematic desensitization, new cognitive-behavioral approaches are promising even more effective outcomes. In fact, it is now to the point where a social worker would be hard pressed to make an argument for an alternate treatment method for any of the phobic disorders.

At the same time, there is a serious problem concerning the slow and incomplete transfer of these evidence-based findings into day-to-day social work clinical practice (Fixsen, Blase, Naoom, & Wallace, 2009). Examining the quantity of behavioral articles in social work journals and books, behavioral social work has been characterized as a "major school of practice" (Thyer, 1991, p. 1). In a survey of clinical social workers, one-third of the practitioners

who participated in the study preferred a behavioral approach to their practice (Thyer, 1987a). Social workers reported that behavioral interventions were most influential when applied to disorders such as anxiety, depression, phobias, addictions, sexual dysfunction, and relationship distress. Nevertheless, many misconceptions about behavior therapy continue to persist and may account for why more social workers do not employ evidence-based behavioral strategies in practice.

Education and Training

Training for behavior therapy occurs in a variety of educational contexts. The content, format, and objectives of behavior training vary widely (Alberts & Edelstein, 1990). A social work curriculum generally provides an overview of behavioral change principles and techniques but not detailed training (Thyer & Maddox, 1988). More intensive training may be offered in organizations or treatment settings to social workers, foster parents, and teachers of child and family centers and schools. Given the emphasis on evidence-based processes, the efficacy of behavioral methods, and the extensive application to problems identified in clinical practice, an argument can be made for the inclusion of CBT as part of the core curriculum in social work education. As evidence-based practice—it works!

Culturally Responsive Behavioral Practice

Concern for the needs of culturally different groups has received attention from behavior therapists as the population has increasingly become more diverse. Behavior theory, like many practice theories, emerged from Western cultural values, assumptions, and philosophy. In reality, both clients and behavioral social workers are racially and ethnically diverse. Efforts to offer ethnically sensitive social work practice are very much affected by the political, social, and economic power, and status of each group and setting. Disparities are well documented and barriers exist in terms of accessibility and participation in social work interventions. Barriers include philosophical and values differences, languages, as well as individual and organizational structures associated with Western helping systems (Corcoran & Vandiver, 1996).

Working with culturally diverse individuals involves recognizing diversity in both the context and behavior of individuals. Each cultural group develops its own coping strategies for problems, and like any identified group, cultural groups are not homogeneous. Its profile originates from the group's cultural values, history, rituals, religion, migration experiences, organization and family systems, and class values and norms (Devore & Schlesinger, 1996). Pay attention to the levels of assimilation, and factors such as language, religion, lifestyle, expectations, and attitudes toward helping (Thomlison, 2010). Many of the techniques used by Western-trained behavioral social workers may employ strategies that run counter to the values, beliefs, and family traditions of the cultural group. For example, an understanding of time is critical to the concept of shaping, reinforcement schedules, and extinction. This concept may be understood differently by those who measure time by activities. Also, what constitutes problematic behavior, help-seeking behavior, and inappropriate behaviors is interwoven into a Western culture perspective of the person, and what behaviors, thoughts, and feelings make up the person. Many behavioral social workers argue, however, that on a theoretical basis, the principles underlying behavior cross the boundaries of culture. The main concern actually is the fact that the assumptions beneath principles of learning are not universally accepted. For example, a positive reinforcer, operationally defined as an event that increases behavior frequency, would not be culturally determined, albeit a specific positive reinforcer such as TV watching, which works in one culture may not work in another.

It is therefore very important for behavioral social workers at the beginning of assessment to understand how the concept of family and the individuals who constitute a family are defined in a given culture and recognize that individuals make different choices based on their culture (Thomlison, 2010). If social workers mislabel behavioral interactions, then interventions can compound rather than resolve parenting

dilemmas or other problematic behaviors. Therefore, interventions should be carefully sculpted to fit the client's cultural orientations and preferences. It requires modification of existing interventions and understandings of behavior, so that behaviors are grounded in local contexts for understanding (Landrine & Klonoff, 1995).

It is suggested that organizations in ethnic and diverse communities ensure that services have diversity represented in the social work staff and that staff have a high level of self-awareness and openness. Behavioral social workers need to remember that individuals develop problem-solving styles that fit their culture and values, and therefore solutions must fit the cultural attributes of diverse populations. In summary, current research of the relationship between cultural competencies, behavior theory, and outcomes requires further study.

Conclusions

This chapter has taken the reader through the evidence-based world of cognitive-behavioral therapy and discussed how to proceed with assessment and intervention in social worker practice. Evidence has accumulated for the efficacy of a variety of treatments for mental health and behavioral problems, and the application of cognitive-behavioral practices to real-world clinical practices is possible. As for final thoughts, we conclude with the following summary:

1. CBT is action-oriented and relies heavily on an educational focus for client change. For those who want insight or talking psychotherapy, this approach is not appropriate.
2. The focus is on behavior and/or cognitive change, or both, and generally requires a structured approach to change by both client and therapist.
3. Some non-professionals and professionals misunderstand or misrepresent the approach, seeing it as very simple and a quick fix for complex problems. Such misunderstanding is probably most often illustrated by inappropriately designed child-management programs that rely on aversive methods of punishment for undesired behavior, often coupled with the unsystematic use of rewards for compliant behavior. Such interventions are devoid of the elements of behavior analysis and the systematic use of behavioral techniques that is essential for successful behavioral change.
4. The behavior therapies are often thought to be derived from a homogeneous theory, when in fact they are made up of numerous theories of behavior with an array of optional intervention strategies and techniques. Many social workers fail to understand that different approaches are often available for specific problems identified through the process of behavioral assessment. Matching technique to problem is essential. Differential applications relate to the problem and are guided by the behavioral analysis of the conditions under which the problem behavior occurs.
5. Cognitive behavioral techniques depend on relationship development and sensitivity to the client's needs.
6. Because CBT has been applied to clients who have severe, debilitating or difficult-to-treat conditions, ethical considerations play a prominent role in behavior therapy. Many programs have established protective mechanisms, such as treatment-review processes, to address the issues of utilizing aversive procedures, determining appropriate individualized assessment and intervention, and keeping written records and assessment checklists and questionnaires (Sundel & Sundel, 1993).

To summarize then, CBT, as it has been presented here, comprises a variety of distinctly different approaches to facilitating behavioral and, in some cases, cognitive changes. It has been developed from a strong commitment to planned and systematic assessment, a distinct strength over other therapeutic models of change. Intervention strategies evolve from the prescriptive approach to assessment, within a context of empirical inquiry, utilizing nominal and ratio levels of measurement to establish the frequency and duration of problems. Its impact on social work practice continues to be felt, both directly in clinical practice and indirectly in practice areas such as task-centered approaches, as well

as in single-system designs in research, and evidence-based processes. Behavior therapy has been demonstrated to be effective in most areas of social work practice. Behavior theory as an effective therapeutic intervention is well established, and it can be argued that behavior theory is the most advisable therapeutic option. CBT will be invaluable to social workers in every practice situation.

Note

1. Some argue that the concepts of "behavior therapy" and "behavior modification" are differentially applied (Franks, Wilson, Kendall, & Foreyt, 1990). For this chapter, we prefer "behavior therapy," but the concepts will be used synonymously.

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5

Cognitive Theory and Social Work Treatment

Pranab Chatterjee and Suzanne Brown

The famous French philosopher Rene Descartes (1596–1650) made a statement that has become well known in the annals of intellectual history: "I think, therefore, I am" (Descartes, 2014). This statement guides one to the area of human thought, ways of organizing and classifying human thought, and the various forms of behavior that are then influenced by it. It is this study of human thought and consequent behavior that has come to be known in modern social sciences as "cognitive theory." Social work and other helping professions use this theory for interventions with individuals, families, groups, communities, and organizations.

A dictionary definition of the word "cognition" is "the process of knowing, or the capacity for it" (Merriam & Merriam, 1957, p. 160). The term "cognitive theory" has come to mean the art and science of understanding how humans perceive, think, and process various forms of information and then respond to them. It has emerged as a discipline in sociology, anthropology, sociobiology, psychology, biology, sociolinguistics, and social work. It engages in the study of how humans reason, make judgments, make decisions, and engage in problem solving. It includes how the human mind forms concepts that help us respond to various forms of situations.

The development of cognitive theory has been significantly influenced by the fields of computer and information technology, with their interest in information-processing and memory. Alternative forms of intelligence, logic, and memory were applied by theorists to the human mind and its processing of memory and cognition. In the social sciences, the rise in popularity of "logical positivism," with

its focus on phenomena that are empirically verifiable, also contributed significantly to the development of cognitive theory and interventions. In the social sciences, logical positivism encouraged movement away from a belief in internal drives and unconscious forces as causes for human behavior. It pointed toward more observable and measurable phenomena such as environmental events and internal identifiable cognitions. The "personal construct theory" of George Kelly (1958), with its focus on interpretation and reasoning, further influenced the development of cognitive theory and interventions (Walsh, 2008). Of special importance here is Kelly's notion of "personal constructs" (1955), referring to how individuals learn, create, and use important ideas to understand social realities.

Kelly (1955) identified three primary construct types, or "frames," through which individuals interpret the world: preemptive constructs, constellatory constructs, and propositional constructs. The "preemptive constructs" prevent the reexamination or reintegration of new information, and allow individuals and events to be placed only in one realm (Hjelle & Ziegler, 1976). Once an opinion has been made, new information is not utilized to change or modify that opinion, and once a label is applied to a person or event, that label remains fixed. Rigid or fundamentalist belief systems may be considered to be preemptive constructs. In psychological terms, the concept of learned helplessness (cf. Seligman, 1992; Peterson & Ma, 1993) may be considered a preemptive construct. Individuals with learned helplessness have taught themselves over time that their actions are always ineffective, leading to hopelessness and a sense of helplessness in the face of problems. For these individuals, the preemptive construct of helplessness prevents them from considering alternative actions and generating effective solutions to problems.

Like preemptive constructs, Kelly's (1955) "constellatory constructs" also encourage fixed assignment of individuals or events to one group. However, unlike preemptive constructs, constellatory constructs allow more flexible thinking (Hjelle & Ziegler, 1976). Stereotypes are exemplars of constellatory constructs; an individual who belongs to a certain ethnic group is also assumed to reflect the stereotypes assigned to that group. A "propositional construct," however, allows individuals to change their opinions based on new information and maintains room for the examination of new information and the reinterpretation of events (Hjelle & Ziegler, 1976). Kelly (1958) also identified lesser constructs: comprehensive constructs, incidental constructs, core constructs, and peripheral constructs. An extension from the idea of personal constructs is the constructs developed and used by groups, communities, and organizations, variously known as collective cognition, groupthink, definition of the situation by a group, or the social construction of reality.

Disciplines and Political Correctness

Cognitive theory may be used to understand how the individual client or patient thinks about a social reality and how such thought, in turn, influences his or her behavior. It follows that this client can be a group, a family, a community, or an organization, and a helping process defines or guides ways of assessing and altering their thought and behavior. However, this very process can be turned around to ask: How does the help-provider organize his or her thoughts about the client or the patient? Often an academic or professional discipline may get caught in the appropriateness or "political correctness" (the idea that people should be careful to not use language or behave in a way that could offend individuals or a particular group of individuals) of a word, a concept, a linguistic usage, and ideas to understand clients or patients, and then some pathways to intervention become "politically correct" while others are seen as "politically incorrect." Before one ventures into how clients or patients and their cognition should be understood to guide intervention, it is important to review how the cognition of the help-provider is often immersed in the norms of political correctness of a professional culture.

Our first example of such political correctness emerges from the professional help provider's notion of "functional" or "dysfunctional" thought and behavior. Within a modern society, the United States, for example, disciplines

of clinical psychology and clinical social work often define an individual or a family as functional or dysfunctional within its environment. Such a way of defining an individual or a family is often supported by a "medicalized" (meaning using the traditions, rituals, and vocabulary of the medical profession) culture. Sometimes, however, defining a group or a community culture as functional or dysfunctional is seen by others within that profession or those outside the profession as politically incorrect: for example, gender role norms differ for both men and women across different cultures within the United States. This is something that is known to social work professionals, but it is considered not appropriate to interpret these differences as evidence of a dysfunctional community culture. In the discipline of social work, it is this norm of not seeing a community culture as dysfunctional that has contributed to what is known as "the strengths model" (Saleeby, 2005), or deliberately not focusing on "the deficits" of a group or a community.

Comparable to the concepts of functional and dysfunctional are those of "adaptation and maladaptation," "normalcy and deviance," "normal and pathological," and "wellness and illness." All of these concepts are used by academic disciplines and the helping professions to define an individual client, a family, a group, a community, or an organization. These constructs, when seen as cognition and consequent behavior in a given environment, however, may still be useful, because they guide social workers in setting goals and in identifying what kind of thoughts or behaviors need to be changed. The profession of social work has long used the term "person in environment" (and by derivation, a family in an environment, a group in an environment, a community in an environment, or an organization in an environment), and use of this paradigm clarifies how clients are functional or dysfunctional, adaptive or not adaptive, normal or deviant, well or ill, and normal or pathological within one or more social environments.

Origins in Sociology

Goffman's (1974) concept of "frames" and frame analysis is also helpful to our understanding of how social workers conceptualize problems with individuals, groups, and communities. Frame analysis is a method of social inquiry that analyzes the cognitive schemas influencing the interpretation of events by individuals and groups. In Goffman's own words regarding frames, the "definition of a situation is built up in accordance with principles of organization which govern events . . . ; frame is the word I use to refer to these basic elements" (Goffman, 1974, p. 10). An example of the use of frames is our interpretation of popular rap music lyrics such as Eminem's

> Now I don't wanna hit no women when this chick's got it coming.
> Someone better get this bitch before she gets kicked in the stomach.

Our interpretation of such lyrics either as empowering creativity and expression for young, urban, poor, primarily black men—or as oppressive misogyny for women—is ultimately determined by the frame we use to analyze and define the situation.

The classic work of Chicago sociologist W. I. Thomas (1923) introduced the phrase "definition of the situation," which meant how any given situation can be seen, interpreted, and acted upon differently by different individuals from different backgrounds. His axiom was then used in the classic study of Polish peasants in Europe and America (Thomas & Znaniecki, 1927). The Polish immigrant in American society, for example, viewed a situation very differently than did a peasant who was a member of Polish society. Since the work of Thomas (1923), the axiom "definition of the situation" has become an important way of understanding how different individuals see and react to the same situation differently. Since the work of Thomas, Talcott Parsons (1951) added the idea of "pattern variables," which suggests that there are about five ways one can view and respond to a given situation. One of these five ways is a definition of the situation prompted either from affectivity or from affect-neutrality. A tragic accident may create serious wounds to a given person, and an onlooker may define this situation with affect and start screaming. A medic or an emergency room physician is likely to respond to the same situation from affect-neutrality, since the response is prompted by years of medical and

technical training that mandates a calm and problem-solving demeanor.

A further development of the ideas of Thomas and Parsons can be found in the treatise by Berger and Luckman (1966), where they introduce the idea that "reality" is socially constructed. An example of this way of thinking can be found in the story of Teresa of Avila during the Spanish Inquisition. In this story, about 14 nuns were found to be communicating with spirits and other beings that most people could not see or hear. Some professionals in clinical social work today would label this behavior as hallucinations and delusions. The church fathers of the time, however, defined this behavior as "evil," and called for them to be tied to a stake and burned alive. At this point, Teresa is supposed to have said that the nuns should be treated as *comas enfermas*, meaning that they should be treated *as if sick* (Bates, 1977, p. 9). In this example, the first construction of reality was done by the church fathers when they defined the situation as "evil." Then, the second construction of reality was done by Teresa of Avila, when she declared that the nuns should not be treated as "evil," but defined as "sick." The definition of the situation by the church fathers called for burning the women, whereas that by Teresa called for putting them in the custody of persons qualified to provide treatment.

The changing of a definition of the situation by Teresa of Avila from "evil" to "sick" can be called a form of "cognitive restructuring" (Cuncic, 2014). Here, the cognitive structure of the church fathers is being restructured. Later in this book it will be shown that cognitive restructuring is an important technique used by psychologists and social workers.

Many individuals past and present believe that the experiences of Teresa of Avila were genuine experiences of God's actual presence, through which Teresa gained the wisdom and strength to establish convents and monasteries throughout Spain. Furthermore, Teresa's visions are presumed to have led her to a deeper, more reflective spiritual practice, and the dissemination of her spiritual understanding through inspirational writings. For individuals with more mystical religious beliefs, a situation may be defined as a significant religious or spiritual experience. Walsh (2008) reminds us of the importance of incorporating this understanding into the social work assessment process.

The concept of the definition of the situation has seen important usages in current studies of managers in industry (Trompenaars & Hampden-Turner, 1997), who point out that managers in industry learn how to think and solve problems using their own personal, organizational, and other backgrounds. The study of organizational culture today, in order to understand management behavior (Schein, 2010) and make management effective and efficient, evolves from these contributions by sociological theorists.

Origins in Anthropology

How humans think and react to a situation was the subject of an elaborate study by the anthropologist Malinowski (1955). The variety of ways in which different cultures appraise a situation was the focus of his study. For example, the finality of death is a universal experience in all human groups. However, how to give meaning to death by socially constructed funeral procedures varies from culture to culture.

A controversial paradigm emerged in anthropology when Lucien Levy-Bruhl (1926) introduced the idea of "cognitive relativism." His work suggested that all human groups develop a cultural style of adaptation to their environments. This cultural style, in turn, teaches their members how to think. Within the different styles of thought, some are more functional (that is, they help in the group's adaptation to its environment better) than others. The implication of this is that certain cognitive styles adopted by some cultures may be "superior" to those of others. The contemporaries of Levy-Bruhl saw this theory of cognitive relativism as somewhat ethnocentric. However, even to date, the idea of functional versus dysfunctional cognition at the individual level is very much accepted, and current psychologists and clinical social workers engaged in cognitive-behavioral intervention use the idea of functional versus dysfunctional cognition (that is, an individual client or patient's way of thinking is either adaptive or maladaptive) in their professional practice. The controversy begins when one suggests that the cognitive style taught by

one culture is more functional than that of another.

Origins in Sociobiology

An important pioneer in sociobiology is Edward O. Wilson (1978), who argued that human cognition and behavior cannot be well explained by the ideas of individual development, social environment, or cultural context, and should be understood as having emerged from an evolutionary sequence. This means that human cognition and behavior originate, not exclusively from individual development (as many psychologists suggest) or from group or community culture (as sociologists, anthropologists, and social workers suggest), but from genetic and biological adaptation. This position created a controversy, and it was hotly disputed by many social scientists who argued that it was close to the ideas suggested by social Darwinism (the belief that persons are subject to the same laws of natural selection as plants and animals) and eugenics during the latter part of the 19th and early part of the 20th centuries. This idea in sociobiology is especially unpopular in social work, since it leads to a position that many forms of human cognition and behavior are biological in origin, and subsequently not subject to social intervention.

Origins in Psychology

The work of Swiss psychologist Jean Piaget is usually seen as an important beginning of cognitive theory in the discipline of psychology. Piaget was the first to propose that "schemata" form the basic structures of mind that allow individuals to organize information and intellectually develop (Piaget, 1932; Robbins, Chatterjee, & Canda, 2012, pp. 264–277). He further proposed that humans maintain two biologically inherited cognitive functions: "Organization," which refers to the tendency to blend and coordinate physical or mental structures into higher-order structures; and "adaptation," which refers to the ways the mind changes information in order to accommodate the external environment (Robbins et al., 2012, p. 278). According to Piaget, important processes in cognitive development include three areas: (1) *assimilation*, meaning the ways in which new information is assimilated into existing mental schemata; (2) *accommodation*, which is the development of new schemata through assimilation; and (3) *memory*, which is the ability to learn and maintain new learning over time.

Piaget (1951) further proposed a linear and stage-based model of cognitive development where each stage is built upon the previous stage. Stages are associated with a specific childhood age, and in each stage, the child is expected to master specific sensorimotor and cognitive tasks. Stage one, the sensorimotor stage, occurs between birth and age two, during which children develop goal-directed behavior, gain a sense of objects and permanence, and develop the capacity for symbolic thought and for mentally representing objects (Robbins et al., 2012, pp. 264–266). Stage two, the preoperational period, occurs between ages two and seven and involves the development of language, increased use of symbolization and mental representations, and increased skill in understanding interrelationships between objects. In stage three, concrete operations, which occurs between ages seven and eleven, children learn the cognitive functions of reversibility and compensation. They become capable of focusing on more than one perception at once (compensation) and of undoing or redoing an action in their minds (reversibility). Stage four, formal operations, occurs between ages eleven and fifteen, and includes the development of reasoning and increased capacity for abstraction.

While Piaget also proposed a theory of moral development that included a premoral stage, moral realism, and moral relativism, it was Kohlberg (1969) who proposed a more complex theory of moral development in children. Kohlberg's is a six-stage theory divided into three levels (Robbins et al., 2012, pp. 276–277). The first level, the preconventional level, includes the obedience and punishment stage and the egoistic orientation stage. This level is distinguished by its focus on rules, punishment, and rewards as motivators for moral behavior. The second level, the conventional level, includes the stages of the good boy/nice girl orientation and authority-maintaining morality. The focus at this level is on approval from authority figures

and the avoidance of social disapproval. In the final level, the postconventional, which occurs from age 16 into adulthood, social contracts and the principled conscience are developed. At this level, "emphasis is placed on democratically accepted law and consensus as well as an understanding of the greater good and the potential to modify an unjust social contract" (Robbins et al., 2012, p. 278). It is important to note that Kohlberg believed that this third level was rarely achieved by most individuals.

A simple extrapolation from Kohlberg's theory of moral development, however, can be used to return to the matter of cognitive relativism of Levey-Bruhl (1926). This extrapolation may be framed in the following manner. Kohlberg proposes (1969) that formal education can be an important contributor to the development of postconventional morality. This may mean that the more the formal education an individual has, the greater the probability of attaining a moral frame that can be considered postconventional. However, formal education is also often used as a measure of social class (Hollingshead, 1975; Beeghley, 2007). That is, the more the formal education one has, the higher the likelihood of one's placement in a higher social class. Does that mean that persons placed in a higher social class are more likely to attain postconventional morality? This very awkward (and perhaps politically incorrect) position was raised by Kanjirathinkal (1990). Since his work, this politically incorrect question has not been pursued in subsequent research in the social sciences.

An example may be important here. Preserving the environment is a moral position adopted by many individuals. Is this a postconventional morality? Is it more common among the members of the upper classes than among the members of the poverty classes? Do the members of the upper classes have more investment in preserving the environment than those from the bottom end of the socioeconomic ladder? It is questions like this that return to the idea of cognitive relativism, and the political correctness of questions like this remains unsettled.

Three other scholars have made substantial contributions to cognitive theory in the discipline of psychology: Jerome S. Bruner, Leon Festinger, and Albert Bandura. Bruner, influenced by the work of Lev Vyogotsky, contributed to understanding how children learn in a social environment. He called it the "theory of cognitive scaffolding," which describes how children learn more when provided with enough support during the initial stages of learning (Bruner, 1966; Bruner, 1979; Bruner, 1990; Bruner, Goodnow, & Austin, 1956). By implication, it means that all human beings acquire more knowledge when provided with cognitive support. Recent research has revealed that cognitive support of children provides substantially more and better learning than the use of corporal punishment (Reid, 2014).

Psychologist Leon Festinger suggested that humans often struggle to reach cognitive consistency. He suggested that "cognitive dissonance" is an antecedent condition that leads to activity toward dissonance reduction, much like hunger leads toward activity that leads to hunger reduction (Festinger, 1957). Festinger's work continues to develop new works about cognitive consistency and what it does to human behavior (cf. Hamilton-Jones & Mills, 1999).

Albert Bandura (1977; 1986; 1989) delineated how cognitive and social factors influence imitative behavior, which, in turn, influences learning. He suggested four processes that contribute to learning: *attention, retention, production,* and *motivation*. First, a child must pay *attention* to selected stimuli and filter out other stimuli. Second, the child must *retain* selected stimuli, either by semantic symbols, or by visual representation. Third, the child must be able to *produce* a given behavior that has been retained. Fourth, a child must have the *motivation* to produce a given behavior. These four processes affect the cognitive and social factors that mediate learning.

Biology and Cognitive Theory

Recent years have seen an increase in interest in and research on the biological basis of cognition. Biological and neurological research has examined the ways neural systems mediate the relationships between cognition and the social environment, leading to increased understanding of disorders such as autism (Nurius, 2008). Technological methods for examining and

measuring neuronal activity related to cognitive functioning such as positron emission typography (PET), which measures cerebral blood flow, and functional magnetic resonance imaging (fMRI), which measures brain activation, have been widely used over the past 15 years.

It is assumed that better understanding of the neurological components of cognition will allow researchers to understand the effects of different types of neuronal activity on information coding, processing, and interpretation (Morris, Tarassenko, & Kenward, 2006). One important insight regarding cognitive processes established from neurobiological research has been in the area of implicit cognitions. Research has found that separate brain areas are responsible for explicit cognitive processing which is reflective and controlled, and for implicit processing which is more impulsive processing responsible for automatic appraisals that we may not be aware of (Wiers & Stacy, 2006). This dual cognitive-processing model has informed social workers' understanding of emotion regulation and impulse-control disorders, especially those associated with addiction and trauma (Shapiro & Applegate, 2000).

As neurobiologically driven interventions are utilized, some may be concerned that they could make social work interventions obsolete. However, these areas of research have informed new clinical interventions that have been adopted by social work practitioners. These include mindfulness-based interventions (Bowen, Chawla, & Marlatt, 2011) and dual-processing models of intervention (Matto & Brown, 2013) that address implicit processing in addictive disorders and relapse. Additionally, neurobiological research on the effects of trauma on cognition support experimental interventions such as movement, art, and music that many social workers integrate into clinical practice (van der Kolk, 2014). Recent research on the effects of environment on cognitive processes mediated through neurobiological mechanisms also offers social workers an enhanced evidence base from which to advocate for policies that improve ecological, social, and educational environments that impact neurological and cognitive development (Odom, Pungello, & Gardner-Neblett, 2012).

Language Use and Cognitive Theory

Begley (2009, p. 31) has summarized several research findings suggesting that language usage may shape cognition. An example given by her is that a very tall bridge in the south of France, the Viaduct de Millau, is seen as feminine by German speakers. In French, it is seen as masculine. German speakers see it as a form of beauty, whereas French speakers see it as a powerful structure with an impressive presence. Begley then goes on to suggest that each language is embedded in a culture, and even though she does not use the term "cognitive relativism," she concludes that each and every language defines a situation in a unique way that is different when seen in comparison with other languages. Thus, within a language, words chosen to define a situation may vary from person to person, from group to group, and from profession to profession. Furthermore, in two different languages, as shown in the example cited above, a situation may be defined in one given way in one language and in another way in another language.

Another example of linguistic construction of reality comes from how "madness" is defined in English-speaking cultures (Bates, 1977) and how its translation in Bengali (called *paglami*) is defined in Bengali-speaking cultures. In English-speaking cultures, "madness" essentially has two definitions, and at times they can be overlapping (cf. Kutchins & Kirk, 1997; Watters, 2010). The first leads to defining a person who is not in contact with reality as the larger society knows it, and the person is seen as having hallucinations or delusions. This definition often leads to seeing the person as "sick," as was done by Teresa (discussed above) during the Spanish Inquisition. This definition often calls for appointing members of the medical and psychological professions as custodians of the situation. A second definition also exists in English-speaking cultures, and this leads to defining a person as "deviant" according to the norms of larger society, and requires ostracizing or incarcerating the person. In the latter case, members of the justice system are seen as appropriate custodians of the situation. Thus one can suggest that English-speaking cultures,

for the most part, maintain two definitions arising from the use of the word "madness."

In Bengali-speaking cultures, however, the two above-mentioned situations also prevail. In addition, the behavior of a person who gives up living as an everyday householder and pursues the meaning of life by deep introspection, or persons who go from village to village engaged in wanderlust and support themselves by begging and singing, may often be framed as additional forms of madness or *paglami* (Bhattacharya, 1984; Chatterjee, 2009). The act of begging is not seen with stigma in Bengali culture. However, the same act in Europe and America, as done by the Hare Krishna groups (and the ideology of the Hare Krishna group was imported from Bengal to Europe and America) is seen as an annoying form of mild deviance that calls for both expressions of disapproval and, at times, forcible removal from public spaces by law-enforcement authorities. The implication of this position is that language used by a therapist, a clinical psychologist, or a clinical social worker may guide the cognition of a patient or the ways in which a client thinks and acts. Thus, a therapist's choice of words may influence the outcome of therapy.

Yet another example of language use and cognitive theory can be derived from the use of the Arabic word *haram* (or *haraam*). It means "sinful." In Islam, it can be applied to any act that is forbidden by God (*Allah*). It is applied to any act or object in the human experience that is prohibited, and carries immense power. In Nigeria, it is used to name the fundamentalist Islamic group *Boko Haram*, which means Western education for girls is sinful and prohibited. Just the utterance of the word defines a situation as sinful and calls for violent suppression of that situation.

Using Kelly's (1955; 1957) idea of preemptive constructs, it can be suggested that a culture may use language to create preemptive constructs. Thus, the word *haram* may be used as a preemptive construct by Arabic-speaking people, or the word may be imported into other languages where Islam is the eminent religion. Similarly, the word *nigger* is used by English-speaking people as a preemptive construct to define persons of dark skin, or the word *achchhut* (meaning "untouchable") may be used by Hindi-speaking people to define persons of certain lower castes. Yet another example is the use of the word *asati* (meaning "unchaste") by Bengali-speaking people to describe some women. Just the utterances of these words are used as preemptive constructs.

Social Work Treatment with Individuals and Families: Current Ideas

The focus of cognitive theory and intervention is on the conscious thought processes, which are considered the basis for all behavior and emotion (Walsh, 2008). The underlying assumptions of this theory are that behavior is affected by thoughts or cognitions, that these cognitions may be modified, and that behavior change may occur through the modification of these cognitions (Dobson, 2001). Albert Ellis, the developer of "rational-emotive" therapy (Ellis & Bernard, 1985), is considered one of the parents of cognitive theory in the field of psychology. Trained in psychoanalytic methods, Ellis decided to pursue more active treatment methods. Ellis developed what has come to be known as the "ABC model" for assessing symptoms. This model maintains that an activating event (A), is followed by an individual's cognition or belief about the event (B), which leads to an individual's symptoms or consequences (C). This ABC model remains central to assessment in cognitive therapy. Ellis further maintained that individuals are irrational, and he identified common beliefs or cognitive distortions to which individuals are vulnerable (Cuncic, 2014; Dobson, 2001). This concept is also central to current cognitive theory, which emphasizes the identification of cognitive distortions in assessment and intervention.

During the 1970s, Aaron Beck made significant strides in the use of cognitive theory to develop interventions for the treatment of individuals with depression and anxiety (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979; Beck, Emery, & Greenberg, 1985). Beck developed his cognitive theory initially for the treatment of depression. Trained as a psychoanalyst, Beck attempted to embrace psychoanalytic theories of depression, but he eventually concluded that depression was maintained by negative cognitions and negative schemas. These negative

schemas were composed primarily of "personal ineffectiveness, personal degradation, and the world as an essentially unpleasant place" (Walsh, 2006; 2008). Beck's most significant contribution to cognitive theory was the importance of identifying automatic thoughts and challenging them (Leahy, 2004; Leahy & Dowd, 2002). As Beck continued to develop his cognitive theory and interventions, he extended the technique to include treatment for anxiety, phobias, and personality disorders.

Glasser (1988) further extended cognitive theory in his development of "choice theory," which informed his approach to intervention. It was called "reality therapy." Choice theory maintains that humans, rather than being externally motivated, have five intrinsic motivating needs for survival: love, belonging, power, freedom, and fun (Corey, 2009). Glasser's theory is based on the assumptions that individuals choose their behaviors and that the only thing individuals have control over is their own behavior (Glasser, 2001). Furthermore, individuals' behavior is based on their thoughts, feelings, physiology, and prior experience (Austad, 2009). Emerging from this theory, reality therapy encourages individuals to take responsibility for their choices, maintains a present focus in treatment, and rejects focusing on symptoms (Corey, 2009).

Recently, cognitive theory has led to the development of treatment for a variety of individual and relational problems. These include treatments for post-traumatic stress disorder (Foa, Keane, & Friedman, 2000), eating disorders (Fairburn, 2008), anxiety (Beck, 1976), stress and coping (Meichenbaum, 1996), depression (Ellis, 2006; Beck, 1976), obsessive-compulsive disorder (Steketee, 2006), schizophrenia (Kingdon & Turkington, 2004), other personality disorders (Linehan, 1993), and relational concerns (Dattilio & Padesky, 1990). Emery, Hollon, and Bedrosian (1981) extended the use of cognitive theory in the treatment of the elderly, individuals with sexual dysfunction, and individuals with alcohol dependence. Granvold (1994) added the dimension of constructivism to his discussion of cognitive theory highlighting the individual's responsibility in forming their own reality. This line of cognitive-constructivist thought eventually developed into "narrative theory" and the narrative approach to counseling and psychotherapy (White & Epstein, 1990).

In the field of social work, at the level of what was earlier called "casework practice," and now called "case management practice," the use of cognitive theory became popular in the late 1970s (Goldstein, 1982; Chatterjee, 1984). Goldstein (1982) identified the development of psychoanalytic therapy as the impetus for the use of cognitive theory in social work: "Caseworkers at that time were admonished not to dabble in the psychoanalyst's domain of the unconscious . . . (therefore) social workers assumed guardianship of the more conscious and cognitive realms of their clients' lives" (p. 546). Werner (1982) underscored the humanistic underpinnings of cognitive theory as a theory focused on the human capacities of thought, reasoning, and learning. An earlier book by Werner, *A Rational Approach to Social Casework* (1965), had marked the beginning of the purposive use of cognitive therapy in the field of social work. More recently, Sharon Berlin modified established principles of cognitive therapy to propose a "cognitive-integrative perspective." While relying on established cognitive interventions, this model also focuses on the social causes of meaning in a client's cognitions and utilizes other therapeutic approaches such as advocacy or case management for intervening in the client's environment (Berlin, 2002; Berlin & Barden, 2000).

The task-centered methods used in social work practice are also derived from cognitive theory. The task-centered model is usually time-limited and focused on the client's problem as defined by the client. In this model, the individual's beliefs, or views of him- or herself and the world, are considered to be the motivation for action (Reid, 1978). Emotions are the product of an individual's beliefs. The distance between what individuals want and their evaluation of their capacity to attain that is the focus here. Values underlying this model include client self-determination, a present–future focus, time-limited intervention, and "contracting," which means an agreement between client and social worker regarding the work to be done, and empirical orientation (Fortune, 1985). Many of the underlying values and assumptions of this model are similar to the values and assumptions of cognitive theory.

Assessment, as informed by cognitive theory, includes the identification of cognitive distortions (cf. Grohol, 2014) through Socratic questioning. Cognitive distortions include overgeneralizing, negative scanning, personalization, catastrophizing, dichotomous thinking, emotional reasoning, magnifying, minimizing, and selective abstraction (Gambrill, 2006; Grohol, 2014; Walsh, 2008). Socratic questioning is done with the purpose of assisting people in identifying the distorted aspects of their thinking. Such questioning allows client and worker to understand the client's core beliefs about a situation and to examine the evidence both supporting and refuting those core beliefs. Cognitive therapy interventions include cognitive restructuring (see Cuncic, 2014), where the worker assists clients in changing their perception of a problem and generating alternative interpretations of it. The task then is to develop and use coping skills that entail learning new behaviors and thought processes such as problem-solving techniques and communication (Walsh, 2006; Walsh, 2008).

Case Example

Martha is a 34-year-old married mother of three young children. She has been referred to treatment by her primary care physician, who noticed her depressed mood and irritability during her most recent doctor's visit. When questioned, Martha revealed that she has been feeling "overwhelmed" recently, irritable with her children, and discouraged by what she considered their "bad behavior." She also complained of marital concerns and a deteriorating relationship with her husband. Martha was referred by her physician to the area outpatient mental health center and was seen by a social worker. During the initial assessment, Martha described herself as depressed and anxious. She had three children under the age of six, and a husband whom she described as "withdrawn" and "unhappy."

Assessment

After gathering a complete family, psychiatric, and medical history from this client, the social worker began to monitor the cognitive distortions evident in Martha's thinking. These included over-generalizations such as thinking, "I am a horrible mother," and "My children hate me." Magnifying and catastrophizing occurred frequently with Martha. When her eldest child was sent to the principal's office at school for talking during class, Martha immediately had thoughts such as, "My child is heading for trouble," and "I have failed as a mother and my children are failing." The social worker then utilized Socratic questioning to challenge the rationality of Martha's thought process. The social worker also used an example presented by Martha that described a common and repetitive interaction between Martha and one of her children. Using the client's own example, the social worker identified the ABCs in this scenario: the activating event, belief about the event, and Martha's responses of hopelessness and depression.

Intervention

The social worker worked with Martha on cognitive restructuring (cf. Cuncic, 2014). Using a typical event—her child spilling his milk at the dinner table—Martha was made to identify her belief that her child was "purposefully trying to get my goat" and the anger and resentment that resulted. This event was usually followed by Martha yelling at this child. Her son would then tell her he hated her (activating event), leading to Martha's thought that she was a bad mother (core belief) and the resulting hopelessness and depressed mood (emotional consequence).

Following an exploration of the ABC process in Martha's scenario, the social worker encouraged her to consider other thoughts and interpretations with which to replace the identified distortions. The social worker asked Martha to generate and consider other reasons why her son might spill his milk at the dinner table. He asked her: "Can you imagine how you would feel if you thought that David's behavior was simply an accident or that he was tired from a long day at school? How might you react differently if these were your thoughts?" In this way, Martha was able to consider alternative interpretations to events and generate different emotional responses within herself. The social worker attempted to challenge Martha's irrational beliefs by setting up tasks for her to try in her daily life in order to test the veracity

of her distortions. The social worker encouraged Martha to try an experiment at home, and instructed her that "when David spills his milk this week, calmly give him a towel with which to clean up the mess. Then notice the ways in which the outcome of this event changes." Martha was also instructed in the use of self-instruction training (Meichenbaum, 1996) or positive self-talk. The social worker helped Martha create statements that she could say to herself when upset with her children during difficult parenting moments. These included such statements as "My children are doing the best that they can," "Everyone makes mistakes, and this one isn't the end of the world," and "All in all, I am an adequate mother."

Given that Martha's depressed mood was also related to marital discord, the social worker recommended couple's treatment for Martha and her husband, Mark. Following three months of work with Martha individually, the social worker invited Martha's husband in to engage in the couple's treatment. Cognitive restructuring, communication skills training, and training in problem solving were utilized with Martha and Mark. Each member of this couple was able to identify distorted core beliefs that affected their interactions with each other. Using Beck's (1976) model, the social worker helped Martha identify the event—Mark's withdrawal from her; her automatic thought—"He refuses to help me with the house and kids"; her core belief—"I am unappreciated"; and her emotional reaction of depression and resentment toward Mark. Mark identified his automatic thought in response to Martha's resentment, which was "She's unhappy with me and I don't know why." His core belief was "I am inadequate," leading to his withdrawal from the relationship. Over time, the social worker helped Mark and Martha use "I" statements in communicating with each other, to reflect back to each other the thoughts and feelings expressed by the other, and to make clear requests of each other.

Social Work Intervention with Groups: Current Ideas

At times, the use of the "treatment" metaphor may give an impression (or define the situation) that cognitive theory is more often applicable to social work intervention with individuals and families in clinical social work. This is not true, because cognitive theory is also useful in social work interventions with groups, and such interventions can be done for attaining ends of primary socialization (as in school social work and in neighborhood-based community centers), re-socialization (as in prisons and other settings where juveniles and adults are incarcerated), and treatment (as in purposive group work with patients and substance abusers). Cognitive theory can also be used to accomplish what is called "consciousness-raising." For example, it can be a useful tool in working with groups of victims of domestic violence, child abuse, or elder abuse. The purpose of such intervention using the method of group work is to change the cognition of the group members from a definition of the situation of "I am a victim" to "I am capable of overcoming a victim role."

The legacy of Grace Coyle (1937) can be suggested as an intellectual journey that had its foundations in cognitive theory. Even though formally not referred to as an intervention based on cognitive theory (it was called a paradigm based on theories of socialization), the practice goals of this paradigm were focused on helping a group (like adolescent peer groups and other various types of human groups) change its cognitive style. Thus, for example, a group worker dealing with working class adolescents would struggle to teach this group that the pursuit of success in schools and that developing a career is more functional than the pursuit of gang violence.

Social work practice with groups has evolved into multiple areas of practice since the pioneering work of Coyle. Today, it can be used in healthcare settings to teach groups about cognition and behavior that contribute to wellness, avoiding addictions, and engaging in prevention of illness. It can be used in prisons and juvenile incarceration settings so that inmates in these settings learn how to become productive members of society. It can be used to bolster support groups for victims of domestic violence or child abuse. Groups that develop as "cults" or "new religions" often use a new form of cognition to indoctrinate their members. Thus, for example, the Nation of Islam may teach cognitive styles to its members that

are different from those offered in Christianity or Judaism. The same holds true for groups like Moon's Unification Church, Scientology, or Hare Krishna groups. Depending on social position, one may identify these groups as "cults" or as "new religions." Also, there have been interventions developed in psychology and social work about how to engage in deprogramming persons who have become indoctrinated by one or more of these groups.

Case Example

Jamal Bana is the third Somali-American from the city of Minneapolis to head for Somalia and die there. He is one of more than a dozen missing Somali-Americans whose families believe that they have gone back to fight a holy war. "Someone must have put something in his mind," Omar Jamal of Minneapolis' Social Justice Advocacy Center said. "He must have been somewhat disillusioned and indoctrinated because he didn't have any clue about Somalia at all" (CNN.com/world, 2009).

Interpretation

Viewed from the discipline of sociology, this is a case of ideological indoctrination of an American young man to join *al Qaeda* and become a part of the Islamic fundamentalist war call. Viewed from the discipline of psychology, this is a case of a cognitive structuring of a Somali-American young man to join a call to war by a terrorist group. This was a case that, viewed from a psychological perspective, called for a cognitive restructuring. Such a restructuring would have deprogrammed Jamal Bana from thinking of *al Qaeda* as a noble organization to recognizing it as a very destructive and deviant group. Here, cognitive structuring could be undertaken by two groups: the first were the recruiting agents of *al Qaeda* programming Jamal to go and fight in Somalia; and the second are the psychologists and clinical social workers who might have been able to engage in deprogramming Jamal to help him reject ideas to engage in terrorist causes. In this case, the act of deprogramming never happened.

Social Work Intervention with Communities: Current Ideas

Just as "truth," "justice," and "morality," are culturally constructed (cf. Geertz, 1973), so are "domestic violence," "child abuse," "elder abuse," and "setting up and utilizing mental health services." For example, violence in a family may be defined by one group as a situation requiring intervention, and by another group as a private matter in a family that should be ignored. Similarly, child abuse, elder abuse, or not seeking help for personal problems may be seen by one group as problems requiring intervention, and by another group as private matters that should be left alone. Working with community groups may necessitate developing awareness at the community level that these social problems require solutions at the community, regional, and national levels. Community organization and community development efforts can be established toward the pursuit of these ends. A special example of such efforts is in the work of Paolo Freire (1970), who taught that members of a community can be taught to see the inherent contradictions within a community culture, and that such an education can create a new form of cognition in disadvantaged communities. He called this form of change in the cognitive structures of the disadvantaged *conscientization*.

Two other traditions contribute to the study of cognitive structures at the community level, and they generate ideas for social work practice with communities. They are the semiotic tradition and the tradition that explores how the use of authority is socially constructed in a community culture. The semiotic tradition focuses on the study of meaning that a given behavior, ritual, art form, or procedure has for a given community (Danesi & Perron, 1999). In fact, the term "semiotics" means the study of semantic or linguistic structure. The common method for doing such studies is to develop narratives of these behaviors, rituals, art forms, or procedures in such a way that the cognitive foundation and meaning inherent in them emerge by themselves. The discipline of cultural or social anthropology has pioneered this tradition, though the discipline of cultural sociology has also contributed to such efforts. This tradition can be used to develop narratives about

an entire community culture, or about some important parts of a community culture, like how justice, morality, adolescence, or providing and utilizing mental health services are viewed in this culture.

Yet another tradition in community-based work may be called "explorations in different forms and sources of authority." This tradition focuses on the study of different types of authority and their legitimacy in different sociocultural situations. Often this tradition is seen as having started with the work of Weber (1999), and his influence on modernization theorists (Jaffee, 1998), on the works in economic sociology (Swedberg, 1990; 2003), and the work in the social construction of reality by Berger (1977) and Berger and Luckman (1966). The method used here is the tracing of events that show the bedrock of the authority structure in a given social setting, assessing whether that authority is based on tradition or modernity, and implying that authority and methods of production and governance based on modern knowledge are more likely to produce social and economic development.

Social Work Intervention with Organizations: Current Ideas

While the classic work of Weber (1999) can be seen as a formal beginning of the study of organizations, a current development influencing how organizations should be seen is emerging from the ideas of Schein (2010). At least two types of organizations are important in social work practice: social agencies that are the means of social service delivery (where the personnel are mostly social workers); and organizations built for empowerment of community members (where the members of the organization often are community residents and are clients of social workers). Schein's work informs us that, in order for organizations of both types to be effective (meaning, is this organization capable of attaining the goals it has set for itself?) and efficient (meaning, is this organization capable of pursuing its goals with efficient use of its resources, or is it caught in efforts that are not always cost-conscious?), organizational culture and the cognitive assumptions that maintain this culture must be considered. Schein's work is informing social workers that it is important to learn how the "cognitive scaffolding" of an organization may have developed, which, in turn, is sustained by the culture of that organization, and that this cognitive scaffolding is either capable of making an organization effective and efficient or may be caught in its "trained incapacity" (a term coined by Veblen, 1997).

Conclusions

Many disciplines have contributed to the ways in which cognitive theory is used to understand human thought and its consequent behavior, and have fed the development of interventions in the field of social work. The early developments of computer processing and logic, the anthropological and sociological examinations of culture and society, and the psychological understanding of cognitive development and intervention, have all contributed to the person-in-environment perspective, encouraging the use of cognitive theory at multiple levels. Cognitive theory is a very useful tool in social work practice, community organizing, social casework, and nonprofit management, as well as clinical social work. While it has emerged as a popular form of intervention at the level of social work practice with individuals and families, it also has immense potential for social work practice with groups, communities, and organizations.

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6

Constructivism: A Conceptual Framework for Social Work Treatment

Donald E. Carpenter and Keith Brownlee

Constructivism as a conceptual framework for social work practice is relatively new. While various practice perspectives and treatment approaches in social work have historically reflected constructivist concepts and principles, only relatively recently have these been recognized as such. Constructivist ideas, however, have a long history in human thought, having found expression in such diverse fields as art, mathematics, literary criticism, philosophy, the social and behavioral sciences, and related helping professions. Any exhaustive examination of constructivism for its relevance to human behavior alone would lead to the complex deliberations of philosophers on metaphysics, epistemology, and ontology, as well as to the studies of psychologists on the nature of perception, cognition, and learning, and more recently, an exploration of the burgeoning field of neuroscience would need to be included. While an investigation on this scale is obviously beyond the scope of this chapter, aspects of these fields of inquiry will be visited in formulating a constructivist conceptual framework for social work practice.

In classifying the various theory development approaches taken by social work, Turner (2011) identified a variety of new theoretical approaches that represent innovative ways of conceptualizing social work treatment. Constructivism, as will be shown in this chapter, is indeed a relatively new system of thought for social work that has remained on the "fringes" of the profession (McWilliams, 2015, p. 1) and is specifically identified here as a philosophical-behavioral-methodological thought system. Philosophically, constructivism is concerned with the nature of reality and being (metaphysics and ontology) and the nature and acquisition

of human knowledge (epistemology). According to Baerveldt (2013),

> constructivism maintains that cognition is fundamentally adaptive and that knowledge needs to be "viable" rather than "true." Constructivists emphasize that knowledge emerges when cognitive agents actively try to make sense of their experience by constructing ideas, concepts, or schemas that organizes this experience in a coherent way. (p. 157)

The behavioral aspect pertains to certain understandings of human perception and cognition, personal and interpersonal dynamics, and the nature and execution of change. From the philosophical and behavioral components, methodological implications emerge for social work practice. It will also be shown that constructivism as a postmodern relativist theory can be deployed as a meta-theory for attaining a deeper understanding of the nature of modern or realist theories.

It should be clarified at the outset that constructivism is not a practice theory but a conceptual framework that can inform given practice theories, in the sense that ecological-systems theory informs the Life Model of practice, as one example. While general practice guidelines can be inferred from constructivist concepts and principles, some of which will be identified later in this chapter, specific and detailed practice guidelines reflecting constructivism as a conceptual framework can be found in a number of practice theories (e.g., narrative and solution-focused theories) described elsewhere in this volume.

Historical Foundations

Historical Context

One can trace the ideas of constructivism as early as Kant (1781), Piaget (1929), Kelly (1955), Maturana (1975), Watzlawick (1976), and Von Glasersfeld (1984). The intent to infuse these ideas into the helping professions, including social work, has continued to this day, with more recent theorizing by Baerveldt (2013), Carpenter (1996), Lindquist (2013), Mahoney (1991), McWilliams (2015), and Strong (2014). Constructivism as a thought system is best understood when placed in a context of major historical ideas about reality (ontology) and how human knowledge develops (epistemology). Three historical periods can be identified in the evolution of major human belief systems—pre-modern, modern, and post-modern—each characterized by certain approaches to understanding ourselves as humans, the world, and indeed the universe. These understandings become reflected in the nature of the theories that we devise for helping people with psychosocial problems. Following is an overview of human belief systems based on Sexton (1997), adapted from Mahoney (1991).

During the pre-modern period (the sixth century BC through the Middle Ages), idealism, religion, and faith mixed with rationalism were the primary mechanisms people employed for understanding the major questions raised about human life. During the modern era (from the Renaissance to the end of the 19th century), the predominant approaches for understanding the world were empiricism (sense experience is the only true source of knowledge), logical positivism (observation is the prime means of accessing truth), and scientific methodology (a highly rational approach to objective truths, primarily through testing hypotheses of deductive theories).

Whereas the pre-modern and modern periods stressed the discovery of objective knowledge and fixed truths, the postmodern constructivist era stresses the creation of knowledge and relativity of truth. The proposition that knowledge is constructed, not discovered, is a major contribution of constructivism to social work practice theory, the implications of which will be discussed in a subsequent section of this chapter.

During this postmodern/constructivist era (the current era), there has been less emphasis on the validity of knowledge (characteristic of an emphasis in scientific research in the modern era), but rather an emphasis on the viability of knowledge and increasing concern with how we know what we think we know (Sexton, 1997, pp. 4–6).

Early Beginnings of Constructivism

While constructivism has gained visibility in the social and behavioral sciences only recently in historical terms, the deepest roots of constructivism as a general theory are in the soil of

antiquity (i.e., the pre-modern era). The Greek Sophist Protagoras of Abdera (c. 490–c. 420 BC) maintained that "humans are the measure of all things—of things that are, that they are, of things that are not, that they are not": For Protagoras there was no "objective" world and no perception any truer than another, although some were more useful and should be followed (Ide, 1995, p. 752). Emanuel Kant (1724–1804), in his *Critique of Pure Reason* (1781/1938), argued that the human mind has an inherent structure that it imposes on both thought and experience and that *a priori* knowledge (knowledge independent of, or prior to, experience) is possible and in fact occurs. Kant maintained that the mind is not a passive slate upon which experience is written but a result of the proactive molding of experience. The Kantian epistemological tradition concerning the nature and acquisition of knowledge, frequently cited as a major foundation block of constructivism, maintained that human knowledge is ultimately a function of the interaction of the world of experience (empirical) and the basic nature (*a priori* state) of the human mind.

Another major constructivist, Hans Vaihinger (1852–1933) emphasized the importance of cognitive processes in determining behavior. Vaihinger formulated the philosophy of "as if," which postulates that we hold concepts and beliefs as if they were true because of their utility (Mahoney, 1991, pp. 97–99). Vaihinger's "as if" concept is related, though not identical, to the postmodern-constructivist concept of "viability": an idea or action is viable if it works relative to a stated purpose, and it need not represent some assumed fixed quality or truth, as a state of validity is presumed to establish.

The epistemological position of philosophers such as Protagoras and Kant is in direct opposition to that of the Lockean empiricists. John Locke (1632–1704) maintained that knowledge is imparted to the human mind from an external objective world by way of the senses and that, contrary to what Kant had maintained, *a priori* knowledge is not possible (Wolterstorff, 1995, pp. 437–440).

More Recent Contributions

In more recent times, the developmental psychologist Jean Piaget (1886–1980), from his studies in child development, formulated a theory of developmental epistemology. Piaget concluded that the newborn comes equipped with mental regulatory mechanisms (evolutionary in origin), which, in interaction with the child's environment, result in the development of intelligence (1929, 1950, 1970). The cognitive psychologist George Kelly has contributed significantly to constructivism with his theory of personal constructs, which he predicates are the means by which an individual construes, perceives, interprets, understands, predicts, and controls his or her world (Kelly, 1955). For Kelly, mental constructs are imposed on the world, not imposed by the world on the mind. Another psychologist, Paul Watzlawick (1976, 1984, 1990), must also be cited as a major contributor to modern constructivist theory, especially to constructivist epistemology, in his examination of our assumed "realness" of an "objective" world and of the possibility of constructing more desirable individual "worlds." Two other theoreticians, Ernst von Glasersfeld (1984) and Heinz von Foerster (1984), must be credited for significant contributions to constructivism. Each has accomplished important formulations of the aspect of constructivist epistemology that is concerned with the nature of reality as observer-dependent.

Two Chilean neurobiologists, Humberto Maturana and Francisco Varela, have exerted perhaps the most basic influence on present-day constructivist thought in the biological and behavioral sciences, and this influence has most recently found its way into the behavioral helping professions. From their experimentation with animals have come some rather astounding conclusions about the basic organization of living systems and the nature of the influence of perception on behavior (Maturana, 1980; Maturana & Varela, 1987). According to Maturana and Varela, living systems are "autopoietic" or self-organizing. The behaviors of organisms are not directly influenced by their mediums (environments) but are determined by their structure—that is, their neurophysiological makeup (Maturana & Varela, 1987, pp. 95–97). The neurobiological contributions of Maturana and Varela to constructivist theory are seen to hold important implications for social work practice theory and will be drawn on throughout

the formulation here of a constructivist framework for social work practice. It is important to recognize that "despite their steadily growing influence, constructivist psychologies have not evolved into a single, coherent, theoretically consistent orientation. Given numerous theoretical differences, there is not even agreement among constructivist psychologists that arriving at a singularly recognizable orientation is desirable" (Raskin, 2002, p. 1). Therefore, a variety of evidence and ideas will be presented throughout this chapter that represent various contributions to constructivism.

Path into Social Work

Constructivism has been making its way quietly along the path into social work theory for some time, but only recently has it been recognized as such. All theoretical frameworks that stress the importance of the individual's internal processes, especially perception and cognition, for understanding human behavior have kinship with constructivism. Some of these will be discussed in a later section of this chapter comparing constructivism with other theories that actually have constructivist elements that have traditionally gone unrecognized.

Examples of contributions to the application of constructivism to social work are Butt and Parton (2005), Cooper (2001), Fisher (1991), Granvold (2001), Laird (1993), Longhofer and Floersch (2012), and Strong (2014). Other specific case applications are in Dean and Fenby (1989), Hartman (1991), Dean and Fleck-Henderson (1992), Greene and Lee (2002), and Tijerina (2009).

Variants of Constructivism

While the general theory of constructivism is clearly rooted in philosophical relativism, two major varieties of the theory can be identified. Longhofer and Floersch (2012), Mahoney (1991), and Raskin (2002), make a clear distinction between the two:

Radical constructivism is on the idealist end of the spectrum and has been differentially endorsed and expressed by Heinz von Foerster, Ernst von Glaserfeld, Humberto Maturana, Francisco Varela, and Paul Watzlawick. This perspective is most elegantly expressed in theory and research on the concept of autopoiesis (self-organizing systems). In its most extreme expressions, radical constructivism comes close to the classical position of ontological idealism, arguing that there is no (even hypothetical) reality beyond our personal experience. Essentially, reality or our perception of ourselves cannot be independent from social constructions of it, according to radical constructivism. The self can be seen as a mere concept resulting from human interaction (Longhofer & Floersch, 2012).

Critical constructivists, on the other hand, do not deny the existence and influence of an unknowable but inescapable real world. They are, instead, critical or hypothetical realists, admitting that the universe is populated with entities we call "objects" but denying that we can ever "directly" know them. Representatives of modern critical constructivism include Guidance, Hayek, Kelly, Mahoney, Piaget, and Weimer. For critical constructivists, the individual is not a self-sufficient, sole producer of his or her own experience. Rather, the individual is conceived as a "co-creator" or "co-constructor" of personal realities, with the prefix co emphasizing an interactive interdependence with their social and physical environments. (Mahoney, 1991, p. 111)

The radical variety of constructivism is so termed because of its assumptions about the nature of reality. It questions certain basic beliefs whose validity most people take for granted. For example, it questions our "common sense" notion that reality is obviously what all competent observers know is "real" or "true" about the world in which we live. It maintains that, instead of there being only one reality, as might seem to be the case, there are as many "realities" as there are perceivers of reality (Goodman, 1972, pp. 31–32; Watzlawick, 1990, pp. 131–151). Common sense would have us believe with Gertrude Stein, for instance, that "a rose is a rose is a rose" because all competent observers agree that a certain kind of flower is a rose and not an elephant. Radical constructivists (Baerveldt, 2013; Raskin, 2002) would maintain, however, that greater accuracy is achieved by saying there are as many "rose realities" as there are individuals who experience the things we call roses. Each individual will experience "la rose" in some different way and derive a somewhat different meaning from the experience than all other individuals, but each will still call it a rose. By the same token, a

therapist in her office with a mother, father, and three children is not in the presence of a family but as many families as there are family observers (the family members plus the therapist). For the radical constructivist, the roses and families that we ordinarily refer to are products of our nervous system. Radical constructivism moves sharply away from the Newtonian-Cartesian certainty of a single reality and a knowable objective world.

In contrast to radical constructivism, critical constructivism, which is frequently referred to in the literature as "social constructivism," does not deny the existence of an objective external world to which we all react. It does maintain, however, that we cannot "know" this world directly, but only indirectly through the filtering mechanisms of perception, cognition, affect, belief systems, and language. Despite disagreements about particulars, the different constructivist approaches nevertheless all challenge mental health professionals "to refocus their attentions on the critical importance of the human meaning making process" (Raskin, 2002, p. 18).

Presuppositions of Constructivism

Philosophical Relativism

The philosophical component of constructivism reflects the basic conceptions of a school of thought in Western philosophy known as *epistemological relativism*. This position expresses the idea that our frameworks of thinking, ways of seeing things, values, and interests are all affected by our life experiences and sociocultural situations and therefore can influence and make a difference in how we see or approach situations (Lawson, 2003). The relativist position denies certainties, absolutes, and permanence. Although writing a few decades ago, the philosopher Nelson Goodman (1972), a proponent of philosophical relativism, highlights this position well; this justifies its inclusion when discussing this topic here.

> There are very many different equally true descriptions of the world and their truth is the only standard of their faithfulness. And when we say of them that they all involve conventionalizations, we are saying that no one of these different descriptions is exclusively true, since the others are also true. None of them tells us the way the world is but each of them tells us a way the world is (Goodman, 1972, pp. 30–31)

In opposition to the position of relativism is that of *philosophical realism*, which maintains essentially opposite notions about the "realness" and "objective" existence of the world:

> Reality is a singular, stable order of events and objects external to and independent of mind and mental processes . . . the senses and other technical methods of observation are said to reveal, albeit imperfectly, regularities and principles of reality. (Mahoney, 1991, p. 36)

While realists hold the position that an ontologically existing world is not observer-dependent for its reality, relativists contend that such a world, while seeming to exist, is actually observer-dependent relative to the nature of the perceptual and cognitive apparatus of human beings, which reveals, not a world, but, as Goodman says, versions of a world (Goodman, 1984, pp. 29–34). It is the relativist position that is the philosophical bedrock of constructivism.

Constructivist Epistemology

An age-old problem for philosophers pertains to what is knowable by humans and the means by which knowledge is acquired. In constructivist epistemology, knowledge is not composed of impressions of an objective world or "reality" existing independently of knowers, but instead is the creation of individual knowers, resulting in as many "worlds" or "realities" as there are world/reality observers. If this is so, how, then, do individuals seem to experience a common, objective world? Constructivists maintain that what we refer to as common human experiences are based on a consensual world of language, thought, and experience. Boiled down to its essence, *reality* is *what we agree on*. The "we" can refer to a unit as small as a dyad or as large as a society. For example, during the pre-modern era of history, a common understanding was that the earth was flat and the sun circled around it. That was our "reality," upon which our beliefs and actions were based. World explorers carefully plotted their routes across the seas so as not to sail off the edge of the earth. We thought

(agreed) this was the "truth" of earth geography. At this present point in history, however, based on the scientific knowledge of geographers and astronomers, we say this understanding was not true. The earth is spherical, and orbits the sun; "we" (most people) now believe this to be true. However, to further illustrate the constructivist concept that truth is agreement, there are a few individuals who still believe what most people of the pre-modern era believed about the shape of the earth and the danger of going over the "edge:" This small number of individuals constitutes another "we," and they tell each other that "we believe the earth is flat": this is their "truth" and their "reality." (Interested readers can check "flat earth beliefs" on the Internet.)

A practice-related example of the constructivist conception of "true" and "real" is provided by Cottone (2007):

> What becomes real, for instance, about drugs to teenagers in a drug culture may be quite different than what is "real" to a parental system linked to a drug prohibitionist culture: therefore, whether drugs can be labeled as "good" or "bad" is defined in the communities of understanding within which a teenager or a parent is imbedded. And of course, a counselor, being imbedded in the sociolegal system, is limited when defining acceptable behavior related to use of illegal substances. So, in effect, social constructivism appears to form a triangle with objectivism and subjectivism, in a position outside the objectivism-subjectivism continuum and representing a different view about how things are known to be "true," i.e., truth derives from consensualizing [agreement). (Cottone, 2007, Social Constructivism Movement section, para. 4)

To appreciate the constructivist view of the nature of human knowledge and its acquisition requires a willingness to set aside some very basic prevalent beliefs about the phenomenon we have called "knowledge." As McWilliams (2015, p. 7) observes, "The constructivist perspective suggests that we invent or develop knowledge, as interpretations of experience, and that such understanding emerges in historical contexts and depends on human activity." Constructivism encourages the social worker, therefore, to regard knowledge as progressive and modifiable rather than static. This implies that the knowledge or understanding that people, including social workers, have is limited by the experiences that they have encountered. Knowledge based on this experience would develop due to a constantly changing external world and can be seen as ever evolving. It requires suspending notions of certainty, realness, objectivity, and externality, and the belief that these are indeed the anchors of human experience:

> the phenomenon of knowing cannot be taken as though there were "facts" or objects out there that we grasp and store in our head. The experience of anything out there is validated in a special way by the human structure, which makes possible "the thing" that arises in the description . . . every act of knowing brings forth a world. (Maturana & Varela, 1987, pp. 25–26)

The major contributions to epistemological theory have traditionally come from philosophy and psychology. Constructivist epistemology, however, has acquired foundational contributions from the experimental work and theoretical formulations of these two biologists, Maturana and Varela. Much of what they have contributed runs counter to traditional realist views. The following, pertaining to the nature of the functional relationship between the brain and the environment, is an example:

> The nervous system does not "pick up information" from the environment, as we often hear. On the contrary, it brings forth a world by specifying what patterns of the environment are perturbations (stimuli) and what changes trigger them in the organism. The popular metaphor of calling the brain an "information-processing device" is not only ambiguous but also patently wrong. (Maturana & Varela, 1987, p. 169)

The central importance of constructivist epistemology for practice is that people behave and lead their lives based on what they believe to be true and real, and this is where the practitioner must initially "meet" his or her clients if effective help is to be given. Appreciating that knowledge is ambiguous assists social workers with encounters situated in cultural and personal differences, in that a social worker would recognize that a client's knowledge is equally affected by the specific cultural influences and experiences they have encountered. A case example is provided in a subsequent section of this chapter.

Conceptual Framework

Structure Determinism

The conceptual framework for constructivism as formulated here draws primarily on the neurobiological conceptions of Maturana, Varela, and associates. In gathering evidence in support of their concept of organisms as closed systems, they conducted several biological experiments. One of these, cited by Bell (1985), is representative of the nature and general outcome of the experiments:

> [Maturana] demonstrated that no correlation could be established between colors (as defined by spectral energies and the relations of activity of retinal ganglion cells of either pigeons or human beings) (Maturana, Uribe, & Frenk, 1968). Instead, he found that the nervous system demonstrated its own internal correlations: the relations of activity of retinal ganglion cells correlated with color-naming behavior of the organism (but did not correlate with the actual colors as defined by spectral energies). The implication of this finding is that the nervous system functions as a closed, internally consistent system and does not contain representations or coded transforms of the environment. (p. 6)

Efran, Lukens, and Lukens (1990) elaborate on this radically different conception of the relationship between the neurophysiological makeup of the individual and the environment:

> People are brought up to believe they perceive the outside world. The visual system, for example, appears to provide direct and immediate access to our surroundings. The eyes are said to be our windows of the world. However, although the eyelids open, the neurons of the retina do not. Energy waves bump up against the retinal surface . . . but outside light cannot get in. . . . Obviously, experiences we attribute to light—as well as all our other experiences—are created entirely within our own system. . . . This is evident in dreams, in response to sharp blows (when we "see" stars), when neurons are directly touched with electrical probes, and when chemical substances are ingested. At a fireworks display, there may be a lot going on outside, but nevertheless the sparkling colors we see are internal creations. That we are fooled into believing that we "see" the world outside dramatizes how well coupled we are with our environment. (pp. 67–68)

Based on this conception, what one actually "sees" in a visual experience is not an "outside" world but the nervous system itself, a counterintuitive conception indeed.

An important consequence of the structure-determined state of organisms is immunity to the reception of "information": contrary to prevalent views in communications and systems theories, Maturana and Varela hold that structure determined systems are informationally closed. What Maturana and Varela call "instructive interaction," which is the direct influence of one person on another, is held to be impossible. Mahoney (1991) explains:

> The ongoing structural changes (and exchanges) that living systems undergo are the result of "perturbations": which can arise from interactions with their medium (environment) or, recursively, with themselves. These perturbations "trigger" structural changes in the organism but do not automatically convey information about the nature or properties of the perturbing entity. They are not, in other words, "instructive" in the traditional sense of that term. Perturbations do not "cause" changes in the organism by putting something into it (like "information"), they simply trigger changes of state that arc structure-determined by the organism. From this perspective, "information" is not something transferred or processed. Instead, "information" is literally, translated from its Latin origin: *in formare,* "that which is formed from within." (p. 392)

Another important aspect of structure determinism pertains, again, to neurobiological considerations and distinguishes *feedback* (information processing) from the constructivist concept of *feed-forward* (information creating). Mahoney (1991) provides an example of feed-forward:

> On the assumption that visual experience is highly correlated with neurochemical activity in the visual cortex, only about 20% of that activity can be attributed to impulses from the retina . . . impulses from the retina can influence—but do not specify—activity in the visual cortex. On the average, as much as 80% of what we "see" may be a tacit construction "fed forward" from the superior colliculus, the hypothalamus, the reticular formation, and the visual cortex itself. (p. 101)

In other words, the elements that finally result in a visual experience point to an "inside-in" process (feed-forward) rather than an "outside-in" process as in feedback. Structure determinism, and autopoiesis, to be discussed in the following

section, form the cornerstones of constructivist theory as formulated by Maturana and Varela.

Autopoiesis

Because they are structure-determined and organizationally closed, living systems are said to be *autopoietic* or self-organizing entities. Autopoietic entities are autonomous in the sense that they survive, prosper, or perish under the "self-law" of their own makeup (Mahoney, 1991, p. 393). In contrast to a state of autopoiesis is that of *allopoiesis*, which is the essential principle of systems theory. A number of parts interrelate among themselves to produce a specified outcome. An example is an automobile. It is composed of a number of interrelated parts that work in unison to propel it down the road, but it has no capacity to produce and maintain itself as an autopoietic system does:

> Autopoietic entities, because of the way they are structurally organized, are engaged in the process of producing more of themselves. This process is manifest at every level of organization, from the cell to the colony. Cells grow and split, forming additional like-structured cells. Parents have offspring, perpetuating the family line. . . . Living, from the ingestion of food to the excretion of waste, consists of cycles of self-production. For a living system there is a unity between product and process: in other words, the major line of work for a living system is creating more of itself. (Efran et al., 1990, p. 47)

Structural Coupling

It is the constructivist principle of *structural coupling* that explains how autopoietic individuals interact with entities other than themselves and their own nervous systems. The principle of structural coupling also allows constructivist theory to avoid the epistemological pitfall of solipsism or a state of complete self-reference. Structural coupling corresponds roughly to the more traditional concept of "interpersonal interaction" that takes place in a "relationship" between individuals but with the important difference that the interaction is seen to be between closed, not open systems:

> . . . Maturana and Varela assert that the interactions of living systems with their medium [environment] are "structure determined"; meaning that changes in either are "triggered" (as contrasted with "produced") by their interaction. Thus, learning does not consist of being "instructed" by external agents or environments. Maturana and Varela have also asserted that learning cannot consist of the "pickup" of pre-packaged information from outside the living system, nor can it be understood as the acquisition of internalized "representations" of its medium. The changes exhibited by an organism in the course of its "structural coupling" with its medium reflect the organization and structure of the organism. They do not offer information about the medium itself. (Mahoney, 1991, p. 391)

Episodes of interactions between individuals and their environments are instigated through mutual "perturbations" or triggering stimuli. These perturbations form the basis for changes in each (person and environment) but do not determine the changes, which are instead brought about by the nature of their respective structures. One person does not "cause" another person to do anything; this would be instructive interaction, or direct influence, which, according to Maturana and Varela, is not possible because of the closed nature of each person as a system.

Based on its epistemology, which blurs subject–object distinctions and questions notions of objectivity and reality, constructivism shift us to a "many worlds" frame of reference and away from normative views of truth and falsehood, right and wrong, functional and dysfunctional. Significant practice implications arise from the "many worlds" constructivist way of thinking about human behavior and experience.

Implications for Assessment, Diagnosis, and Treatment

Implications for Assessment

The case assessment process involves the knottiest of all problems in understanding human behavior—that of causality. Positivist causal explanations have assumed that a great deal of both individual and aggregate behavior is the direct result of identifiable "external" influences. Constructivist causal assumptions, however, are based on a view of the nature of the human nervous system and its relationship to the environment. This view maintains

that the nervous system can only be perturbed or "bumped up against" but not "entered" by external stimuli, indicating a closed system. What, then, are some constructivist implications for assessment if the individual is viewed as a structure-determined closed system?

In constructivist theory, the individual is the only unit of attention seen to have ontological existence. Aggregate units such as family, group, and community are reifications existing only in language and thought and are devoid of ontological existence. While the term "system" is used in constructivist-based practice theories, it is only a convenient term referring to two or more individuals in relation to each other or to an individual made up of various bio-psychological components. The constructivist practitioner may think in terms of working with systems but keeps in mind that there are as many "systems" involved in a case as there are system observers (i.e., clients and others). A major implication of this for assessment is that the practitioner must bring to each client case a "many worlds" mindset, and from within this mindset must dedicate himself or herself to learning as much as possible about each individual client's ongoing views, understandings, and intentions toward self and others concerning problems being discussed. It is the client's sensing that the practitioner's main concern is to learn about him or her as a unique individual that conveys to the client a sense of high respect from the practitioner. This sense of being valued and respected helps free the client to develop alternative views or "stories" of problems and to reconstrue or reframe his or her problematic life situation. In this sense, constructivist theory supports the time-honored assessment principle in social work of starting (and staying) where the client is.

On the clinical level, essentially what is assessed in a constructivist-based approach is the client's frame of reference (constructions) pertaining to the problems being discussed, and the nature of reciprocal perturbations between the client and relevant aspects of his or her medium (environment). This is a process representing close collaboration between practitioner and client in which the client is made to feel that it is the practitioner who is learning and the client who is teaching.

According to Strong (2014), the reflexivity of these negotiations must be clear to clinicians so that the active role of the client is fully understood and respected. The implications for social work practitioners is that they cannot influence events or decisions made within therapy from an objective stance, but rather must embrace the duality involved in being an active agent in the change process and working collaboratively within practice situations (Cooper, 2001).

Implications for Diagnosis

"Diagnosis," in the sense that it has been used in the so-called medical model by the behavioral helping professions, is not supported by constructivist theory. "What's wrong" is not seen as an entity in the same sense that the physician views a fractured leg or as inflamed appendix as entities having ontological existence. The principle of structure determinism negates the validity of externally imposed predetermined categories and labels. In the approach represented by *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), for example, the diagnostic task in a case falls to the practitioner and his or her skill in use of the classification system applied to a particular client's "symptoms." The client's role becomes that of passive recipient of the practitioner's expertise. A constructivist-based approach to developing ideas about the nature of problems stresses the need for practitioner–client collaboration and mutuality, with the expert role of the practitioner being redefined from its usual meaning. The practitioner's expertise is in assuming a learning stance with the client by approaching each case assuming he or she knows nothing about the client. A case example in the next section illustrates this stance.

Treatment Implications

While radical and critical constructivism were previously discussed as the two major varieties of constructivism, considerations for treatment as discussed here will refer predominately to the assumptions of critical constructivism, generally referred to in the social work literature as *social constructivism* (see, for example, Cottone, 2007). Social constructivism assumes

the existence of an objective reality, but one that is knowable only through perception, language, and mentation. In the social constructivism view, the "reality" of structural and psychosocial social problems is fully acknowledged.

In more traditional practice approaches, especially psychodynamic ones, uncovering the "real problem" in a case has been seen as an essential job for the practitioner. The "real problem" concept implies that there is an objective pathological/dysfunctional condition of the client and/or his or her situation that can be discovered through the clinical skills of the practitioner, as when the physician finds malignant cells and diagnoses cancer—the "real" problem underlying the patient's pain and other symptoms. In constructivist-based assessment and treatment, however, no "real" problem is assumed to exist in the sense that there is an underlying problem with objective consequence[s] not yet glimpsed by the client but that the practitioner will help him or her discover. This should not be misconstrued to mean that in the constructivist view no problem exists. Through the lens of critical constructivism (social constructivism), clients are seen as co-constructing their personal realities through interdependence with their social and physical environment. Contrary to a widespread practice among practitioners in the behavioral helping professions, the practitioner using a constructivist-based treatment methodology (e.g., narrative therapy) would not attempt to get the client to "own his problem" but to cognitively divest himself or herself of it instead.

For some cases dealt with in a narrative approach to treatment, separating the problem from the person is seen to be essential. A technique called "externalizing the problem" is frequently used, often with dramatic positive results (see, for example, White, 1989; O'Hanlon, 1994, p. 24). It is believed that externalizing the problem (essentially a process of giving it a name as apart from the client) helps free the client to view the problem as an adversary outside instead of inside him-/herself, thus freeing him or her to develop alternative problem versions and solutions. This is thought to be especially helpful in cases where the client has seemed to incorporate the problem with his or her identity, such as, for example, in anorexia.

Client Self-Determination

The observance of client self-determination has been held as a major intervention mandate in social work from the beginnings of the profession. Constructivism views self-determination, not only as a treatment mandate to be followed, but also as a natural state of the person based on the individual's structure-determined, autopoietic nature. If the responses of individuals are structure-determined, they are by definition self-determining. The practitioner has no option of respecting or not respecting this as a practice principle. A practitioner could believe that he or she is executing a "controlling" technique of some kind (e.g., giving a client paradoxical instructions); however, the client's response would not be determined by the paradoxical instructions, but only selected by them—that is, they would "trigger" some response but would not determine what response, which would be brought about by the individual's neurophysiological structure and psychological makeup. However, acknowledging the client's self-determining nature does not mean accepting everything the client might want to do.

> While accepting that there are multiple versions of reality, we may choose not to accept versions that are congruent with the perpetuation of racism, domestic violence, school dropouts, runaway teenagers, and other destructive behaviors. We may still try to change uglier versions of reality. (Colapinto, 1985, p. 30)

Practitioner Demands

Because of the counterintuitive flavor of constructivist theory, a certain tolerance for ambiguity is required of practitioners—this making it possible to embrace the "many worlds" perspective of constructivism to accommodate the subjective (constructive) variability among their various clients while staying attuned to a presumed normative world to which they and their clients must respond. Some may feel uncomfortable with such a paradoxical-sounding professional mindset, while others will have no difficulty.

Case Example

Perhaps one of the most difficult aspects of constructivism to comprehend pertains to its epistemology, which deemphasizes traditional normative perceptions and understandings of an "objective" world and stresses instead the importance of the individual's subjective idiosyncratic world as the primary basis for behavior. For those who may think constructivism is too philosophical to be practical, a case example may help clarify. The following vignette, described by Harlene Anderson as cited by Sykes Wylie (1992), illustrates a practice implication of the constructivist epistemological stance.

A family came to therapy after the children had been removed from their home and the mother had gone to a shelter because the father had so severely beaten them. The mother came in looking disheveled, wearing house slippers and missing several teeth. The father—a huge man, barefoot, weighing probably 300 pounds and wearing denim, bib-front overalls with no shirt on underneath—began shouting as soon as he was in the room that he was poor, white trash, he'd never be anything, but he would not be told what to do by anybody. He would handle his family the way he saw fit, and the only reason he was there was because "the fuckers downtown" had made him come. He also announced, rather mysteriously, that he "hated niggers."

At that point, says Anderson, "everyone behind the mirror instinctively moved their chairs back," except Harriet Roberts, a consultant to the clinic, and a black woman. She got up, walked into the therapy session, calmly introduced herself and with apparently complete sincerity said she wanted to learn more about what he was saying and why he disliked blacks.

> Roberts continued the therapy. Seeing both husband and wife separately and together (the wife had gone back to live with him, as she always had in the past), bringing in the man's mother, and the staff from the shelter where the woman had stayed, and consulting with the child protective agency. Gradually, as he became more human in therapy, his behavior outside improved: after the first session, he stopped beating his wife, and when his children were eventually returned, he did not beat them again, either. (Sykes Wylie, 1992, p. 28)

A practice principle applied here, derived from constructivist epistemology, was in evidence from the therapist's assumption of the role of learner with the client—a client who at the moment was potentially dangerous to her and had proven himself dangerous to his family:

> According to Anderson, the therapists [*referring to other therapists subsequently involved*] entered therapy with an attitude that they did not know, objectively, better than the man or his wife or the children or any of the other people involved in the case, what constituted universal truths about good and bad families, emotional pathology and health. They did not feel that their professional expertise allowed them to "write the story" for the family. Instead, they believed that in conversation, all these participants together could come up with a better, more humane story that locked nobody out of the process of creating it.
>
> What seems to have happened is that a man who has felt ignored, ostracized and generally loathed for most of his life, meets a therapist who is unafraid of his hostility, uninsulted by his bigotry and unoffended by his repulsive persona. . . . He says that for the first time in his life he feels he has been listened to and understood. (Sykes Wylie, 1992, pp. 28–29)

By walking calmly into the client's presence saying she wanted to understand more about why he disliked blacks, the consultant demonstrated her respect and unconditional positive regard for him in the face of his anger and implied threats, making it possible for him to reconstrue his constructive world. Through her actions, the consultant recognized the client's structure-determined nature as reflected in his insistence that he would "handle his family as he wanted" and that he had the right to hate black people. In her acknowledging the very being of this man as the only person he could be at the moment, he then became free to reconstrue his meanings closer to those of his medium (environment).

This case analysis reflects narrative intervention concepts (e.g., helping the family rewrite their story to a less destructive one). For more extensive discussion on narrative intervention as a constructivist-based approach, see Chapter 19. A case example of treating depression using the narrative approach can be found in Neimeyer (2009, pp. 97–100).

Convergence with Neuroscience

From its birth in antiquity as a philosophical framework, constructivism has evolved in importance from the utility of its various applications. From the structure determinism and autopoiesis formulations of Maturana and Valera, constructivism can now be related to the burgeoning field of neuroscience. While various definitions of "neuroscience" can be found in the literature, depending on the particular focus of concern, it can be defined appropriately here (for relating it to constructivism) as the field of study pertaining to the structure and function of the brain and nervous system as related to various aspects of subjective experience and behavior. While an extensive examination of relevant aspects of neuroscience for the further understanding and development of constructivism is beyond the scope of this chapter, the topic is being flagged here for its potential significance. Toomey and Ecker (2007) have written about the convergence of constructivism and neuroscience:

> Psychological constructivism's central insistence on the active role of the individual in shaping experiential reality receives extensive corroboration from findings on how the brain functions . . . the neuroscientific community appears to be converging to a consensus regarding the capabilities of individual neurons and neural networks to actively shape and define what is experienced as reality. The emerging paradigm, which has been referred to as neural constructivism (Quartz & Sejnowski, 1997), aligns well with psychological constructivism. (p. 205)

This view points to the influence that specific realist ("objective") entities (i.e., neurons and neuronal networks) exert on our experience of "reality." While constructivists have maintained all along that the human experience of reality is subjective, Toomey et al. now cite the specific brain structures responsible for that experience. These authors further state: "Not only are neural networks constructivist in their organizing and model of reality, but the way the brain forms and organizes [*constructs*] those neuronal networks is itself a significantly experience dependent constructivist process" (p. 209).

An interesting development between neuroscience and constructivism involves neural networks and the learning properties of constructive development. Much of the neuroscience research highlights networks with fixed architectures that are often described as in place and unchangeable from birth. However, in line with constructivist theories, a growing body of literature is now focusing on constructive neural networks (Quartz, 1999). Constructive neural networks stress the capacity of the neural architecture to be altered and modified based on learning (Quartz & Sejnowski, 1997; Quinlan, 1998). Consequently, constructive thinking within neuroscience highlights the importance of a rich learning environment for infants and young children in order to help encourage neural growth and development. Exposure to a variety of experiences within our environment can lead to structural changes within our neural system, which supports the idea of constructive learning and growth instead of a preset mental capacity that is predetermined at a young age.

Although it may seem burdensome for a neural system to learn through activity-dependent change, from a constructivist perspective, this is a positive method of learning and growth. It anticipates an immature system's learning solutions to novel and increasingly complex problems that are encountered in one's environment. Therefore, the learning capabilities that will be required for human development and success in the future are constructed through experiential exposure. Instead of beginning this process with a fixed neural architecture and then selectively only using some processes, starting with a limited but evolving architecture allows a network to pass "through a phase of limited representational power during early exposure to some problem and then build successively more powerful representational structures" (Quartz, 1999, p. 52). This implies "that cortical development involves the progressive elaboration of neural circuits in which experience-dependent neural growth mechanisms act alongside intrinsic developmental processes to construct the representations underlying mature skills" (Quartz, 1999, p. 48).

The idea of constructive learning is not intended to be a return to *tabula rasa* learning, but rather represents a unique and dynamic interaction between changing environmental conditions and neural mechanisms. Constructive learning acknowledges that

there are general constraints imposed by neural architecture, but this does not mean that representations for specific cognitive problem domains are preexisting. Rather, constructive learning builds these classes of representations under the influence of the environment, acting in tandem with the natural constraints within neurobiological architecture. This view allows for the possibility of "powerful learning abilities while minimizing the need for domain-specific pre-specification and so avoiding the heavy burden that nativism places on genetic mechanisms" (Quartz & Sejnowski, 1997, p. 539).

Developments in both constructivism and neuroscience would seem to warrant further investigation of the ways in which they converge, potentially providing constructivism with a foot in science to help balance its more philosophical aspects. One avenue of investigation that would seem to be productive relating to practice concerns is the nature of the client's subjective experience (psychological constructions) related to specific brain structures thought to be the ground of subjective experiences. Following is an example of a therapist's attending to these considerations:

> When these authors first began reflecting on the possibility of viewing psychotherapy through the lenses of neuroscience, there was a fear that increasing consideration of brain function would lead to coldness and estrangement in the psychotherapy process. It has been surprising that the opposite has been the case. For example, empathy with a client being overwhelmed by flashbacks of previous trauma has seemed stronger when these authors reflected on the implications of research indicating that visual cortex used to encode current information is also required for recall of memories of previously established visual images; while being used during visual memory of a traumatic event, visual cortex is unlikely to be available for processing of current experience. How frightening it must be not to be able to see the therapist even though the client can hear the therapist's voice "in the distance" during a flashback. Clients have seemed remarkably reassured when their inability to see the therapist is explained in terms of possible brain mechanisms for such an experience; the apparently "crazy" experience of not being able to see someone sitting in front of them now makes sense. (Folensbee 2007, p. 2)

The constructivist element here is the practitioner's acknowledging the "realness" of the client's intense subjective experience (his constructed world harboring a flashback) while staying in touch with another "reality," which was his knowledge and utilization of brain science—an example of a therapist's observing the constructivist "many worlds" conception and the relative nature of "truth" and "realness."

In addition to increasing the efficacy of psychotherapy by utilizing knowledge of brain science, Folensbee also sees an additional important dimension:

> Assessment, conceptualization, intervention, and communication in therapy all seem likely to improve when the underlying nature of brain functioning as currently understood is kept in mind during the implementation of psychotherapy. Consideration of psychotherapy in terms of the framework of brain function offers the potential for integrating and coordinating various traditional treatment modalities within a structure that can facilitate communication between proponents of various schools of treatment, and can support collaborative rather than competitive interventions. (p. 186)

While social workers in their formal training typically receive minimal exposure to the topics of neuroscience, rapid advances in behavioral neuroscience with implications for various psychosocial problems dealt with by social workers may bring about increased attention to this area in schools of social work, particularly on master and doctoral levels. Examples for further reading in neuroscience related to psychotherapy can be found in Badenoch (2008), Pliszka (2003), Cozolino (2002), and Gabbard (1992).

Constructivism and Emotions

The constructivist view of emotions has arisen as a growing field of interest, along with that of neuroscience. From a constructivist perspective, "emotions are emergent conditions reflecting multiple modalities of affective reactions to psychologically important situations" (Clore & Ortony, 2013, p. 336). Emotions can therefore be considered a variable set of reactions for coping with the diverse situations that one encounters (Lindquist, 2013). The exact emotions that a person exhibits in a situation are subjectively chosen by the individual, based on their previous

life history and their interpretation of the current situation. Therefore, stereotypical beliefs about how a person should respond emotionally in a specific situation are not necessarily predictive of individual behavior from a constructivist perspective.

The constructivist view of emotions and emotional themes highlights the idea that the themes we encounter most within our life experiences become prototypes, schemas, or stereotypes. We then use our preferred emotional schemas to organize, understand, and communicate our own personal stories and life experiences (Clore & Ortony, 2013). Humans have a tendency to use these emotional schemas to infuse meaning and reorganize events into emotional vignettes. During the retelling of stories, we often infuse such emotion and passion into these stories that listeners and readers may feel some of that emotion, too. This ability to detect emotions that others are experiencing or describing can be considered adaptive, as it enables the detection of dangerous situations, and also allows for companionship and bonding during pleasant emotions.

Although having these emotional schemas appears useful and adaptive in everyday life, there are also costs associated with having these clear schemas. As researchers and social workers, we may readily become engrossed in analyzing the responses of participants, searching for the "emotional modules" that correspond to specific emotions, and we may confuse these emotional stereotypes with reality (Clore & Ortony, 2013, p. 343). Instead, emotions can provide a key gauge of important life events for purposes of understanding and planning for action. It is not necessary that we understand exactly where in the brain these emotions originate, even if they are constructed by life experiences.

This overview of emotion from a constructivist viewpoint confirms that we develop our schemas or stereotypes about emotion based on experience. These emotional schemas are not fully present from birth and cannot develop without life experiences and exposure to various emotional states in others. The nativist opinion of emotional modules' being present from birth and predetermining what emotional schemas one will possess is therefore discounted. Rather, individuals construct and change their emotional stereotypes and schemas throughout their lives, and, although the basic cognitive structures are necessary in order to recognize and process emotion, people construct emotions based on their experiences in the social world. Therefore, constructionism holds that emotions are "events that are created in the mind of a perceiver to fit a certain situation" (Lindquist, 2013, p. 356).

According to Lindquist (2013), constructivism offers a better understanding of how discrete perceptions and experiences of emotion are due to a variety of psychological ingredients being combined based on past situations and life events. When a person experiences an emotion, this could be considered a perception of the body, in that it involves categorizing internal and external sensations and perceiving these as specific emotions (Bar, 2009). Since the construction of emotions depends heavily on context, emotions are sometimes referred to as "situated conceptualizations" (Lindquist, 2013), in that emotions may be used specifically for interacting with different situations.

While neuroscience and the construction of emotion appear to coincide through the correspondence of brain regions to emotional states, the observation that a particular anatomical area of the brain shows increased activity during an emotional experience does not mean that this particular anatomical area should be considered the circuit for that particular emotion category. "Neural activity should instead be thought of as a snapshot in time of a particular combination or 'recipe' of networks that correspond to basic psychological ingredients" (Lindquist, 2013, p. 364). It is clear from this overview that emotions evolved for a purpose, even if the emotions are not packaged in a modular way but instead represent more basic processes that flexibly combine in humans to produce our reactions to events in the world around us.

In respect to social work treatment, it would seem beneficial for social workers to understand emotions from a constructivist perspective. For a practitioner trying to understand how an individual is feeling before and during treatment, this perspective sheds light on how meaning is subjective for each individual and is developed

on a personal level. It implies that social work practitioners must attend to the level of meaning for a person, and that this meaning will be unique for every client.

Empirical Base

Attitude Toward the Empirical Stance

The constructivist view of positivistic science as a component of constructivist theory and the use of empirical evidence as data in its approach to research have evolved over time. Some constructivists hold the belief that empirical evidence does not play a significant role in evaluation due to the fact that there is no such thing as a pre-given known reality; rather, they hold that reality is fundamentally subjective, and therefore knowledge must be viable and malleable rather than empirically true (Baerveldt, 2013). Therefore, many constructivists do not acknowledge whether their position can be empirically supported, as this is redundant from their perspective. This clearly puts constructivism at odds with empiricism, maintaining that it cannot be evaluated by something it dismisses as an invalid instrument. While some constructivists would still agree with this statement, a competing stance has lately gained prominence. Morris (2006) provides a clear statement of and basis for this competing stance in the constructivist approach to research:

> The Oxford Dictionary defines research as "careful search or inquiry after or for or into; endeavor to discover new or collate old facts, etc., by scientific study of a subject, course of critical investigation." This definition rests on facts and science. It does not state that only variables measured quantitatively are facts, or that science is positivism. Constructivists argue that subjective constructions are facts and that the constructivist approach is science. A subjective description of living with HIV-AIDS is something that is known to have occurred or be true; it is precise, its existence cannot be ignored, and it is real. All these are criteria for deciding whether something is a fact according to the same Oxford Dictionary. The constructivist approach develops knowledge that is systematic, deduced from self-evident truths, and follows consistent principles. Constructivist research thus builds a legitimate body of knowledge using a methodology that is scientific. (p. 196)

In this view of constructivism's relationship to the science paradigm (of which empiricism is the hallmark), which is very different from its earlier stance, we see the manifestation of a basic tenet of constructivism applied to the theory itself—that is, change and variation are inevitable for progress.

Connections to Other Theories

A cursory examination reveals numerous theories that are compatible with constructivism. The phenomenological/humanistic-based theories such as client-centered and existential approaches place heavy emphasis on the client's perceptions, feelings, and attitudes. Other notable examples are the psychodynamic approaches that emphasize the importance of perception, meaning-making, and idiosyncratic subjective experience (e.g., the psychosocial model and psychoanalytically oriented approaches). There are, of course, clear connections with approaches based in cognitive theory, with its emphasis on the "knowing" processes and mentation.

Agreements are also to be found between the feminist perspective and constructivism. Both maintain that reality is socially constructed, and that each person has his or her own reality, of equal worth with all others. Both emphasize the oppressive influence that certain sociocultural norms can exert on individuals, families, groups, and organizations, and the contribution of these "toxic norms" to the development of psychosocial problems on all levels. Theoretical perspectives that emphasize the individual's subjective experience and autonomous functioning will find compatibility with constructivism. Theories that may be trapped in an echo chamber hearing only their own voices saying they have found the truth will find less kinship with the constructivist perspective.

Another observation is being made here concerning constructivism's relationship to major value positions and goals of the profession. While constructivism draws attention primarily to the autopoietic nature of the individual (structure-determined, organizationally closed), it should be emphasized that there is no implication of blaming the victim or negating social work's concerns with problems of social

justice, discrimination, oppression, domestic violence, or other psychosocial or structural problems of concern to the profession. It does, however, require a constructed ever-changing view of reality from client case to client case. Granvold (2001) has written about the compatibility of constructivist approaches with the profession's more traditional ones:

> Constructivist treatment is highly compatible with a generalist-eclectic social work practice perspective. Constructivism emphasizes the client's strengths and possibilities (Saleebey, 2012). A collaborative relationship is sought with the client in which the therapist assumes a non-authoritarian, albeit knowledgeable, stance. Although the primary focus of constructivist assessment and intervention is on the meaning-making process (internal dispositions), in the social work tradition, environmental conditions and social factors are considered in the promotion of the client's immediate goals and ultimate personal development. The profession's distinctive focus on person-in-situation and the interdependence between people and their environments remains intact with constructivism in the social work theory arena.

Constructivism as Meta-Theory

Constructivism can be seen to connect with other theories on various levels. One of these, which has received little attention in the literature to date, utilizes constructivism as a meta-theory for understanding the deeper nature of theories that have traditionally been classified primarily in the realist/objectivist tradition. Hansen (2007) has argued that a seemingly paradoxical situation, which he calls "epistemic contradiction," is present in many theories used by the counseling professions. As an example, referring to Freud's famous case of Little Hans, who was diagnosed with a displaced Oedipal complex, Hansen writes:

> When evaluated from an epistemological perspective, the archeological metaphor is simultaneously constructivist and objectivist. It is constructivist in the sense that psychic artifacts determine individual perception, as Hans's image of horses was internally constructed by ancient, psychically buried conflicts. The counselor (i.e., archeologist), using a psychoanalytic shovel, can dig through the psyche, thereby bringing to light the ancient relics in their pristine form. In this latter sense, the archeological metaphor is objectivist, because the counselor is deemed able to discover the essential nature of the buried conflict, as Freud discovered Hans's Oedipal conflict. Clearly, then, constructivist and objectivist epistemic assumptions are each present in the archeological metaphor. (Hansen, 2007, p. 113)

Hansen maintains that this oscillation between subjectivity and objectivity in counseling theories reflects an essential part of human experience that is not simply subjective or objective, but both. He further contends that cognitive, humanistic, and even behaviorist theories all have elements of constructivism, although presumably built on foundations of objectivist assumptions. Examining other theories, then, for this epistemic subjective-objective oscillation reveals that not only postmodern theories have constructivist elements in their very architecture (Hansen, 2007, p. 112). As stated at the beginning of this chapter, constructivist elements have been around in theories used by social work for some time, but have not been specifically recognized as such.

Training for Constructivist-Based Practice

Constructivist ideas are beginning to find their way into the Human Behaviour in the Social Environment (HBSE) curriculum, practice theory courses, field instruction, and research courses in most schools of social work. To help ensure a thorough grounding in the principles of constructivism as formulated in this chapter, social work students should have course work pertaining to all three aspects of constructivism as a thought system—philosophical, behavioral, and methodological. For the philosophical aspect, social work students should have an introductory exposure to the basics of epistemology in order to compare realist and constructivist epistemologies. Study of the behavioral aspect of constructivism should expose social work students to topics in psychology such as sensation, perception, and cognition presented on a level directly related to basic constructivist concepts such as structure determinism, autopoiesis, and structural coupling. Due to further development of the convergence of constructivism with neuroscience as presented in this chapter, topics in basic behavioral

aspects of brain science would be in order. For the methodology aspect, the basic concepts and postulates of constructivism would be translated into assessment/treatment principles, techniques, and strategies, with opportunities provided for social work students to learn practice applications in their field experiences. One practice model that is specifically based upon constructivism, and a model that could receive more attention within social work, is George Kelly's personal construct theory.

As noted earlier, Kelly's personal construct theory (PCT) proposed that people organize experiences that they have as constructs by interpreting experience and developing different dimensions of meaning (Raskin, 2002). These constructs are utilized by individuals to predict how the world and people in society might behave (Winter, 2012). The model suggests that a person's constructs are continually tested in everyday life, based on how well they predict life circumstances, and that an individual might be challenged to revise a construct when it is no longer useful or are accurate (Winter, 2013). Kelly coined the term "hostility" to refer to individuals who continue to hang on to faulty constructions even if there is disconfirming evidence for those constructions. In other words, "hostile people" fail to alter their constructions to better fit the world and prefer to force their experiences in the world to fit their constructions (Raskin, 2002).

PCT allows social workers to better understand how clients come to view their sense of self, and which aspects of this sense of self are malleable and flexible, and which are fixed and more resistant to change. In PCT, the self is viewed as constructed and generated by the way a person successively construes her or his self (Efran, McNamee, Warren, & Raskin, 2014). However, there are also basic constructs that are developed early in life that become deeply embedded constructions of self (Raskin, 2002). These become more impermeable to self-reflection and alteration. It is important for social workers to understand that these enduring senses of self and aspects of individual identity are the most difficult to modify, and individual clients may rebel against threats of change to these constructs (Winter, 2013). Although social and relational factors may play a role in the constructive process, individuals are still viewed as the primary source of their own constructions. This is also important for social workers to understand, as oftentimes social workers may assume that environmental causes contributed solely to a person's sense of self, when in reality, the client played an active role in that construction.

Kelly also developed the idea of "fixed role therapy," in which a client acts out the role of someone psychologically different from himself or herself in everyday life (Raskin, 2002). This is considered an avenue to encourage the client to experiment with new modes of behaving and new constructs for a set period of time. A client is not explicitly instructed to incorporate these new constructs into his or her sense of self. However, many clients feel as though new possibilities are available as they have the opportunity to incorporate new perspectives into their current constructions (Efran et al., 2014). This theory clearly incorporates constructivist ideas, as experimenting with new vantage points is viewed as central to change within clients. This is especially helpful for clients who have been stuck in ineffective problem-solving modes, because it encourages the revision of these personal constructs.

In essence, PCT allows social workers to build new perspectives with clients from a constructivist point of view. This provides clients with the power to construct new models or roles for themselves that enable self-efficacy and empowerment. The social worker encourages the client to incorporate these new identities into her or his sense of self to bring about clinically significant change. PCT has a strong support base and has been actively developed through the *Journal of Constructivist Psychology* (Strong, 2014) suggesting that it can be an important perspective for understanding client experiences and behavior and an effective method of creating change for clients.

Some of the study topics mentioned heretofore are highly technical and specific to disciplines other than social work, and might require broad areas of study. This, however, should not deter social work educators. The virtual explosion of findings from the life sciences taking place makes it essential for social work educators to move in the direction of incorporating

highly technical/scientific material in coursework if social work is to remain a highly credible discipline among related professions such as psychology and psychiatry. For an excellent source of information on some of the ways constructivist ideas have been incorporated into social work curricula, see Laird (1993), *Revisioning Social Work Education: A Social Constructionist Approach*. Although this is a 1993 publication, the material remains sound in terms of its presentation of the theory of constructivism and strategies for training students to incorporate constructivist concept and principles in their practice. Articles by Dean (1994) and Greene and Lee (2002) also provide sound guidelines for the application of constructivist concepts to practice.

Limitations and Problems

As is always the case with any new theory (and old ones, too), controversies and various concerns have arisen about constructivism and its implications for human behavior and change. On the conceptual side, it can be difficult to know if there are substantive differences with non-constructivist concepts that are seemingly essentially similar. For example, Bell (1985) has questioned the validity of Maturana's view of interpersonal causation:

> When Maturana says that causality is impossible, he means, for example, that the professor's lecture did not determine the response of his students (that would be instructive interaction). The professor's lecture selected the students' responses, but their structure determined their responses. . . . Maturana is claiming that our everyday use of the word "cause" always implies or threatens to imply a determining in the sense of instructive interaction—whereas "causation" is always only a selecting. Thus, he says causality is impossible. (p. 8)

Other concerns about conceptual and practical aspects of constructivism have been expressed by Mahoney (1991):

> Beyond the heuristic abstractions of "structure determination," "organizational closure," and "structural coupling," what is it that determines an organism's adaptations to/of its environment? What are the parameters of "congruence" between the structures of a living system and its medium? Why are some systems capable of much wider ranges of self-restructuring than others, and what are the explicit implications for parent, education, and psychological services?
>
> Another way of expressing this reservation is to say that . . . current autopoietic theory pays too little attention to the world in which the living system lives, not to mention the mentation involved and the processes by which that system learns, changes, or develops. . . . As many cognitive therapists have learned over the last two decades, psychotherapy clients can be urged to "restructure" their perceptions and beliefs about self and world, but the self-perpetuating aspects of that self and the everyday constraints imposed by that world are not always conducive to that undertaking. (p. 396)

It should be noted, in relation to Mahoney's concern about the lack of an adequate concept in constructivist theory to account for the individual's adaptation to the environment, that Mahoney, as a psychologist, is not taking into account, nor would he be expected to, the role of constructivism as only one member in the family of theories employed by social workers. Systems and ecological theories have long been effectively incorporated by social workers in their practice for understanding how the individual adapts to the environment (see chapters in this volume on the Life Model [Chapter 18] and Systems Theory [Chapter 14]). Mahoney's observation, however, about the need for further development of the abstract concepts in constructivism toward the operational level remains valid.

Conclusions

The selective use of an ever-expanding body of knowledge and theory in social work becomes increasingly important in order to meet the challenges of the increasing complexity of social work practice demands. Constructivism as a conceptual framework for social work practice has recently added to the profession's available technology. The future for constructivism in the profession will most likely unfold according to the extent to which it is found to be compatible with social work values, useful to practitioners, and effective with clients. Payne (1991) wrote what is still true today:

> New ideas within social work theory arise in various ways and go through a process of naturalization

by which they become adjusted to the conventional framework of social work. Some theories have not fully naturalized, because they do not deal well with some of the important features of social work within the period in which they become important. Theories which do naturalize affect the common features of social work. (p. 7)

Cole (1992) has distinguished between "core" knowledge in a discipline and "frontier" knowledge. The core knowledge, including a relatively small number of theories, is the "given" or the "starting point" for that discipline. The frontier component is composed of the knowledge that is in the early stages of being developed and about which substantial consensus is still lacking (p. 15). Constructivism as a framework for social work treatment fits into the frontier category at this point. Further use by practitioners and testing of constructivist-based practice approaches by researchers will be necessary for constructivism to arrive at a point where it may slip over into the core of social work knowledge, and it is making progress in that direction.

It has been shown in this chapter how some of the basic postulates of constructivism are not only compatible with major social work practice principles but also provide them with additional support. Constructivist-based practice clearly addresses current major concerns of the profession, such as the need to empower clients; the rights of racial, cultural, ethnic, gender, and age groups to be self-determining; and the need to enhance the degree of dignity and respect accorded to all people. We have also shown that the tenets of constructivism are compatible with recent developments in neuroscience and the neuroscience of human emotion.

The formulation of constructivism set forth in this chapter as a conceptual framework for social work treatment has drawn substantially from the conceptions of Maturana and Varela. These conceptions are rooted in neurobiology, in contrast to the social and behavioral sciences that social work has traditionally drawn on for foundational theory. In closing this chapter, a statement of what might be viewed as the essence of the neurobiological constructivism of Maturana and Varela provided in their own words would seem appropriate:

> Every human being, as an autopoietic system, stands alone. Yet let us not lament that we must exist in a subject-dependent reality. Life is more interesting like this, because the only transcendence of our individual loneliness that we can experience arises through the consensual reality that we create with others, that is, through love. (1978, p. 63)

From this constructivist duality of the individual standing alone in a subject-dependent reality, a central mandate arises for the practitioner, which is to carefully and persistently respect the individuality of clients as self-determining beings and, by following this mandate, to increase the likelihood of clients' being able to deal more effectively with the requirements of a normative world while broadening their vision to catch sight of more satisfying ways to conduct their lives (see the Case Example in this chapter).

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7

Social Work Theory and Practice for Crisis, Disaster, and Trauma

Diane M. Mirabito

A crisis is "an acute emotional upset arising from situational, developmental, or sociocultural sources and resulting in a temporary inability to cope by means of one's usual problem-solving devices" (Hoff, Hallisey, & Hoff, 2009, p. 4). Parad and Parad (1990) expand upon this definition by describing a crisis as "an upset in a steady state, a turning point leading to better or worse, a disruption or breakdown in a person's or family's normal or usual pattern of functioning" (pp. 3–4).

As these definitions convey, crises take many forms, including the sudden death of a family member; a school shooting; poverty; a devastating hurricane or earthquake; homelessness; diagnosis of a chronic or life-threatening illness; job loss; sexual assault; family, domestic, and intimate partner violence; psychosis; divorce; retirement; physical and sexual abuse; rape or sexual assault; a family's immigration from a war-torn country; suicidality; and homocidality. While some social work practice settings specifically provide crisis intervention services such as hospital emergency rooms or mobile crisis programs, most social workers encounter crises, at various times, in all practice settings, with all client populations.

In response to a wide range of crises, traumatic events, and disasters, many people experience significant distress, do not function at their normal levels, and are in danger of ongoing dysfunction if they do not receive appropriate help in a timely way. In a similar manner, organizations and communities experience these reactions in response to crises and disaster. As is the case with the individuals within it, the organization or community's continued health and ability to function effectively will

depend on receiving prompt and effective crisis intervention.

Danger and *opportunity* (Hoff, Hallisey, & Hoff, 2009; Knox & Roberts, 2008; Parad & Parad, 1990; Slaikeu, 1990), as represented by two symbols in the Chinese language for *crisis*, are two words that are frequently associated with crises. "Danger" describes the states of disequilibrium and vulnerability that can result from a crisis and the possibility that individuals will experience long-term distress and impaired functioning. "Opportunity" describes the unexpected possibilities that exist for growth and development when individuals discover previously unknown or underutilized resources and strengths within themselves or their support systems as a result of a crisis. This opportunity for growth results from the markedly increased abilities individuals have for developing alternative coping mechanisms when they experience a crisis (Parad & Parad, 1990).

Crisis theory and intervention are historically integral to the social work profession. However, over the past decades, as a result of events such as the September 11, 2001, World Trade Center and other terrorist attacks, more frequent natural disasters related to climate change, and dramatic increases in school and violent mass shootings, social workers have increasingly been called upon to help people respond to a wide range of public emergencies (Mirabito, 2012; Patterson, 2009). Consequently, disaster mental health has become an area of expertise for social workers across all fields of practice, including in hospitals, schools, agencies, and within communities (Carp, 2010; Mirabito, 2012; Pomeroy, 2009).

As direct practice providers and as members of crisis teams, social workers are frequently leaders in providing crisis intervention services to individuals, families, and groups, as well as within organizations and communities. Therefore, in addition to crisis intervention skills for direct practice, it is equally important for social workers to develop an enlarged vision of practice that focuses on the strengths and resilience of individuals, organizations, and communities that have experienced chaos (Carp, 2010). As highlighted by Patterson (2009), social workers need skills in the provision of micro interventions to assist victims and survivors of disaster, as well as mezzo and macro skills to intervene with complex systems and entire communities. As a result of the training and education social workers receive in both clinical and organizational responses to crisis and trauma, they are often better prepared than other professionals to provide crisis intervention in the aftermath of a traumatic event.

History of Crisis Theory and Intervention in Social Work

Crisis theory and crisis intervention have a rich history in the social work profession, which developed largely during the time period from the 1950s through the 1980s, in collaboration with leaders from other disciplines including psychiatry, psychology, and community and public health. Important contributions that led to the development of crisis theory included observations of soldiers in combat, research on grief and mourning, the expansion of suicide prevention programs, and the proliferation of crisis-oriented services resulting from federal policy initiatives to develop community mental health, disaster relief, and victim services.

Eric Lindemann and Gerald Caplan, both psychiatrists, were the first professionals to conceptualize and develop crisis theory and intervention and are considered the "pioneers" or "grandfathers" of this area of practice (Knox & Roberts, 2008). In 1944, Eric Lindemann, a community psychiatrist affiliated with the Harvard Medical School and Massachusetts General Hospital, observed, evaluated, and treated 101 survivors and close relatives from the devastating 1942 Coconut Grove nightclub fire, which killed 493 people (Roberts, 2008). In his seminal paper, "Symptomatology and Management of Acute Grief," Lindemann (1944) described a predictable sequence of stages during the grief process. He further established that the duration and severity of grief reactions depended on the success with which the bereaved were able to mourn their multiple losses (Knox & Roberts, 2008; Lindemann, 1944). One of Lindemann's key contributions was his belief that clinical interventions prevented psychopathology, leading to his development of the first community mental health center for bereaved disaster victims and their families (Roberts, 2008).

Gerald Caplan, also a psychiatrist, built on Lindemann's concepts about grief and mourning by extending our understanding about the significance and impact of normative and developmental life transitions and extraordinary traumatic events (James & Gilliland, 2013; Knox & Roberts, 2008; Regehr, 2011). Caplan (1981) is credited with advancing the field of preventive psychiatry and psychiatric consultation by developing community-based programs for early intervention of situational stress and also for training medical and mental health professionals to intervene in critical life transitions (Goldstein & Noonan, 1999; Roberts, 2008).

Observations of soldiers during World War II and the Korean and Vietnam wars who suffered from "combat fatigue" or "combat neurosis," now conceptualized as post-traumatic stress disorder (PTSD), led mental health practitioners to understand that soldiers who were exposed to traumatic events could be treated effectively with immediate, brief therapy, at or close to the front lines of battle (Goldstein & Noonan, 1999; Parad & Parad, 1990; Roberts, 2000).

Pivotal developments during the 1960s and 1970s included the expansion of community mental health services and suicide prevention hotlines, funded through the Community Mental Health Centers Act of 1963, which contributed significantly to the development of crisis intervention services. In 1958, Bellak developed the first psychiatric emergency 24-hour walk-in clinic in the United States at Elmhurst Hospital in New York City (Parad & Parad, 1990). Funding through the community mental health movement established 24-hour emergency and crisis intervention services, which rapidly expanded from 376 centers across the country in 1969 to 796 centers in 1980 (Roberts, 2000). Suicide hotlines were first established in 1906 by the Salvation Army in London, England, and the National Save-a-Life League in New York City; between 1968 and 1972, almost 200 suicide prevention programs were established throughout the United States (Knox & Roberts, 2008; Roberts, 2000). Federal funding from the National Institute of Mental Health established the Disaster Relief Act of 1974, which provided support for brief crisis services to victims of disaster as well as training for professionals who provided crisis intervention services (Parad & Parad, 1990).

Throughout the 1960s and 1970s, social workers expanded upon the pioneering work of Lindemann and Caplan by further conceptualizing and integrating key concepts of crisis theory and intervention into social work practice. Rapoport (1962, 1967) advocated that clients have rapid access to crisis intervention services and developed the phases of engagement, assessment, and goal setting in crisis intervention services (Roberts, 2000). Golan (1978) delineated the components of "the crisis situation" (p. 7), described later in this chapter. Strickler (1965) identified similarities between crisis intervention and social casework and also recommended that the short-term, focused nature of crisis intervention required modifications in traditional casework practices. Parad & Caplan (1960) and Hill (1958) applied crisis theory and intervention to social work practice with families (Ell, 1996). Other important social work contributors included Kaplan (1962, 1968); Jacobsen, Strickler, and Morely (1968); and Smith (1978, 1979). Parad and Parad (1968a; 1968b) conducted a major descriptive study of 1,656 cases that provided evidence, from both clients' and clinicians' perspectives, that demonstrated planned, short-term crisis-oriented treatment as an effective intervention.

Key Concepts of Crisis Theory

Naomi Golan (1978) conceptualized the "crisis situation" (p. 7) as composed of five components: the hazardous event, the vulnerable state, the precipitating factor, the state of active crisis, and the stage of reintegration or crisis resolution (pp. 63–64). Golan described these five components of the "crisis situation."

The Hazardous Event

The *hazardous event* is a specific stressful event occurring in a period of relative stability. Changing the previous state of stability, it may initiate a chain of events that further disrupt the previous state of equilibrium. Hazardous events can be anticipated and predictable, resulting in *developmental crises*, which are experienced during normative developmental stages such as adolescence, aging (adulthood) and retirement,

or the birth or adoption of a child. In contrast to *developmental crises, situational crises* are unanticipated or unexpected and are often sudden, such as job loss, parental divorce, sexual assault, sudden death, a school shooting, a hurricane, or a terrorist attack.

The Vulnerable State

The *vulnerable state* describes the individual's immediate and longer-term response to the hazardous event. Common distressing reactions include anxiety, depression, mourning, shame, guilt, anger, and cognitive or perceptual confusion, as well as potentially positive feelings of hope, challenge, and excitement.

The Precipitating Factor

The *precipitating factor* is the "straw that breaks the camel's back" (Golan, 1978, p. 66), or the factor in a chain of events that can convert the vulnerable state into a state of disequilibrium.

The State of Active Crisis

The *state of active crisis* describes the disequilibrium that occurs once an individual's previous coping mechanisms have broken down. In this state, predictable responses are experienced, including physical, emotional, and cognitive imbalance, as well as preoccupation with the events that led to the crisis. During the state of active crisis, previous defensive and coping mechanisms are ineffective, and individuals are typically highly motivated to accept and utilize assistance. As aptly described by Rapoport (1967), "A little help, rationally directed and purposefully focused at a strategic time, is more effective than more extensive help given at a period of less emotional accessibility" (p. 38). Individuals do not remain in this state of active crisis indefinitely. The time frame for the state of active crisis is variable, though it is time-limited, often described as lasting from one day to four to six weeks (Regehr, 2011).

Two pathways lead to a state of active crisis: the precipitating factor can activate a previous vulnerable state that may have been caused by a prior hazardous event(s) or the precipitating factor may be same as the hazardous event. For example, the September 11th terrorist attacks were for some individuals the *precipitating factor* that *activated* a *vulnerable state* created by a previous *hazardous event(s)*, while for others, the September 11th terrorist attacks *were* the *precipitating factor.*

The Stage of Reintegration or Crisis Resolution

The *stage of reintegration or crisis resolution* is the final component in the "crisis situation," during which individuals struggle to master a cognitive perception of what has occurred, as well as release and accept feelings related to the crisis. In the final stage of reintegration and resolution, new patterns of coping are developed and environmental supports are identified and utilized, which can include access to, and use of, social work intervention (Mirabito & Rosenthal, 2002; Rosenthal-Gelman & Mirabito, 2005).

Key Concepts of Disaster Theory

"Disaster" is defined by Golan (1978) as "a collective stress situation in which many members of a social system fail to receive expected conditions of life, such as safety of the physical environment, protections from attack, provision of food, shelter, and income, and the guidance and information necessary to carry on normal activities" (p. 125). Disaster is followed by three predictable phases: (1) the *impact*, (2) *recoil and rescue*, and (3) *recovery* phases, (Hoff, Hallisey, & Hoff, 2009; Raphael, 2000).

Victims experience the reality of the disaster in the *impact phase,* during which they are concerned about their survival in the immediate present. One sees a wide variety of common reactions during this phase, ranging from people remaining calm and organized, to becoming shocked, confused, hysterical, and paralyzed with fear (Hoff, Hallisey, & Hoff, 2009). In the aftermath of a disaster, victims may be surprised that they were able to function as well as they did during the impact phase.

Rescue activities begin during the *recoil and rescue phase*. The wide range of common physical and emotional reactions during this phase includes denial, shock, numbness, flashbacks, nightmares, grief and sadness related to potentially devastating loss, anger, despair, and hopelessness (Raphael, 2000). Survivors of the disaster may feel relief and elation, though these reactions are difficult to accept if destruction

and devastation have occurred. "Survivor guilt" may be experienced if death or injury occurs that they were unable to prevent, or if they do not understand why they survived while others died (Lifton, 1982).

During the *recovery phase,* individuals and the community face the complex task of returning to a new state of "normal." A primary goal during this prolonged phase is to regain a pre-crisis state of equilibrium. At the outset, individuals and communities may experience an outpouring of altruism and interpersonal connectedness in response to the disaster. Following this initial stage, referred to as the "honeymoon period," a period of disillusionment frequently occurs in which realities of the devastation and loss brought about by the disaster must be faced and resolved (Mirabito & Rosenthal, 2002; Raphael, 2000).

Key Concepts About Trauma and Traumatic Events

Types of Trauma

Traumatic events are extraordinary situations that are likely to evoke significant distress in many people. *The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5; American Psychiatric Association, 2013), defines traumatic events as "exposure to actual or threatened death, serious injury, or sexual violence" (p. 271) by direct experience, witnessing it, learning that it occurred to others, or experiencing repeated exposure to the details of it. Traumatic events include exposure to war, physical assault, childhood physical abuse, threatened or actual sexual violence and abuse, being kidnapped or taken hostage, terrorist attacks, torture, natural or human-made disasters, and severe motor vehicle accidents (American Psychiatric Association, 2013, p. 274).

Traumatic stressors may be discreet, one-time events, "Type I trauma"; or ongoing, chronic life circumstances, "Type II trauma." Type I traumas are acute, "single-blow" traumatic events such as suicide, homicide, sudden accidental death, rape/sexual assault, acute illness, transportation accidents, natural disasters, (e.g., tornadoes, hurricanes, earthquakes, and wildfires), and rare overwhelming events, such as school shootings, hostage takeovers, or terrorist attacks.

Type II trauma, also known as "complex trauma," is defined as multiple, repetitive, and continuous trauma (Terr, 1991), such as ongoing physical or sexual abuse, domestic violence, community violence, war, genocide, experiences of combat or concentration camps, being a prisoner-of-war, or the victim of political torture (Courtois & Ford, 2009). Type II trauma may be perpetrated by an individual known by, or related to, the victim, and can be accompanied by a betrayal of trust in primary relationships (Courtois & Ford, 2009). Complex trauma can have significantly detrimental effects on emotional and behavioral regulation and stability; the ability to think, learn, and concentrate; impulse control; self-image; and attachment relationships with others. Complex trauma is associated with a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders (National Child Traumatic Stress Network, www.nctsn.org, 2014). Treatment for complex trauma includes a range of trauma-specific service models for children, adolescents, and adults (Jennings, 2008). For example, *trauma-focused cognitive behavioral therapy* (TF-CBT) is an evidence-based approach for the treatment of complex trauma that develops resiliency-based coping skills with children and adolescents and utilizes active parental involvement to support the treatment goals (Cohen, Mannarino, & Murray, 2011).

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a syndrome of persistent reactions following a traumatic stressor that is diagnosed when a combination of symptoms in four categories have persisted for one month or more and when the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013). The four categories of post-traumatic symptoms identified in the DSM-5 (American Psychiatric Association, 2013) include: (1) intrusion symptoms, (2) persistent avoidance, (3) negative alterations in cognitions and mood, and (4) hyperarousal and reactivity.

Intrusion symptoms include recurrent, involuntary, and intrusive distressing memories of the traumatic event, such as distressing dreams, intense psychological distress or physiological reactions to internal or external cues (triggers) related to the traumatic event, and dissociative reactions (e.g., flashbacks, dreams, nightmares) in which individuals can visualize the traumatic event and feel as if it is happening again (American Psychiatric Association, 2013). Dissociation can serve as a protective mechanism in the aftermath of a traumatic event to shield the individual from the full realization of the horror that has occurred. With dissociation, the individual is unable to remember details of a traumatic event, or experiences numbness or disbelief that the trauma occurred.

Persistent avoidance includes conscious and purposeful avoidance of distressing memories, thoughts, and feelings, and of situations, places, and people associated with the traumatic event. In efforts to avoid strong feelings that may be overwhelming, individuals may be reluctant to return to places where a trauma occurred and may consciously avoid talking about a traumatic event.

Negative alterations in cognitions and mood include:

> Inability to remember an important aspect of the traumatic event(s); Exaggerated negative beliefs about oneself, others, or the world; Persistent, distorted cognitions about the cause or consequences of the traumatic event that lead the individual to blame himself/herself or others; Persistent negative emotional states (e.g., fear, horror, anger, guilt, shame); Decreased interest or participation in significant activities; Feelings of detachment from others; Inability to experience positive emotions. (American Psychiatric Association, 2013, pp. 271–272)

Hyperarousal and reactivity symptoms include alterations in arousal and reactivity associated with the traumatic event. Symptoms include "Irritable behavior and angry outbursts; Reckless or self-destructive behavior; Hypervigilance; Exaggerated startle response; Problems with concentration; Sleep disturbance" (American Psychiatric Association, 2013, p. 272). In the aftermath of a traumatic stressor, people frequently report having difficulty sleeping, an increased startle reflex, and "jumpiness" or anxiety, including fear that the traumatic event could happen again.

Acute stress disorder (ASD) includes the same symptoms as PTSD; however, symptoms are present for three days to one month following exposure to the traumatic event. The DSM-5 (American Psychiatric Association, 2013) includes distinct criteria for symptoms and reactions pertaining to children six years old and younger. Frequently, PTSD coexists with other psychiatric disorders such as anxiety, depression, conduct disorders, and substance abuse. As described by Santucci (2012), "While comorbidity among psychiatric disorders is high, with PTSD it appears to be the rule rather than the exception" (p. 124).

Many traumatic events include the threat or actuality of death, and almost all deaths involve trauma as well as grief. Many of these deaths are by suicide, homicide, or sudden accidents, and many involve violence, which can elicit both trauma and grief reactions. When grief and post-traumatic symptoms are both present, post-traumatic reactions must be attended to first, before the grieving process can proceed (Nader, 1997).

Reactions to Trauma and Predictors of Distress

Although traumatic events are defined as extraordinary situations that are likely to evoke significant distress in a large proportion of the population, many individuals experience only mild, transient responses and symptoms in response to trauma. For those who are resilient in the face of traumatic events and do not develop post-traumatic symptoms, stress can lead to adaptive and constructive psychological growth (Bonanno, 2004). While many people who experience positive outcomes from traumatic events utilize social work intervention and support, others handle traumatic stress with their own natural support systems (Mirabito & Callahan, 2016).

Three key variables that predict the intensity of post-traumatic reactions are the meaning of the event to the individual, the amount of past exposure to trauma, and the level of social support available (Webb, 1994). The meaning that an individual attaches to a traumatic event

is particularly important in predicting and understanding her or his response (Lazarus & Folkman, 1984). Individuals who attach malignant meanings to traumatic events have higher levels of distress, while those who are able to find benevolent or positive meanings in these events fare better. Furthermore, there appears to be a natural inclination to try to find some positive meaning in the aftermath of a trauma, and eventually many people find satisfaction in having survived and in having done the best they could under the circumstances.

Another key factor that has an impact on the outcome of traumatic experiences is the amount of prior trauma an individual has experienced. Individuals who have experienced multiple traumas, a lack of family support, or other risk factors such as mental health or other emotional concerns are more likely to be severely affected by trauma. Conversely, individuals who have protective factors, such as stable and supportive environments, and who possess the personal qualities of "resilience" or "hardiness" are better able to withstand stressful events.

Finally, social support plays an important role in protecting an individual from the severest impact of traumatic stress. Numerous studies of normative and traumatic stress have demonstrated that individuals with supportive families and friends cope with trauma more effectively than those without supportive social networks.

Social Work Intervention in Crises, Trauma, and Disasters

Practice Principles for Crisis Intervention

Parad and Parad (1990) define crisis intervention as "A process for actively influencing psychosocial functioning during a period of disequilibrium in order to alleviate the immediate impact of disruptive stressful events and to help mobilize the capabilities and resources of the persons affected by the crisis" (p. 4). Goals of crisis intervention include managing the immediate crisis, and strengthening the coping and problem-solving strategies of the individual, family, group, organization, or community for the future. The practitioner intervenes at whatever level is necessary—micro, mezzo, or macro-to help the client system return to the previous state of equilibrium. As noted earlier, while the goal of crisis intervention is to return to the pre-crisis level of functioning, some individuals achieve either a higher or lower level of functioning in the aftermath of a crisis.

Crisis intervention uses the strengths perspective that is central to social work practice to help individuals mobilize their own strengths, assets, and capacities as well as to identify the resources and supports that exist in their environments, including within families, social networks, neighborhoods, and communities. In combination with the strengths perspective, an empowerment approach is used to help clients access and use inner and environmental resources. Ego psychological techniques are also utilized to assess the individual's level of functioning, coping, and adaptation (Mirabito & Rosenthal, 2002).

Consistent with the social work strengths and empowerment approaches and ego psychology concepts, intervention in situations of crisis, trauma, and disaster employs the following key practice principles (Ell, 1996; Rosenthal-Gelman & Mirabito, 2005):

- Help is provided immediately, including outreach to populations who may not otherwise seek assistance. For example, in the case of a school shooting or natural disaster affecting the entire community, active outreach, such as home visits to isolated residents or holding community meetings, may be provided to reach all community members who are in need.
- Interventions at the time of the crisis or disaster are time-limited and brief. Since the "crisis state" is time-limited, often lasting four to six weeks, interventions are focused on the immediate crisis with referral for longer-term services, as needed.
- The social worker takes an active, often directive, role in helping efforts. During the assessment process, the practitioner engages quickly and explores sensitive and potentially difficult areas, such as abuse and neglect, violence, suicidality, and dying or death.
- The primary goal of intervention is the reduction of symptoms and a return to the earlier state of equilibrium. While the focus

of intervention is on the immediate problems, crises can reactivate past, unresolved problems, and provide a "second chance" to rework earlier problems reactivated by the current crisis (Goldstein & Noonan, 1999; Mirabito & Rosenthal, 2002).
- Interventions include a combination of counseling to handle emotional concerns, the provision of practical information and concrete community resources, and the mobilization of social and environmental support systems.
- The expression of feelings, symptoms, and worries is encouraged. Intervention strategies such as education, clarification, and reassurance about the normative, expectable reactions to crisis and trauma help individuals reduce their intense fear and anxieties.
- Strategies for problem-solving and effective coping are encouraged and supported to help individuals return to a state of equilibrium.

The immediate, time-limited nature of crisis intervention requires that engagement, assessment, and interventions all occur in an expeditious manner to ensure that prompt assistance is provided. This approach capitalizes on the "window of opportunity" during which individuals often are considerably more receptive to helping efforts. A rapid, thorough, and focused assessment is needed to determine pre- and post-crisis functioning, including the coping styles and skills individuals have used to handle previous stressful life events, crises, and preexisting vulnerable states. Emotionally charged areas of functioning are directly and thoroughly explored, including any potential for self-harm and violence, abuse and neglect, use and abuse of alcohol and drugs, sexual assault, and loss or grief. In situations such as physical and sexual abuse, self-harm, violence, drug and alcohol abuse, rape, and natural or man-made disasters, it is particularly important to assess and ensure clients' emotional and physical safety, and to collaborate with and engage reliable and supportive individuals, in order to develop detailed safety plans to protect clients.

Case Illustrations of Social Work Skills and Roles in Crisis Situations

Social work practitioners take on multiple roles in crisis intervention, including direct service provider to help clients express their emotions; educator to provide practical information and psychoeducation; case manager to obtain and coordinate community resources for concrete and mental health services; and advocate and broker to mobilize existing social and environmental support systems. The challenges of crisis intervention require that social workers develop skills to provide focused, direct, and in-depth assessments; be effective in taking an active, directive stance in asking difficult questions; engage in making sound clinical judgments and decisions; challenge clients who may be at risk to ensure their safety; and take a confident and proactive stance in interprofessional collaboration and consultation with a wide range of professionals. The following vignettes of crisis intervention provided by social workers in varied settings illustrate the use of the practice principles, skills, and roles utilized in situations of crisis and trauma.

Case Examples

"On-call" evening/weekend social worker in an urban hospital emergency room: The social worker provides crisis intervention services to the pediatric, adult, and psychiatric emergency rooms and hospital-wide consultation regarding discharge problems. The demands are unpredictable and include intervention in an unlimited variety of problems such as death, rape, child or elder abuse, domestic violence, psychiatric emergencies, acute illness, homelessness, and discharge problems. The social worker must engage quickly, assess complex problems thoroughly, intervene, disengage when the immediate crisis has stabilized, and implement a follow-up plan.

On one weekend evening, such a social worker was referred the following cases: the emergency discharge of an HIV-positive infant to a foster care home; a seven-month-old with a cigarette burn; an 85-year-old frail elderly woman without family support who could not return home alone; a 20-year-old brought to the ER by police due to domestic violence who presented concerns about harming both her children and herself; and a 17-year-old who put his hand through a window while watching his mother die that evening. Crisis intervention in this setting requires a broad set of generalist social work skills, including a high level of skill in clinical assessment,

intervention, and advocacy with patients; accessing and managing community resources; and providing education and consultation to interdisciplinary hospital staff. Specifically, the social worker must be able to form relationships with patients and interprofessional staff rapidly and effectively; make decisions quickly and authoritatively; work both autonomously and collaboratively; have the flexibility to handle multiple situations simultaneously, and the capacity to confront and handle considerable emotional distress.

School social worker in a rural high school: A 15-year-old girl in the 10th grade with a history of depression and two psychiatric hospitalizations committed suicide. In response to this traumatic event, the school social worker, as leader of the school crisis team, convened a meeting of the team with goals to help students, teachers, and parents process the trauma and prevent future suicides in the school. The social worker and principal provided team members with psychoeducation regarding the range of reactions that could be expected from students and parents in response to this traumatic event. The crisis team prepared a statement that all teachers read in homeroom classes. Teachers were given guidance by the social worker and the team to help them lead classroom discussions so all students could address and process the event and also to provide psychoeducation about depression, suicidality, and problem-solving/coping strategies. In addition, a drop-in center was set up for students who wanted to further discuss the event. The social worker and other community mental health professionals provided ongoing support and consultation to teachers to help them manage their own reactions to this traumatic event and to guide them in assisting the students. The social worker and the crisis team identified students considered to be at risk for suicidal behavior, including those with a history of serious depression, previous suicide attempts, or suicide in the family; close friends of the deceased student; and other students strongly affected by the death. The social worker conducted detailed, in-depth, thorough clinical assessments of depression and suicidality with all of these students and arranged for safety planning, as needed. In situations of significant risk, the social worker contacted parents and arranged for mental health follow-up in the community. Support groups composed of the close friends and peers from classes met for six sessions to more fully process the untimely death and also to provide opportunities to observe how students were responding to the event in order to refer students who were in need of additional mental health services. The social worker and principal provided outreach, support, and guidance to parents by leading a parents' meeting as well as family meetings, as needed. Finally, the social worker helped students and parents organize and implement a memorial service for the bereaved student and a scholarship fund that was presented on the anniversary of the student's death.

Disaster Mental Health Interventions

The concept of "psychological first aid" (PFA), though not developed by social work practitioners, has been used in the field of disaster mental health for many years. Five basic principles of PFA that facilitate positive adaptation following disaster include promoting: (1) safety, (2) calming, (3) self and community efficacy, and (4) connectedness, and (5) instilling hope (Hobfoll, Watson, Bell, Bryant, Brymer, Freidman, . . . Freidman, 2007; Vernberg, Jacobs, Watson, Layne, Pynoos, Steinberg, . . . Ruzek, 2008; Watson, Brymer, & Bonanno, 2011). Components of the PFA model include: (1) contact and engagement, (2) safety and comfort, (3) stabilization, (4) information gathering, (5) practical assistance, (6) connection with social supports, (7) information on coping, (8) linkages with services, and (9) psychoeducation (Vernberg et al., 2008). In a similar vein, Brymer, Reyes, and Steinberg (2012) recommend that in the aftermath of a disaster, interventions and services should be "proactive, protective, and pragmatic" (p. 147). Three tiers of disaster mental health interventions described in the literature include:

- *Tier 1*: provides outreach, public health information, needs assessments, and PFA.
- *Tier 2*: provides more specialized interventions for those with moderate to severe distress and difficulty functioning.
- *Tier 3*: provides specialized psychiatric services for those who require immediate and/or more intensive intervention, including psychiatric care and/or hospitalization (Brymer et al., 2012).

According to the National Institute of Mental Health (2002), effective early intervention following exposure to mass violence can be

facilitated by careful screening and needs assessment for individuals and groups. Follow-up should be offered to individuals and groups at high risk of developing adjustment difficulties, including those who: (1) have acute stress disorder or other clinically significant symptoms stemming from the trauma, (2) are bereaved, (3) have a preexisting psychiatric condition, (4) require medical or surgical attention, or (5) experienced intense and prolonged exposure to the incident.

Watson et al. (2011) indicate that the major components of a global disaster public mental health approach include screening and assessment; multiple, culturally competent intervention strategies at different post-disaster time points (early, mid-, and long-term intervention); increasing access to services by using diverse and alternative service delivery methods; and providing training and consultation to increase providers' abilities to implement evidence-based interventions. Walsh (2007) provides a multisystemic, resilience-oriented practice approach that focuses on strengthening family, interpersonal, institutional, and community resources in the recovery process. This approach recognizes the widespread impact of traumatic loss in situations of community violence, major disasters, wars, genocide, refugee experiences, and terrorism.

Secondary Traumatic Stress, Vicarious Traumatization, and Self-Care

Intervention with individuals, groups, families, organizations, and communities who experience crises and trauma has a significant impact on the health and well-being of social workers. Secondary traumatic stress (STS), vicarious traumatization (VT), and compassion fatigue (CF) describe the psychological and emotional risks and consequences social workers can experience when they provide services to traumatized populations (Newell & MacNeil, 2010). These conditions, considered to be occupational hazards resulting from clinical and organizational practice focused on trauma, can potentially interfere with professional effectiveness and the social worker's health and well-being (Bride, Radey, & Figley, 2007).

Given the ongoing challenges and stress of providing intervention to clients who experience crises and trauma, it is essential for social workers to develop and routinely implement strategies for professional effectiveness and self-care. Naturale and Pulido (2012) recommend a range of organizational and personal interventions to help social workers minimize the effects of secondary traumatic stress or vicarious trauma. Organizational interventions include organizational support, training, staff and peer supervision, adequate breaks, and workload balance. Personal self-care strategies include getting adequate rest and relaxation, developing and maintaining positive connections with social supports (e.g., family and friends), engaging in enjoyable interests and activities, exercise, and practicing mindfulness.

Current Trends and Future Directions in Research, Training, and Practice

Critical incident stress debriefing (CISD) is a structured group discussion developed by Mitchell and Everly, which incorporates theoretical concepts from both crisis intervention and trauma theories (Bell, 1995; Miller, 2001; Mitchell & Bray, 1990; Mitchell & Everly, 1995). Though originally developed to help first responders, the CISD model is a commonly utilized group intervention with many populations in diverse settings. The purpose of debriefing groups are to: (1) review what occurred, (2) process the wide range of reactions experienced, (3) provide psychoeducation about normative responses to trauma and useful coping mechanisms, (4) engage in problem-solving, support, and mutual aid to help members practice self-care, and (5) provide referrals for individuals who require further services (Miller, 2003; Kirk & Madden, 2003). Miller (2003) points out that the CISD model is consistent with the social work profession's commitment to empowerment and strengths approaches, group work, and social justice.

There is considerable controversy and disagreement regarding the effectiveness of CISD, and further research is needed in this area of practice. While anecdotal accounts have reported debriefings to be helpful, there has been no conclusive evidence that CISD prevents

PTSD (Miller, 2001, 2003; Pack, 2012; Pender & Prichard, 2009). Moreover, multiple studies and reviews of CISD have not only failed to support its effectiveness but, in some cases, have found it to be harmful (Watson et al., 2011; Bonanno, Brewin, Kaniasty, & La Greca, 2010). As noted by Regehr (2001), the two components of crisis debriefing that have some empirical support are the social support and psychoeducational components. The aspect of the model that is not empirically supported is the detailed review of events, which can cause intrusion symptoms.

Roberts and Everly (2006) provided support for crisis models in a meta-analysis that reviewed 36 of the most commonly used crisis intervention treatment modalities. This study demonstrated that both adults with trauma symptoms and abusive families in acute crisis can be helped with intensive crisis intervention services. In 2006, the authors of this meta-analysis noted that research on crisis intervention was in a beginning stage of development. In the past ten years, while research has expanded, further systematic research on interventions in situations of crisis, trauma, and disaster are needed to better understand what strategies are most effective with specific populations.

Studies of social work field training indicate that the growing challenges of contemporary practice require social workers to assume a variety of roles and intervene at multiple levels with clients who are experiencing severe psychosocial stressors and crises (Rosenthal-Gelman & Mirabito, 2005). Several studies have established that practice areas and skills identified as most relevant for training social work students include crisis intervention, short-term treatment, advocacy, case management, death and dying, and grief and loss (Birkenmaier, Rubio, & Berg-Weger, 2008; Bronstein, Kovacs, & Vega, 2007; Mirabito 2012). Furthermore, Regehr, Roberts, and Bober (2002) highlight the urgent need for training mental health professionals to develop culturally competent clinical and community skills for both individual and community level intervention in disasters.

Current literature in social work and related disciplines includes discussion of both practice and research using crisis intervention strategies with a wide range of populations, such as veterans (Franklin, 2009); suicidal adolescents and their families (Wharff, Ginnis, & Ross, 2012); families in crisis (Al, Stams, van der Laan, & Asscher, 2011); survivors of disasters and public emergencies (Bonanno et al., 2010; Patterson, 2009); psychiatric patients with dementia (Johnson, Niedens, Wilson, Swartzendruber, Yeager, & Jones, 2013); incarcerated persons with mental illness (Lord & Bjerregaard, 2014); survivors of rape and sexual violence (Westmarland & Alderson, 2013), in a variety of settings including, fire and police departments (Cacciatore, Carlson, Michaelis, Klimek, & Steffan, 2011; Watson, 2010); emergency rooms (Kondrat & Teater, 2010); community-based mental health respite programs (Grant & Westhues, 2012); schools (Werner, 2015); and disaster mental health crisis counseling projects (Rosen, Greene, Young, & Norris, 2010).

Conclusion

Social work professionals are actively and continuously engaged in applying specialized knowledge and skills in situations of crisis, trauma, and disaster, with individuals, families, groups, organizations, and within communities, in their practice with a wide range of populations and problems in diverse settings. The modality of crisis intervention is a short-term intervention technique with a rich history in social work and other mental health professions. Social workers have ongoing opportunities to practice crisis intervention, since clients of all ages can experience crises in response to the challenges of normative developmental stages and life circumstances as well as in response to extraordinary, traumatic events, which can occur to anyone at any time. In response to the ever-increasing frequency of crises, trauma, and disaster in everyday life, it is essential that social workers understand crisis and disaster theory and develop practice skills to effectively provide crisis intervention services to a wide range of clients.

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8

Ecopsychology: Adding "Eco" to the Biopsychosocialspiritual Perspective

David S. Derezotes

As never before in our history, humans are being challenged to face the threats to our survival that we ourselves have created. At the same time that we are exploring outer space, and can view the earth from far above, we are realizing that our home planet is an ecosystem that is limited in its resources and under increasing stress from human activity. The increasing physical threat to the ecosystems that support all life is also a psychological threat to our individual and collective sense of safety, security, and a sustainable future.

The threats to our global ecosystem are real. In the 20th century, as our world population quadrupled, our energy use increased by 16 times, water consumption nine times, air pollution five times, and farmland doubled (McNeill, 2000). Global warming is linked to such factors as air, land, and water pollution; the destruction of local and global ecosystems, and the extinction of plant and animal species. All of these factors are largely human-caused (McBay, Keith, & Jensen, 2011). Global warming continues to accelerate in the 21st century, as annual global temperatures relentlessly increase (Kolbert, 2014). Scientists estimate that, at current rates, annual temperature averages could grow by up to 30 degrees Fahrenheit by 2100 (McBay, Keith, & Jensen, 2011).

The process of global warming has been linked to significant physical health problems worldwide. In the past century, air and water pollution has killed millions of people globally, and damaged the health of many more (McNeill, 2000). Environmental health both directly and indirectly affects the health, safety, and welfare of most humans today (Russ, 2010). As more animal and plant species face

extinction, evidence mounts that the survival of the human species itself will ultimately be at risk as well (Kolbert, 2014).

The term "ecopsychology," apparently first used by Roszok in 1992, is now the name of an accepted division (Number 34) in the American Psychological Association. "Ecopsychology explores humans' psychological interdependence with the rest of nature and the implications for identity, health and well-being" (Society for Environmental Population and Conservation Psychology, 2014). Increasing evidence for this interdependence continues to emerge in the psychology literature (Doherty & Clayton, 2011). A global epidemic of depression and anxiety has been linked to our collective refusal to face the reality of global warming (Macy & Johnstone, 2012).

Adding the Ecological ("Eco") Dimension to Social Work's Biopsychosocialspiritual Perspective

The person-in-environment perspective has informed our assessments and interventions throughout the history of social work. This perspective is arguably the most unique and significant contribution of social work theory. Within the person-in-environment perspective, we developed psychosocial assessment, and later added "bio-" and "spiritual" to the factors we consider in our social work practice. With our broadening and inclusive view of the factors that influence human well-being, we have learned to include micro-, mezzo-, and macro-level issues in our interventions, and related social and economic justice issues in our curricula. Most social work theorists, however, have emphasized the social aspects of the environment, such as family, culture, and nation, and have largely ignored the physical aspects (Gutheil, 1992; Kapf, 2010).

Increasing numbers of social workers, however, are recognizing the importance of these physical aspects of environment. A "global community" paradigm of advanced generalist practice was theorized, for example, that would include an "ecosystem social work" approach to practice. In this approach, the social worker has a responsibility to develop an environmental consciousness in which she sees the connections between human welfare and the health of the local and global ecosystems (Derezotes, 2000). Similar calls for inclusion of a new world view of social work that addresses our global environmental crises have been made by a growing number of social work scholars (Coates, 2005). The person-in-environment perspective could be expanded to include a "person is environment" value perspective that may help reduce our modern sense of separateness from the environment, and that has implications for micro-, mezzo-, and macro-level practice (Derezotes, 2005).

Many theorists and scientists have stressed the interconnectedness of the physical environment with human well-being. In the 1990s, authors started to theorize that the current psychological relationship people have with nature is dangerous both to human well-being and ecosystem well-being. In 1992, Roszak suggested that the disciplines of psychology and ecology could help inform each other. Hillman (1995) proposed that we need to re-vision our view of human psychology to include a "psyche the size of the Earth," that re-welcomes our interconnection with nature.

Given our growing and collective awareness of our interdependence with the natural environment, as well as the mounting evidence of human-caused ecological damage and associated physical and psychological impact, a more inclusive model of human development can be postulated. The biopsychosocialspiritual model that has helped inform social work practice can be expanded to an "ecobiopsychosocialspiritual" model that informs engagement, assessment, and intervention.

Theories and Philosophies Informing Ecopsychology

Ecopsychology is a river with many tributaries. Some of the major sources of ecopsychology are introduced in this section, including shamanism, transpersonal anthropology, biophilia, deep ecology, ecospirituality, transpersonal ecology, sustainability, the green movement, ecofeminism, and "eco-nomics." Although currently adopted by many scholars, the term *ecopsychology* is not accepted by all theorists and practitioners (Schroll, 1994).

Shamanism

Shamanism is a spiritual approach to healing that may have origins as early as the Paleolithic age. Shamanism was replaced by other religions in most regions, but is now having somewhat of a revival, in both some rural and highly urbanized locations. Evidence of shamanic practice has been uncovered in the histories of our ancestors across the world, and shamanic practice may have informed the contemplative practices that are now part of the world's great wisdom traditions (Harner, 1990). *Transpersonal anthropology* studies transpersonal experience across cultures, including the altered states of consciousness experienced in shamanism (Campbell & Staniford, 1978).

Human beings seem to have a natural affiliation with nature and other living things. This "*biophilia*" can be seen in our interest in house plants, pets, windows with views, and suburban landscapes. Our biophilia may actually reflect a deep psychological and biological need to connect with natural things (Wilson, 1984). *Deep ecology* is a modern philosophy that finds intrinsic value in ecosystems and nonhuman lifeforms, regardless of how they may serve the economic, political, or other needs of mankind. Humans recognize our interconnection with and responsibility to care for nature's ecosystems and other living things (Naess, 1973).

Eco-spirituality

Eco-spirituality is a discipline that studies and promotes the relationship between a reverent life and the natural world (Cummings, 1991). Appreciation and responsibility for the Earth is seen by many spiritually oriented authors as an essential aspect of their spirituality and religiosity (Fox, 2000). *Transpersonal ecology* integrates philosophy and psychology into a worldview that recognizes the intimate connection of person and environment. In this worldview, the psychological, spiritual, and physical well-being of people is viewed as inseparable from the well-being of the ecosystems that sustain and contain all life (Fox, 1990; Metzner, 1991).

Sustainability

Sustainability can be thought of as a multidisciplinary effort to understand and promote the lasting health and wealth of natural ecosystems. Most environmental scientists argue that, not only the economic systems and social cultures of mankind, but our very survival, depends upon sustainability. New sustainable economic approaches (Sachs, 2008) and sustainable political approaches (Romm, 2007) have been offered that are informed by scientific data. Overpopulation of human beings remains a key threat to sustainability, as food, water, and living space are limited on Earth (Lovelock, 2014). The environmental concerns highlighted in Rachel Carson's (1962) *Silent Spring* helped launch the modern "Green movement" in the United States. Concerns about pesticide use helped develop new public policies that helped protect the environment in 1970. Similar movements across the world have pushed for environmental protection and other sustainability-friendly policies, with varying degrees of success.

Ecofeminism

First defined in the 1970s, ecofeminism is a philosophy that links the abuses of Western patriarchal culture to the oppression of both women and nature. Women are seen as having a special interconnection with nature, based upon their values and work (Warren, 2000). Some male authors, such as Fox (2008) have also looked at the damage that patriarchal thinking has done to nature, and have offered men a new philosophy of ethics towards nature.

"Eco-nomics"

Finally, an emerging approach to economics, which we could perhaps call "eco-nomics," is deconstructing the dominant paradigm of Western economics and its impact on the well-being of living things and ecosystems that support all life. The current capitalistic economic system has been framed, for example, as a "free market fundamentalism" that ultimately destroys the sustainability of our Earth's ecosystems (Klein, 2014). The study of economics can thus help inform decision-making processes

that result in social policies that support sustainability (Shi, 2004).

Ecopsychology as a Bridging Theory in Social Work Education

Ecopsychology is thus an inclusive, multidisciplinary collection of theories, or a paradigm, that can help inform social work practice and also ultimately help bridge some of the theoretical "divides" in social work education. Some of the ways ecopsychology might help bridge these divides are introduced here.

Bridging the Micro-Mezzo-Macro Divide

Social work students often receive separate classes in micro-, mezzo-, and macro-level interventions. Ecopsychology can inform interventions on all three levels of social work practice. Examples of interventions on the three levels are described in more detail later in this chapter. The broad ecopsychological theme of *interconnectedness* of people, other living things, and ecosystems has implications for practice with individuals, families, and local and global communities. A class on ecopsychology could thus contain examples of assessments and interventions on all practice levels.

Returning Community Organization to Social Work Education

Community organization was especially popular and well-funded in the 1960s and 1970s, but interest has declined since those decades. Ecopsychology can help bridge the gap between social work education and community organization, because it provides a focus on a large scale issue that affects all people on Earth, and especially the poor and under-represented (Coates, 2005). Community development that focuses on sustainable development is informed in part by population concerns, the women's movement, and environmental concerns (Gamble & Weil, 1997). In ecopsychology, social workers are challenged to integrate social, environmental, and economic goals (Roseland, 2000). Thus ecopsychology could become a major organizing principle in future community work in social work curricula.

Bridging the Practice–Social Justice Divide

Social work students often do not often receive instruction in how to promote diversity and social justice in most practice classes. However, the threat to sustainability is a local and global social justice issue that especially affects poor and under-represented populations. An ecopsychology class could offer students interventions that both help heal their clients and empower them to help protect and heal the environment.

Bridging the Body-Mind-Spirit-Environment Divide

The ecopsychology approach helps *embody* social work practice. Thoreau's (1862) famous comment "In wildness is the preservation of the world" can be applied here, because as human beings we are, at least in part, wild beings who have evolved multiple ways of knowing the world. Social work students can be encouraged to be, not only intellectually intelligent, but also aware of their "whole-body" intelligence, which includes sensing through emotional, sensory, and social awareness. Instructors can help students develop this artistic or intuitive aspect of social work practice in their assessments, engagements, and interventions. The student can check out these intuitions by asking the client for feedback, which is an essential part of what is now called "practice-based evidence" (Hubble, Duncan, Miller, & Wampold, 2010).

Assessing the "Eco" or Ecological Dimension in Social Work Practice

The ecological dimension in social work practice includes all environmental factors, both human-made and "natural." Social workers can include the following ecological categories in their assessments of each client system.

Human-Made Ecosystems

Social workers assess the impact of the human-made environment on the client system. They assess the potential effects of such factors as the livability of the home, local noise and air pollution, access to local green spaces, and length of

daily commute to work or school. For example, we know that the chemicals commonly used to purify ordinary tap water can increase food allergies (*The Week*, 2012).

Local "Natural" Ecosystems

The social worker also assesses the quality of the local ecosystem. He studies the accessibility of wild land or water spaces to local people, as well as the quality of local air and water and the availability of local healthy food. We know, for example, that hospital gardens can have such beneficial effects on patients as reduced anxiety, physical pain, and blood pressure, and improved relaxation (*Scientific American*, 2012).

Ecopsychological Development

Developmental psychology has offered theories of lifespan growth in such areas as human needs (Maslow, 1954), psychosocial development (Erikson, 1964), ego development (Loevinger, 1987), cognitive development (Piaget, 1957), and moral development (Kohlberg, 1981). A multidimensional theory of human development was worked out by Wilber (2006, 2000) that integrated these theories and others into various schema, including his prepersonal, personal, and transpersonal stages of development (see column 3 in Table 8.1, and Cowley's chapter in this book).

Ecopsychological development can be defined as the biopsychosocialspiritual growth process that a person can have in her or his relationship with the physical environment. The physical environment includes human-made spaces, other living things, and the local, global, and universal ecosystems that support all life. This developmental theory and its relationship with some other theories are illustrated in Table 8.1.

In Table 8.1, column 1, the six levels of ecopsychological development are listed. These levels are a model for the lifespan development of the person's relationship with other living things and the ecosystems that support all life. The six levels are hypothesized to correspond to three other developmental schemas, in rows 2, 3, and 4. Column 2 shows what aspects of the body, mind, and spirit are most emphasized in the ecopsychological levels. Column 3 shows how the levels correspond to Wilber's (2000, 2006) levels of consciousness. Finally, column 4 shows how the levels match up with Berne's (1966) ego states. Following are brief descriptions of these ecopsychological levels:

1. *Safety and security: Environment as womb:* When the baby is born, she must leave the placenta and enter the outside environment. Just like a baby is connected to her mother through the umbilical child, the young child appropriately seeks life and nurturing from the environment. Some people might stay "stuck" in this level for years or even through an entire lifetime, expecting the world to nurture them, and not feeling a responsibility to nurture the world in return.
2. *Need-based: Environment as source of my pleasure:* The child and adolescent naturally uses the environment to seek pleasure and avoid pain. He wants to have his needs met, and is upset when the environment is unfriendly or harsh. He might ask, "Why can't the weather be nice this weekend?" As the person matures, hopefully he will come to accept that the world is not always pleasurable; sometimes the weather is too hot or

Table 8.1 Ecopsychological Levels of Development

Ecopsychological Levels	Body-Mind-Spirit	Consciousness Levels (Wilber 2000, 2006)	Ego-states (Berne 1996)
1. Safety and security	Body-emotional focus	Pre-personal (unconscious)	Child dominant (I want, I don't want)
2. Need-based			
3. Rebellion ethics	Cognitive-social focus	Personal (conscious)	Parent dominant (I should, I shouldn't)
4. External ethics			
5. Internalized ethics	Spiritual-ecstatic focus	Transpersonal (beyond the self)	Observing-self dominant (beyond the self)
6. Interconnectedness			

too cold, for example, and we must deal with reality as it is.

3. *Rebellion: Rejecting the "letter of the law"*: The young adult may need to question authority and even rebel against authority, and thus may reject rules about littering, hunting, fishing, and logging, for example. Rebellion may be a phase in the person's development of critical thinking and critical feeling. Many young people think and feel that they are victims of life and thus feel justified in taking whatever they want from the environment. Although the adult will hopefully give up the idea of being a victim, many people may continue to stay in a position of rebellion against society and against the environment, however, and thus continue to try to "get away with" taking all they can from the environment.
4. *External ethics: Following "letter of the law" about the environment*: Eventually, the adult accepts society's rules, including environmental laws. If it is socially unacceptable to litter, many adults will comply with the rule out of desire to conform and perhaps fear of punishment. Obedience to the external rules, however, means that the individual is dependent upon what the current culture teaches. Hopefully, the maturing adult eventually moves past such conformity to levels 5 and 6.
5. *Internalized ethics—expressing my own spirit of law for environment; service*: At some point, the adult internalizes those external rules that fit with her own personal ethics and values. These rules become the person's own values. A personal commitment to the spirit or intent of the law thus becomes more important than the specific externally imposed rules of the law.
6. *Interconnectedness: I am "response-able" for the well-being of the environment*: Ultimately, the maturing human feels a deep interconnectedness with and responsibility for the environment. There is no longer a duality between the self and the rest of the universe. Responsibility is recognized to refer to the awareness of and commitment to what he is *able* to do for the environment. Thus each individual, having a different ability, has a different responsibility.

How can the social worker use this theory of ecopsychological development to help inform her practice? The worker can first try to assess the stage at which her client currently operates. This will help the worker not only understand, interpret, and accept the client's current thoughts and behaviors related to the physical environment, but also identify possible goals related to the next sequential level of development. The client may have become "stuck" at this stage for many years, with negative consequences (such as feelings of depression and despair). The worker tries to match interventions that fit with the client's current developmental level, knowing that she is wise to engage the client "where he is." Evaluation can also be informed by the developmental model, as the worker looks for new expressed behaviors and thoughts that might help the client see his progress. Clients may shift between different levels over periods of time (see also the case study later in the chapter).

Ecopsychology Approaches in Social Work Practice

Ecopsychology interventions do not replace interventions drawn from other practice paradigms, but rather add the ecological physical-environment dimension to social work practice.

Indoor Micro-Mezzo Approaches

Approaches to social work practice can be organized into four interrelated categories, as shown in Table 8.2. Indoor micro-mezzo approaches include work with individuals and groups, typically in an office or institutional space. Guided visualizations can be used, for example, to help clients identify and work with "sacred landscapes" that they find nurturing or uplifting. Clients might use an empty-chair dialogue technique to have a "conversation" with other living things or ecosystems. Animal-assisted therapy frequently utilizes dogs and other animals to help clients work with difficult emotions or issues. Environmental dialogues can be held between groups of people who have different views about local sustainability issues (such as land or water rights). Some clients

Table 8.2 Examples of Ecopsychology Approaches in Social Work Practice

	Micro-Mezzo Levels	Macro Level
Indoors	Guided visualizations Animal-assisted therapy Artistic expressions Empty-chair dialogue Environmental dialogue	Indoor environmental quality (IEQ) Advocacy for clean air and water Environmental justice work Population control initiatives Environmental dialogue
Outdoors	Nature walk Equine therapy Gardening Vision quest Outdoor retreat	Community gardening Urban planning and architecture Holistic/organic agriculture Community environment projects Re-wilding projects

might want to explore the "wild" aspects of their own lives, and rediscover the roles of such aspects as exercise, sexuality, sleep, and eating in their well-being.

Outdoor Micro-Mezzo Approaches

Outdoor micro-mezzo approaches include work with clients in outdoor settings. Some social workers can take their clients, with permission, on walks outside during counseling sessions. Equine therapy utilizes horses as a vehicle to work with clients. Many people enjoy gardening, and social workers can engage clients in planting, weeding, and harvesting activities as a way to interact and engage in conversations. Some clients might decide to participate in vision quests, in which they find locations in nature where they become receptive to learning more about themselves through interactions with other living things and natural events. Groups of clients might go on outdoor retreats, facilitated by social workers who then do counseling with them, in natural settings.

Indoor Macro Approaches

Indoor macro approaches include indoor environmental-quality work, in which social workers empower clients to work together to improve the quality of the living and work spaces they inhabit every day. Clients can also be organized by social workers to advocate for local sustainability issues, including clean air, clean water, and human population control. Environmental justice work focuses on eliminating the unequal burden that the poor and under-represented populations have in dealing with the negative consequences of environmental pollution and deterioration. In environmental dialogues, the social worker facilitates dialogue between groups with different views on sustainability issues. An example of such a dialogue might be a conversation with advocates for a new national monument who meet with ranchers and corporate representatives who oppose the monument.

Outdoor Macro Approaches

Finally, outdoor macro approaches include participation in community gardening and maintenance of other open urban spaces, as well the development of affordable local holistic/organic agricultural products. Another area is urban planning and architecture, in which social workers can lead or participate with interdisciplinary teams of professionals and lay citizens in developing our large-scale towns and cities, transportation networks, and housing and work environments. "Re-wilding" projects are intentional efforts to help return land and water spaces to more "natural" conditions, so that indigenous living things can recolonize those spaces.

Case Example

This brief case study shows how social workers might add ecopsychology to their work with clients. The assessments and interventions described here are introduced as examples of ecopsychology work and are not meant to represent a complete case formulation and treatment strategy.

A school social worker sees a family at her office. The presenting problem is that the oldest girl (Sal, 17 years old) was caught smoking marijuana at her high school. The girl has a younger brother, Rob (14 years old). They are cared for by their father, who has raised the children by himself, after their mother went to prison three years ago. The social worker discovers that Sally has engaged in a number of "externalizing" behaviors, starting in high school, including truancy from school, unsafe sex, and alcohol abuse. Her brother, who is an "A" student, has more "internalizing" symptoms, such as moderate depression and anxiety (with no apparent suicidal ideation). The father has two jobs and lately has been concerned that he is not home enough to supervise Sal. The family lives in a poor neighborhood, near a freeway.

The worker starts by asking the family what goals they have for themselves. The children and father all agree that they (1) want the mother back home, (2) wish they did not live such separate lives, and (3) wish they did not worry so much about their individual and collective futures. The worker assesses that family members are operating between the safety-security, needs-based, and rebellion levels of ecopsychological development (levels 1, 2, and 3). She accepts where the family is, understanding many of the contributing familial, cultural, and other influences in their history.

In addition to getting some traditional family counseling for the family and individual counseling for the two children, the social worker introduces some interventions drawn from ecopsychology. She visits the prison, meets with the mother, and with the mother's permission helps set her up in a new prison gardening program, which the family visits when they come to the prison to see the mother. The social worker, aware of the negative impact of living near a freeway, helps the family relocate to a location near a city park. She helps the father and the two children develop better diets and join aerobic exercise programs. The social worker finds out that Rob loves horses, and enrolls him in an equine therapy program run in a local suburb. She works with Sal's probation officer to get her into a diversion program. Sal picks a program in which she helps design a community garden near her new high school. With the help of the family, the school social worker evaluates these interventions and makes modifications as necessary.

Limitations of Ecopsychology

Like every other practice approach, ecopsychology has limitations. The field is still being defined, and there remains a lack of consensus about how to assess the degree to which our clients are impacted by their physical environments, how to engage them in noticing this impact, and how to help them take actions that could make a difference in their lives. We have had evidence for a long time that people who are committed to take some action—in fact, any action—to deal with their world tend to be physically and mentally healthier than those who do not (Keniston, 1968). We do not know yet how to consistently help people empower themselves to take such actions in effective and nonviolent ways.

Although, as this chapter suggests, there are several theories and approaches in ecopsychology, the field lacks a unifying theory. There is also a lack of consensus in many areas of the world, often politicized, about whether global warming is actually real, or the extent to which it is human-caused. These limitations are also strengths, of course.

Future Opportunities and Challenges for Scholars

Ecopsychology offers a number of opportunities for scholars. The lack of definition consensus, the need for more evidence, and the political controversy mentioned above can also be seen as exciting opportunities for exploration by young scholars. Although evidence for global warming is now overwhelming, more research will help us understand exactly how, and how fast, human activities are contributing to climate change. More research will also help us better understand exactly how human and natural ecosystems interact with the biopsychosocialspiritual well-being of people.

Researchers can study the many unexplored aspects of ecopsychology. We need to study the factors that are associated with empowerment and disempowerment of people in reaction to the gradual decline in our ecosystems. Why do some people avoid and deny climate change, while others became active in promoting sustainability? Also we need to better understand

Table 8.3 The Four Forces and a Possible Fifth Force?

Force/Paradigm (Time of Appearance)	Underlying Psychological Issue/Threat	Focus of Paradigm
Psychodynamic (late 19th century)	Rediscovery of family of origin trauma	Exploration of past trauma to help the person get her needs better met now
Cognitive behavioral (early 20th century)	Accelerating expectations to behave, achieve, and demonstrate intellectual mastery	Changing the way we think and act
Experiential/humanistic (1960s)	A decade of rebellion, questioning, and seeking personal expression and freedom	Awareness and expression of feelings and other internal experience
Transpersonal (1980s)	Resurgent interest in religion and spirituality	Inclusion of the spiritual dimension in practice
Ecopsychology (1990s–2000s)	Increasing awareness of climate change and other global survival threats	Appreciation of, connection with, and responsibility for our life-sustaining ecosystems

why people sometimes can cooperate to work to protect ecosystems, and why sometimes we fail to do so. We need to show more accurately, the degree to which ecosystem decline affects physical and mental well-being.

Scholarly work is not just restricted to what we call "research." Scholars can also help develop new models of engagement, assessment, intervention, and evaluation in ecopsychology, on the micro, mezzo, and macro levels. As models of ecopsychology practice are developed, they can also be evaluated, using both practice-based evidence and evidence-based practice approaches. I believe that we can develop effective ways to work with people across the life span and across cultures, to help individuals, groups, and communities empower themselves to do something positive about the threats to global survival.

Conclusion

In 1971, Maslow suggested a Four Forces model of psychological theories, with four paradigms that correspond to the four Western psychological "eras" in which each they were first developed. As summarized briefly in Table 8.3, the First Force was the psychodynamic paradigm, which emerged in the late 19th century. Psychodynamic theory responded in part to Freud's discovery that his clients suffered from childhood trauma. The Second Force cognitive-behavioral paradigm responded at least in part to frustrations with changing norms in the larger culture, and with the perceived slowness of psychodynamic work. The experiential Third Force was largely associated with the movements for personal expression and freedom in the 1960s. The resurgence of interest in religion and spirituality is seen as a factor in the development of Fourth Force transpersonalism.

Thus, the first Four Forces of psychology emerged historically, in response to the evolution of Western culture. There is no reason to think that the evolution of culture ended in the 1980s, as transpersonalism developed. In fact, the dates in column 1, Table 8.3, highlight how the changes in our culture seem to be accelerating, as the time between the origins of the paradigms seems to be generally shrinking. The greatest underlying psychological issue and threat to all cultures on the Earth today is arguably global survival. If Maslow were alive today, perhaps he would postulate that a new Fifth Force is emerging today, the ecopsychology paradigm, which is a response to the global survival threats to the ecosystems that support all life on earth.

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9

Empowerment Approach to Social Work Treatment

Judith A. B. Lee and Rhonda E. Hudson

Today the importance of empowerment as process and outcome in social work practice is taken as a given. Discourse about empowerment in social work practice began in the late 1970s and flourished throughout the 1980s (Solomon, 1976; Pernell, 1986; Lee, 1989; Parsons, 1989; Cox, 1989; Gutiérrez, 1989; Mancoske & Hunzeker, 1989). It was developed throughout 1990s and the first two decades of the 21st century. It has gained momentum and acceptance in practice and theory in the United States and globally, remaining relevant to the present time.

"Empowerment" is now a household word, a word in common usage with many meanings often related to overcoming obstacles. It is used in many professions as diverse as social work, education, nursing, psychology, politics, ministry and theology, economics, and business (Read & Laschinger, 2015; Biden, 2013; Argyris, 1998). Avon, a company known for the selling of cosmetics door to door and the self-employment of women, now sells merchandise to support women's empowerment. Using the infinity sign as a symbol of empowerment and discussing it in empowerment terms, Avon also sells "empowerment" bracelets and pendants and devotes a portion of their profits to agencies serving women who experience domestic violence. Both local and international literature speaks of empowerment zones where indigent people, especially women, can become economically self-sufficient.

There was a large mural on display during a demonstration of community response and outrage in Baltimore, Maryland, at the killing of a 25-year-old black man, Freddie Gray, in May of 2015. Mr. Gray was given a "rough ride" without a seatbelt in a police van and sustained a mortal

spinal cord injury. The words "Rest in Power, Freddie 'Pepper' Gray" were on the mural. Power was on the minds of the demonstrators, and indeed, a fully empowered community is what is needed to overcome the obstacles of racism, poverty, and classism and abuse of authority that are still very much alive. Due to similar incidents of brutality in Ferguson, Missouri, New York, and several other cities, banners reading "Black Life Matters" led large numbers of Americans in processions, both peaceful and not peaceful. After Hurricane Katrina in 2005, Tom Brokaw noted that the public exposure of "the realities of poverty and race in America" gave America a wake-up call (Brokaw, 2007, p. 295). The recent demonstrations, protests, and riots are another jarring wake-up call. In both authors' social work practice and ministry with the poor, homeless, and marginalized, we have experienced many expressions of how hard life is in low-income communities. For us, helping people to internalize that "your life matters" is a hoped-for outcome of empowerment-oriented practice.

Many helping agencies describe the "empowerment" of clients as a goal in their mission statements. This frequent use of the concept is potentially helpful, but simply using the word makes nothing happen. As social workers, we need grounded approaches to empowerment-oriented practice that specify meanings, and engender knowledge, values, and especially skills to make the concept of empowerment operable and useful. This chapter operationalizes empowering helping.

The empowerment approach to social work practice that we discuss here is concerned with the unity of the "person–environment" configuration and the knowledge and skills needed to address this unity. The ultimate hoped for outcome is building the beloved community, a concept and dream first made popular by Dr. Martin Luther King, Jr., to describe a world where social and economic justice and compassion prevail. King also spoke of the "giant triplets of racism, materialism and militarism" that together are "insurmountable." By materialism, he meant the greed and concentration of wealth at one end of society and abject poverty at the other end, both locally and globally. He noted that while endless money goes into militarism, there is no way to solve the problems of poverty. He joined himself with the struggles of the poor and called for "a radical revolution of values" that shifts us from a "thing-oriented society to a person-oriented society" (1967). Noting that we must ask why there were 40 million poor in America in 1967, he challenged structural inequity and the uneven distribution of wealth. Much has changed since then, but much has also remained the same. Now he might ask us to reflect on why there are 45.3 million Americans living in poverty (http://www.census.gov/hhes/www/poverty/data/incpovhlth/2013/highlights.html).

Poverty has remained a constant over the years, well known by those who continue to live at the margins and those, including social workers, who stand by them. Such unyielding poverty takes its toll on individuals, families, and communities, draining them physically, emotionally, and spiritually (Katz, 1986). Those who are economically disadvantaged often feel powerless against natural, social, economic, and political forces that overwhelm like a tsunami wave (Ozawa, 1989).

Additionally, the continuing realities of terrorism, war, distressed inner cities, rural poverty, and natural disasters, including the effects of global warming, present challenging realities demanding our attention. These realities and immersion in endless new technologies are the context in which current social work practice takes place. Wulff (2011, p. 362) notes that the survival of social work in postmodern society is about a search for new paradigms that empower the socially excluded. Adams (2008) notes that "in the postmodern era, empowerment has the potential to become either a unifying or a divisive theme of social work" (p. 22). The empowerment approach discussed here (Lee, 1994, 2001; Lee & Hudson, 2011; Hudson, 2009) and a variety of related empowerment-oriented conceptualizations (Turner & Maschi, 2014; DuBois & Miley, 2013; Adams, 2008; Hudson, 2009; Miley, O'Melia, & Dubois, 2013; Shera & Wells, 1999; Gutiérrez & Lewis, 1999; Walton, Sandau-Beckler, & Mannes, 2001; Eamon, 2008; and others) are sorely needed at this juncture in postmodern history.

Social work at its best is an empowering profession. DuBois and Miley (2013) see

empowerment as "the heart of social work practice and social justice as its soul." They affirm Lee's empowerment approach that links personal and political power, and see general and clinical social work practice that attends to individual need and environmental change as empowering (2013). British social work theorist Robert Adams (2008) reminds us, however, that not all social work practice is empowering. Many mandated services are in fact delivered in disempowering ways. They may follow guidelines that are not responsive to empowerment-oriented principles or to the exigencies of the people served. The authenticity of empowerment should derive from and be rooted in the circumstances of those who use the services. Adams notes that an empowerment approach must be enacted on multiple levels, often simultaneously. He says, "To attempt to work at one level and separate it from the others is to risk tokenism at best and, at worst, failure" (p. 3). Furthermore, empowerment practice must take into account global awareness and interdependence and apply in developing countries. He notes that Lee (2001) advances an empowerment approach that does this.

Lee's empowerment approach (2001) deals with empowering people across the life span individually and in families, groups, and communities to develop their capabilities and assets and change noxious environments. Building the beloved community where justice reigns is both the process and the hoped-for outcome of individual and political empowerment. It is where we are going and how we will get there. Lee offers many case examples to illustrate how diverse users of service in relational systems of all sizes are empowering themselves. Turner and Maschi (2014) note that both feminist and empowerment theories and approaches are especially suited to the understanding of individual and sociopolitical levels of social work assessment and intervention. Both approaches in practice will provide social workers with the knowledge, values, and skills most likely to promote human rights and social justice. They see Lee's empowerment approach as a clinical and community-oriented approach that contributes to building a better world. Their case example of Claudia, a 33-year-old Hispanic college graduate who is struggling with issues of substance abuse and the aftermath of early sexual abuse and later abusive relationships, shows the power of empowerment-oriented support groups in her life. Claudia develops a sense of self-worth and also becomes an activist against human trafficking, realizing her personal and political empowerment.

The United States of America has experienced several defining events that have challenged us to acknowledge that community and individualism are at least equally important, and that local and global interdependence are imperative. September 11, 2001, was a major tragedy that forced us to acknowledge our position in world politics and our vulnerability and dependence upon one another for survival. Many social work articles describe the heroic, caring, and skillful responses of friends, family, neighbors, and strangers, as well as professionals in the wake of the trauma caused by the tragedy and massive crisis. Similarly, terrorist acts, war, and many natural disasters such as tornadoes, hurricanes, earthquakes, and mudslides in the past few years demonstrates the care with which people can respond to one another in the midst of tragedy. Ultimately, we are challenged to empower ourselves and one another back to "normalcy," health, confidence, security, and hope, personally, socially, and economically.

At the same time, the era of managed care and private interest placed a stranglehold on health and mental health care, and all but dictated the kinds of social work practice that would be valued—that which is simply and easily measured as "successful" in short periods of time. In 2008, 45.7 million Americans lacked health insurance coverage. The Patient Protection and Affordable Care Act (ACA) signed by President Obama on March 23, 2010, was a clear and major step forward in insurance coverage despite the rancorous partisan divide on this bill, also called "Obamacare." By the second quarter of 2015, according to Rand researchers, almost 17 million (16.9) Americans were covered for the first time. This figure takes into account that 22.8 million Americans were newly covered, while 5.9 million lost coverage, some of whom found other coverage (Diamond, 2015) (www.forbes.com/sites/dandiamond/2015/05/06/how-obamacare-changed-health-insurance-maybe; www.washingtonpost.com/national/health-science/

obamacare-adds-164million-tohealth-insurance-rolls). The *Washington Post* saw this as an "especially robust gain for minorities" while acknowledging the need for greater effort in outreach (Bernstein, 2015). The gain for working people is unmistakable. Yet, some working Americans whose salaries are too low continue to fall through the cracks and sadly remain uncovered, necessitating further attention to medical coverage for all. When President-Elect Donald Trump takes office in January, 2017, "Obamacare" is on the short list, and likely to be repealed. While some hope to replace it with something more affordable that includes more marginal wage earners, the question is "replace it with what?" And, what will happen to the millions now covered for the first time under "Obamacare"?

The word "empowerment" took on new meaning as the election of the first African-American president of the United States, Barack Obama, in November, 2008, ushered in a new age of hope. The "yes, we can" mentality enlivened a wide range of new and first-time voters, including young people and minorities of color. His 2012 re-election was also a product of careful organizing on the grassroots level and continued hope, although it was known by then that "no, you can't" was a counterpoint to presidential and progressive progress. We saw in Hillary Clinton's Democratic Party nomination and run for the for Presidency a hope that women will finally break through the class ceiling of political power in the USA. We also saw how difficult that is and now our hope and our grass roots level work moves toward a future that includes a woman President of the USA and progress for all people. The challenge is now to move beyond expectations of magic cures and do the hard work to finally make some of the reforms and changes, including continued healthcare reform, actually happen. Ultimately, matters fall into the hands of the people who empower themselves to take action. Frances Fox Piven (1989) suggests that a people's movement protesting for the changes still needed would, in fact, empower a president (and Congress) to deliver what people need to survive and thrive (2008). Making such change is, fortunately, not in the hands of social workers or any one profession or group of people alone. But, our knowledge base, values, and empowerment-oriented skills superbly fit us to be helpful in the pursuit of distributive justice in the form of health care, income, services, and a range of resources for those who have been left out of the mainstream.

It is important to note that a key factor in the development of personal, group, and community empowerment are strong mediating structures in the community. Viable schools, community centers, youth programs, and churches and other places of worship may be among the strongest of such structures. For many, particularly in low-income, black, and other minority communities, the church remains a center of activity, activism, support, and positive identity (Martin & Martin, 2003). While in more well-to-do communities religious affiliation is on the decline, especially among the young, the spiritual and faith dimensions of people's lives may be sources of strength and empowerment (Canda, 1988, 1998, 2006; Cowley & Derezotes, 2011; Derezotes, 2009; Martin & Martin, 2003).

It is tragic that little has changed for the poor and outcast of the global world except that the ranks of the poor are swelling. Over half of the world's 6 billion people live under the poverty line of $2.00 a day. One point two billion earn less than $1.00 a day. Poverty and its tolls on human life are a global issue of major concern. And, while it is not linear, the connection between poverty and violence is well established. Terrorists are known to use poverty as a means of recruitment (Atwood, 2014). For Americans in poverty there has been some progress, as noted above in health care, and also in the overall poverty rate. While the unemployment rate was 9.8% in 2009, in April of 2015 it was 5.4% (Roubini, 2009; http://www.bls.gov/web/empsit/cps_charts.pdf). However, the unemployment rate for blacks was 9.6% and for Hispanics 6.9% in 2013, indicating little economic progress for blacks (www.bls.gov/news.release/empsit.a.htm). In 2008, almost 40 million (39.8 million) Americans lived in poverty (U.S. Census Bureau, 2009), while in 2013, 45.3 million people lived in poverty (www.census.gov/hhes/wwwpoverty/data). Poverty data released by the U.S. Census Bureau on September 5, 2014, reveals that child poverty dropped significantly for the first time since 2000, from 21.8% in 2012, to 19.9% in 2013. While child poverty decreased for Hispanic, white, and Asian children, black

children saw no decrease, and continue to have the highest child poverty rate at 39%.

The empowerment approach to social work practice enables practitioners to co-investigate reality and challenge obstacles with people who are poor, and to stand with people who are pushed to the edge of American or global society. This necessitates a joining with, and validation of, that experience and a dual focus on people's potentials and political/structural change. The synthesis of a wide range of theories and skills in the empowerment approach is needed for effective empowerment practice.

Classic theorist William Schwartz (1994b) elaborated on C. Wright Mills's notion that the "personal troubles of milieu and public issues of structure must be stated in terms of the other, and of the interaction between the two. . . . There can be no choice or even a division of labor between serving individual needs and social problems . . ." (p. 390). Integrating these in theory and practice is the dual focus of the empowerment approach. Despite polarization in the profession throughout history, a focus on dual simultaneous concern for people and environments can guide social work past falsely dichotomizing individual growth and social change (Schwartz, 1994a, 1994b; Germain & Gitterman, 1996). But even this dual view of function needs an additional component: that people/clients *themselves* actively work to change the oppressive environment and mitigate the effects of internalized oppression. A side-by-side stance of worker and client is needed. As bell hooks (1990), African-American feminist writer, notes: "Radical post modernism calls attention to those shared sensibilities which cross the boundaries of class, gender, race, etc., that could be fertile ground for the construction of empathy—ties that would promote recognition of common commitments and serve as a base for solidarity and coalition" (pp. 26–27). Such empathy is the "sine qua non" of the empowerment process. It enables bridges to be made and crossed so client and worker can stand together to confront both personal blocks to empowerment and injustice.

Empowerment Concepts

The empowerment approach makes connections between social and economic injustice and individual pain and suffering. Utilizing empowerment theory as a unifying framework, it presents an integrative, holistic approach to meeting the needs of members of oppressed groups.

As Adams (2008) notes: "Empowerment is holistic and non-hierarchical. Empowerment is about taking control, achieving self-direction, seeking inclusiveness rooted in connectedness with the experiences of other people. It concerns individual achievement and social action. One aspect feeds another" (p. 18). This approach adapts an ecological perspective as advanced by classic theorist, mentor, and our friend, Carel Germain, which helps us see the interdependence and connection of all living and non-living systems and the transactional nature of relationships (1979; 1987; 1991). Potentialities are the power bases that are developed in all of us when there is a "goodness of fit" between people and environments. By definition, poor people and oppressed groups seldom have this "fit," as injustice and a paucity of resources stifles human potential. To change this unfavorable equation, people must examine the forces of oppression, name them, face them, and join together to challenge them as they have been internalized and encountered in external power structures. The greatest potential to tap is the power of collectivity, people joining together to act, reflect, and act again in the process of praxis. This process is fueled by mutual caring and support.

Multifocal Vision

Multiple perspectives are used to develop an empowerment practice framework. This "multifocal vision" also determines the view of the client: The historical perspective-learning a group's history of oppression, including a critical-historical analysis of related social policy; an ecological perspective, including a stress-coping paradigm and other concepts related to coping (a transactional view of ego functioning that takes oppression into account, problem solving, and cognitive restructuring of the false beliefs engendered with internalized oppression); ethclass and feminist perspectives that appreciate the ceilings imposed by class, race, and gender, the concept that power may be developed, and the unity of the personal and political; and a critical perspective, analyzing the status quo; and

cultural and global perspectives Van Den Bergh & Cooper (1986).

Imagine a pair of glasses with several lenses seamlessly ground in. Our vision is sharpened in particular areas, yet clearly focused. In addition to this multifocal perspective, the empowerment approach is based on values, principles, processes, and skills that are integrated into an overall conceptual framework to be discussed in this chapter. Helping processes include the support of strengths and ego functioning, challenging false beliefs, challenging external obstacles and unjust systems, developing pride in peoplehood, problem solving and problem posing, consciousness raising and dialogue, and building collectivity. These are used in the one-to-one, family, small group, and wider community, including the political arena. The group, in particular the "empowerment group," is the heart of empowerment practice. The uniqueness of this approach is the integration of the personal/clinical and the political in a direct practice approach relevant to poor and oppressed people.

Empowerment's Path into Social Work—Historical and Contemporary Precedents

Three important historical precedents of empowerment practice in social work history are the settlement movement, particularly the work of Jane Addams and her cohorts (Addams, 1910); the generally unrecognized women's club and social reform work of 19th-century African-Americans and other minority groups with self-help approaches (Gary & Gary, 1975; Berman-Rossi & Miller, 1992; Shapiro, 1991); early group work theorists, particularly Grace Coyle, who worked with a progressive group called the Inquiry (Coyle, 1930); and the work of Bertha C. Reynolds, the radical psychoanalytic social caseworker (1934).

The great women who are the predecessors of an empowerment approach did not have the right to vote, to live alone or unmarried without scandal, to attend universities of their choice, or to freely enter the professions as they built the profession of social work. The interested reader might see Lee (2001, pp. 104–121) for a detailed account of the amazing foremothers of empowerment practice.

In the current time, sociology psychology, political science, economics, and religion, especially feminist theory, oppression theory, liberation theology, and the inclusion of spirituality in social work practice, have contributed to social work's synthesis of empowerment theory for social work practice (Lee, 1994, 2001; Simon, 1994; Simon, 1990; Turner & Maschi, 2014; Valentich, 2011; Martin & Martin, 2003; Robbins, 2011). For some, the concept "liberation" more accurately describes the processes and objectives of empowerment. Social work can assist people in empowering themselves to work toward liberation (Germain, 1991). There are two strong streams that feed into empowerment theory for social work practice: social/political/economic movements and human development/clinical theories from the helping professions related to releasing human potentials. The empowerment approach seeks to channel the two streams into one mighty flow.

Barbara Bryant Solomon (1976) was the first major social work thinker who developed the concept of empowerment for the profession. Solomon identified direct and indirect blocks to power. Indirect power blocks represent internalized negative valuations (of the oppressor) that are "incorporated into the developmental experiences of the individual as mediated by significant others." Direct power blocks are applied directly by some agent of society's major social institutions (1976). Powerlessness is based on several factors, including: economic insecurity, absence of experience in the political arena, absence of access to information, lack of training in critical and abstract thought, physical and emotional stress, learned helplessness, and the aspects of a person's emotional or intellectual makeup that prevent them from actualizing possibilities that do exist (Cox, 1989). The actual and perceived ability to use resources that are available contributes to a sense of power that is directly connected to self-esteem (Parsons, 1989). Society "blames the victim" for power deficits even as power is withheld and abused by dominant groups (Ryan, 1971).

William Schwartz builds on Bertha Reynolds's mediating function idea, and appreciates the oneness of private troubles and public issues. This is a foundation stone for the empowerment approach (Schwartz, 1994a, 1994b; Shulman,

2008). Radical casework approaches (Galper, 1980) seek to unite the personal and political and are an important forerunner of empowerment thinking. Tully (2000) adapts Lee's (1994) "conceptual framework" as a model for using the empowerment approach with gay and lesbian people. Gutiérrez and Lewis (1999) apply an empowerment perspective to social work practice with women of color, while Yip (2004) and Hung (2012) apply an empowerment model to the Chinese culture, and Letendre (1999) applies it to school social work. Andrews, Guadalupe, and Bolden (2003) apply empowerment concepts to women in poverty, while Johnson and Lee (1994) apply them to homeless women, and Bay-Cheng, Lewis, Stewart, and Malley (2006) discuss empowerment in a feminist mentoring program. Chadiha, Adams, Phorano, Ong, and Byers (2003) explore African American caregivers' stories of empowerment. The uniqueness of the empowerment approach is that it weaves clinical and political thinking into one fabric.

Empowerment Defined

Empowerment "deals with a particular kind of block to problem-solving: that imposed by the external society by virtue of a stigmatized collective identity" (Solomon, 1976, p. 21). Merriam-Webster's (2009) definition of the word "empower" is: "to give power or authority to; to give ability to, enable, permit," which implies that power can be given to another. This is rarely so. Staples, (1984) sees empowerment as the process of gaining power, developing power, taking or seizing power, or facilitating or enabling power (Parsons, 1991). Barbara Simon (1994, 1990), who has documented the empowerment tradition in social work practice, stresses, "Empowerment is a reflexive activity, a process capable of being initiated and sustained only by (those) who seek power or self-determination. Others can only aid and abet in this empowerment process" (1990, p. 32). The empowerment process resides in the person, not the helper.

Narayan (2002), speaking from a global economic point of view, defines empowerment as "the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable institutions that affect their lives." Assets are "physical and financial while capabilities are inherent in people and enable them to use their assets in different ways to increase their wellbeing" (p. 11). Assets and capabilities are social and political, individual, or collective. These may include good health (physical and mental), education, production, belonging, leadership, relations of trust, a sense of identity, the capacity to organize, and values that give meaning to life. Empowerment-oriented social workers may assist people in developing their capabilities so they can increase their assets.

There are three interlocking dimensions of empowerment:

1. the development of a more positive and potent sense of self;
2. the construction of knowledge and capacity for more critical comprehension of the web of social and political realities of one's environment; and
3. the cultivation of resources and strategies, or more functional competence, for attainment of personal and collective social goals, or liberation.

In his classic work, Beck (1959) noted that as we partialize and operationalize the concept of empowerment, it is a keystone concept of social work.

The "life model" of social work practice (Germain & Gitterman, 1980, 1996; Gitterman & Germain, 2008; Gitterman, 2011) fits well with an empowerment approach, as it allows multilevel examinations and interventions that may be clinical or political; it is almost by definition a praxis model; and the empowerment perspective gives direction to life model practice (Mancoske & Hunzeker, 1989). The specialized assessment and interventive methods used in the empowerment approach (Lee, 2001) build on the categories and the spirit of the life model.

Critical consciousness and knowledge of oppression are power. Power also comes from healthy personality development in the face of oppression, which fuels the ability to influence others. This includes self-esteem/identity, self-direction, competence, and relatedness (Germain, 1991). Clinical and political interventions must challenge the external and internal obstacles to the development of these attributes. Transformation, or throwing off oppression in

personal and community life, occurs as people are empowered through consciousness-raising to see and reach for alternatives (Harris, 1993). It requires anger at injustice and the dehumanization of poverty, negative valuations, and the culture of personal greed (Mancoske & Hunzeker, 1989). The strengths perspective of Saleebey (2008, 2011) and the structural approach of Wood-Goldberg and Middleman (1989) are also compatible with the empowerment approach. Carol Swenson's development of the concept of justice as a meta-practice principle in social work practice (1998) is foundational in empowerment-oriented social work.

Social work practice with the oppressed builds on community and not on self-interest and broadens the possibility of the imaginable as it goes beyond immediate problem solving to the promulgation of hope (Mancoske & Hunzeker, 1989).

Powerlessness has low social attractiveness due to poor resources—(material and emotional resources and knowledge). To help empower, we must first learn to speak openly about power with clients, then engage in examination of power bases stemming from personal resources and articulation power, symbolic power, value power, positional power or authority, and organizational power. Unfair social stratification and unfair distribution of goods are the most difficult questions facing world society. Critical education and guaranteed basic incomes are imperative. International social work can help link different groups/cultures together to claim a fair share of power resources and resist domination (Staub-Bernasconi, 1992).

Paulo Freire

A major contributor to empowerment thinking in social work is Brazilian educator Paulo Freire (1973, 1990, 1994). It is the translation of Freire's critical thinking into social work theory that marks the uniqueness of this empowerment approach.

The "radical pedagogy" and "dialogic process" of Freire (1973) is clearly a relevant method for empowerment in social work (Lee, 1989, 1991, 2001; Mancoske & Hunzeker, 1989; Gutiérrez, 1990; Breton, 1989; Parsons, 1989; Pence; 1987; Freire, 1990; Narayan, 2000). "Every human being is capable of looking critically at (the) world in a dialogical encounter with others . . . in this process. . . . Each wins back (his/her) own right to say (his/her) own word, to name the world" (Freire, 1973, pp. 11–13). Freire's group- and community-oriented methods of dialogue promote critical thinking and action.

Liberation theology, with its notions of base communities as units of social and political change, mutual support, and use of consciousness-raising, is particularly pertinent to social work thinking (Breton, 1992; Mancoske & Hunzeker, 1989; Germain, 1991; Evans, 1992; Lewis, 1991; Lee, 1994, 2001). Freire defines "conscientization" as "learning to perceive social, political and economic contradictions and to take action against the oppressive elements of reality" (1973, p. 20). Critical consciousness-raising and dialogue are the key methods that help people think, see, talk, and act for themselves (Freire, 1973).

Lorraine Gutiérrez, cites consciousness-raising as goal, process, and outcome in empowerment work (1989, 1990). She sees group work as central to empowerment-practice based practice based on research on the effective use of ethnic identity and consciousness-raising groups with Latino college students (Gutiérrez & Ortega, 1989).

Empowerment Theory and Groups

Empowerment theory applied to group work was first introduced in 1983 by Ruby Pernell at the Fifth Annual Symposium of the Association for the Advancement of Social Work with Groups. She noted that group work is a natural vehicle for empowerment, as its historic goals include "growth towards social ends" (1986).

Noting that black Americans have borne the lion's share of power insufficiency and inequities, Pernell emphasized that empowerment practice cannot remain politically neutral.

> Empowerment as a goal is a political position, as it challenges the status quo and attempts to change existing power relationships. . . . It goes beyond "enabling." It requires of the worker the ability to analyze social processes and interpersonal behavior in terms of power and powerlessness . . . and . . . to enable group members to . . . develop skills in using their influence effectively. (p. 111)

The skills of working with indigenous leadership, knowing resources—where the power lies and how to get it, and enabling the group members to do for themselves are important in attaining empowerment.

Margot Breton (1994) and Elizabeth Lewis (1983) have been major contributors in integrating humanism, liberation theology, and community group work into empowerment practice. Groups that seek change in the environment are empowering to the degree that group members (not organizers) have actually brought about and reflected upon the change.

The Interactionist approach of William Schwartz (1994a) is a stepping stone to an empowerment approach. The group is a microcosm of social interaction. The worker's role is to mediate the processes through which individuals and their systems reach out to each other, particularly "when the ties are almost severed." This approach appreciates reciprocity and the strength of the group itself as a mutual aid and self-empowering system (Berman-Rossi, 1994). Papell and Rothman's (1980) conceptualization of the "mainstream model" of social work with groups draws on the Interactionist approach. Formed or natural groups can encompass a variety of empowerment purposes. A blending of critical education and conscientization group methods with the Interactionist and mainstream models form a foundation for the empowerment group (Lee, 1994, 2001, 2011).

Ruth Parsons (1989) emphasizes the importance of the group in empowering low-income girls. Empowerment is an outcome and a process that comes initially through validation by peers and a perception of commonality. Groups may have consciousness-raising, help to individuals, social action, social support, and the development of skills and competence as their overlapping foci in order to help members facing oppression gain equality and justice (Garvin, 1987). Reed and Garvin have made important contributions regarding the empowerment of women through groups (1983), while Tully (2000) discusses the empowerment of gay, lesbian, bisexual, and transgendered people. Mullender and Ward (1991), major British theorists, stress that empowerment group work must be a self-directed (not worker-directed) process. Parsons (1989, 1991) identifies empowerment as a developmental process that begins with individual growth, and may culminate in social change; a psychological state marked by heightened feelings of self-esteem, efficacy, and control; and liberation. The conceptual framework presented here integrates these three kinds of empowerment into a unified approach.

Basic Assumptions

A basic assumption of the empowerment approach is that oppression is a structurally based phenomenon with far-reaching effects on individuals and communities. These effects range from physical death due to infant or child mortality, the death of adolescents and young adults due to gang violence, drugs, other forms of homicide and suicide; to incarceration and the death of hope. Hopelessness leads to self- and other-destruction, despair, apathy, internalized rage, and false beliefs about the worth of the self (Harris, 1993). When the effects of oppression become internalized, the maintenance of oppression may become a transactional phenomenon. Strong support networks and good human relatedness and connection are essential to developing a positive sense of identity and self-direction. The assumption is that self is found in community with others (Swenson, 1992). The problems caused by oppression almost always necessitate a dual focus on changing the environment and strengthening the self.

The assumption about people in this approach is that they are fully capable of solving immediate problems and moving beyond them to analyze institutionalized oppression and the structures that maintain it, as well as its effects upon themselves. They are able to strengthen internal resources, and work collaboratively in their families, groups, and communities to change and empower themselves in order to challenge the very conditions that oppress. The basic principle of this approach is that "people empower themselves" through individual empowerment work, empowerment-oriented group work, community action, and political knowledge and skill. The approach sees people as capable of praxis: action-reflection—and action, action-in-reflection, and dialogue.

A unitary conception of person-environment prevents us from victim blaming on one hand and naïveté regarding the panacea of environmental change on the other. It leads toward developing helping "technologies" (strategies, methods, knowledge, and skills) that are both clinical and political. Feminist social work theory, a forerunner of empowerment in social work, necessitates "both/and" conceptualizations of practice (Turner & Maschi, 2014; VanDenBergh & Cooper, 1986; Bricker-Jenkins & Hooyman, 1986; Bricker-Jenkins, Hooyman, & Gottleib 1991; Valentich, 2011). People can and must take themselves and their environments in hand to attain empowerment. To envision social change that comes about without the full efforts of oppressed people is to envision a Machiavellian utopia. To envision oppressed people making this effort without changing themselves: to refuse oppression, to actualize potentialities, and to actively struggle to obtain resources is to negate the effects of oppression in the lives of the oppressed. Both changed societies and changed people who will work toward this are the nature of the sought-for change. The goals are collective more than individual, yet these two are inseparable. The assumption here is that both the oppressor and the oppressed, as well as those who seemingly stand by or pass by on the other side, are damaged by oppression and in need of liberation. This view seeks unity and harmony among oppressed groups. Yet, it does not shy away from nonviolent confrontation and conflict, which may be a necessary part of liberation.

Value Base of the Empowerment Approach

Most practice models or approaches that serve "all people" neglect to pay adequate attention to people who are poor, of color, women, and otherwise oppressed (Lum, 1986). The NASW Code of Ethics and the ethical principle of impartiality entreat us to cultivate our knowledge and skill to reach out to the clients who face bias and discrimination and to act (with them) to challenge oppression. Attempts at equanimity minimize central aspects of people's lives that necessitate exceptional coping abilities. Color, class, gender, stigma, or difference "blindness" is not useful to clients (Lum, 1986). Empowerment means that people (both workers and clients) draw strength from working through the meaning of these different statuses in their lives, which enables them to be the fullness of who they are, persons with a rich heritage. The value base and the conceptual framework which underpins this empowerment approach is summarized in Figure 9.1.

A Conceptual Framework

The Empowerment Approach to Social Work Practice

Professional Purpose

This is based on a dual simultaneous concern for people and environments: to assist people who experience poverty and oppression in their efforts to empower themselves to enhance their adaptive potentials and to work toward changing environmental and structural arrangements that are oppressive.

The Value Base

This is the preference for working with people who are poor, oppressed, and stigmatized, to strengthen individual adaptive potentials and promote environmental/structural change through individual and collective action; preference for social policies and programs that create a just society where equality of opportunity and access to resources exists.

Knowledge Base and Theoretical Foundations

Theory and concepts about person–environment transactions in situations of oppression—which include multifocal vision: the history of oppression; ecological, "ethclass," cultural, feminist, critical theory, and global perspectives; knowledge about individual adaptive potentialities, unique personhood, and the ways people cope—ego functioning, social and cognitive behavioral learning, and problem-solving in the face of oppression; empowering individual, family, group, and community helping processes; and larger systems and structural change processes in order that we may assist people in empowering themselves on the personal, interpersonal, and political levels.

Method—Principles, Processes, and Skills

The empowerment method rests on empowerment values and purposes and the eight principles that undergird the approach. The method may be used in the one to one, group, or community relational systems. It depends on a collaborative relationship that encompasses mutuality, reciprocity, shared power, and shared human struggle; the use of empowerment groups to identify and work on direct and indirect power blocks towards the ends of personal, interpersonal, and political power; and collective activity that reflects a raised consciousness regarding oppression. The method uses specific skills in operationalizing the practice principles to address and promote action on all levels of living.

The Roles, Processes, and Skills of the Empowerment Approach

Processes and Skills to Promote Coping and Adaptation/Social Change

In an empowerment approach, the worker promotes reflection, thinking, and problem solving on person–environment transactions, including the client's role in them and the experience of oppression. Sustaining skills, particularly the use of well-attuned empathy born of multifocal vision and listening, make the difficult work of empowerment possible (Germain & Gitterman, 1996). The worker also assesses ego functioning and provides ego-supportive intervention to bolster clients' strengths (Goldstein, 1994, 2011; Lee, 1994, 2001; Lee & Hudson, 2011). Client and worker together then seek to change oppressive conditions, using a range of skills.

According to Carel Germain (1984), people must develop certain attributes in order to cope and adapt. The attributes achieved by good enough person-in-environment transactions are: motivation, which corresponds to the incentives and rewards provided by the environment; problem-solving skills, which correspond to the strengths and efficacy of society's socializing institutions (including the family and schools); maintaining psychic comfort (including managing feelings), and a favorable level of self-esteem that corresponds to the kind and degree of emotional and other support in the environment; and self-direction, which corresponds to the provision of information, choices, and adequate time and space (Germain, 1984, 1991).

Empowering Skills to Bolster Motivation

Motivation can only be sustained if basic needs for housing, food, clothing, and support (financial and emotional) are met. As these needs are met by client and worker through gaining resources and opportunities, and attending to presenting problems, the worker can help keep hope alive. In Lee's current work with the homeless in Fort Myers, she utilizes a "clubhouse" approach, where people regularly gather on a Tuesday and enjoy lunch and socializing as well as group and individual services. Over several years, a core group of 12 and a strong, caring community have formed where mutual aid abounds and people serve one another. Since this city has few options for shelter and affordable housing, a strong focus of this practice is to help people obtain basic financial and housing resources. Over six years, more than 100 people moved from homelessness into permanent housing as a result of the hard work of this helping community.

The specific skills that bolster motivation are encouraging the client's own words about the problems and her unique life and accepting the client's problem definition. The worker can also reach for and convey understanding of feelings of difference, isolation, alienation, and being misunderstood, as well as experiences of discrimination at the hands of systems needed to sustain life and growth. Lanetta, a white woman, age 48, with a long history of bipolar illness and homelessness, wrote a story about a "throw-away dog" that identified her feelings about herself and her struggle (Lee, 2011). Easily agitated, she had literally been thrown out of every program in Fort Myers and slept in the woods and on the streets before she came to live in our Joshua House transitional residence for six months. The worker empathically conveyed understanding of "being thrown away." Lanetta then worked hard individually and in groups and with a local mental health team to get stabilized on her medications, internalize her self-worth, and turn

her life around. She left Joshua House with a new sense of the intelligent, creative, witty, and capable person she was. And, she was reconciled with her daughter and grandchild as well. Her disability benefits were in place, and she was able to rent her own small home. She continues to be a respected leader in our "beloved community." As the worker partializes the stressful demands into workable segments with the client, she also encourages the client to share how she has dealt before with similar problems. The skill of having the client name and own her strengths also provides motivation to continue. Hope of changing the oppressive systems must also be offered through the worker's skills of lending a vision and beginning to enlist the client's energy in this thinking. The worker may also use skills of appropriate self-disclosure around dealing with oppressive conditions to build bridges to the client's experiences and to offer further hope of change. The worker should also use skills of system's negotiation with the client so that the client gains expertise in this area.

To Maintain Psychic Comfort and Self-Esteem

In helping the client maintain psychic comfort, manage feelings, and attain an optimal level of self-esteem, the worker has the additional tasks of externalizing the sources of oppression in order to reduce self-blame and to foster pride in "peoplehood." Here she has the role of co-teacher and critical educator as she helps the client identify and own his/her group's achievements and heighten awareness and appreciation of the client's own culture.

The worker uses family and group skills to help members share and validate each other's experiences with oppression (Wood-Goldberg & Middleman, 1989). As members discover they share a common experience, self-deprecatory feelings may diminish. Here also, the worker co-teaches about the oppressed group's achievements against the odds, which builds communal and self-esteem. Giving information helps clients gain familiarity with how systems work, diminishes fear, and adds to feelings of competence. The worker also helps mobilize natural helping networks and structures and focuses on changing systemic inequities that promote the clients' discomforts and anxiety.

To Enhance Problem Solving and Promote Self-Direction

The skills of problem solving are especially important in an empowerment approach. Ultimately, the aim is to help people to think differently and act differently. Berlin (1983) suggests a nine-step cognitive behavioral problem-solving process that moves from awareness of the problem to taking action. Eamon (2008) discusses a cognitive behavioral approach that is empowering as the goals are the client's not the worker's. Germain (1984) adds the dimensions of teaching the skills needed for achieving the solutions by providing group experiences for such learning and working with the environment.

Particular skills are needed to problem-solve in an empowerment approach. These skills include consciousness raising, praxis, and critical education. Skills of maintaining equality in the problem-solving process are critical. This includes observing the rules of symmetry and parity in communication. The worker who is directive and lectures or filibusters or interprets frequently in the process is not providing the conditions necessary for empowerment. Lee's agency was gifted with a second-year social work student, Lucy Conley, from Flinders University in Australia. A particularly helpful skill that Lucy used was to ask members of our Tuesday "club" to share their expertise about homelessness in Fort Myers and how they coped with it. A corollary question was what might she do to make herself available to people who are homeless. One of our "elders" told her to watch and listen before she spoke, so she could learn who the people are by what they did as much as by what they said. Another told her to "lead with her love," not her knowledge. Even as she empowered them in the role of experienced expert, they in turn empowered her as a growing practitioner.

Consciousness-raising is a process of developing a heightened awareness and knowledge base about situations of oppression, which leads to new ways of thinking about the social order. As with all skills and processes discussed here,

it may be done on the one-to-one, family, group, or community levels. This is a tall order. The four attributes (motivation, psychic comfort, problem solving, and self-direction) are interdependent and must be sustained throughout the helping process. A raised consciousness provides motivation, but motivation and psychic comfort are necessary to raise consciousness because ultimately it means change in thinking and doing. To view the world differently may be initially both a frightening and a freeing experience. The worker's skill of working with feelings will include hearing, naming, staying with, validating, and helping the client to express the pain, anger, and sadness that come with consciously realizing that they have been oppressed and victimized socially and economically. The use of "codes" developed by the clients and of their own experiences—for example, using books, art, music, poetry, and other ways of reaching people's level of conscious awareness—can be extremely helpful.

The skills of gently sharing information in the co-teaching role are critical here as well. Knowledge is power. To be kept from knowledge is oppression. The skills of cognitive restructuring (Berlin, 1983) are needed to raise consciousness about being oppressed. The worker helps clients identify thinking patterns, revise false beliefs, devise more adaptive ways of dealing with internalized and external oppression, and to talk and think in a healthier way about herself, her group, and her situation. The worker then encourages the client to rename and recreate her own reality using her own words.

One of the groups that the senior author works with is her church youth group. This group serves from four to nine African-American low-income young people from age 14–22. They meet regularly on Sundays, and also attend and assist in the summer enrichment program with younger children. The building of knowledge and consciousness-raising about African American cultural history as well as religious and moral content is part of the group's work. They are rewarded for completing workbooks containing this history and perspective and also for their regular attendance and participation and their school progress. In 2014, five teens earned a trip to Washington, D.C. Their first air flight and first subway rides were exciting to share with them. Talking with them as we toured the capitol and saw Frederick Douglass, Sojourner Truth, and Rosa Parks etched in bronze statues and then touring the Martin Luther King, Jr., Memorial and the section on slave and freedmen's contributions in the Revolutionary period at the Custis-Lee Mansion at the Arlington Cemetery was an enlightening exercise in the development of new consciousness. Keeron, 16, said "the King Memorial made me proud to be black and also made me think 'what will I do with my life'?" He and Keeondra, 14, posed for pictures by the capitol statues, and the group linked arms under the King Memorial and knelt beside the words of the "I Have a Dream speech." Natasha, 18, who was about to enter college, took notes on the exhibits in the Custis-Lee Mansion, and she took pictures of everything. "I can't forget this," she said; "I never knew about freedmen and women and I never knew about any contributions of slaves. Knowing about slavery makes me sad, but knowing what they accomplished makes me proud of my people, and of myself in another way."

The worker's skills of guiding in the process of praxis are extremely important. As noted, praxis: action—reflection and return to action, involves sometimes painful unpeeling of awareness and feeling that take place over time. The ability to promote competence and action is critical. This is also a good time for the worker to share her own struggles in challenging such obstacles. As we relaxed after touring Arlington Cemetery, we reflected as a group on all they saw there. I then asked them, "What does all of this make you want to do?" Their answers were about working hard in school and making their own contributions to a better world and better community at home. But they thought this would not be easy. Then I asked "So, what's holding you back?" The need for computers and web access and worries about their housing and family and community troubles were named and looked at as solvable problems. Lack of self-confidence was also a major obstacle for one of the 16-year-old girls—"but talking about it helps," she said.

It is as important to be a "problem poser" as it is to facilitate problem-solving. The skills of critical education are central to the empowerment

process. This includes the skill of posing critical questions that help people think about the oppressive situation in new ways. This is combined with the skills of information-giving noted above. For example, one can use recent newspaper articles or discuss a local news item.

As noted, Freire's method of critical education (Freire, 1973; Mancoske & Hunzeker, 1989; Pence, 1987) has five steps, which are taken with a team of representative persons called a "culture circle." First, a survey is conducted. The team listens to what is on people's minds, assessing what people talk about and what their emotions are linked to. This work must include emotionally cathected concerns. Second, a theme is chosen, and problems are posed in question form. Themes broaden the base of an issue. For example, a theme in Pence's battered women's groups was, "What is the effect of abusive behavior on women?" (Pence, 1987). Third, the problem is analyzed from three perspectives: the personal, the institutional, and the cultural. Questions are asked about each perspective. Fourth, a code is developed. A code is chosen to focus the work when a theme generates work on all three levels. Finally, options for action are generated on all three levels. When actions are taken, a process of praxis is used to consolidate and deepen the work of developing critical understanding and a vision of social change. Ultimately, work that promotes motivation, problem solving, and psychic comfort contributes to a client's self-direction and empowerment (Weiner, 1964).

Skills to Promote Social Change

Beyond the gains to the self, empowering work can empower communities. Group- and community-centered skills are essential. Much of the above noted-work is done most effectively in small groups, which then may build coalitions with other groups and forces in the community to effect social change (Breton, 1991). Empowerment group skills include: making a clear mutual contract that bridges the personal and the political and includes a social change focus (Lee, 1991), establishing the common ground and common cause among members, challenging the obstacles to the group's work, lending a vision, and reaching for each member's fullest possible participation in the process (Schwartz, 1994a). The worker will also skillfully pose critical questions and develop codes to focus the group's work, as discussed above (Freire, 1973). Combined, these become the "empowerment group" method. "Community skills" incorporate these group skills but include coalition-building and the skills of task-oriented action. Here one wants to help members choose initial tasks at which they can achieve success. Wider political skills include lobbying and testifying at legislative hearings as well as organizing meetings, protest, and nonviolent resistance activities. These are skills for workers and clients to develop together (Lee, 1994; Staples, 1984; Richan, 1991).

Roles and Stance of the Worker

Above all, the worker in the empowerment approach is a real person who has awareness of her/his own experiences of oppression and/or membership in the oppressor group. This awareness begins with self-awareness, including issues of counter-transference, but goes beyond this to having a raised consciousness about oppression itself and an ability to share this in the helping process through appropriate self-disclosure. There is no mysticism about the helper or the helping process. The stance is "side-by-side" and an authentic, transparent, presentation of self. With the youth group, Lee shared that she, too, had lots of "money problems" while growing up poor and living "in the 'hood" like them, and that working and going to college was really hard, but it had to be done so the family could eat. The group members travelled to the home of an African-American woman and art teacher now living in Washington, D.C., whom Lee grew up with, and Lee said, "Both Martha Andrews Gentry and I shared stories of our youth that brought peals of laughter and a few tears from the kids." Including them on this personal level opened a deeper level of communication. The helping process itself is shared with the client initially and as the process unfolds.

Assessment is important in this approach. The worker must gain understanding of who the client is in her own story and what tolls oppression has taken on the client's well-being currently or in past history. The concept of "the

client's story" includes the presenting problem as primary but often goes beyond it to the client's view of historical material that is relevant to the problem at hand. This is both a narrative and oral history approach, which also seeks to unearth the strengths of individuals and their people over historical time (Martin, 1995). While principles of good clinical assessment are utilized, two important differences of this assessment process from "purely" clinical approaches are: the level of mutuality of the process as the worker shares what her thinking is openly, while seeking to comprehend how the client "makes sense" of the situation; and the explicit inclusion of "ethclass," race, gender, and other areas where oppression and power shortages or power deficits may have been experienced by the client. Hence, the assessment is of the client in transaction with oppression and of the oppressive environment, not of the client as if he or she exists in a vacuum. For a detailed outline for "An Empowerment Assessment: Content and Process," please see Lee (2001, pp. 216–218).

The contract or mutually derived working agreement then also explicitly includes looking at the experience of oppression as one of the foci of the work. Of course, as in any approach, immediate and material problems have priority. The client may choose, after being made aware of her options, to focus only on immediate problem-solving. This approach assumes that poor people and other oppressed groups already have a point of view on their oppression and the ability to reflect on, challenge, and take action to rid themselves and their cohorts of oppression. Many clients already have a raised consciousness and may in fact be surprised that a social worker shares this consciousness. Some, however, have become so accustomed to living in oppression that the anger or despair at victimization and discrimination has been unconsciously repressed. This illuminates another level of the term "consciousness-raising."

Whatever time it takes to both solve the issue(s) at hand and raise consciousness in order to challenge immobilizing oppression is the optimal time frame. It is important to note that this work is not open-ended. At some point in the process, the client feels empowered enough to continue the work without the worker. The worker, in effect, does herself out of a job as empowered people stand ready with awareness, resources, and knowledge to pursue their own goals.

Worker Training Within the Empowerment Approach

Workers need both clinical and political knowledge and expertise to do the job. They need to be "generalist-specialists," both broad and deep (Morales, 1977). They need to be individual and family clinicians, group workers, and community workers and know how to use political process to effect change. Some master's and bachelor's programs with integrated curricula aim at producing this kind of graduate. Others are over-specialized in one end or the other of the spectrum of roles. It may take some shifting of curricula as well as postgraduate training and supportive supervision to develop this kind of social worker. Team approaches may also help practitioners deliver the breadth of empowerment-oriented services. This kind of work comes to fruition in agencies where there is flexibility in the way workers may approach services.

The vocabulary of empowerment work includes a few new words, which we have defined in this chapter. These include *consciousness-raising, praxis, dialogue*, and *codes*. The usual vocabulary of the clinically and politically astute practitioner has been used and explained as well throughout this chapter. As in all empowerment, as we use different words to describe our thoughts, we begin to think differently. The tried and true approaches to personal/clinical work and to group, community, and political work and the newer strategies of empowerment are grafted in an approach that is therefore both old and new. Hence the practitioner is empowered with a new, yet not unfamiliar, level of knowledge to share in working with oppressed groups. We conclude this chapter with practice vignettes.

Case Examples

Lee's work with homeless and low-income people in New York City and in Hartford Connecticut, Guyana,

South America, and now in Fort Myers, Florida, grounded the empowerment approach in practice reality (Lee, 1986, 1990, 1991, 1994, 2001, 2011). All the people she worked with, especially Judith Beaumont (1987), "co-authored" the empowerment approach.

Case Example 9.1

The "Successful Women's Group": Formation

Membership in an empowerment group is a matter of personal choice based on knowledge of the experience. A "try it and see" philosophy helps members who share common ground understand what it is like to be in such a group. In forming an empowerment group for women who had "graduated" from the services of the women's shelter, the co-workers began by inviting large groups of "alumnae" to six evening get-togethers. This approximated Freire's culture circle. The codes and themes for the empowerment work would emerge from these six meetings, as would a nucleus of women interested in pursuing empowerment together. The format of the evening, which took place in the homey atmosphere of the shelter, included a dinner where introductions and an informal style of sharing mutual concerns could take place, and then a formal period of group discussion when empowerment notions were introduced. Many attended national and local protest activities regarding affordable housing that coincided with these meetings. Seven African-American women, ages 22–34, decided to become the "Alumnae Empowerment Group."

The co-workers started off as more central to the process in helping the group develop a structure and maintain a focus on issues of empowerment, but they soon took on a more advisory role. Within four months, the group developed a club-style structure with a president who called the meetings and maintained the work focus. They chose the meeting nights, time, frequency (biweekly), outreach to new members, and content of the meetings. The workers bolstered the leadership structure and continued to contribute information and to assist in guiding praxis and reflecting on feelings and facts to deepen the work. The group existed for two years, though some of the members continue to be activists and to be there for each other. This is an excerpt from a meeting nine months into the life of the group in which they named themselves.

Tracey, the president, said, "Alumnae just don't get it."

"Who are we?" asked Vesalie.

"We are successful women," said Tracey.

"Yeah," said Latoya, "The Successful Women's Group."

"No," said Vesalie, "we can't call ourselves that."

"Why?" Shandra asked.

Vesalie strongly replied, "It implies too much power, that we are powerful."

The worker asked if they felt powerful. Vesalie said, "Yes we are more powerful now—we've got good jobs, we're good mothers, we help others who are homeless, we are meeting our goals, but we haven't gotten there yet."

The worker asked, "When you get there, then you have power?"

Tracey replied, "But that's just it, we need that power to get there, and we're on our way. Let's convey that we are powerful women, we are successful women, let's take that name and make it ours. We deserve to walk with that name!" The others strongly agreed. Vesalie thoughtfully accepted this, and the name "Successful Women" was enthusiastically adopted.

Names mean a great deal. The worker's questions here are consciousness-raising questions. This renaming after nine months of meeting represents a 360-degree turnaround in self-esteem, group pride, and conscientization. The use of codes helped the group achieve this new image.

In the Successful Women's Group, two themes were codified; one was "barriers to success" and the other was "African American womanhood." On the first theme, the worker asked the group members to define success. It was defined as personal achievement and "people-centered" accomplishments (giving back to the community). The Wall of Barriers was the code.

> The members were asked to imagine and dramatically act out climbing and pulling bricks down from a wall that represented barriers. *The worker posed the question: What are the barriers to young African American women getting over the wall to success for themselves and their people?* Amika was first to try to dramatize it. She said, "The wall is over there, I'm going

toward it. OOPS . . ." she said as she slipped and fell with a great thud, "they greased the ground, I can't even get to the wall. Forget it!" Everyone roared as Amika, a large, heavily built woman, dramatized falling down in disarray.

Tracey said, "It isn't really funny, Amika is right, some of us can't even get to the wall. The grease is prejudice and racism."

"And sexism," Ves added, "don't forget that."

Shandra said, "Yeah, but determination makes you try and you reach the wall. Like you finish high school and you think you're somewhere, but you didn't take the right courses to go to college so you got to start all over again."

Tracey said, "I was angry too when I found out my diploma meant so little. . . ."

Shandra got up and started using a hammer and a chisel saying, "And this one you got to strike at, its prejudice on the job. You get the job, but they treat you like you're stupid just because you're black." She told of how she was treated by a nurse she worked with . . . She unwedged the brick and threw it down hard. Everyone applauded.

Ves said, "O.K. Watch out! I'm driving this bulldozer right into the wall. Later for brick by brick, or climbing, the whole thing is coming down. Slam, crash." Everyone cheered her on.

"Wait," said Latoya, "a brick hit me, I'm hurt." She wiped imagined blood from her head: "It's the brick of hating myself because I believed 'if you're black stand back,' and I stood back and didn't go for even what you all went for, a real job and all. But I survived and stand here to tell it, I'm going to get me some too!" Everyone encouraged her.

The use of humor by African Americans and other oppressed groups is an adaptive mechanism. But no one should mistake the seriousness of the meanings in this dramatic enactment and decoding which was at once therapeutic and political—leading to a variety of actions.

Their next codification on African American womanhood was the reading together of Ntozake Shange's choreopoem *For Colored Girls Who Have Considered Suicide When the Rainbow Is Enuf* (1977). After several readings of selected poems and their discussion, Tracey, who had committed some to memory, concluded:

"These are our lives. It could have gone either way for us, we too could have died, or chosen paths that lead to death of our spirits and our bodies. But, we didn't because we found other women who was feeling what we were feeling and living what we was living. I will always see myself in Shandra. I will always be there for her. We found true shelter and we found each other, and we found God in ourselves, like the poem says."

"Yes," said Ves, "and we found the truth about our struggles too. And we are free, no turning back."

For Shandra's story and a summation of the empowerment work with her, including the tools of empowerment-oriented assessment and the skills of the work phase, please see Lee (2001, pp. 218–249).

Case Example 9.2

Brenda: The Personal/Political Empowerment of a Woman with Mental Illness

Brenda Gary, a 39-year-old African American woman with multiple physical problems and chronic paranoid schizophrenia, experienced periods of intermittent homelessness for five years. Leaving her children with relatives, she moved cyclically from the streets, to the hospital, to several shelters. Then she entered a residential support program, which set her up in her own apartment and offered daily support and empowerment services. For the first time since the onset of her illness, Brenda experienced inner peace. Brenda's appearance is marred by skin eruptions, but she radiates a quiet joy. She is not spontaneous, but when she is called on, her good intellect is revealed. Brenda volunteered to testify at public hearings on proposed state cutbacks of mental health programs. This is an excerpt:

"We need our programs to keep us aware of life's possibilities. No matter what you want to be it's possible. These programs kept me on track and looking forward to life. If the State cuts these programs, the State also cuts the good that they do. . . . We have a women's group every week. We talk about what goes on in our lives—the problems we experience and solutions to them by getting feedback from each other. . . . "

To get Brenda and her peers to this point, the worker, Gail Bourdon, prepared the empowerment group to understand the issues and the process of testifying before asking for their participation. First, she shared specific details of the proposed cuts and elicited the group member's reactions. She proposed that they might want to learn how to testify at the hearings and speak up for themselves. Then, when interest was high, she took two volunteers (Brenda and Vicky) and the staff to a workshop on the legislative process. Two weeks later, during an empowerment meeting, a summary of the legislative process was given to the group by the worker and the members who went to the workshop. Brenda volunteered to speak and composed her testimony that night.

> Early the next evening we went to testify. Brenda patiently waited two hours in line and the and additional 2 l/2 hours before testifying. The testimony was presented in the Hall of the House of Representatives. Brenda and I presented our testimony. It was a striking image to see Brenda, in her woolen hat, speaking so well from the seat of the Minority Leader. One senator thanked Brenda for her testimony. Brenda was clearly the group leader that night.

The group then reflected on their actions in the next meeting. The worker invited praxis, the members' reflections on the process of testifying and going to the legislative hearing.

> Group members read the entire newspaper article to each other. I asked what the women thought and felt about attending the hearings. Brenda smiled and proudly stated she felt good about having spoken. I asked Vicky how she felt about attending the hearing. Vicky said, "I was happy. It was one of the happiest times in my life. I saw and heard things I never thought I'd even learn about." The entire group cheered. . . .
>
> I asked Brenda if she thought her message was heard. Brenda said she thought so because they did not ask her unfriendly questions. They accepted her word and even thanked her. I asked the group members who went how it was for them and each replied affirmatively. Vicky added, "I feel like I could do that sometime . . . I feel the strength." The entire group agreed, noting that they had a voice and were heard. Ida said that those who simply sat there also brought support and power in numbers, so they had a presence as well as a voice. . . . Brenda added, "It's good to know that I can accomplish things even with a mental illness. Sometimes people think you can't do things because you have a mental illness. I live with the illness, but this does not mean I am not able to take care of business." The other members thoughtfully agreed.

The careful preparation of the members paid off in the group members' confident action. The skills of guiding praxis helped the members own their gains and expand their understanding and political skill as well as their self-esteem and self-direction.

Use of Groups and Research as an Empowering Process

At the invitation of a Guyanese social work educator, Lecturer Stella Odie-Ali, the senior author, collaborated with the Social Work Department at the University of Guyana in South America, and the Guyanese Association of Professional Social Workers over a three-year period, as a resource person and consultant on empowerment and homelessness. This mutually empowering experience included several workshops, conferences, and research projects, as well as direct practice with Guyanese social workers (Lee, 1999). A group of Guyanese social work students also visited Lee in Fort Myers, Florida, to see empowerment practice in a North American context. The findings of four research studies done by the Guyanese social workers using qualitative and quantitative methods were shared with the appropriate minister in the government, and this precipitated some changes in services to the homeless of Guyana. Reports of these studies of the mentally ill, street children, and the total homeless population include: Lee, Odie-Ali, and Botsko (2000); Lee and Odie-Ali (2000); and Lee, Cudjoe, Odie-Ali, and Botsko (2002). In each study, we hear the voices of those who have not been heard before.

Lee conducted a demographic and qualitative study with 133 homeless and low-income people who gathered for a meal, socialization, social and material services, and worship on a Friday night in a Fort Myers park over a two-year period. Data were collected in the summers

of 2007 and 2008. She wanted to know who they were, their experience of homelessness, and what they felt would help empower them. As a pastor, she also wanted to know how they viewed both God and church. Lee and her assistants recorded verbatim the words used and the stories told in response to open-ended questions. Some chose to write their own answers. A key finding of this study was the importance of the support system that was developing in the park, of caring and empathy as well as the provision of needed services and goods. Their resilience and the power of their faith in God was remarkable. Most people said thank you for asking for their thoughts and experiences. The interested reader might see Lee, *Come by Here: Church with the Poor* (2010).

In 2015, Lee asked her Tuesday "Clubhouse" group of formerly homeless and low-income core members if they wanted to share what factors in their life were most empowering. Nine of 15 present (five women and four men, ranging in age from 32–62, six African-American, one white, and two Hispanic) participated by writing the three most important factors in their empowerment. The results of this small study were discussed with great excitement in the next meeting. The study then became an exercise in praxis: reflection, action, and reflection leading to action again. All nine named faith in God and participation in a faith group as empowering. Seven said that their power comes from God's love. Eight named relationships with family, friends, group members, and specific people as empowering. Two named helping others as empowering. One named her medication as empowering "because it helps me think more clearly." One named her job and a social agency as empowering. One named specific religious beliefs as empowering. In reflection, they said that the study itself was empowering as their thoughts were important.

Cattaneo and Chapman (2010) have researched the construct of empowerment for research and practice across disciplines, while Jefferson and Harkins (2011) have researched a qualitative research model for empowering homeless and low-income individuals. Andrews, Guadalupe, and Bolden (2003) have studied the empowerment of women in poverty.

A very promising tool for the measurement of gains in empowerment, particularly with a mental health population, is the Empowerment Scale developed by consumers and leaders in the self-help movement and advanced by E. Sally Rogers at Boston University Psychiatric Services, and her colleagues. This is a well-validated 28-item scale measuring five factors: self-esteem-self-efficacy; power-powerlessness; community activity-autonomy; options and control over the future; and righteous anger (Rogers, Chamberlin, Ellison, & Crean, 1997); www.cpr.bu.edu/wp-content/uploads/2011/11rogers1997c-pdf.) While it is geared toward a specific population, I believe this scale could be used with a variety of populations.

Status in the Profession

Empowerment practice has gained in momentum over the years. Many contemporary thinkers are researching and conceptualizing empowerment-oriented practice. Hence, there is a growing empirical base to anchor empowerment in the professional lexicon of social work approaches. Yet it is difficult to study and measure a concept that is transactionally based and both clinical and political. Perhaps in some ways, such measurement is a moot point, for the power that people develop on the personal, interpersonal, and political levels ultimately makes up a whole that may defy quantification and over-simplification. At best, the separate aspects of the approach will be empirically documented (Rogers et al., 1997). The empowerment approach is grounded in practice and conceptualized from qualitative data, which, I believe, is a prerequisite to quantification of such complex ideas (Lee, 1991, 1994, 2001, 2011). Further grounding in such qualitative data would be helpful.

The empowerment approach provides a conceptual framework for empowerment-oriented social work practice. It brings social work into the discourse between sociology, political science, progressive change, and religion. It is relevant in education, ministry, community work, and a range of helping professions. It is both old and new, both clinical and political. It is also a paradigm for international social work practice, as it offers social workers a way to challenge

oppression and build capabilities with people throughout the world.

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10

Existential Social Work

Donald Krill

Existentialism

Born again in the disillusionment of recent decades, the existential worldview argues for more effective, flexible treatment of the poor and minorities from an enhanced, humanizing perspective.

The impact of existential philosophy upon the social work profession remains unclear. The first article on the subject appeared in social work literature in 1962, and three books by social workers delineated existential perspectives in 1969, 1970, and 1978. The topic of existentialism has seldom appeared at the National Conference of Social Workers.

On the other hand, social workers familiar with the existential viewpoint emphasize that this perspective speaks to the profession's most pressing needs: for more effective treatment of the poor and minorities; for more present-focused, experiential, task-oriented work with families and individuals; for a more flexible and eclectic use of varied treatment techniques; for a lessening of categorization of people and of paternalistic efforts by therapists to adjust the values of clients to those of their families or those of the established society. The existential perspective is even seen as providing an important humanizing effect to social workers' present experimentation with social change.

The failure of the existentialist viewpoint to attract major attention among social work professionals may be twofold. In the first place, writings of this type by philosophers, psychologists, theologians, and social workers tend to present a terminology that seems foreign to the average practitioner ("Being, Nothingness, the Absurd, Dread, I-Thou, Bad Faith," etc.). Social workers tend to be "doers" rather than theoreticians, and even the theorists tend to be pragmatic rather than philosophical. Second, existential social work writers have proposed a more philosophical perspective rather than specific working techniques. This is primarily because there does not really seem to be an existential psychotherapy per se. To be more accurate, one might say there is an existential philosophical viewpoint of how one sees oneself and one's client system and what can happen between them. Various theoretical approaches may then be used to provide techniques compatible with this philosophical perspective.

The Existential Stance

Modern existentialism was born in the ruins, chaos, and atmosphere of disillusionment in Europe during and following World War II. Earlier existential writers, such as Kierkegaard and Dostoevsky, reacted against what they believed to be false hopes for the salvation of humanity and the world through a philosophy and politics of rationalism in their times. In the United States, with its boundless faith in achieving the good life through continued growth in economic productivity and scientific advancement, the interest in existentialism has been slower in coming.

The disillusioning events of the 1960s (assassinations, the "generation gap," protest movements, Vietnam War) continued into the early 1970s (Watergate, economic instability, mounting divorce and crime rates, failures of psychotherapy hopes). These troubling occurrences opened the minds of many Americans to the existential themes that had previously been the interest of beatniks, artists, and a scattering of intellectuals.

Existentialism has been termed a "philosophy of despair," partially because it seems to emerge from disillusionment. But we may view this emergence as the origin and rooting of existentialism and its turning away from a primary allegiance to the idols and values that it deems have fallen. Where it goes beyond this point depends upon which particular existentialist writer, theologian, philosopher, or film director one chooses to follow.

In most of the philosophical literature on existentialism, four themes seem to recur: the stress upon individual freedom and the related fundamental value of the uniqueness of the person; the recognition of suffering as a necessary part of the ongoing process of life—for human growth and the realization of meaning; the emphasis upon one's involvement in the immediate moment at hand as the most genuine way of discovering one's identity and what life is about (not in any finalized sense but, rather, in an ongoing, open way); and the sense of commitment that seeks to maintain a life of both discipline and spontaneity, of contemplation and action, of egolessness and an emerging care for others. In all of these there is an obvious emphasis upon an inward turning in contrast to the "organizational" or "outer-directed" man of the 1950s.

The existentialists disagree with those who hold human beings to be either essentially impulse-driven animals or social animals of learned conditioning. Both of these ideas deny the individual what is, for the existentialists, one's source of dignity: the absolute value of one's individual uniqueness. A person discovers one's uniqueness through the way one relates to one's own experience of life. Sartre points out that this subjectivity is a person's freedom; it is something that is there; it cannot be escaped or avoided; one can only deny one's own responsibility for choices made within this freedom. From the existential view, psychoanalytic theory is sometimes misused by encouraging the individual's denial of responsibility on the basis of impulsive forces; similarly, sociological and learning theory may be misused by excusing a person on the basis of totally determining social forces.

Characters from fiction, drama, mythology, and philosophical tradition have portrayed the existential posture. Stoicism, courage, and individualism are common attributes. Existentialist heroes are often characterized as living on the edge of the traditions, values, and enticements of their society, prizing the preservation of their own uniqueness and authenticity above all else. They commonly suspect the motives of others, bordering on the cynical, and therefore avoid complete identity with any group espousing a "good cause." They are tough-minded in holding to their own code, evaluating it and preserving its integrity. They refuse to be "put down" by dehumanizing social forces through conformity or by selling themselves out to their rewards. They are against systemic efforts to suppress the individuality of others in society. They live forever with a clear awareness of life's limits, the absurd, the tragic, yet they maintain a committed faith in their groundings of freedom—the springboard for unique assertion. Their interactions with life define who they are, rather than the acceptance of some definition of themselves imposed by an outside authority, such as family, church, or economic system. The rhythm of responsive life-swinging-in-situation is a primary guide.

Existentialism is rejected by many as a narcissistic withdrawal from life when disappointments arise. At first glance, this might appear true, as we hear existentialists proclaim their own consciousness, subjectivity, and uniqueness as the sole absolute: "Truth is subjectivity," said Kierkegaard. Existentialists do reject the world, in one sense, in their new commitment to their own deepest self. What they reject, however, is not life—its conditions, limits, joys, and possibilities—but the mistaken hopes and expectations they had held about life, which, under closer examination, failed to fit with the reality of their life.

What is real does shatter cherished yearnings in us all—about love, about divine protection, about our own abilities and goodness. Yet in surveying the landscape of rubble from broken aspirations and beliefs, we find that we still have a choice of how to relate to these realities. We can allow ourselves to be driven to despair, or to choose new illusional hopes, or we can accept the reality and go from there.

The Hemingway hero is a portrayal of this. We might expect him to say, "We lose in the end, of course, but what we have is the knowledge that we were doing great." One's manhood, the sense of realistic pride, comes from the engagement with and assertion of one's own uniqueness. Each must discern what is right for him in terms of talent and skill, what is of value, and what is enjoyable. This becomes his own private personal perspective for which he alone is responsible. It changes throughout life, but it remains always his own, and hence truly unique.

The blank concept of "soul" has been defined as "the force which radiates from a sense of selfhood, a sense of knowing where you have been and what it means. Soul is a way of life—but it is always the hard way. Its essence is ingrained in those who suffer and endure to laugh about it later." Soul is the beauty of self-expression, of self-in-rhythm. One swings from inside and in response to what is outside as well. Soul is mind operating free of calculation. It is humor and spontaneity and endurance. This concept of soul is consistent with the existential aim of authenticity. Here we have a shifted view of spirituality emphasizing personal integration arising from direct life engagement. This is not a remote God, but rather God found at the heart of our daily experience in our interchange with others, ourselves, and nature.

Subjectivity

What is this subjectivity, this freedom, that holds the devotion and loyalty of a person? To Sartre, freedom is "nothingness." For Kierkegaard, it is the human encounter with the Transcendent—one's moment before God. Buber sees this as the "I" meeting the "Thou" of life. Kazantzakis speaks of the cry from deep within the human personality. To respond to it is our sole possibility of freedom.

Yet this subjectivity, while termed by some as an encounter with the transcendent, should not be mistaken for a direct expression of the Divine. Each of us is all too soon aware of the finite nature of subjectivity. It is not all-knowing, and subjectivity is different in each person and constantly in the process of change within the same person. Subjectivity exists as a unique responsive relation to the world. Its primary activity is the conveyance of meaning through thought and feeling, intuition and sensation, and the assertion of this unique perspective through creative acts. Some would term this the activity of spirit, a divine possibility available to human beings. Yet divine and human remain intertwined.

It is this relationship between one's own subjectivity and the outside world that is the basis for responsible freedom instead of narcissistic caprice. One experiences failures, misjudgments, hurt of others, neglect of self, conflict, and guilt. There is inevitable death, uncertainty, and suffering. These limiting situations, this suffering, becomes a revealing, guiding force of one's life. In a similar way, one realizes one's potentials. We sense that the world wants and needs some response from us. We feel called upon to choose, to act, to give, and to imprint ourselves on the world. This awareness of both limits and potentials is the foundation upon which we can judge our own unique perspective and readjust it when necessary. The ongoing encounter between subjectivity and the outside world may be looked upon as a continuing dialogue, dance, responsive process of inner and outer reality.

Each of us must assume the burden of responsibility for our own freely chosen perspective and the associated consequences of our actions. To be a person is to assert our intelligence, knowing that we do not have an absolute knowledge of truth and that we may hurt others or ourselves; our efforts will often end in mistakes or failure.

We fail, finally, in our resurging hopes, the existentialist might say, but then we are a brotherhood in this—not only with others, but with all of nature. For there is a striving everywhere, a fight, and, in the end, only the remnants of our struggles—and a little later there are no longer even the remnants. Our loyalty is to the thrust behind this struggle in all things. What is this thrust? A mystery! A meaningful silence! Can we be sure it is meaningful? Who is to know? The questions of salvation or an afterlife must be held in abeyance. They can no longer be certainties. For many, these very uncertainties become the springboard to religious faith.

The mystical flavor of life is shared by both existential believers and nonbelievers alike. It affirms life as meaningful, not because it has been clearly revealed as such through science or Scripture, but rather because one has sensed a deeper or clearer experience of reality in certain moments. These moments are not dismissed lightly, but are preserved as precious and illuminating even though the full meaning of their revelation may be unclear. Such experiences as love, beauty, creative work, rhythm, awe, and psychic phenomena suggest seeing "through a glass darkly." Those followers of religious faiths may find a "rebirth," an adult reorientation to the message of revelation in religious writings. Yet the revelation of ultimate significance remains personal.

The Bond with Others

If subjectivity and its uniqueness, development, and expression is valued in oneself, it must be valued in others as well. Since there is no absolute subjective perspective, each person's unique view and contribution contain an intrinsic value. Existentialists feel a bond with others and are responsive to their needs and to friendship, for they respect their subjectivity as being as valid as their own. They also know that the assertion of courage is difficult and often impossible without occasional affirmation from others. Human love is the effort to understand, share, and participate in the uniqueness of others. It is validating in others that which we also value within ourselves. Love is sometimes an act of helping, at other times a passive compassion. At times it reaches a total merging that takes one beyond the fundamental awareness of isolation.

The existentialists realize, too, the dangers in human relationships. Just as we guard against self-deceptions that tempt us toward a narcissistic idolization of ourselves, so we remain on guard in relation to the institutions of society. The assertion of individual uniqueness is often a threat to others and to a smoothly functioning social group. This is because such assertion will frequently defy the rules, patterns, habits, and values that are sources of defined security for others, or a group. Thus society and subgroups within a society will again and again attempt to suppress arising individual uniqueness out of a sense of threat or an inability to comprehend. Conformity is urged. It happens with family, friends, neighborhoods, and church, professional, and political groups. Existentialists often finds themselves estranged from others because of their own creativity and authenticity. Even when there is a relationship of mutual respect, with moments of unity through love, there will also come the moments of threat and misunderstanding because of the impossibility of one person's subjectivity fully comprehending that of another.

Yet conflict and threat in relationships do not move existentialists into a schizoid withdrawal. They may display a touch of cynicism as they hear others identify themselves wholly with some group effort or as they proclaim the hope of humanity to be in their sensitive and loving interchange with their fellow man. But existentialists know that their growth depends upon both affirmation from others and their occasional disagreement with them. Existentialists believe in the beauty and warmth of love even though it is momentary.

The philosophical position described has stressed both faith and commitment to a perspective of life deemed valid as a result of one's direct and sensitive involvement in the

life process. The subjective involvement of the whole person is essential to the life perspective that we finally conclude is our reality. Human life is highly complex, and we must seek an openness to its totality of experiences if our search is to be legitimate. This should not neglect an opening up of oneself to the meaning of experience as described by others as well.

What becomes apparent is a movement in personal awareness—from egotistical striving to self-understanding; then to I–Thou relationships with one's immediate surroundings; and finally, in the incorporation of some overall principle where humanity and universe are joined. Disillusionment, freedom, suffering, joy, and dialogue are all important happenings along the way. The end of this process does not really arrive until death. It is a continuing way that requires again and again the reaffirmation of that personal perspective called "truth." A transcendent view of existential freedom might be that of an illuminating light seeking understanding, compassion, and sometimes protective action in the surrounding world. This luminosity may also recognize that this very awareness is shared by all other humans, whether they know and validate it or not.

Professional Contributions

These ideas can be found in philosophical and religious writings as well as in motion pictures, plays, novels, and poetry labeled "existential." One of the earliest examples of existential literature is the Book of Ecclesiastes in the Old Testament. From the Orient, Zen Buddhism is also often compared with Western existential thinking.

Existential philosophy as we know it today had its initial comprehensive presentation by Soren Kierkegaard (1813–1855), whose writings were a passionate reaction to the all-embracing system of Hegelian philosophy. Later developments included the thought of Friedrich Nietzsche and Henri Bergson. Modern-day existential philosophers include Martin Heidegger, Jean-Paul Sartre, Albert Camus, Simone de Beauvoir, Miguel de Unamuno, Ortega y Gasset, Nicholas Berdyaev, Martin Buber, Gabriel Marcel, and Paul Tillich. This array of names suggests the widespread interest in existentialism among several European countries.

Much of existential psychology had its ideological rooting among the phenomenologists, most notably Edmund Husserl. Two European analysts, Ludwig Binswanger and Medard Boss, were constructing an existential psychology during Freud's lifetime.

Viktor Frankl, a Viennese psychiatrist, developed his "logotherapy" following his imprisonment in a German concentration camp during World War II. Logotherapy is based on existential philosophy, and Frankl remains one of the most lucid writers in conveying existential thinking to members of the helping professions.

Rollo May's monumental work *Existence* (May et al., 1958) represented the first major impact of existential psychology upon American psychiatry and psychology. May presented the translations of existential psychologists and psychiatrists from Europe, where such thinking had become popular and in many places had replaced psychoanalytic thought. There was a readiness in America for existential thinking, and it quickly became part of the "third force" or humanistic psychology movement. This group included people such as Karen Horney, Carl Jung (1933), Clark Moustakas (1956), Carl Rogers (1961), Abraham Maslow (1962), Gordon Allport (1965), Andras Angyal (1965), and Prescott Lecky. Two journals devoted specifically to existential psychology and psychotherapy began quarterly publication in the United States in the early 1960s.

Existential thought was related to Gestalt therapy (Frederick Perls 1969), the encounter movement (Carl Rogers and Arthur Burton 1969), rational-emotive psychotherapy (Albert Ellis 1962), and R. D. Laing's provocative "anti-psychiatry" writings (1964/1967). Thomas Szasz (1984) pursued a similar attack upon psychiatry, particularly in relation to the "therapeutic state," the insanity plea, and the dehumanizing use of clinical diagnostic categories. Ernest Becker and Irvin Yalom (1980) presented challenging reappraisals of psychoanalytic thinking from existential postures. Perhaps the most intense descriptions of the existential therapists' use of self are found in the works of Thomas Hora and William Offman.

Perhaps the earliest social work writings with a decided existential flavor were by Jessie Taft of the functional school, which had its roots in the psychology of Otto Rank. In his Pulitzer prize–winning book *The Denial of Death*, Becker produced a monumental integration of the thought of Rank and Freud (Becker, 1958). Social workers, who once avidly debated the "dynamic" versus the "functional" schools of social work theory, appear to have totally ignored Becker's incisive thought. A welcome scholarly exception to this is Robert Kramer's work, which links Rank with Carl Rogers and Rollo May (Kramer, 1995).

In 1962, David Weiss's article appeared in *The Social Worker* (1962) and Gerald Rubin's paper in *Social Work* (1962). Andrew Curry was publishing articles in the existential psychiatry journals. In the late 1960s, several articles appeared in various social work journals, written by John Stretch, Robert Sinsheimer, David Weiss, Margery Frohberg, and myself. These papers were specifically related to the application of existential philosophy in social work thought and practice.

There were also several social work papers published during this period that did not specifically emphasize existentialism but were related to similar concerns of the existential social work group. These writers included Elizabeth Salomon (1967), Mary Gyarfas (1969), and Roberta Wells Imre (1971).

The first book on the subject of existentialism in social work was published in 1969 by Exposition Press. It was Kirk Bradford's *Existentialism and Casework* (1969). Its subtitle expresses its intent: *The Relationship Between Social Casework and the Philosophy and Psychotherapy of Existentialism*. It should be considered an introductory and integrative work rather than a comprehensive or prophetic book. In 1970, Alan Klein related existential thinking to social group work in his book *Social Work Through Group Process* (1970). A second book was published in 1975 by Dawson College Press of Montreal, authored by David Weiss and titled *Existential Human Relations*. This was a more comprehensive work applying existential thought to various aspects of social work practice. In 1974, James Whittaker's book *Social Treatment* (1994) legitimized existential thinking as one of the four major theories contributing to social work practice. An effort to clarify both spiritual and systemic ideas for social workers appeared in *Existential Social Work* (Krill, 1968) by myself. Two of my subsequent books in practical application were *The Beat Worker* (1986) and *Practice Wisdom* (1990). The former focused on psychotherapy and the latter on teaching the integration of self-awareness, philosophical thinking, and the therapeutic relationship to graduate students. Other social work writers utilized the existential view when addressing instances of child abuse (Brown, 1980), social work education (Swaine & Baird, 1977), and cross-cultural counseling (Vontress, 1979).

While there appears to be a rising, if somewhat limited, interest in existential philosophy in social work literature, it would seem that the interest is far more widespread among social work students and younger professionals. Many of the newer therapeutic approaches being performed by social workers are closely akin to the existential view of the therapeutic process. Such points of emphasis as choice and action; here-and-now problem orientation; dispensing with the use of diagnostic categories; stressing the expression of the worker as a vital, human person; and recognizing the connection of personal identity with the quality of "significant other" relationships all have their existential linkages.

Therapeutic Concepts

The philosophical perspective discussed earlier suggests five organizing concepts of existential thought: disillusionment, freedom of choice, meaning in suffering, the necessity of dialogue, and a stance of responsible commitment. These same concepts can provide a way of viewing the therapeutic process (Krill, 1969).

Disillusionment

In existential thinking, one can move from a life of "bad faith" to one of authenticity. To do this, one must risk the pain of disillusionment. Similarly, in psychotherapy, change can be viewed as a result of giving up those very defensive beliefs, judgments, symptoms, or manipulations that interfere with the natural growth

process. This growth process would be seen as the emergence of unique personhood through responsive acts in relation to one's surroundings. Realistic needs and potentials begin to be the source of choice and action, instead of neurotic, self-deceptive security needs.

An important therapeutic task, then, is to help clients experience disillusionment with the various security efforts that block their own growth. Disillusionment will seldom result from a rational exploration of one's past with the hope of realizing causal factors of present defensive behavior. It is rare that one gives up security patterns because they are viewed as irrational, immature, or no longer applicable. Disillusionment occurs through the pain of loneliness and impotence. On the far side of such despair arise the possibilities of new values and beliefs. It is the therapist's concern that these be more human values than those abandoned. The therapist acts as a midwife for the release of the natural growth energies within the personality so that what is wholly and individually unique may emerge.

Freedom of Choice

Sartre characterizes consciousness as "nothingness," for it is an awareness of oneself that transcends or goes beyond any fixed identity one might have concluded about oneself. Personality is always emerging. To view it as static or secured is our act of self-deception (bad faith). This conception of consciousness as freedom is a break with conceptions of personality as being totally ruled by "unconscious" or by early learned behavior.

Despite our past, despite any diagnostic label pinned upon us, we always have the capacity to change ourselves. We can choose new values or a new lifestyle. This does not always necessitate years or months of "working something through"; it may occur within days or weeks.

Choice is for action and differs from intellectual meandering or good intentions. Chosen actions occur in the present. Therapy is, therefore, present-focused and task- or action-oriented. People learn from experience, not from reason alone, although the very process of understanding how one's current belief and value system operates (and its consequences) can itself lead to new choices.

The critical ingredient for change is the client's wish to do so. Therapy must, therefore, be designed to clarify quickly the nature of change sought by the client, and the therapist must be able to work within this framework rather than seeking to convince or seduce the client into redefining his or her problems and aiming for some type of change goal that pleases the therapist but is only vaguely understood by the client.

A therapist's belief in the client's capacity for change is a message of positive affirmation conveyed throughout treatment. There is no question but that a therapist's focus on unraveling the intricacies of past relationships conveys a deterministic message that is a commentary on the weakness and helplessness of a client.

Meaning in Suffering

Just as existentialists see suffering as an inherent part of a life of authenticity based on responsibility and freedom, so, too, existential therapists do not seek to discredit or eliminate anxiety and guilt in their clients. Instead, they affirm such suffering as both necessary and directional for a person. They will help reveal what real anxiety and guilt may lie disguised behind neurotic (unrealistic) anxiety and guilt. But they would not seek to minimize or eradicate realistic anxiety and guilt. Such efforts would themselves be dehumanizing unless used to prevent decompensation. In many cases, the normalizing of pain or a problem as a natural consequence of one's valued conclusions about adjusting to life can enhance one's sense of responsibility and the potential for changing one's orientation.

Necessity in Dialogue

People do not grow from within themselves alone. Their emergence happens in responsive relation to their surroundings. They create their own meaning in response to situations, and these meanings become the basis for choices and actions. However, their own meanings are no more absolute than those of any other person. Their own growth has to do with the continued reassessment of personal meanings, and they depend upon feedback from their environment

(particularly human responses) for this reassessment activity. In order to gain honest feedback, one must allow others to be honest and free in their own expression. In therapy, therefore, it is critical to help clients open themselves to relationships with others wherein they give up their manipulative or "game" efforts in order to invite free responses from others. In doing this, they not only allow themselves experiences of intimacy, but they also realize that their own emerging sense of self requires such honest transactions with others.

Commitment

Clients' recognition of and commitment to their own inner emerging unique lifestyle is a hope of the existential therapist. Clients realize this commitment through their experience of the therapist's own affirmation of their worldview. This unique worldview is affirmed from the beginning in the therapist's acceptance of how clients perceive their symptoms, problems, conflicts—how they perceive change and what they want changed. The client's uniqueness is also affirmed during treatment by the way a therapist relates to "where a client is" in each interview. The theme of a session comes as an emerging force from the client, rather than as a rationally predicted starting point made in advance by the therapist. Both the goal-setting process and the activity of entering upon and working with an interview theme are therefore client-centered rather than therapist-centered. When possible, a client's sense of destiny may be clarified and emphasized.

Clients' awareness of and respect for their own unique lifestyle might be described as a turning away from self-pity and impotence. Rather than complaining about their lot in life, they discover that they are intricately involved in the life process itself. They learn to listen to what life says to them and find meaning in the response that is unique to themselves. This is what is meant by the existential concept of destiny and commitment.

Related Therapeutic Approaches

As suggested earlier, there are obvious differences among therapists who claim the existential label. This becomes more understandable if we consider the above therapeutic principles and note how they may be activated in a number of differing ways. A consideration of the ranging techniques that may fit with the principles outlined will also clarify how other treatment theories tend to be compatible with the existential view. Existentialism claims no technique system of its own and needs none. Its affirmation of the uniqueness of each client results in a perspective that each treatment situation is also unique. Whatever techniques can be used, from whatever treatment theory, become the tools to work toward accomplishment of the special goal chosen. In this sense, existentialism is thoroughly eclectic. Techniques are always placed secondary to the world view of clients and the puzzle they present to the therapist.

Several therapeutic systems are compatible with existential thinking. (Some are not, and these will be considered later.) The reality-oriented therapists (Glasser (1965), Ellis (1962), O. Hobart Mowrer (1961), and Frankl 1965/1967) all stress choice and specific behavior change. William Reid (1979), Laura Epstein, and Harold Werner have described similar cognitive-oriented approaches in social work literature. They are present-focused and commonly propose specific tasks for clients wherein the client is expected to put into immediate practice a decision for change. They tend to use reason to aid the decision for change, but then stress action. The action is usually expected to occur outside of the therapy interview (often as homework assignments), but its results are brought back for further discussion. Reality therapists focus on the disillusionment process by clearly identifying "faulty or irrational beliefs" that are responsible for problematic behavior. They affirm the client's freedom to choose and encourage a value shift through action.

Gestalt therapy, psychodrama, client-centered therapy, and provocative therapy techniques all stress a heightening of a client's awareness through action in the here and now. They seek the immediacy of experience as a thrust for change rather than a rational process of analyzing causal connections. They differ from the reality therapies in that the stress is upon choice and action that is more immediate;

it is to occur in the here and now of the therapy meeting itself. Whether clients seek to make use of this experience in their outside daily life is usually left up to them. There is less effort to deal rationally with the disillusionment process of beliefs and manipulations. In group therapy, these are dealt with experientially as group members are encouraged to give direct and open feedback to the attitudes and behavior expressed by others. The activity of dialogue is stressed.

Family-system approaches, like those of Virginia Satir (1964), Salvador Minuchin, and Murray Bowen, combine awareness-heightening with choices and tasks, yet add the ingredient of activating the "significant other" system in the helping process. Here the dimension of dialogue and intimacy is at last addressed within its daily living context. Bowen and Satir emphasize individuation, while Minuchin focuses more on action tasks.

There are a few therapists whom the term "existential" fits more accurately than any other: Carl Whittaker (1989), Frank Farrelly (1974), Lester Havens, William Offman (1976), Walter Kempler, Irvin Yalom (1980), Sydney Jourard (1964), and Thomas Hora (1977). Their common attribute is an intense, often surprising use of their personal self-expression combined with a general disdain for conceptualization about clients from theory. Here the subjective emphasis of existentialism reaches its height of therapeutic expression. When these therapists are paradoxical in their actions, it is seldom as a result of planned strategy. Paradox results from their intuitive response to the client and often expresses the paradoxical life stance of the therapist him- or herself.

From the foregoing comparisons of therapeutic approaches as they relate to existential thought, several areas of existential theory become more clear-cut. We shall look at these in more detail, considering the therapeutic relationship, nature of personality, concept of change, use of historical data and diagnosis, and treatment methods.

The Therapeutic Relationship

One might conclude that all psychotherapies value theory, techniques, and the therapeutic relationship, but the priority of their importance varies. Ego psychology clearly elaborates theory in its maze of complexities. Behaviorism delineates a vast variety of techniques, matched to specific symptoms. Humanistic psychology, and especially the existential worker, stresses the relationship itself, its transparency, spontaneity, and intensity. The therapist's use of self and the type of relationship he or she seeks to foster with a client will be considered from two vantage points—first, the attitude of the therapist toward the client and the client's problems; and second, the behavior of the therapist as he or she interacts with the client: one's use of self as a unique person in one's own right.

There is a critical difference between a therapist who sees the client as a complex of defenses or learned behaviors that are dysfunctional and a therapist who views the client as having a unique, irreplaceable worldview that is in the process of growth, emergence, and expansion. The latter is an existential position. It views the problems and symptoms of clients as their own efforts to deal with the growth forces within themselves and the risks these pose to them in relation to their self-image, their relationship with significant others in their life, and their role in society.

The writings of R. D. Laing are aimed at clarifying the critical differences between the two types of therapists (1967). He points out that therapists who see the client as a mass of complexes, defenses, and dysfunctional learnings see themselves as "the authority." Their task is to diagnose the nature of these "dynamics" and convey these insights to the client, either through verbal commentary or through specific behavioral tasks given to the client. But in doing so, the therapist also acts as another societal force that seeks to adjust the client to someone's definition of the "functional" personality. Such a therapist tends to support the view that the client's symptoms and problems identify him or her as ill (even "dysfunctional" implies the client is out of step with his or her surroundings). The therapist often becomes another dehumanizing force in the client's life in the sense of urging the "patient" to adjust to his or her family, instincts, needs, society's needs, etc. In contrast, existential therapists have no prescriptions of how the client should live. They see their task as

that of a midwife, an agent who has knowledge and skills to aid in the unblocking process that will allow the client to resume his or her own unique growth and emergence—whether or not this puts him or her in further conflict with family, friends, and society. The therapist may point out the potential risks and consequences of an emerging lifestyle, but will not negate its potential value.

The existential therapist's attitude affirms the inherent value of the client as a unique person with a very special worldview or lifestyle that is his or hers alone to chart. The client is also aware that the therapist sees in him or her the power of free choice. Instead of being helplessly at the mercy of forces beyond his or her consciousness, clients can see the significant choices in their present life situation and have the power to decide which way they will proceed in shaping their life.

In one sense, existential therapists do stand for a particular lifestyle, but it is one based on their belief in the nature of humanness rather than a cultural viewpoint of how a person should pursue his or her role in family or society. The values conveyed by the existential therapist are these: Human beings have the capacity for free choice; they are of fundamental worth in their own unique perspective of life and their assertion of this perspective; they require an open interaction with their surroundings in order to grow—emergence is a responsive and interactive process; suffering is an inevitable part of the growth process, for emergence involves risks and unknowns; and self-deception is a potent force.

These values are in opposition to several values supported by society at large: that an individual is a helpless creature, both at the mercy of an unknown unconscious and of utter insignificance in the complex mechanisms called society; that one can and should find happiness through avoidance of suffering and pain and by means of the distractions and pleasures offered at every turn; that a person is what he is, so he should fulfill his role in his family or social system as best he can and be satisfied with his already finished identity; and that since there are groups of humans considered ultimately wise in politics, in universities, at the executive level of business and the military, in churches, and in medical buildings, Mr. or Ms. Citizen should essentially consider a conforming obedience to what these soothsayers say is best for him or her.

The behavior of the existential therapist reflects his or her philosophical-psychological attitudes toward the client. Another useful axiom regarding the therapeutic relationship is this: What facilitates change in people most powerfully are the values of the worker, not spoken, but demonstrated in his or her response to the client's concerns. If the worker is not the authority with the answers, what is he or she? Existential therapists do see themselves as experts, but their expertise has to do with their skills and talents of empathy; understanding; appreciation of and compassion for individual human beings and their struggles; experience in the process of self-deception, having struggled with growth-defensive process within themselves; and affirmation of the value of the unique soul, having themselves been disillusioned with all the society-made authorities who offer solutions, happiness, etc.; and an open honesty that offers the client the possibility of genuine dialogue, if the client seeks to engage in such. Existential workers, then, seek to normalize the problems of the client by reference to the struggles of the human situation. They avoid paternalistic conclusions about the client, viewing both problem- and person-exploration as a mutual process. Another way in which the worker avoids paternalism is by being honest and clear, rather than hidden and deceptive, in relation to strategies utilized.

Existential workers may exhibit a type of detachment, but this detachment is not the cool aloofness of the objective mechanist who is dissecting and reforming the patient. The detachment of existential therapists is an expression of their profound belief in the freedom of the client. The client has a right to his or her own lifestyle. If the client chooses not to follow a direction of personal growth but chooses to maintain his or her defensive posture for security or other reasons, so be it. The therapist's sense of worth is not in the client's hands but within himself or herself. His or her detachment is from results, even though his or her actual activity in the helping process will be quite open and involved.

Detachment must not impair vitality and therefore cannot take the form of intellectual aloofness, analyzing the client from afar. Vital engagement through spontaneity, surprise, and unsettling responses is one of the valued methods of the existential worker. Genuine dialogue calls for an immediacy of feedback in many cases, and considered responses in others. Habitual mindsets and communication patterns of clients require interruption and jostling, on occasion, in order for the new, the creative, to be brought to awareness. The use of vitality, lightness, spontaneity, and humor will often unbalance a client's defensive posturing. The client becomes engaged emotionally and often released from a fixed role or value position. At such moments, he or she is freer to experiment with new possibilities.

The relationship between therapist and client is seen by many existential writers as the essential ingredient of change. The concepts of individual growth and genuine encounter with others are interdependent in the thought of Martin Buber. David Weiss emphasizes this same connectedness in his discussion of healing and revealing (1970). This I–Thou relationship need not be seen as mystical. Carl Rogers's description of this activity suggests that the therapist provides an atmosphere for growth by means of a nonthreatening, affirming, understanding responsiveness (1961). But this does not mean therapists remain passive. On the contrary, Rogers emphasizes the importance of therapists' being themselves in the expression of important arising feelings. To offer a dialogue is at least to present one side of it in an open, honest fashion. Therapists reveal themselves in another manner at times. They share some of their own struggles, disillusionment, and experiences wherein they, too, sought growth in the face of pain. In both these examples of the therapist's openness, we see that the therapist sees his or her own unique world view as an important experience to share with the client—not in a "go and do likewise" spirit, but rather showing himself or herself as a fellow traveler on the rocky road of human existence.

Human Personality

Freudian theory proposed the ego as a balancing, organizing, controlling, harmonizing agent among the demands of the superego, the pressures of the "outside world," and the cravings of the id. Behavior theory suggests a passive psyche that is primarily molded by outside forces. What one learns from others is what one is. Both roles render the individual practically helpless to resist the many forces that work upon him or her.

Two key concepts differentiate the existential view from those above. The first is the idea of an integrating, creative force for growth at the core of the personality. The second is the belief that all individuals have the capacity to shift their style of life radically at any moment.

In terms of the human dynamo, the existentialists would not disagree with Freud's formulation of the id as a composite of Eros and Thanatos, or life and death instincts. To this is added, however, the notion of a force that moves one toward meaning and toward relations with one's surroundings on the basis of meanings concluded. There is an integrative, unifying, creative force within people that synthesizes their own experiences, potentials, and opportunities and provides them with clues for their own direction of growth. No matter how emotionally disturbed patients may seem, there is this integrative core within them that prompts them in the direction of experiencing and expressing their own uniqueness (realistic needs and potentials). They may shut themselves off from such integrative promptings; they may refuse to listen, or mislabel such messages as dangerous. But they are with the person always.

The existential idea of a core integration and creation suggests a conflict-free portion of personality that survives and transcends any dysfunctioning that may possess a person. Such a force toward integration and meaning need not be considered separate from the id. It is an expression of id activity. Teilhard de Chardin (1959) posits such a force as existing in all forms of existence: animals, plants, and even inanimate matter. Chardin sees in humans the fruition of this drive toward complexity, and it is experienced in the human need for meaning and for love. Martin Buber, too, suggests a force in humans that permits them to enter the realm of relationship with nature, ideas, other humans, and God (1955, 1965). This is a force that transcends what otherwise appears to be

a person's limited, finite, individual self. This thinking helps distinguish the existential view of the creative force in humans from what the ego psychologists have attempted to add to basic Freudian theory to explain creative functioning through certain basic powers of the ego.

The second major distinction has to do with the power of free choice possessed by every person. Even the most disturbed individuals are not solely at the mercy of chaotic, irrational, destructive forces—an id gone wild. Nor are they at the total mercy of environmental forces that seek to identify, coerce, dehumanize, conform, or destroy them. The individual personality is always in the process of changing and emerging. Sartre defined human consciousness as a "nothingness." Since it is always in the process of becoming, it is never fixed and completed. This "no-thing-ness" is an openness to the new, the unknown; it is forever moving beyond whatever identity one has concluded about oneself. Sartre sees this as an essential human construct. One may deny one's freedom and find ways of avoiding responsibility for this very process of change and emergence, but the process itself goes on. Pathology is not the arresting of growth, but the self-chosen distortion of growth (Barnes, 1959).

Human consciousness is itself freedom—for it is a force that moves forever beyond whatever one has become as a fulfilled identity. As such, it is the power within humans to change, to alter their lifestyle, their direction, and their sense of identity. It is an ever-present potential for a conversion experience. "To find oneself, one must lose oneself." If one has the capacity for free choice and also some awareness of integrative promptings toward growth from the very core of the psyche, then why should one choose dysfunctioning, defensive symptomatology, or madness?

Freud's concept of the superego and his view of defense mechanisms and pathological symptomatology are seen by the existentialist in a more holistic manner. The existential idea of "bad faith" is a person's activity of denying his or her nature of freedom and emergence for the sake of a sense of security and identity. Such people deceive themselves by a set of beliefs that define specifically who they are and what they can expect from others. This belief system contains both positive and negative judgments about oneself and suggests how one must relate to other people. It is the center of one's defensive control efforts, of one's symptomatology, of one's manipulations of relationships, and of one's fostering myths about who one is. These people choose to believe certain notions about themselves when they are quite young and undergoing the socialization process with parents, teachers, peers, etc. The beliefs they hold to are used to maintain a sense of secured identity. They are tempted somehow to reassure themselves of the solidity of their identity whenever they feel threatened. This they can do through manipulations of others, physical or psychological symptomatology, and reassuring beliefs about themselves. The belief patterns may change somewhat over the years, so that ideas implanted by parents may become more personalized. But it is the rigidity and response to threat that characterize this person's security image, rather than the nature of the beliefs themselves.

This defensive belief system, or "security image configuration," has its values, too. It helps the young, developing ego with limited experience and judgment create a manner of survival in a family constellation. The beliefs concluded about self and others provide habit patterns that furnish a sense of security so that one can use one's energy for other achievements as well. Even the adult ego is occasionally on the verge of exhaustion and needs to resort to the security image patterns of reassuring contentment. One will at times choose security image behavior, even when one knows it to be irrational and defensive, simply as a means of enduring and managing under considerable stress.

Security image patterns take the form of outer identifications, as well as inner passions. "Outer identification" includes all the ways that people use others to decide who they are as a fixed identity—using their parents, spouse, children, friends, employer, profession, politics, church, race, social norms, etc. Inner passions have to do with feeling responses to life's situations that also fulfill a sense of identity, so that certain feelings become fanned into possessing passions. For the self identified as "Top Dog," irritation can become rage. For the self-identified "Don Juan," sensual excitement

can become lust. For some people, competition becomes greed. For others, pride becomes a quest for power. In the outer identifications, one identifies with beliefs and roles; in the inner passions, one identifies with specific feelings. In either case, the sense of self is experienced as fixed, solidified, and defined, rather than flowing, free, and emerging.

The defensive belief system or security image configuration is sometimes referred to as one's "world design," composed of self-concluded value positions. These are seldom the idealized values thought to be one's "ego ideal," but rather the everyday pragmatic values related to security-based hopes and fears. Such values are easily discerned by attending to the "self-chatter" of one's thinking at times of troubling stress.

The Process of Change

If you want to know who you are, don't conceptualize about it: look at your actions, your behavior, your choices. Existentialism is a philosophy rooted in personal experience. "Truth is subjectivity," Kierkegaard's slogan, and "Existence precedes essence," Sartre's assertion, are both ways of rooting identity in personal experience—one's active and unique response in a situation. Being-in-the-world is a concept of Heidegger's that asserts the same notion.

There are two components commonly accepted as necessary for the change process—one rational, and the other experiential. Almost every form of psychotherapy includes both these components, despite their occasional assertions to the contrary.

The experiential component has to do with clients' experiencing themselves in a new and different way. They may discover that they are being dealt with differently by a significant other person in their life. They may also find new kinds of feelings or symptoms arising within themselves. The rational component has to do with self-understanding through the process of reflecting and conceptualizing about themselves—the cause–effect relationships in their background, evaluating how they handled recent situations, considering the meaning to them of a new way they have experienced themselves, and so forth.

The existentialists see values in both components of change—one reinforces the other when both occur. The existentialists, however, are particularly wary of the common self-deception of intellectualizing about oneself—of dwelling on self-evaluation and introspection in a manner that negates any action or choice in the here and now. The self-understanding of importance is that of one's world design, its orienting values, and the negative consequences that naturally accompany this.

Here are some therapeutic activities that promote both clarified self-understanding and emotion-inducing experiences:

1. The attitude of the therapist toward the client can present a new type of affirmation by a significant other person that the client has never experienced.
2. The therapist's skill with empathy may provide the client an experience of being understood more intensely than by others in his or her life.
3. The openness of the therapist about himself or herself as a revealing, engaging person provides an invitation for the client to the dialogical experience. It can also offer an experience of an authority figure as human and of equal status. Such openness by a therapist may constructively take the form of provocative, negative feedback to the client about his or her appearance, attitudes, feelings, and behavior. Here the client experiences a candid honesty that may be otherwise denied to him or her in the everyday world of interactions.
4. Techniques designed for here-and-now heightening of awareness, such as in Gestalt, psychodrama, and encounter groups, or the dealing with "transference" interactions between therapist and client, are obviously aimed primarily at the experiential component of change. Similarly, efforts to vitalize new interactions between group or family members quickly stir new areas of individual awareness.
5. Action tasks for the client to perform outside of therapy sessions provide new behavioral experiences.

Compatible with the existential therapist's emphasis on experiential change is his or her lack of interest in historical data. Some history

may be of value in the early interviews to help the therapist see the client in a more human, better rounded perspective, so that the therapist is less inclined to make superficial judgments about the client in response to the stereotype the client usually presents to other people. But the therapist often does not even need this aid. It is far more important to understand the dynamics of clients' present struggles, and what their symptoms or complaints reveal about their efforts to grow and meet their own needs (the present beliefs and activities of their defensive belief systems).

If client themselves bring up historical material, the existential therapist will often seek to make it immediately relevant. The therapist may do this by relating the past experience to present choices, or else (using Gestalt techniques) by asking the client to bring the early parent figure into the present interview session by role-playing the past interaction that the client is describing.

The existential therapist is in agreement with Glasser's (1965) position that an intense focus on early historical material plays into the client's feelings of helplessness and/or efforts to rationalize his or her own impotence. History does, however, sometimes serve a useful purpose in relation to understanding a client's world design. When clients are able to recall patterns of thinking, feeling, and behavior that have recurred time and again, the power of their determining value positions, or conclusions, becomes more poignant.

World Design and Diagnosis

Clinical diagnosis has its value as a shorthand way of communicating to peers about clients, in terms of their areas of conflict and types of defenses. Other than this, it is of questionable value in the eyes of the existential therapist and commonly results in more harm than good. The danger of diagnosis is the categorization of a client, so as to provide therapists some "objective" way of defining prognosis, goals, the role therapists must play as they interact with the client, and their decision about termination. Such "objective" efforts based upon generalizations about clients with a similar history, symptomatology, and mental status constellation miss what is unique about a particular client. A further danger described by Laing is that diagnosis is often used as a way of agreeing with the family that this client is "sick" and in need of readjustment to the demands and expectations of the family.

This depreciation of the value of clinical diagnosis, however, does not suggest a disregard for understanding the nature of a client's present struggles, conflicts, strivings, and fears. World-design understanding remains of key importance. Here existentialists differ with behavioral modifiers who relate themselves only to a specific symptom without regard for its meaning and the client's present lifestyle.

It is critical to understand the unique world view of the client. This consists of patterns of relating to meaningful others and expectations of them. It also includes beliefs about oneself, both positive and negative judgments, and assumptions about oneself and how these affect the way one meets one's own needs and handles one's frustrations of need-satisfaction. It is important to see how clients are interfering with their own growth, and this includes both the beliefs they hold about the sort of person they are and the notions they have about how they must deal with the significant people in their life. It may even include how they evaluate forces of society that play upon them and attempt to conform their behavior into some stereotype that is useful to society's needs (employers, church, racial attitudes, etc.). Normalization in the assessment phase conveys this message: "Given your special way of viewing the world and your patterns of affecting it and responding to it, your problem is perfectly understandable—it is a natural expression of you." This is not to say that the client created the problem; nor, on the other hand, is he or she a total victim of it.

This type of self-understanding in relation to orienting value conclusions stresses the here-and-now lifestyle—the client's present being-in-the-world. How the client gets this way is of questionable significance. The values of identity formulations are twofold. First, they provide the therapist with an understanding of each unique client and how the client's present symptoms are ways of handling a particular stress or conflict area. Second, world design gives therapists

somewhat of a guideline to assess their own work with the client, particularly when they discover that their therapeutic efforts are bringing no results.

The world-design understanding of an existential social worker will often emphasize family dynamics (interactions, scapegoating, alliances, etc.). These usually make up the most significant area of the client's lifestyle functioning. Intervention efforts will frequently involve other family members for the same reason. The existential understanding of the person as "being-in-the-world" is wholly compatible with the dual focus model of social work. The personal, unique truth of the individual is known best through his or her relations with others and forces beyond his or her own ego—usually social, but at times, perhaps, transcendental in nature.

Even when the problem is not set forth as family or marital in nature, the therapist will tend to see the presenting symptom as a means of dealing with significant others in the client's life. An interpersonal appraisal of symptoms is attuned to the absence, loss, breakdown, or dysfunctioning of important human relationships in the person's life. Therapeutic work will commonly be addressed to the creation, the restoration, or the improvement of such relationships. This interpersonal focus upon symptomatology need not neglect the individual's subjective experience of attitudes, values, and feelings; the two are obviously interdependent. However, the existential therapist sees catharsis and self-understanding as a vehicle for altering the person's world of human relationships, which is the fundamental goal. This interpersonal emphasis distinguishes the existential social worker from most existential psychiatrists and psychologists.

Treatment Methods

It is difficult to talk of treatment methods without first considering the types of clients and problems for which the methods are used. In one sense, the existential perspective is loyal to no particular treatment system. It is eclectic and uses whatever techniques will best meet the needs of a particular client. In another sense, the existential therapist may be considered best equipped to work with clients whose problem involves a loss of direction, a value confusion, a shaken identity in a swirling world of anomie. For these clients, certain techniques have been developed to focus precisely on such difficulties. However, it should be clearly understood that the existentialist works out of his or her unique philosophical perspective with all clients and should not be viewed only as a specialist with clients experiencing personal alienation.

There are three principles of treatment that clarify the therapeutic approach of the existentialist:

1. A client-centered orientation
2. An experiential change emphasis
3. A concern with values and philosophical or religious perspectives.

Client-Centered Orientation

The client-centered focus has already become apparent in our introductory comments on the existentialist's anti-authoritarian stance. Client centeredness was also the major issue in the discussion on diagnosis and world-design formulation. Two other areas exemplify client-centeredness: goal formulations and work with an emerging theme in any given interview.

Goal formulation involves the therapist and client working out a mutual agreement in the early interviews as to the purpose of future treatment. What must be guarded against here is the type of therapeutic dogmatism that seeks to convince the client of the "true implications" of his or her symptoms or problem so that he or she will work in the manner the therapist wishes. The most important initial step in treatment, following the age-old social work principle, is to "start where the client is." This adage refers to focusing on how the client is experiencing the problem, what it is the client wants changed, and other ideas about the type of help the client is seeking.

Elsewhere, I enumerated a framework of possible goals from which social workers may proceed with treatment (Krill, 1966, 1968, 1978). These are: provocative contact, sustaining relationship, specific behavior (symptom) change, environmental change, relationship change, directional change, and combinations of the above.

The type of goal left off this list is the extensive insightful analysis that a client who enters psychoanalysis may be seeking. Whether or not the client ends up with any more significant change through insightful analysis than in some of the above-mentioned goals is highly questionable at this point in time, considering research efforts into the effects of treatment.

The previously-stated goals can be briefly differentiated by considering the client's view of change in each category:

Provocative Contact. The client seeks neither change nor help of any kind. The caseworker assertively seeks to provoke a client into wanting change. This occurs often in protective services, in residential treatment centers for children, and in the "back wards" of psychiatric hospitals and institutions for the developmentally delayed. It is also common with the "hard-to-reach" families who present various problems to the community via the schools and police departments. Just how far caseworkers should go in their provocative efforts is itself an ethical decision related to the right of a client to his or her own unique lifestyle. Nevertheless, provocative efforts are often justified insofar as they provide an outreach effort and offer an opportunity that the client might otherwise never consider.

Sustaining Relationship. Here the client seeks help, in that he or she is lonely and wants an affirmative, interested contact in his or her life, but the client has no hope for changing his or her lifestyle in any way and will resist any such efforts. The client's need is for an affirming relationship without expectations of changed behavior. Change will commonly occur anyway as the client's self-esteem is boosted through a caring, non-demanding relationship.

Specific Behavior (Symptom) Change. The client is distressed by a particular troublesome behavior but has no interest in widening the problem area by seeing how this particular symptom is related to his or her past or present lifestyle and system of relationships. The client's motivation is restricted to symptom alleviation.

Environmental Change. The client sees his or her difficulty in relation to the environment beyond his or her family. The problem may have to do with employment, education, social contacts, or community forces that he or she experiences as dehumanizing. The client does not see himself or herself as part of the problem. The client seeks help in dealing with social institutions and systems.

Relationship Change. Here the client experiences difficulties in relationships with significant others in his or her life—spouse, children, parents, relatives, friends. The client realizes his or her own involvement and wants to alter a relationship pattern.

Directional Change. The client's sense of identity, of values, of personal direction is confused. He or she has difficulty in making choices and feels impotent in relation to the immediate future. The conflict is experienced as within himself or herself.

The mode of therapy used (individual, couple, group, family) or the types of techniques (reality, behavioral modification, encounter, psychoanalytic ego, Gestalt, etc.) will vary, of course, in accordance with the interest of the client, the skills of the therapist, and the nature of the treatment setting itself. However, certain techniques are obviously more appropriate for certain goals. Behavior modification would be particularly useful with the goals of provocative contact and specific behavior (symptom) change. The core conditions elaborated by Carl Rogers (1961) will be most useful in providing a sustaining relationship for a client. Social work literature provides many useful approaches to accomplishing the goal of environmental change. The goal of relationship change can be dealt with using communications theory (Satir, Haley 1976, Jackson) and other family and marital therapy models. Directional change can be effected by techniques described by Rogers, Farrelly, the Gestaltists, reality therapy, cognitive therapy, task-centered casework, and psychoanalytic psychotherapy. The critical point here is that the therapeutic approach must fit the unique goal and needs of a client, rather than fitting clients into some pet system of psychotherapy and dismissing the misfits as "unmotivated."

What is important to understand in this goal framework is that it provides a starting point for treatment in a manner that recognizes the unique experience of the client as valid. The goal may change during treatment as the client begins to experience his or her problems in some other light. The goal must also be tested out in early interviews so as to ascertain whether the goal agreed upon is merely a verbalized goal of the client, or whether it is indeed the way in which the client experiences the need for help and hope for change. With this framework, the therapist engages the client in a manner by which they can both "talk the same language" and have similar expectations about what is to follow.

There would appear to be a contradiction between some of these therapeutic goals and what has previously been described as the existential focus upon disillusionment, freedom of choice, finding meaning and suffering, discovering the growth value of dialogue, and coming to a sense of personal commitment in relation to one's future. Such a focus seems most applicable to the goal category of directional change. The existential therapist, however, is not bound to pursue such a focus if it does not seem appropriate. Existentialist therapists' concern with client-centered treatment and an emphasis on experiential change enable them to assert their philosophical perspective to a degree in all goal categories described.

The other client-centered activity deals with the interview theme of any given session. The client is not a problem to be solved, a puzzle to be completed; the client is a person who is undergoing constant change from week to week, day to day. Change occurs in the client's life for both the good and the bad, apart from what happens during therapy sessions. For the therapist to pre-plan an interview, picking up where the last one ended or getting into what the therapist considers to be an area of increasing importance, is often presumptuous.

The interview begins and the therapist listens to both verbal and nonverbal expressions of the client, staying alert to possible inconsistencies among what the client says and the client's feeling state and behavior. The therapist's most important listening tool is his or her capacity for empathy. In the initial stages of the interview, therapists must free themselves of preconceptions about the client and preoccupations with themselves in order to open themselves to the whole person before them.

How the theme is made known and how it is dealt with are related to the goal of therapy (thinking in terms of the goal framework described earlier) and what particular therapeutic approach a therapist favors for work on such a goal. The therapist and client work together from the point of thematic clarity.

An Experiential Change Emphasis

The experiential emphasis has already been discussed. The activities encouraging experiential change include: attitude of therapist, empathy, therapist's openness or transparency, heightening of here-and-now awareness, tasks for choice, and action. In the earlier discussion of how various theories of therapy reflected existential points of emphasis, it was apparent that techniques could be tapped from many theoretical sources.

It is clear by now that the existentialist is radically concerned with the here-and-now encounter between a person and the person's world. For it is in this moment of responsiveness, of being-in-the-world, that one experiences freedom of choice and meaning-making. Who the person is stems from what he or she does—the choice he or she activates—not from the intellectual conceptualization he or she holds about the self, nor from any dogmas or groups to which he or she holds allegiance in exchange for some bestowed identity.

A Concern with Values and Philosophical or Religious Perspectives

The concern with pinpointing, challenging, and clarifying values and philosophy or religious perspectives is also dealt with by various writers. There are strong similarities between the rational-emotive psychotherapy of Albert Ellis and the Morita therapy of Japan. Both pinpoint "irrational" or "unrealistic" beliefs and specifically propose other, more realistic and human beliefs in substitution for the dysfunctional beliefs. Hobart Mowrer's integrity therapy follows a similar course, where the emphasis is on

helping client see their guilt as a contradiction between the values they hold in common with their "significant others" and their behavior or actual lifestyle. Frankl has developed two techniques, "dereflection" and "paradoxical intention," that are designed to help clients reexamine and alter their philosophical perspective to affirm a new way of viewing themselves in relation to their symptoms, choices, and life direction.

These "reality-oriented" approaches include four common ingredients:

1. Pinpointing specific values (attitudes, beliefs, and judgments about self and others) manifested by the client's lifestyle
2. Clarifying how these very values may be interfering with the client's own growth and intimacy needs or efforts
3. Helping the client consider more realistic, human values and beliefs rather than the dysfunctional ones so that the client's realistic growth and intimacy needs might achieve more direct satisfaction
4. Encouraging decisions, choices, and actions (often as homework assignments) in order to activate the new values concluded to be more valid.

Thomas Hora (1977) discusses values by distinguishing between two versions of reality: "the way it seems" and "the way it is." The first of these describes the distorted and limited views the client has about his or her lifestyle and its related value perspectives. The second view of reality is that expanded by the therapist as he or she highlights other values in the client's lifestyle that are being ignored or minimized. Like Offman, Hora will also clarify negative consequences in relation to some of the client's value positions and pose alternative possibilities for the client's consideration. Hora emphasizes the personal stance of the therapist to be one of a "benevolent presence" through which the therapist may convey peace, assurance, gratitude, and love as important human realities.

This therapeutic emphasis on values and a philosophical perspective is designed for certain types of clients—those whose working goal is directional change. There is a growing recognition of the effects of anomie in modern culture with its resulting personal alienation from the roots of human needs and human strivings. Jung reported this phenomenon many years ago, and existential novelists, philosophers, and psychologists have been emphasizing the extent of alienation ever since.

In relation to religion and spirituality, the existential teacher would strongly endorse a recent development in some graduate social work programs. Related to the emphasis on diversity, schools are developing courses on religion and spirituality in order for students to address their own prejudices and appreciate the varied religious resources in the lives of their clients.

The American culture has finally felt the same impact of alienation that shook Europe during and after World War II. In America, this awareness was helped along by the revolt of the youth, minority groups, and poor people. At this point, it is unclear whether alienation is a problem of a particular client population or whether it is really at the root of all emotional distress. The writings of Laing, Becker, and, recently, Irvin Yalom are certainly weighted toward the latter view.

Considering the three therapeutic principles discussed (the client-centered orientation, focus upon experiential change, and concern for values and philosophical perspectives), it becomes clear that existential caseworkers seek to work with all types of clients and human problems, and that they could function with any kind of social agency or therapeutic setting, provided they were given the administrative approval to work as they wished. It is also clear that the existential position is in opposition to the therapeutic practices that seek to adjust clients to family and social norms or to prognostic norms stemming from the rigid use of diagnostic categories. The authoritative misuse of behavior modification and psychoanalytic theory is a major concern of the existential social worker.

The existential social worker is also concerned with how monetary preoccupations of insurance companies and funding sources of agencies are dictating therapeutic approaches. The popular emphasis on short-term, symptom-relief therapies ignores the existentialist's view that a presenting problem is commonly a warning sign of more troubling value issues of the

client's lifestyles. This Band-Aid, patchwork approach simply reinforces the inclination of many clients to view themselves in a superficial manner.

Considering the eclectic use of treatment approaches suggested by the existential perspective, it is also apparent that social workers can make more creative and varied use of the existential perspective than can psychiatrists, psychologists, ministers, or nurses. This is because of the wide-ranging problem activities that engage the efforts of social workers, necessitating a manner of work that includes multiple skills.

The modes of therapy (individual, couple, family, and group) are all effective ways of conducting an existential-oriented treatment. Application to individual counseling has been elaborated upon, particularly by Rogers (1969), Farrelly (1974), May (1961, 1967), Frankl (1967), and Perls (1969). Work with groups with an existential perspective has been described by Helen Durkin (1964), Carl Rogers (1961), Arthur Burton (1969), and Irvin Yalom (1980). Social work writer Alan Klein relates the group work approach to existential thinking. Family therapists whose approaches are highly compatible with the existential perspective include Jay Haley, Virginia Satir, John Bell, and Carl Whittaker.

The existential approach fulfills two major needs of modern social work practice. First, it is the only social work approach that emphasizes value issues related to the client's problem. With the apparent increase of alienation and anomie, social work may require methods of response to value questions. Second, the emphasis on the human ingredients of the therapeutic relationship, coupled with an "atheoretical" understanding of the client as a person, results in a restoration of humanitarian helping. Self-aware workers are better able to appreciate all clients as more like themselves and less as objects for diagnostic categorization and manipulation.

Case Example

The case presented here could be considered an example of the existential social work approach. It involved short-term casework with an individual from the goal framework of specific behavior change. It should be clear from the previous discussion about differing goals and the eclectic use of treatment techniques that other case examples would take much different forms than the one described. The three existential principles of client-centered focus, experiential change, and value focus are illustrated in this case.

A Latin-American woman, aged 34, came to me complaining of a severely inhibiting depression. In the course of the evaluation, it appeared that she had little interest in or sensitivity for seeing any connection of her symptoms to her past or present living situation. She was somewhat troubled over her recent divorce, which had happened only a year ago. There was also a problem with her mother (living across the street), who tried to dominate her and provoke her guilt, and who often took care of her two teenage daughters. Some rebellion in the older teenage daughter was apparent. She also believed herself "hexed" by her former mother-in-law. These were areas of complaint, yet she saw no prospects for changing them. Her concerns for change were very concrete: she could not do her housework or cook the meals or discipline the children, for she would usually go to bed soon after she returned from work. In bed, she would either sleep or fantasize about how badly off she was, and the running of the house was left to the children, particularly the rebellious older one. She feared losing her job as a nurse's aide at the local hospital and had already missed several days of work because of feeling too tired. She had given up on going out with her boyfriend and felt extremely alone and worthless.

Within ten interviews, seen on an alternate week basis, the depression had lifted. She managed her housework well; disciplined the children—the older one was much less rebellious; she could stand up to her mother on a realistic basis; she was dating again; and she was taking a training course to become a practical nurse. The goal was specific behavioral change, although its successful accomplishment resulted in a broadening of this woman's constructive activity in several areas of her life.

My techniques dealt primarily with the symptoms of depression and helplessness. In the second interview, I emphasized what I sensed to be her inhibited potential: I said that she could make herself get out of bed (or refuse to enter it) by performing the tasks of her housework and by going to her hospital work every day, no matter how tired she felt. I recognized

that feelings of depression were strong within her, but pointed out that they represented a part of herself that seemed to be trying to convince her that she was no good. She could go on believing this or she could challenge this idea. In the third interview, I dealt actively with another belief, challenging its power and questioning her need to be dominated by it. She thought the depression resulted from being "hexed." I told her that I had doubts about the magic of hexing, and if there was anything to it, it probably had to do with her own reaction to the notion that she had been "hexed." I linked this belief with the part of her that was trying to convince her that she was helplessly useless and inadequate.

As sessions went on, she did bring up material about her mother, former husband, children, job, and relatives, but this was more from the standpoint of content for discussion in what she felt to be a positive, affirming relationship. The actual therapeutic effort, in terms of pinpointing her problem and a way of dealing with it, was primarily in relation to the depressive symptom described. The techniques used were my ways of responding to her area of concern and view of change. We could communicate through the goal of specific behavior change. She was able to see the depression as being a self-defeating part of her. This freed her from the belief that the depressive symptom was a condemnation and failure of her whole personality, which had been implied in her notion of "being hexed."

While this was a limited shift in the belief system of this woman, it could still be a significant one. Furthermore, her resumption of responsibility in the family had its rewarding feedback responses from the children, as well as from her own mother, who was closely involved with her family.

Note the three principles involved: a client-centered focus in terms of goal selection and interview management; emphasis on experiential change through use of task assignment as well as through the attitude of the therapist toward the client's potential strengths; and finally, an effort to deal with the woman's value system, specifically suggesting that she did have some capacity for free choice and need not identify herself completely with her symptoms (feelings of fated helplessness).

This case raises an interesting cultural issue in relation to the client's view of the change process and how she viewed change as possibly occurring. An alternative approach might have been a referral of this woman to a *curandera* to handle the "hexed" issue. Had she been unresponsive to my rational efforts to deal with her belief about "being hexed," I would have considered such a referral. Since she had sought out my help, I chose to deal with this belief issue in this more personal, challenging way. I felt free to share my personal view of most hexing experiences after sensing that she wanted to differentiate herself from her mother, who had been emphasizing the power of hexing.

Existentialism and Community

Existentialism is sometimes criticized as an individualistic philosophy lacking a social ethic. This is a misconception. Philosophers such as Camus (1969), Berdyaev (1944), Tillich (1952, 1960), and Buber (1955, 1965) have written extensively on the application of existential thinking to social issues. Members of the helping professions have also related existential philosophy to social concerns. Edward Tiryakian (1962), a sociologist, compares existential thought with that of Durkheim. Lionel Rubinoff writes a critique of modern philosophical, psychological, and sociological thought on the subject of the individual and his relationship to society. Rubinoff's (1967) basic premises are existential. R. D. Laing (1967) also uses an existential framework in his critique of society and of the helping profession often being dehumanizing extensions of society's values.

Beginning with the existential belief that truth is not found in an objective fashion, within a doctrine or within a group of people, we find some implications for a view of society and social change. In the first place, the existentialist stands against tyranny in any form—not only by politically conservative, status-quo-oriented leaders, but also by the rational social engineers who would seek to establish the utopian society necessitating many controls and committed to adjustment of individuals to a "properly functioning" society. The existentialists are a prime opponent of B. F. Skinner (1971) in his appeal for a society that meets humanity's needs by limiting freedom and nonconformity.

The existentialists know that power corrupts, and that much of the evil perpetrated is unpredictable at the moment of its inception. If, on the other hand, there is an effort to decondition

evil-producing behavior, this effort itself, if successful, would result in the profoundest evil of all: the dehumanization of people by depriving individuals of freedom—the only valid source of their sense of personal meaning and dignity.

On the other hand, an appeal for a completely free and open society, such as proposed by Charles Reich's *Greening of America* (1970), is again a naïve position founded on a disregard for the sometimes self-defeating, the aggressive, and the evil-producing behavior of people. Spontaneously "doing one's own thing" is too simple a commitment. We can be defeated by our own instincts and self-deceptions as easily as by our efforts to organize and construct the happy state.

Power itself results in an increased effort toward solidification and self-perpetuation. Society must be a dynamic, growing system, just as an individual is a being of responsive emergence. The healthy society is one attuned to the creative ideas and efforts of individuals and groups within its structure that propose change and new ideas. A participatory democracy is an expression of the existential affirmation of the unique perspective of each individual. In a participatory democracy, groups are seen to possess their own truths, which will differ from the attitudes and values of others who have not had the same life experiences.

The direction for a society's emergence stems from the sufferings and potentials of its people, and not from an elite group of rebels or social organizers. Eric Hoffer was right in saying that the most creative and innovative shifts in a society stem from its outcasts, nonconformists, and those who experience the failures of its present functioning. The existential model for social change would be one wherein the very people who suffer from dehumanizing social forces would be the indicators of what sorts of changes are needed. The community organization social worker would have a facilitating, clarifying, enabling role here, perhaps, and once a direction is clear, he or she may use his or her knowledge of power structure and change tactics in order to mobilize the social change effort.

The "antiexistential" community organizer would be one who decides for himself or herself what change other people really need and then uses his or her knowledge and skills to "educate," seduce, and pressure a disadvantaged group into deciding what their problems are and the change that is indicated. The worker's basic notions of change, here, come either from his or her own needs, or his or her rational, analytical conclusions of what this group or community lacks in comparison with some ideal he or she holds about how people should live. The impetus for change is worker-oriented rather than community-oriented.

The opposite extreme, also antiexistential, is sometimes seen in community mental health clinics. Although such clinics are committed, by their very purpose (and federal funding), to a community-outreach stance, there is often little genuine effort at dialogue with the needy members of the community who do not enter the portals of the clinic itself requesting some specific help. In contrast, the genuinely committed community mental health clinic is actively seeking contact with the groups in its community who are known through police, welfare, and schools to have problems, but who are not availing themselves of any helping services. Primary prevention at times of family or neighborhood crisis becomes a major way of help, and this most often takes the form of consultation with police, welfare workers, teachers, nurses, ministers, and physicians.

As discussed earlier, the existentialists see many of the forces of society as being in opposition to the individual's effort to create an authentic lifestyle, establishing his or her unique direction out of an awareness of his or her own freedom, responsibility, and what he or she learns through personal suffering. Modern society encourages anomie and personal alienation by its forces of seduction and oppression. Insofar as the economic-political system uses people as objects in order to preserve its own efficient functioning, it may be said to be dehumanizing. Various social institutions combine their efforts to achieve this goal. Certain roles in the system are rewarded with status, financial remuneration, and prestige, while others are ignored. Happiness is defined in such a way as to keep the public at large an active consumer of economic goods. An attunement to personal suffering is discouraged through the various tranquilization forms of drugs, alcohol, treadmill activities, and a work ethic that

implies a solution to all of one's problems with the purchase of the next automobile, house, or packaged vacation plan. Such writers as Erich Fromm (1955) and Henry Winthrop (1967) have elaborated on the multiple forms of social dehumanization, which are too numerous and complex to mention here.

Helping professionals are faced with a critical choice in relation to social dehumanization. They can become a part of this system that is a purveyor of anomie by the very way they perform their helping role. Or, on the other hand, they can be members of a vanguard actively in touch with many of society's victims, who can help bring individuals and groups to an active awareness of themselves as free and responsible beings despite the negative forces bestowed upon them by society. Beyond such awareness, such workers will help them toward personal direction and actions that affirm human dignity in the face of tyrannical and dehumanizing social forces.

The institutions of society can and do provide constructive, affirming forces for individuals and groups, of course, through education, employment, protection, health and welfare care, as well as valued traditions, a sense of history, and a national spirit that affirms a set of values that is generally accepted and may be quite compatible with the freedom, responsibility, and valuing of uniqueness and personal dignity that characterize existentialism. The existential helping professional realizes, however, that the constructive forces of society cannot in themselves bring an individual to authenticity. The matter of personal choice and acceptance of responsibility for one's own worldview and lifestyle remain essential. The existentialist is, therefore, cynical in response to social utopians who seek to construct a society of needs-met, happy people.

Research and Knowledge Gaps

The existential approach eludes research. Its lack of a specific theory of personality, its emphasis on subjectivity and uniqueness, its eclectic use of varied techniques, and its concern about values are all factors that make structured studies difficult. On the other hand, the existential perspective extends the hand of gratitude to the numerous research studies that have clearly unseated dogmatic-authoritative assumptions proselytized by "sophisticated" adherents to the varied theories of personality. When it comes to practice, the existential worker tends to agree with the behaviorist: We should utilize what was proven effective in practice to avoid forcing clients to submit to our favored (though ineffective) methods. Research indicates that effective treatment can occur with the following conditions: client and worker who like each other; use of the "placebo" effect in structuring the treatment process; core conditions (warmth, genuineness, empathy) when combined with attitude change; attitude change when accompanied with emotional change as well as task assignments; and the use of significant others in the assessment and treatment process wherever possible (Krill, 1986).

Another important conclusion from practice research has been that no theory of treatment has proven itself superior to any other model. The existentialist sees this as a crucial statement about the place of theory in practice. Theory does not seem to be the important ingredient in helping people, and is therefore considered of secondary (informative) value. While it is not clear what, then, is the magic ingredient, the existential worker would suggest it to be human sensitivity as developed over time through both self-awareness and learning from many experiences with clients. The better one comes to know oneself, the more clearly is one able to see oneself within the client's experiences as well. This is a most important area for future research study.

How are social work education programs preparing students for present practice? Do they foster ingredients that may eventually result in a wise practitioner, given a few years of additional experience? Here the existentialist has serious concerns. An educational tradition has existed for many years in social work that has emphasized the pragmatic, diagnostic, rational-authoritarian approach. Teachers have often viewed students in this categorical manner and have in turn urged students to view their clients in a similar way. This has been the phony guise of "scientism" that has sought to identify social workers as "scientific," when in fact the "objective nature" of most of their

knowledge would be scoffed at by physical scientists. Many students, in their insecurity, seek comfort in categorizing clients according to the knowledge system taught them. Other students, rebelling against what feels like a rigid authoritarianism, will completely abandon diagnostic understanding of any type and naïvely seek to provide "Band-Aid" answers to problems posed by clients. It would appear that students need to be somehow "humanized" rather than "objectified." Self-awareness has been a goal of social work education, but it would seem that new educational approaches need to be devised to achieve this goal more effectively. Only by appreciating one's own personal complexity can one begin seriously to understand the complexities of others.

Human sensitivity is a bed-partner of humility. Humility results from personal disillusionment, or humiliation, providing the student is warned against too quickly attaching oneself to the notion that one has now achieved some "sophisticated maturity" as a result of personal insights. Humility can be also the springboard toward creativity. As one realizes one's personal blind spots, gaps in awareness, and withdrawal from knowledge and situations posing threat, students find a personalized direction for their reading and openness to new experience. They sense, too, that their search for expanding truth will enable them to understand and help more clients.

I have found the classroom situation a useful "experimental lab" for generating human sensitivity among students. Assessment of clients is dealt with simultaneously with students' self-exploration. Personal exercises to promote such examination are used in class as well as through homework assignments. Peer sharing in small groups engenders honesty, spontaneity, and supportive feedback in relation to results of exercises (Krill, 1990). Exercises explore dimensions of the interplay between personal problems, emotions, attitudes, and values; of roles with family and significant others; and of trouble spots in personal response to certain clients. Reading of theory is encouraged, then, as the student's means of building upon and expanding self-knowledge in the directions necessary to handle areas of confusion, insufficient self or client understanding, and intrigue with new ideas. Values need to be clarified by both the instructor and the students in terms of how they are used constructively with clients. Vitality and spontaneous engagement with clients are demonstrated and practiced in role-plays of common client–worker situations.

In conclusion, the existential stance provides a philosophical perspective that can be related to the many avenues of social work practice. One does not need a profound acquaintance with existential philosophy in order to benefit from the perspective. One might, instead, view the existentialists as emphasizing a sense of direction and a style of working that are primarily concerned with a greater humanization of the social work profession. From their emphasis on the value of the uniqueness of the individual there comes an affirmation of a client-centered focus and an awareness of the dangers of anomie in a mechanistic society. From their view of growth through choice and action there comes a primary effort aimed at experiential change with clients. From their model of humans as meaning-making beings there comes a recognition of the importance of values, philosophy, and religion as ingredients of the casework process. From their emphasis on dialogue there comes the concern for therapist transparency and authenticity, as well as the valuing of a participatory democracy. And from their appreciation of the powers of self-deception at work with human beings, there comes an emphasis on personal commitment in the face of suffering and uncertainty, as well as a suspicion about any authority that establishes itself as knowing how other people should live their lives.

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11

Feminist Theory and Social Work Practice

Eveline Milliken

In *Changing Their World: Concepts and Practices of Women's Movements*, Srilatha Batliwala (2008) describes feminism as

> both an ideology and an analytical framework. . . . The past three decades of activism, advocacy and research, and changing global geopolitical context, have generated powerful insights and experience about our gains, setbacks, and the challenges of the future. . . . We now stand not only for gender equality, but for the transformation of all social relations of power that oppress, exploit, or marginalize any set of people, women and men, on the basis of their gender, age, sexual orientation, ability, race, religion, nationality, location, class, caste, or ethnicity. (p. 11)

It is an exciting time to be a feminist social worker. "Rising feminist advocacy for human rights, social justice and gender equality" is noted in the Canadian Association of Social Workers' (CASW, 2008) *Social Work Scope of Practice* (p. 1). The advent of the Internet, the ubiquity of smartphones and tablets, the ease and cost of international communication via text, Skype, and blogs, and access to solar technologies and wireless communication in places without widespread electrical grids have enabled feminists to communicate worldwide. Classrooms can be created anywhere through distance delivery. Social movements are created now, not at a kitchen table or workplace, but via tweets with hashtags. *#SayHerName* is informing and mobilizing against violence. *#BringBackOurGirls* demands the return of 273 Nigerian kidnapped schoolgirls. *#AmINext* raises awareness about murdered and missing Aboriginal women. Feminist journalists can create their own followers through e-zines, blogs and web publishing. Facebook, Instagram, Twitter, Whatsapp, Tumblr, etc.,

enable the global distribution of stories not deemed important enough to be covered in mainstream media:

> The fact that we can send messages via Twitter and Whatsapp to each other and a global response occurs around our issues whether it be rape, or sexual violence, or violation of the our human rights, proves that the notion of sisterhood is one that has existed for centuries and continues to be a strong part of this movement. (Moiyattu, 2015)

Activism has been rejuvenated. SlutWalks and Take Back the Night marches, which became anemic in the 2000s, were rejuvenated and joined by immigrant and indigenous women's groups. While in the 80's and 90's activists may have walked from "the campus" to "the capital," they are now more likely to meet in impoverished neighborhoods like "Murderpeg" (Macdonald, 2015) or the *Highway of Tears* (Carrier Sekani, n.d.), to bring attention to marginalized and exploited women. Pan-Canadian feminist gatherings, such as the 2011 Rebelles Conference in Winnipeg, Manitoba, attract hundreds of young feminists. Pussy Riot, a feminist, punk-rock protest-band in Russia, challenged both church and state in 2012, and gained worldwide recognition and support through mass media. National Equal Pay Day, started in 1996 by the National Committee on Pay Equity (2015), continues to highlight that, *still*, on average, women who work full-time earn only 78 cents for every dollar a man makes.

Consequently, feminism has developed a global reach. Activist movements are made visible worldwide through their websites, allowing for global networking:

> There is a burgeoning women's rights movement in Muslim-majority societies today. From Pakistan to North Africa, each country has a network of activists, writers and academics struggling to bring women's rights to their countries and overthrow centuries of patriarchal oppression. Networking on the internet and on social media enables them to . . . [be] a transnational one. (Friedland, 2014)

Many feminists were at the forefront of the Arab Spring, and have used that impetus to continue their campaigns (Clarion Project, 2015). African feminism has become a phenomenon to celebrate (Banya, 2015). Movements in British Commonwealth countries, like UK Feminista (UK Feminista, 2015), and the Australian Women Against Violence Alliance (AWAVA, 2015) share this community. The Feminist Majority Foundation (Feminist, 2015) identifies that collective action can bring change.

In 2015, feminist messages reached huge audiences through the confluence of fame, technology, and global reach. A Kenyan poet-activist, Chimamanda Ngozi Adichie (2014), is widely known, through her TedTalk, as "a happy feminist." A teenage girl from Pakistan, Malala Yousafzai, advocating for education, earned a bullet to the head, then a Nobel Peace Prize. British actor Emma Watson ("Hermione Granger" in the Harry Potter movie series), launched the *HeForShe* campaign at the United Nations in 2014, and reminded the audience that no country in the world can yet say they have achieved gender equality. Pop singer Beyoncé's performance at the 2014 MTV Video Music Awards in front of the huge word "Feminist" brought attention to feminism to millions globally, and the "Beyoncification of feminism" entered the popular lexicon.

Yet, since its inception, there has been no shortage of those who wish to dismiss feminism as dead, irrelevant, or failed. Valentich (2011a) observed, "the media often questioned whether feminism was dead" (p. 207). Surprisingly, within the last few years, some feminist social work authors also have appeared to express weariness. Iconic feminist Phyllis Chesler, whose *Women and Madness* in 1972 revolutionized psychiatry for women, more recently (2005) wrote *The Death of Feminism: What's Next in the Struggle for Women's Freedom?* Irish social work theorist Garrett in 2013 considered again the question of the "death" of feminism and the "post-feminist era" (p. 10). My own experience, teaching both feminist perspectives on social welfare policy and social work practice, is that despite this vast feminist conversation and influence, students are generally unaware of the policy implications, practice skills, and theoretical underpinnings of feminist social work theory.

The disconnection with feminism extends to those in practice. Students in my "Feminist Perspectives" course interview staff in agencies originating in feminist social work fields such as reproductive health, family resource centers,

intimate partner violence, immigrant women, indigenous women, sexuality education, and housing and resources for sex trade workers. To the question, "Does your agency identify as 'feminist'?" only one of 15 said "Yes." While some admit to having "pro-feminist values," equivocations like "it depends on who is listening," "we have to conform to the community's comfort zones," and "avoiding push back from funders" were common responses and indicate that "there has been a societal backlash to feminism and a trend to social conservatism, resulting in feminist theory and practise standing at a threshold" (Valentich, 2011a, p. 205). Valentich's (2011b) contention that "the process of identification as a feminist social worker is not straightforward" (p. 26) seems correct.

What is the reason for this disconnection? Mandell (2009) and others have suggested that there is sense that feminism has achieved all its goals and consequently is no longer needed. Mandell notes, "Most young Canadian women and men have grown up in a world in which feminism as a social and ideological movement is firmly established" (p. ix). Yet research done with women and gender studies students reveals "a legacy of ambivalence, contradiction, backlash, and marketing; . . . even though young women and men consider gender equity the norm, traditional and often contradictory discourses on masculinity and femininity remain intact" (p. ix). Noting the increase in levels of sexual violence, feminization of poverty, and the loss of social welfare supports for vulnerable women, influential British feminist social worker Lena Dominelli (2002) is incredulous: "I marvel at the idea that feminist cause has been realized" (p. 1.). She scoffs at the "relegation of feminism to the annals of history" (p. 2).

In order to appreciate the ebb and flow of feminist and feminist social work theory today; to see the gains that have been won, lost, or are at risk; and to avoid repeating history, it is helpful to clarify distinctions and gains of past generations. Newcomers to the subject may find helpful a brief orientation to the language of "Waves," types of feminism, and history. Gray and Boddy (2010) and Valentich (2011a) have examined this history in detail, and reviewing their work is recommended.

For the sake of introduction, the following chart (Table 11.1) is offered, with three caveats attached.

The first caveat is that such description will have the limitations of essentialism, the fallacy that complex movements may be reduced to a few or even single characteristics. Essentialism is a viewpoint of patriarchy in which an "authoritative universal voice—usually white male subjectivity masquerading as non-racial, non-gendered objectivity" (Crenshaw, 1989, p. 154), obscures variations and nuances of reality. Feminism has not had a need for such discreet and arbitrary categories. Furthermore, the written record of each Wave has not yet fully described the diversity of participants and activity, in part due to women's varying levels of access to education and publication at the time. For example, there have always been women representing minority groups within feminism, but they have often not been represented in academic works. How many know of Birdye Haynes, a black activist colleague of Jane Addams in creating the settlement movement?

African-American pioneer Birdye Haynes served in prominent leadership roles in New York and Chicago's settlement house establishment. Haynes commitment to the African-American community compelled her to the social work profession in an era of segregation and oppression. Haynes' calling was to serve as an advocate in educating other professionals to

Table 11.1

First Wave	*Second Wave*	*Third Wave*
Late 1800s–1945	1960s–1990s	1990s to present
Maternal	Radical	Intersectionality embraced; postmodern/post-structural; post-colonial continue to expand theoretical and activist definition; more voices developed in third wave
Equal rights	Liberal	
Marxist	Socialist	

understand problems within the context of a racist system that denied African-Americans equal access to resources. (Nsonwu, Casey, Cook, & Armendariz, 2013, p. 8)

Steinem has since pointed out that, contrary to the partial written record, "if you look at the numbers and the very first poll of women thinking about responding on women's issues, African-American women were twice as likely to support feminism and feminist issues as white women" (Vagianos, 2015). For that reason, Tamaki (2001) rightly insists, "Feminism is two parts definition and one part struggle—a constant processing of defining, redefining and struggling against definitions (p. 2)" (cited in Mandell, 2009, p. 63).

The second caveat is that the various social issues addressed by the many feminist philosophies were not limited to particular Waves. For example, gender violence has been a concern in varying ways through all three Waves. During the First Wave, women had no legal right to protection from certain types of violence (such as rape by a spouse). Although the Second Wave succeeded in naming the issue and created rape crisis centers and women's shelters, the problem of violence and the murder of girls and women continued into the Third Wave interval.

In Canada, that there are more than 1,000 missing and murdered indigenous women defies understanding. Richardson (2010) notes that:

Aboriginal clients experience a disproportionately high level of violence compared to European Canadians . . . and may encounter social and judicial responses that are primarily negative. Agencies may function with a set of assumptions that see the client as having equal access to resources and opportunities. (p. 125)

Similarly, immigrant women "suffer from economic, social, linguistic and cultural marginalization" (Mandell, p. 179). "National surveys of ethnic minorities in UK higher education have found women of color are more than any other group to report being victim of sexual harassment and discrimination at work" (Mirza, p. 2). As female bodies are the site for much scrutiny, control, and oppression (Dominelli, 2002), the work of feminist social work scholars such as MacDonald, Carter, Hanes, Skinner, and McMurphy (2014) on feminist analysis of women and disability, is crucial.

In some countries, local feminists are fighting today for rights achieved in Europe and North America in the First Wave (see, e.g., Sampson's *Equality Effects*[2], 2015). Pandya (2014) notes that "the realities of women in India are narratives of oppression, invisibility, and subsequent revolt" (p. 500). On International Women's Day, Rogers (2015) commented, "Gendered issues faced in Haiti are cyclical and directly tied to women being treated as second-class citizens, extremely harsh economic situations and the lack of access to schools and good education" (n.p.).

The third caveat is that tables such as Table 11.1 obscure the importance of intersectionality in which multiple social characteristics have a compounding effect. Crenshaw (1989), for example, explained that problems cannot be solved simply by including, say, black women within already established analytical structures, because the effect of additional (intersecting) experience is greater than the sum of racism and sexism. Theory must be rethought and public policy rewritten.

With those caveats in mind, the conventions of First, Second, and Third Wave feminism may be explained. These terms primarily help to locate various stages of feminist development on a timeline. The metaphor of waves signals that, like life-supporting water, feminist theory has fluidity, rhythms, movement, and is sometimes tumultuous in order to remain healthy and not stagnant. The Waves do not necessarily signify differences of social issue focus, but rather the stages of evolution of feminist thought.

Next, it is useful to comment on labels attached to various forms of feminism. While "feminism can be broadly characterized by a concern with the systematic disadvantage of women and the means by which equitable outcomes can be achieved, it has never had one distinct set of beliefs or a unified position" (Gray & Boddy, 2010, p. 368) and "recognition of difference features prominently in all forms of feminism" (p. 380). Terms like "liberal," "socialist," and "radical feminism" point toward the various foci feminist philosophies and feminist social work theorists were pursuing. "Maternal feminists" believed that women are biologically different from men, and consequently the

biological quality of mothering suggests that women be "social housekeepers" in society. Guided by this view, women's experiences and voices need to be valued more fully.

"Equal rights feminists," as represented by suffragettes around the world, sought access to voting privileges. Equal rights feminism of the First Wave became "liberal feminism" in the Second Wave, which continued to pursue justice for each person regardless of sex or social class. Essential to this perspective is the belief that changing laws and policies is the catalyst needed to eliminate discrimination. From the perspective of liberal feminism, it was thought, sexism could be eliminated by enabling women to have legal access to divorce, to birth control and abortion, to owning property, to having custody of children, and so forth.

"Marxist feminism's" focus on class and gender rights related to how work was valued differently according to gender, and gave rise to "socialist feminism." Socialist feminism argued that structures of the economy are at the root of inequality, and that changing a few laws was insufficient to address this underlying bias. A connection is drawn between a capitalist economic system and oppression, as women owned neither the means of production nor the products of labor. Work at home is not accorded value; women around the world are primary producers of goods and services for which they are not paid (Waring, 1988).

"Radical feminism" is an evolutionary descendent of maternal feminism. Male perspectives have created patriarchy, the root cause of all oppressions:

> Patriarchy is a political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence. (hooks, n.d.)

Radical feminism therefore argues for opposing the very structures of society created by patriarchy, and the creation of healthier relationships and associations by women. Women-only spaces were seen as crucial to emancipation.

"Cultural feminism" extends radical feminism's view of inherent differences of women and looks to build a women's culture. "Lesbian feminism" challenges heteronormativity in policies and practice (including language that restricts definitions of family, and myths about "the nuclear family"); confronts homophobic assumptions and practices (such as discrimination in foster parenting policies), and advocates for legal recognition and human rights. "Ecofeminists" see a connection between how the earth (including the environment, animals, and resources) is mistreated, and mistreatment of people, especially the exploitation and abuse of females.

With the caveats, waves, and types of feminism in mind, it is possible to get a sense of the history of the development of feminist theory that underpins feminist social work theory. During the First Wave, feminism as a theory was in the process of being articulated. As the movie *Suffragettes* (Owen & Ward, 2015) shows, activism, rather than the development of a clearly expressed philosophy, was the goal of the early women's rights movement. From the mid–19th century to the end of World War II (1945), women fought for the vote, personhood, basic legal rights to own property, and the ability to have custody of their own children.

Jennissen and Lundy's (2011) book *One Hundred Years of Social Work* describes the link between the stories of countless women and the development of the profession of social work. Using their own (and their "sisters'") experiences and capacities to reflect and comment, social workers began to build the foundations of feminist social work theory upon the work of their activist feminist foremothers. Wahab (2015) points out that the social work theory concepts of collective action, analysis, and justice, were built upon Jane Addams's (1902, 1916) dedication to building community, Mary Richmond's (1917) attention to documentation and objective analysis, and Bertha Reynolds's (1935, 1942) commitment to a socialist drive for equality and fairness for all. It was during the First Wave that the first schools of social work were developed in the late 1890s in Britain and Europe, 1898 in the United States (Columbia University in New York), and 1914 at the University of Toronto in Canada.

Betty Friedan's *The Feminine Mystique* (1963) is widely recognized as starting the Second

Wave of feminism, by naming the-problem-with-no-name as patriarchy. Having had the opportunity to be "helpers" in the war effort as men were serving in armed forces, women for a time had participated fully and "equally" with males in society. Yet, the postwar era saw women forced back into the stereotyped and limiting roles of caregivers of others, as a matter not of choice but of public policy. Through the 1960s, American civil rights activism and the anti-Vietnam war movement contributed to social unrest and the rethinking of relationships. The Stonewall riots transformed the gay rights movement and led to formation of, for example, the first transgender organization in the late 60's. Women's liberation was one of the many liberating movements that gained energy in those tumultuous years.

In Canada, the issues, and consequences of that patriarchal system, were catalogued by the *Royal Commission on the Status of Women* (1977). One hundred sixty-seven recommendations from that report raised Canadian consciousness of "new" justice issues, including participation of women in pension plans, pay equity, minimum wage, unemployment insurance, and legalization of birth control. Feminist scholars worldwide detailed the effects of such lack of rights in many and various aspects of being: economic (Waring, 1988), family (Meyers-Avis, 1985; Laird, 1995), psychological (Greenspan, 1983; Penfold & Walker, 1986; Miller, 1976; Belenky et. al., 1986; Gilligan, 1982; Levine, 1976), political (Dominelli & McLeod, 1989; Ursel, 1992; Eichler, 1988), and the philosophical analysis of the ethic of care (Manning, 1992; Baines, Neysmith, & Evans, 1991).

It was during this blossoming of "liberatory" consciousness and movements in the Second Wave that developing feminist social work theory flourished. Schools of social work began offering and evaluating feminist social work courses (cf. Pennell, Milliken, Flaherty, Gravel, & Neuman, 1993). Theorists like Levine (1976), Norman and Mancuso (1980), Berlin and Kravetz (1981), Russell (1984), Valentich (1996), Bricker-Jenkins and Hooyman (1986), Van Den Bergh and Cooper (1986), Collins (1986), Dominelli and McLeod (1989), Hanmer and Statham (1989), Van Den Bergh (1995) and Land (1995), to name several, applied the feminist perspective to a wide range of social work issues. Valentich (2011a) noted, "by the mid-1990's social workers in diverse fields of practice were aided by the growth of qualitative research that elicited women's own voices . . . theory building emanates from what social workers actually do" (p. 207). She also observed that developing this body of feminist social work literature, and having a feminist theoretical framework and model accepted into social work texts and curricula, was a great accomplishment of the second-wave feminist social workers (1996).

In 1992, Rebecca Walker coined the term "Third-Wave Feminism" in a *Ms. Magazine* article (pp. 39–41). Thus she began a conversation that reflects on the impact of postmodern perspectives for feminist ideals. "Postmodernism" here is understood as an amorphous philosophical trend in the late 20th century in which singular meanings were overturned by relativism, universal standards were challenged by multi-dimensionality, empirical certainty was undermined by principles of scientific uncertainty, and the distinction between subject and object was dissolved (c.f. Keep, McLaughlin, & Parmar, 1993).

Consequently, postmodern feminism began to challenge binary gender definitions and enabled thinking about gender and sexuality as more fluid identities. Terms like "cis-female" (someone who identifies as biologically and psychologically female) were coined, adding to the number of possible identities and creating space for transsexuals. Thanks to "postmodern deconstruction" (the dismantling of the assumption/perception that social observations are real, absolute, or universal, and the demonstration that such meanings are socially and locally constructed), many feminisms could be articulated.

Post-colonial feminist analyses emerged through this conversation (hooks, 1994; Lorde 1984; Mirza, 1997; Weedon, 2000). Those who had lived in former colonies described their experience of dealing with inequality within the context of colonial dominance and subsequent effects of that oppression embedded in systems that lingered. In *The Equality Effect*[2], Canadian feminist Fiona Sampson (2015) observes:

> Women in Canada and in Ghana, Kenya and Malawi, continue to experience the oppression that

is the result of this legal legacy [colonization]—a legacy that is characterized by laws that are often sexist in their roots, and disadvantage women. In Canada, the impact of this legacy is especially significant for Aboriginal women (n.p.).

The publications of indigenous voices like Maracle (1996), Waters, (2003), Corbiere Lavell & Lavell-Harvard (2006), Green (2007), Sinclair (2007), Pompana et al. (2008), Absolon (2009), Monture-Angus and McGuire (2009), Anderson (2011), Baskin (2011), Milliken, Campbell, DiUbaldo, and Pelletier (2012), and Carriere and Richardson (2013) enrich the growing post-colonial feminist literature in Canada.

Informed by post-colonial and postmodern philosophies, the Third Wave continues today, an expanding movement to include those previously not expressed in written work. Third Wave feminists continue to give wider voice to issues of gender violence, race, heteronormativity, class, ableism and ageism, global care, immigrants, constructions of families, and the amplifying effects of intersectionality (Crenshaw, 1989; Heywood & Drake, 1997).

For Sands and Nuccio (1992), "postmodern feminist theory" is:

highly compatible with social work. . . . [Postmodernism's] emphasis on differences . . . recognizes the diverse constitution of client populations and their unique needs. Furthermore the focus on context is in keeping with person-in-situation perspective. . . . The use of deconstruction uncovers the suppressed voices of marginalized populations. (p. 493)

They noted that words and experiences are historically and culturally bound, thus recognizing that issues have many faces and speak in multiple voices, depending on the context. Meanings cannot be considered absolute and universally real in themselves, but rather are constructed (p. 491). This compatibility between feminist theory and social work practice has been corroborated by many writers (e.g., Collins, 1986; Gould, 1987; Nes & Iadicola, 1989; Van Den Berg & Cooper, 1986). "Feminist principles are closely aligned with social work values and ethics (Bricker-Jenkins & Hooyman, 1986; Van Den Bergh & Cooper, 1986), and some would say that social work is inherently feminist (Collins, 1986)" (cited in Lazzari, Colarossi, & Collins, 2009, p. 348).

Feminism is not only of academic interest to social work *theory*. It is also a method of social work *practice*. Feminist social work not only shares the tenets and values of feminism, but also adapts and merges them with existing social work values, and puts them to work:

Feminism and social work share a commitment to the unique nature and essential dignity of all people. . . . Furthermore, social work's emphasis on the person-in-environment is congruent with the central methodological theme of feminism—the personal is the political—and the feminist value of personal empowerment is a key underlying theme of social work intervention. (Collins, 1986)

Land (1995), in particular, identified the basic skills feminist social workers employ:

- Validating the social context; revaluing positions enacted by women;
- Recognizing difference in male and female experience;
- Re-balancing perceptions of normality and deviance;
- Adopting an inclusive stance;
- Attending to power dynamics in the therapeutic relationship;
- Recognizing how the personal is political;
- Emphasizing a de-constructive perspective, a partnering stance and inclusive scholarship;
- Challenging reductionist models;
- Employing empowerment practices;
- And challenging the myth of value-free psychotherapy (pp. 6–11).

These practices help social workers function in an explicitly feminist way to make visible and conscious the negative effects of patriarchy and to develop alternative narratives in individuals and communities, to provide for alternative (just and egalitarian) expressions of social relationships.

The value of feminist social work practice has been demonstrated empirically. Noting that "empirical evaluations of feminist social work interventions are generally underrepresented in the profession's peer reviewed literature," Gorey, Daly, Richter, Gleason, and McCallum (2002) compared 35 independent studies of feminist interventions with 44 independent studies of social work practice that were based on other theoretical orientations. For this study, Gorey

et al. identified the general attributes of feminist interventions as the following: The importance of gender is explicitly addressed, including addressing inegalitarian resource development and oppression; efforts are made to eliminate false dichotomies; power is reconceptualized; and a strengths perspective is emphasized (p. 40). Finding that "nine out of every ten feminist social work participants do better than the average non-feminist participant" (p. 37), they declare that when "methods have been so validated, it appears that (feminist social work) may be among the profession's most effective strategies" (p. 50). Given the broad range of theoretical applications in feminist social work, ongoing evaluation is needed to address concerns that the volume of research in feminist social work literature is declining.

When social work values are so aligned with feminist values and when praxis is deemed so effective, why, then, is it still necessary to have to justify and fight for the legitimacy of feminist social work? Many challenges remain in the movement toward the equality of all, the end to which feminist social work theory aspires. These challenges may be external or internal to the movement, but at root, they are expressions of a presumption (patriarchy) that is familiar to theorists and activists of the three Waves. As Lazzari et al. (2009) declare: "Patriarchal structures are alive and well" (p. 353). While contemporary expressions of this harmful viewpoint take on new shapes with new technologies, the dynamics remain similar. Patriarchy continues to seek to objectify in order to demean, humiliate, or control by violence. Its institutions continue to undervalue the work of women. Its minions work to exert controls that prevent human rights.

Objectification is a key dynamic of patriarchy that leads to violence. Second Wave feminists had been hopeful that research (hooks, 1997; Kilbourne, 2010) and activism (Jhally, 2007) to expose the misogyny of media objectification of women would lead to a reduction in violence against women and vulnerable others. They could not have predicted the development and popularity of misogynistic software like *Grand Theft Auto V* (Rockstar, 2013) that *literally make it a game to link sexual arousal and violence and "win" points for horrific violence against women*. Nor could they have predicted the worldwide distribution of violent sexual exploitation of females through webcam RATS (remote admission tool software); cellphone cameras used, covertly or predatorily, to film females in sexual acts, leading to extortion and suicide, and those pornographic images circulating perpetually within the worldwide web.

Controlling women is a central dynamic of patriarchal structures. The "body politics" literature, identifying female bodies as a "battleground" for control, is abundant: from de Beauvoir (1949), Firestone (1972), and Butler's (1993) earlier feminist interrogations of women as body, through to the current burgeoning literature on this topic. "The powers at play in body politics include institutional power expressed in government and laws, disciplinary power exacted in economic production, discretionary power exercised in consumption, and personal power negotiated in intimate relations" (Body Politics, n.d.). Sjoberg and Peet (2011) observe that "both in domestic and international policy, and in actual conflicts, functions of gender hierarchy in the theory and practice of both state and global politics mean that wars are . . . *fought on* the bodies and lives of 'their' women" (p. 176). Valentich (2011b) catalogued other recurring issues such as intimate partner violence, sexual assault, survival sex work, human trafficking, and homelessness, and stated the obvious, that social workers "would agree that there is still much work to be done, locally, nationally, and internationally, by those committed to feminisms" (p. 22). Undervaluing women's contribution is a major result of objectification and patriarchy.

Globalization (the closer integration of economic, social, political, environmental, and legal policies across nations) has the potential to promote social justice agendas; uniting of nations, eradicating inequality, ensuring mutual sustainability and peace. However, we are seeing much of the opposite: policies that exploit, increased poverty, environmental degradation, political and economic insecurity, amassing wealth for corporations and investors. The rise of the global market has put pressure on local and national social agendas, impeding some feminist accomplishments and eroding others. The economic bottom line is held up as

more important than social justice and community caring. Those in a position to benefit from the globalization of the marketplace (that is, the dominant patriarchal culture) promote globalization to its own advantage and the disadvantage of others.

Members of lesbian, gay, bisexual, transgender, two-spirited, and queer* communities continue to be "victims of socio-economic, psychological and economic abuse because of their sexual orientation" (Mandell, 2009, p. 178). Economically, women continue to be the majority of single-parent heads of household. Women's work is still not paid equitably. Women are still doing the majority of the child caring and household labor (Home, 2004). Older women continue to bear the brunt of a lifetime of economic inequality, having made less money at work, or to live with results of unpaid work at home, so they may not have earned a pension. A reduction in the social service net has collided with the entrance of large numbers of "the Baby Boom generation" into their senior years. Having dutifully fulfilled their society roles as caregivers, and paying the price economically, senior women are now being characterized as "problems" for the larger society. "A postmodern welfare state that relies on individuals purchasing their own welfare instead of pooling social resources for the benefit of all . . . is one only privileged people can afford" (Dominelli, 2002, p. 62). Clearly, the need for feminist social work remains.

Furthermore, the rise of neoconservative governments has meant a decline in financial support for social work services. Dominelli (2002) not only cautioned that the "market context has devalued professional social work" (p. 52), but added that "social work is constantly being restructured by the state" (p. 15). Dominelli decried the assault on professionalism that is occurring in an increasingly neoconservative world: "State measures linked to globalization have whittled away professional power by devaluing its expertise" (p. 10).

"Neo-conservatism promotes a more traditional society based on patriarchal gender-role arrangements that are explicitly anti-feminist and anti-egalitarian" (Valentich, 2011a, p. 208):

> The notion that caring comes naturally to women fails to consider the significance of the socially patterned roles and the processes of socialization through which sex is translated into gender as women and men learn to incorporate into their behaviour and attitudes, assumptions related to masculine and feminine roles. . . . It is women who learn to take their place in society as informal caregivers to children and elderly relatives, and who transfer this to the public sphere and provide formal caring services as cleaners, child minders and teachers. (Bricker-Jenkins & Hooyman, 1986, p. 17)

When neoliberal (economic and political theory that places the free market system as the central value of policy making) initiatives seek to move these tasks back into the sphere of family care, it is overwhelmingly women, low-paid or unpaid, who end up shouldering the burden of work. Rather than full-time, permanent, union employment, "flexible" private sector work has meant fewer workers, less coverage, shift work, contracts, split shifts, part time, casual labor, and expanded reliance on volunteers (Baines, 2011a, p. 35). As social work is primarily a profession of women for women, the impact of this shift is highly gendered: women still receive lower pay, care work is racialized, and women dominant professions are associated with low status (p. 43).

Changes that have taken place in social work include a shift from engagement with clients and community to an emphasis on regulation and evidence-based practice (Nsonwu et al., 2013, p. 5). Managerialism views work as requiring pro-market, businesslike management solutions rather than social connection, equality, and public service. As a result, work conditions have often deteriorated; caseloads have doubled; standardization has led to a focus on paperwork, not people; issues to be addressed are reduced to checklists, leaving out important contextual information, and the influence of policy and systems upon problems.

Valentich (2011b) argues these trends sustain a public retreat from explicit identification with feminist social work. Despite all of the hard work by feminist social workers to anchor practice in empowerment and collaboration, managerialism and neoconservatism seem to be damaging these gains (p. 27). Commenting on the organizational context of supervision in social work, Davys and Beddoe (2010) note that "most helping professionals work in highly

bureaucratic, organizational contexts and increasingly fewer can claim to control their own work or knowledge" (p. 69). Baines in 2011 asked: "How do managerialism and standardization restrict social workers' opportunities for social-justice oriented practice? Have 20 years of restructuring reduced or removed social workers commitment to, and capacity for social justice practice?" (p. 25). She goes on to remind us that the "source of social work's intellectual integrity . . . is connection to people's every day struggles for dignity and well-being, its ability to alleviate their pain and to address deep roots of inequality and injustice that generates distress" (p. 25).

This constant controlling supervision is tiring. Referring to feminist social work theory, Valentich (2005, p. 148) notes that "its further development remains in the hands of increasingly overburdened and politically constrained social workers and social work educators" (cited in Valentich, 2011a, p. 205). The Gray and Boddy warn that notions of "post-feminism" fuel neoliberal consumerist inequality, thus "intensifying the need for feminist social work critique, scholarship, and activism" (Gray & Boddy, p. 368). Overall, there is a reduction of ability to use critical theory in decision making.

Diminishing the visibility of women's work and value is not only a result of patriarchy for individual women—it also affects women collectively. A neoconservative climate affects the academy (research and education) and feminist social work practice. A challenge that seems to be both external and internal is the invisibility of feminist social work achievement. The work of feminists, like the work of women, is made invisible. The tiredness of overloaded social workers and instructors, and the lack of support available, contribute to a decline in feminist social work research and a decline in the visibility of feminist social work principles and action in the public arena. Observing a lack of contemporary feminist scholarship in social work practice, Gray and Boddy (2010) note that:

> Social workers deliver innovative services in their daily work and are uniquely positioned to disseminate valuable practice experience, but this expertise is seldom disseminated publicly. They would do well to engage in more practice-based research that examines effective feminist approaches to social work practice. (p. 384)

Feminists do not get credit for the gains they have achieved for others. Taylor and Daly (1995) suggest that social work's roots as a profession of women for women resulted in patriarchal devaluing of women's work to "social housekeeping," and that this laid the foundation for "an underestimation and misrepresentation of the analytical, organizational, and management skills that women in the profession employ to effect radical changes in society" (p. 11) that continue. Schiebinger (1999) observes the same invisibility when she notes: "It is a curious phenomenon that when feminist practices or points of view become widely accepted in science, medicine, engineering, or the culture more generally, they are no longer considered 'feminist,' but simply 'just' or 'true'" (n.p.). To the extent that this integration is so thorough, the credit due feminism is quickly lost, and the rights so gained are assumed to have always been present. That women are legal persons, that they can vote, hold jobs, obtain credit, receive parental benefits and custody of children, may well be seen as natural rights, not the legacy of hard-won feminist social work advocacy. The invisibility of women's work has now shifted to be the invisibility of feminist social worker's work.

Feminist thought and feminist social work theory are diminished in academia when these perspectives are subsumed under larger, "more inclusive" categories, such as gender studies, human rights courses, or anti-oppressive practice. Brown and Strega (2005) decry the continuing dismissiveness: "Despite the emergence of critical, feminist and Indigenous approaches to research, anti-oppressive and critical research methodologies still rate little more than a mention in most research methods" (p. 4). Though feminist theorists (e.g., hooks, 1994; Mehrotra, 2010) identified the concept of intersectionality, anti-oppressive practice writers such as Brown and Strega (2005), and Baines (2011), while declaring themselves to be feminists, nevertheless appear to reduce the centrality of the feminist contribution by suggesting, for example, it is an "older theor[y]" (Baines, p. 10), one of several interchangeable theories that (mis)articulate the same larger problem. This seems to be

another way of avoiding association with the feminine in feminist theory. It is feminist social work theory that continues to point out the gender bias of these larger categories. Obscuring violence serves to perpetuate it, to excuse it, and to discourage perpetrators from being held accountable for it (Richardson, 2010, p. 138).

Hence, striving to remain visible is a key challenge and priority for feminist social work. Identifying that the world

> we know as racist, sexist, heterosexist, classist, neglectful, colonizing, occupying, and violent is the problem (Brown, 2006, p. 22), we social workers can create culturally competent practices that support equity and social justice only by understanding the ways in which we are not meeting these goals. (Gentlewarrior, Martin-Jearld, Skok, & Sweetser, 2008, p. 2)

Social workers are committed to advocating for others but are not as effective at educating the public and other professions about our successes and contributions. Our invisibility lets others define and disparage the profession and that ultimately hurts not only us but those we serve.

For that reason, feminist social work research is crucial (Gottlieb & Bombyk, 1987; Gringeri, 2010). In considering what social work will look like in 2044, Howard and Garland (2015) urge a commitment to

> social workers as public intellectuals . . . there is little or no social work presence in public venues such as speaking tours, radio talk shows, television news shows, popular magazines, newspaper editorials, oped pages, or other mechanisms that inform the public about welfare and public policy issues. (p. 200)

Wahab, Anderson-Nathe, and Gringeri (2015) urged feminist theorists to take up the challenge of research in social work, when they wrote *Feminisms in Social Work Research:*

> Showcasing the breadth and depth of exemplary social work feminist research, the editors argue that social work's unique focus on praxis, daily proximities to privilege and oppression, concern with social change and engagement with participatory forms of inquiry place social workers in a unique position to both learn from and contribute to broader social science and humanities discourse associated with feminist research. (Publisher notes)

The importance of feminist thought in their theoretical constructions is visible as the cornerstone of other theories. In 1997, Wachholz and Mullaly affirmed that "feminist research literature . . . offers the most well-articulated body of knowledge that is congruent with structural social work values, beliefs and principles" (p. 25). A challenge to face, therefore, is the advancement of feminist social work research. By finding their voice, Third Wave feminists can create a new reality, for language has always had power; "words make worlds" (Hartman, 1991).

Education is one of the challenges facing feminist social work today. The purpose of university education is debated, but it seems to me that we are committed to transformation through developing intellect, broadening awareness, encouraging questions that unsettle and transform, and pursuing holistic development that attends to students' emotional, psychological, and spiritual wellness. Faculties of social work prepare students for a range of possibilities, offering opportunities to conduct ground-breaking research, collaborative community engagement, insightful policy analysis, beneficial program evaluation, compassionate leadership, and skilled clinical practice. As the "key ingredient of a feminist classroom is helping students find their voice . . . [to] help build confidence to take action" (Curry-Stevens et. al., 2008, p. 297), feminist social work education guides that excitement and potential, and with bell hooks (2000), asks us all to "Imagine living in a world where there is no domination . . . where a vision of mutuality is the ethos shaping our interactions. Imagine living in a world where we can all be who we are, a world of peace and possibility" (p. x).

Exciting opportunities abound in feminist social work education to continue to blend our values and commitments to self-reflection leading to social action. Assignments I employ invite engagement through creative expression. For example, students create manifestos that capture their passion for social action toward an issue of personal significance for them, expressed through described visual art, song/drumming, poetry, rap, or other public performance. To inspire, I show examples of modern feminist leaders, such us Crystal Valentine (Workneh, 2015) reciting her powerful poem "Black Privilege," and describing what she feels being black in America means today. Building

on feminism's roots in the community, we join teaching elders in round rooms, ceremonies, and sweat lodges; get out of the academy to blog about students' experiences at the Canadian Museum for Human Rights, which includes seeing original documents like the Magna Carta and Treaty One, touching a ballot box from the 1994 South African elections that elected Nelson Mandela president of South Africa, and viewing a dress worn by an American teen who, in 2013, successfully fought for a racially integrated high school prom in Rochelle, Georgia. A student in the class I am currently teaching wrote:

> I have come to realize I have much to unlearn when it comes to dealing with oppressed people. My concept of help was based on patriarchal values. While unintentional, I had a concept of "applying treatment" which I now realize could create more harm. I think a feminist perspective—the philosophy I had been taught to devalue and belittle—may empower people more than any other approach I have learned so far in my education. (Personal communication, used with permission)

Feminist social work education must attend to accessibility of knowledge, inclusiveness, continued social action, resilience in the face of the increasing corporatization climate within universities, and continuing commitment to feminist social work education. In a January 2005 interview, offering advice for the journey, Steinem reminded academic feminists that "knowledge that is not accessible is not helpful" (Denes, 2015). Similarly, Gray and Boddy question "the ascendance of academic feminism and the disappearance of feminist political action" (p. 368). Feminist social workers are required to expand the circle of inclusiveness. The perspective of Felly Nweko Simmons, a black woman academic who writes "the world I inhabit as an academic is a white world. . . . In this white world I am a freshwater fish that swims in sea water" (1997, p. 227) (cited in Mirza, 2014, p. 1) is not surprising when research shows that "only 85 of the UK's 18,500 professors are black (university and college union, 2013), and only 17 are black women (Grove, 2014)" (cited in Mirza, 2014, p. 2).

Ensuring forms of leadership in social work, other than managerial control, is a challenge facing contemporary feminist social work. In 1995, Chernesky identified the leadership style of feminist administrators as interactive, transforming, and empowering; the mode of operation as caring, nurturing, teaching, cooperative, facilitative, and inclusive; structures created are collaborative, horizontal, and decentralized; problem-solving style is qualitative, contextual, consensual, participative, and process-oriented, and tasks are to flatten hierarchy, diffuse power, share decision making, equalize rewards, and increase worker participation (p. 80):

> A feminist theory of leadership should apply to, and closely monitor or observe, all levels of leadership power and influence, both formal and informal; the sex differences that exist; gendered expectations; and the process and goals of leadership . . . this practice involves reconstructing power as empowerment. (Lazzari et al., 2009, p. 351)

There is no biological essentialism in feminism or leadership. Men can be feminist leaders, which is important because "in the social work profession, more men than women hold formal positions of power (Sakamoto et al., 2008). . . . This gendered power imbalance presents challenges for all" (cited in Lazzari et al., 2009, p. 353).

It is a sign of hope that Andrea O'Reilly (2008), founder of the Motherhood Initiative for Research and Community Involvement (MIRCI), has succeeded in having motherhood recognized as topic of scholarly inquiry. Feminist scholars (Caplan & Hall-McCorquodale, 1985; Caplan, 2000; Chesler, 2005; Swift, 1995; Turnbull, 2001) were influential in naming "mother blaming" as a patriarchal presumption, and in questioning the lifelong limits assigned to females due to their biological ability to bear children. Hundreds of titles since have been published: including articles on queer mothering, mothering and activism, war zone mothering, and mothering and "disAbility."

By way of response to the need for more social work research, Howard and Garland (2015) recommend a concerted effort to increase funding for doctoral students and fellowships; creation of a national institute in Canada for social work research; improvement in teaching students to write for publication, and, importantly, attending to social work research's crisis: "My hope is that by 2044, social work research will

have resolved its identity crisis, garnered stable funding, grown the number of researchers it produces, and achieved greater recognition for having tackled some of society's toughest problems with notably positive results" (n.p.).

A second sign of hope is that feminist social workers of all ages, experiences, languages, and cultures continue to collaborate. As our history illustrates, the strengths of social work and roots of feminism are in collaboration, blending grassroots, the academy, and the front line. There are considerable resources in the communities we belong to and those with whom we engage, the academy, and practice sites; hence, it is important to rededicate ourselves to revitalizing those links. The shared interest in challenges to professionalism affect both the Canadian Association of Social Workers/Association Canadienne des Travailleuses et Travailleuses Sociaux (CASW/ACTS) and the Canadian Association for Social Work Education—l'Association Canadienne pour la Formation en Travail Social (CASWE-ACFTS), so working together benefits us all. In 1995, women's rights were finally recognized as a global human right by the United Nations:

> A global feminism has evolved [Bunch, 1993] and events around the world from femicide [Caputi and Russell, 1993] to rape [Valentich, 1994] and genital mutilation [Berg, 1995] have captured the attention and engaged the energies of feminist practitioners who none the less, may be working in one domain of feminist practice. (Valentich, 1996, p. 284)

Wetzel (1995) encouraged feminist social workers to keep to their original purpose, to continue to work collectively, sharing experience, not in retreating into isolation, but in keeping connected with others:

> Women's concerns are the concerns of the world. Their well-being is directly linked to the well-being of families, communities and nations. To practice effectively in the 21st century, therefore, social workers must view women as a priority. . . . If economic, political or social conditions, ranging from health care to education are to improve, the advancement of women from a human rights perspective must be embraced as a concept, indeed as a mission. To do so is to advance not only women, but men and children alike—in short, the people of the world. (p. 190)

Yet another sign of hope is that feminist social work theorists continue to publish. For 30 years, *Affilia* has been and continues to be a source for feminist social work writing, providing access to feminist social work voices from around the globe. For example: Pandya (2014) wrote, "Feminist social work has praxis as its core . . . women's realities are not universal and essential, but differential; intertwined with categories of caste, class, ethnicity, and faith which create layers of intersections of power domination and hierarchy that need to be countered" (p. 500). *Herizons: Women's News and Feminist Views* is a Canadian feminist magazine that has been publishing since 1979. A host of contemporary feminists theorists continue to write about contemporary issues in North America (c.f. Baumgardner & Richards, 2010 [(Gen X women]; Valenti, 2014 [full frontal feminism]; Hernandez & Rehman, 2002 [postcolonial feminism]; Nam, 2001 [Asian American feminism]). In his introduction to a new book on social work theories, Garrett (2013) acknowledges the significance of feminism and affirms that the book is informed by feminist analysis (p. 11). The developing literature on cultural safety (Milliken, 2013, 2012; Gentlewarrior et al., 2008) is part of that hope, articulating as it does an approach to inter-cultural cooperation that intentionally reduces the latent power inequalities that favor those in dominant cultures, whether they are racial or gender-based.

What, then, shall we conclude? Gloria Steinem (1995) once said feminism is the only major social movement that has to reinvent itself every generation. Gray and Boddy (2010) affirm:

> Feminism is far from a finished project. Women worldwide are oppressed, marginalized, abused, and disadvantaged because of their gender. Neoconservative values have undermined feminism. If we are to offset antifeminist movements, we must keep social work critique, scholarship, and activism alive. (p. 27)

Though the challenges are significant, Dominelli (2002) retains an optimism, "as feminists continue to envision a world in which people and the environment they live in matter" (p. 2). Finn and Sadye (2011) speak for many when they conclude that social workers

> care deeply about feminism and its relevance for the transformative practice of social work. . . . Inspiration

in new languages and practices of feminism and power in creating spaces for dialogue and reflection . . . appreciation of the complexity of feminisms; the rich and vibrant directions in which feminist practice is being pursued; the possibilities for bold and courageous action in teaching, research, and practice; and the need for communities of connection and support . . . commitments to feminist research, teaching, and practice . . . a collective desire to build community and translate our inspiration into action. (p. 348)

In 2014, Shulamith Koenig, recipient of the 2003 UN Prize in the Field of Human Rights, noted the direct relation between the atrocities experienced by females around the world and the lack of human rights: "Human rights equal peace. Human rights are all about equality; equality is dignity. Patriarchy has put women down. To survive women should not have to exchange equality" (Koenig, 2013).

It is necessarily a struggle to eradicate the ideology of domination that permeates cultures on various levels and in varying ways, as well as a commitment to reorganizing society so that the self-development of people can take precedence over imperialism, economic expansion, and material desires. (hooks, 2000, p. 26)

It may be tiring, frustrating, disappointing, discouraging, and even dangerous work. Abramovitz's encouragement remains valid: "Take time to envision feminist solutions to the country's woes and convert them to fair and humane social policies . . . we must organize for the long haul . . . without struggle there can be no change" (Abramovitz, 1996, p. 256).

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12

The Four Forces: An Inclusive Model

Au-Deane Shepherd Cowley

Moving Toward a Mega Theory

Turner (2011) proposed that, in the search for a "mega" or totally inclusive theory, one of the major goals was the need to increase our ability to use our various theories differentially. He called for the development of the kind of professional clinical expertise and theoretical clarity that provides clinicians with guidelines "to match theory to clients and situations" rather than the reverse. Acknowledging how challenging it is to compare and evaluate the usefulness of the plentiful and diverse possibilities available, Turner agrees with Corey (1995) when he further opines that what we need is to find a way to compare theories so we know where they are similar and in what ways they are different.

The Four Forces is an inclusive model that meets the above criteria. It offers a systematic process for comparing the four major theories that have developed historically in Western psychology: First Force, dynamic theory; Second Force, behavioral theory; Third Forces, experiential, humanistic, and existential theories; and Fourth Force, transpersonal theory. Several charts and theoretical guidelines have already been provided to facilitate the therapist's choice of which of the multitude of psychological theories, models, and specific interventions will help provide the most theoretically based intervention to serve a specific client or situation (Cowley, 1996). The Four Forces Model is inclusive enough that its broad umbrella will provide a home for most, if not all, of the theoretical treatment approaches featured in Turner's compendiums of social work treatments over the years.

Seeking a Science of Consciousness

Robert Ornstein (1972) made the observation that psychology is and always has been primarily the science of consciousness. Bugental (1978), expanded on Ornstein's definition by calling psychotherapy the art, science, and practice of studying the nature of what may reduce or facilitate the development of consciousness. In Western psychologies, attempts to facilitate the development of consciousness (or the increased structuralization of ego) were augmented by Freud's insights. However, according to Bruno Bettelheim (Bettelheim, 1983), key concepts of Freud's work have been mistranslated and therefore totally misunderstood. For instance, Freud wrote about a process of introspection called "soul making" through which an individual was called to an internal exploration of the self with the intention of bringing issues that were unconscious to conscious awareness. Freud never intended analysis of the psyche (soul) to be a process controlled by an external other who psychoanalyzed a person defined as a client. Additionally, the terms Freud used when he divided the structure of consciousness into a hierarchy with three levels still remain misrepresented. Freud wrote about the chaotic "it," not *id*; the "I," not *ego*; and the "above I" rather than the *superego* (Bettelheim, 1983).

Jung also called attention to the centrality of developing consciousness. Like Freud's, Jung's concept of consciousness was three-tiered. The bottom or most primitive level he called *shadow*, the middle level *ego*, and the highest level *Self* (with a capital S (Campbell, 1971). In like manner, Roberto Assagioli (1965), an Italian contemporary of Freud's, designated three levels in the structure of consciousness: *lower consciousness, middle consciousness*, and *superconsciousness*. In 1986, Ken Wilber delineated what he called "the major fulcrums of self-development" and divided it as had his predecessors into three general levels: *prepersonal, personal*, and *transpersonal* (Wilber, Engler, & Brown, 1986, p. 120).

Although Freud, Jung, Assagioli, and Wilber all posited a level of consciousness beyond ego, only Wilber (1986) joined the psychologies of the East with Western versions and offered a full spectrum of consciousness rising out of an undifferentiated matrix to form nine general levels (or basic structures) of consciousness: three prepersonal levels (*sensoriphysical, phantasmic-emotional*, and *rep-mind*); three personal levels (*rule/role, formal reflexive*, and *existential*); and three transpersonal levels (*psychic, subtle*, and *causal* or *non-dual*). In his groundbreaking work, Wilber also described what pathologies are likely to develop at each fulcrum of the full spectrum of consciousness as well as which interventions are most suited for each of the nine levels of development along the continuum of consciousness.

The Development and Differential Role of the Four Forces

According to London (1974), therapy has always been "a reactive trade" whose theories and models have operated as social indexes by evolving "to serve the social ills of the day." As each of the Four Forces emerged out of its own unique place in history, each has offered distinctive perspectives about human growth and development, what constitutes health and pathology, what the primary concern or focus of the therapist should be, and what the role of the therapist should be. Various models and interventions that complement each of the Four Forces were delineated by Cowley (1996) for use in transpersonal social work (see Table 12.2). A practitioner utilizing all of the resources of the Four Forces, along with Cowley's (1996) multidimensional development assessment method (see Table 12.3), is prepared to treat specific issues at six different

Table 12.1 Three Levels of Consciousness

Freud	Jung	Assagioli	Wilber
"Above I" (not superego)	Self	Superconsciousness	Transpersonal level
"I" (not ego)	Ego	Middle consciousness	Personal level
"It" (not id)	Shadow	Lower consciousness	Prepersonal level

Cowley. A. (1993/September). Transpersonal social work: A theory for the 1990s. Social work, 38(5), 532.

Table 12.2 Multi-Dimensional Development

Krueger (1989) (Physical Development)	Basch (1988) (Affective Dev.)	Ivey (1986) (Cognitive Dev.)	Erikson (1950) (Psycho-social Dev.)	Kohlberg (1981)/ Woolf (1984) (Moral Dev.)	Wilber(1986) (Spiritual Dev.)
6. Self-mastery Self-soothing Self-empathy	5. Attunement	6. Deconstruction: Paradox 5. Dialectic: Thesis, antithesis, synthesis	8. Ego integration vs. despair Accrued strength = wisdom (60 yr. +)	6. Universal mind Harmony Congruence	9. Causal level 8. Subtle level 7. Psychic level
	4. Empathetic understanding beyond self-referential		7. Generativity vs. self-absorption Accrued strength = caring (34 yr.–60 yr.)	5. Principled Reciprocity "Spirit of the law" I AM	6. Existential
5. Self-as-a-whole Integration of "bodymind" (36 mo.–6 yr.)		4. Formal: Identifying patterns (12 yr.)	6. Intimacy vs. isolation Accrued strength = love (22 yr.–34 yr.)		5. Formal-reflexive
		3. Concrete: Emphasis on objective reality (7 yr.–12 yr.)	5. Identity vs. identity diffusion Accrued strength = fidelity (12 yr.–22 yr.)	4. Law-oriented Cares about: Self, other, context "Letter of the law"	4. Rule/role mind
	3. Emotion Feeling states are joined with experience (24 mo.)		4. Industry vs. inferiority Accrued strength = competence (6 yr.–11 yr.)	3. Pleaser Cares about: Self and other	
1. Body mind Mental representation of one's body (18 mo.–36 mo.)	2. Feeling sensations are abstracted, objectified (18 mo.–24 mo.)	2. Preoperational: Magical, irrational, ineffective thinking (2 yr.–7 yr.)	3. Initiative vs. guilt Accrued strength = purpose (4 yr.–6 yr.)		3. Representational mind
3. Body self Physical boundaries (15 mo.–18 mo.)			2. Autonomy vs. shame and doubt Accrued strength = will (18 mo.–4 yr.)	2. Self centered Cares about self	2. Phantasmic-emotional (Image mind)
2. Symbiotic (1 mo.–15 mo.)	1. After Unconscious Automatic responses (0–18 mo.)	1. Sensorimotor: Embedded in own sensory construction of the world (18 mo.–24 mo.)	1. Trust vs. mistrust Accrued strength = hope (0–18 mo.)	1. Premoral Doesn't know how to care	1. Sensoriphysical Undifferentiated matrix
1. Undifferentiated (0–1 mo.)					

Numbering explanation: 1=Least developed developmental stage (bottom of chart) to 5-9=Highest level of development in each multi-dimensional development model (top of chart).

Table 12.3 The Four Forces

Theory	Dynamic	Behavioral	Existential Humanistic Experimental	Transpersonal
FOCUS	Pathology Dynamics/ past	Specific behaviors Specific symptoms	Awareness Experience Self-responsibility	Spiritual development Self-transcendence
LEVEL OF INDIVIDUATION FOCUSED ON	"It" Prepersonal	"I" Personal	"I" Personal	Above "I" Transpersonal "Beyond ego"
VIEW OF PATHOLOGY	Unconscious conflicts Sexual repression Disorganization of ego Repetition compulsion Deficits of development	Faulty learning Maladaptive behavior Neurotic anxiety Negative patterns Irrational ideas	Alienation from feelings Reduced potential Ennui Meaninglessness Lacking purpose	Spiritual malaise Dis-spiritation Morbid preservation Egoitis Dark night of the soul
VIEW OF HEALTH	Ego over id A personal self Firm ego boundaries Ability to love/work	Symptoms controlled Appropriate behavior Self-management Anxieties in check	Self-actualized Authentic Purpose of life Open to goodness	Wholeness "Beyond" ego Accepting "what is" Transcender
CURATIVE PROCESS	Insight Long-term/intense Interpretation Introspection Reveal unconscious Structure-building	Action Short-term/ structured Education Diagnostic tests Behavioral contracts Skills training	Eclectic Here-and-now focus Use of relationship Removing blocks Heart-to-heart Making meaning	Healing is "wholing" Meditation Integration Dis-identification Connecting to all Mystical experience
NATURE OF THE HELPING RELATIONSHIP	Vertical Medical model Interpretive Developmental partnering	Vertical Education model Modeling Coaching Goal oriented	Horizontal Person-to-person Process oriented Phenomenological Remove blocks to growth Facilitator	Reciprocal Servant/co-voyager Mutuality Guide Midwife Evocateur
MODELS	Drive psychology Ego psychology Object relations Self-psychology Jungian Adlerian Eriksonian	Behavior modification CBT* RET* Reality therapy Task-centered Case Work Redecision therapy	Humanistic Person-centered Experiential Gestalt Existential Logotherapy	Psychosynthesis Self-creation Holotropic Full spectrum Jungian Process-oriented Transpersonal Social Work
INTERVENTIONS (SKILLS/ TECHNIQUES)	History taking L.S.I.G.* Early recollections Uncovering Free association Sentence stems Interpretation Use of transference Catharsis Analyses of dreams Freudian slips Working through Spitting in the soup Script analysis Ego-gram Ego-state analysis Play therapy Re-parenting Corrective experience	Anchoring Reinforcement Desensitization Behavioral contracts Shaping/ substitution Aversion therapy Perturbation Role-play Education Homework Bibliotherapy Skills training Self-monitoring Stress management Relaxation training Cognitive restructuring Thought-stopping Positive self-talk Rehearsal	Therapeutic love Visualization Creative imagery Stream of awareness Experiential exercises Being present Gestalting dreams Top-dog/ bottom-dog Empty-chair work Psychodrama Choreography Mind journeys Journaling Strength bombardment De-repressing Clearing exercises Burning bowl Dereflection Philosophizing	Mediation Spiritual practice "I AM" affirmation Dream work Breath work Use of seed thoughts Listening within Detached observer Interpreting up Interpreting down Socratic dialogue Wisdom circles Community building Shamanic journey Study with guide Contemplation Path of the yogis Path of the saints Path of the sages

*CBT—Cognitive Behavorial Therapy; *RET—Rational Emotive Therapy; *L.S.I.G.—Life Style Interview Guide

dimensions of being as well as the specific issues that present from the three general levels of consciousness: prepersonal, personal, or transpersonal. This kind of multimodal approach gets close to meeting Nelson's (1994) insightful observation of what a therapeutic intervention should entail; that is, "only when people engage in treatment specific to their level of consciousness can they resume growth" (p. 375).

The First Force: Dynamic Theory

Freud's theory grew out of an "age of repression" as experienced by the traditional or inner-directed man (London, 1974). From the beginning, psychoanalysis was essentially a theory of intrapsychic functioning (Pine, 1985, p. 11). Dynamic theory began to take human behavior out of the realm of mystery. It also made it clear that unconscious drives and impulses were so powerful that, left undiscovered, they could sabotage consciously chosen goals. Even though Freud wrote about a process of intense introspection he called "soul making" (Bettelheim, 1983), the bulk of his work focused on pathology and the basement of human nature. For example, the index to Freud's complete works cites over 400 references to "neurosis" and none to "health" (Walsh & Shapiro, 1983, p. 5).

> Freud's model of man as an organism seeking relief from tension, and society, leaves even the most successful negotiator in a position of impoverishment and is as pathological, in its own way, as any that can be found in the diagnostic manual. (Walsh & Shapiro, 1983, p. 38)

Historically, First Force theory has viewed therapy as a process whereby the patient replaced neurotic conflict by learning how to live with everyday unhappiness. According to Brown (1988), this view was essentially pessimistic.

Pine (1985) divided the evolution of First Force theory into three great Waves or models. Freud's drive psychology was the first Wave. Ego psychology, with a view that focused on the ego, its development, and its functions, was the second. The third Wave, object relations, added key understandings about the importance of early relationships, the potentially serious effects of developmental deficits in early childhood, and the role of defense mechanisms. Object relations' focus on the observation of child development and the progressive differentiation of self from other gave birth to a body of literature on self-esteem and self-psychology.

Generally speaking, all of the models of dynamic theory did a better job of theorizing about pathology and offering developmental explanations about how it came to be than they did in providing guidelines for specific clinical interventions. Having uncovered repressed psychological issues, many practitioners were left unsure about what to do about them. How could such mysterious unconscious forces ever be tamed? Another problem limited the use of this approach as time went on. Its concepts were not readily amenable to empirical research.

The Second Force: Behavioral Theory

Over time, criticism accumulated about the exclusive hold dynamic theory had on psychotherapy prior to World War II. Its methods were too deterministic, expensive, and slow to suit the other-directed man in the "age of anxiety" (London, 1974). As society began to expect quick and mechanistic responses to life challenges, both clients and therapists became more interested in finding relief from specific symptoms than they were in a seemingly endless search for insight into some unconscious, underlying "cause." This led to a search for more practical and precise conceptualizations. Psychoanalytic premises related to repression weren't a good fit for the symptoms of the day in a time characterized by free love, sexual revolution, and value deficits (Schnall, 1981). As psychotherapy reacted to the need for more direct, action-oriented methods, Second Force (behavioral theory) came to the fore.

The behavioral approach sought to create empirical order out of phenomenological chaos. By focusing on the importance of social learning and the process of socialization, it hoped to demonstrate that much of human behavior could be objectified, operationalized, tested, and shaped with proper reinforcement. Specificity and concreteness in understanding human behavior provided, not only concepts and interventions that could be quantified, but also more

predictable relief for specific behavioral symptoms. Structural, strategic, and cognitive models of behavioral theory delivered observable results. This more empirical focus brought confidence to the scientific-minded research/practitioner in an age of accountability.

The Third Force: Experiential, Humanistic, and Existential Theories

In the middle to late 1940s, again reflecting changes in the social context, the longing for a more holistic view of human possibilities and a more humanistic connection between the healer and the client called forth a new approach. Virginia Satir described it like this:

> At the end of World War II, we all heaved a sigh of relief and had hope of building a more just world. The United Nations was a manifestation of that dream. These hopes were also translated into a new psychological construct—the human potential movement. In 1946 we heard the voices of Abraham Maslow, Rollo May, Carl Rogers and others who believed that human beings are and can be more than what their behavior led us to believe. We set on a journey to find out what else there was to the human being that had not yet been discovered and assessed. (Satir, 1987, p. 60)

That journey of discovery emerged out of an "age of existential alienation" to serve psychological man in his efforts to combat ennui through embarking on a search for self-fulfillment (London, l974). It resulted in the development of three Third Force theories:

1. Experiential theory, to work with clients who knew so much but felt so little, to bring back sensation, feeling, and the phenomenological;
2. Humanistic theory, to help individuals who felt isolated and bored to reconnect to life and become more fully human and self-actualized;
3. Existential theory, to deal with ultimate concerns and crises that occur when life loses its meaning and purpose.

Third Force theories dared to suggest that a person didn't need to be sick in order to get better. According to London (1974), the idea of undergoing a therapeutic process for the purpose of growth rather than cure represented a dramatic change in focus:

> Until now, psychotherapy has been mainly reactive to feeling bad, that is to having symptoms. Now it is reacting to not feeling good—that is, to a faulty lifestyle. . . . Men want to be healthy, wealthy and wise in that order. As each is gained, the next gets wanted more. (p. 68)

And so it was, as individuals in an affluent society became healthier, many of their contemporary ailments began to express in existential symptoms that required remedies that were more experiential and philosophical in nature.

The rise of Third Force psychology during the 1970s and 1980s reflected a culture-wide shift away from the Newtonian-Cartesian worldview. Nontraditional therapists began to move out of the mainstream of Western psychology to explore the contemplative practices and psychological traditions of the Far East. When they began to include alternative views and report data that were trans-rational and extrasensory, reactions from other professionals ran the gamut from horrified to celebratory. However, neither reaction altered the determination of Third Force pioneers to expand psychology to transcend the limits of the observable and the measurable (Grof, 1985).

Ultimately, it took the courage of an intellectual loner like Maslow (1968, 1971) to challenge mainstream psychological research to pursue the search for the farther reaches of human nature:

> Abraham Maslow was convinced that the value-life of human beings is biologically rooted. There seemed to him to be a species-wide need (comparable to the need for basic food elements and vitamins) for what he called "B" (for being) values, e.g., truth, goodness, beauty, wholeness, justice, playfulness, meaningfulness, etc. These values are biological necessities for avoiding illness and for achieving one's full potential. The epidemic of spiritual illnesses ("metapathologies") resulting from deprivation of these values include B values include; anomie, alienation, meaninglessness, loss of zest for life, hopelessness, boredom, and axiological depression. (Clinebell, l995, p. 92)

Maslow's early work radically revised our picture of the human species and created a vastly expanded map of human possibilities (Leonard,

1983). In his later work, Maslow's view of human potential continued to expand, and his explorations of human potential delineated three groups of optimally healthy people: self-actualizers, transcenders, and transcending self-actualizers. Eventually, Maslow came to believe that even his definition of self-actualized transcenders was not expansive enough to encompass the highest levels of human potential:

> Maslow has found that the self that was actualized could still be isolated in an alien world. Building on the theory of Erich Fromm (and resonating with Carl Jung and William James before him), Maslow postulated that we long to transcend our aloneness and belong to the cosmos. Even when we have fulfilled every secular need, the hunger for transcendence is not satisfied. So it was a short step from actualization to transcendence and from plateau experiences to the "cosmic connection." (Bradshaw, 1988, p. 228)

Maslow, who read extensively in Eastern literature, is considered the philosophical father of both humanistic and transpersonal theories. Near the end of his life, Maslow was still seeking more. He made yet another call for a fourth psychology that would be "transpersonal, transhuman, centered in the cosmos rather than in human needs and interests, going beyond humanness, identity, self-actualization, and the like" (Wittine, 1987, p. 53).

The Fourth Force: Transpersonal Theory

By 1969, this "fourth psychology" had not only come into being, but had established some common parameters. The professional *Journal of Transpersonal Psychology* was introduced, and in the forward of its first issue, Anthony Sutich made history when he defined the transpersonal domain as "concerned specifically with ultimate values, unitive consciousness, peak experiences, ecstasy, mystical experience, awe, transcendence of the self, spirit, oneness, cosmic awareness, and related concepts, experiences and activities."

Transpersonal theory evolved out of a cultural context exacerbated by, not only an existential vacuum, but a spiritual one as well. It arose to serve the dis-spirited man or woman in an age characterized by spiritual poverty and a lack of what Schnall (1981) called "limits" or traditional values. In 1988, when Bradshaw described this pain as "a hole in the soul," his words resonated with those whose suffering was spiritual in origin. In 1980, Goldberg labeled this postmodern crisis in consciousness "a malaise of the soul": "In a word, we live in an era in which men find it onerous to accept responsibility for their own actions and for the embittered and hollow course their existence has taken Much of our agony is in the soul" (p. l).

In a post–9-11 world, much of our individual and societal pain is lodged in the moral and spiritual dimensions. Transpersonal theory is particularly suited to treat postmodern maladies characterized by economic insecurity, addiction, violence, and a religious extremism that can result in mass casualty terrorism. The most prominent presenting symptom of the day (often oversimplified as clinical depression) is a sense of demoralization or "dis-spiritation" (Bugental & Bugental, 1984). Hence, practitioners are increasingly being challenged by the people they serve to take their spiritual concerns, value conflicts, and existential angst (Park, 2000) into account. Excellent resources to aid the social worker are readily available in the transpersonal literature.

Since each of The Four Forces has a different focus, view of pathology, and distinctive premises about what constitutes health or pathology, the curative process, and the nature of the helping relationship, each practitioner must make at least four conceptual decisions when designing a person-in-situation specific multimodal intervention.

1. Which dimension(s) of self-development will be focused on initially? (The physical dimension, the emotional dimension, the cognitive dimension, the psycho-social dimension, the moral dimension or the spiritual dimension?)
2. Which of the Four Force theories (dynamic, behavioral, experiential, humanistic, existential or transpersonal) will best serve each dimension of self-development chosen?
3. Which model(s) will be the best fit with each theory selected?
4. Which clinical skills or interventions match or complement each theory and model being utilized?

(See Figure 3 on multidimensional development, and Figure 2 on The Four Forces.)

What Relevance Does the Four Forces Model Have in a Post–9-11 World?

Life on planet Earth changed dramatically with the terror attacks events of 9-11. Since then, an omnipresent threat of violence continues to take a toll on both individual and collective consciousness. An individual cannot run a marathon, go shopping at a mall, ride a subway train, eat out at a cafe, etc., any place in the world, without dealing with feelings of uncertainty (Pema, 2013). "Death anxiety" (Yalom, 2008) is often disguised by other symptoms or complaints, but it is no longer just a concern for the elderly. Other social ills of our day include economic uncertainty, loss of trust, cynicism, addictions of all kinds, and for many, a loss of traditional values that makes sure that children in our culture have little opportunity to experience the innocence of childhood.

It would be difficult, if not impossible, to ascertain how events and changes in the larger systems in which we are all embedded affect our individual lives. For instance, researchers are even raising questions about the toll that social media may be taking on, not just interpersonal relationships, but the actual development of the human brain. The list of "new" challenges for practitioners could go on and on. The existential angst (not just in America but around the world) is so palpable that one who is aware can almost taste it. Add to all this the ecological concerns that arise when everyone on the planet is told that climate change or other natural and unnatural factors may destroy our one and only planetary home.

All of the Four Forces will always have their own special domain and usefulness in helping individuals, groups, couples, and families solve the problems of living. This chapter is proposing that (particularly in the terror-filled world we live in today), Third and Fourth Forces have become especially relevant. The challenge to educators becomes answering questions like these: How many practitioners have been introduced to Third and Fourth Force theories and interventions? How frequently do those who seek for answers in such complex and troubling times find the help and guidance that existential and transpersonal theories offer? Third Force Theories are effective in helping those at the personal level of consciousness become self-actualized and fulfill their human potential as rational, caring human beings. Yet far too little is included in public education courses to explicate what such a mature person would look like. In a time when irrationality runs rampant and immaturity is modeled daily on television, where are our models for future generations of mature thinking and behavior? Do we as therapists know and articulate what the epitome of the maturation process looks like so individuals may aspire to become their best possible selves? Jean Houston called this providing "a lure to Being." Harry and Bonaro Overstreet offered a classic description of the "gifts" that maturity can bring that merits a prominent place in every social work classroom and therapist's office:

> What are the gifts that maturity brings? It brings gifts of perspective; established purpose; sense of responsibility toward others; pride in good workmanship, and enough knowledge and disciplined skill to be able to deliver the goods. It brings also certain types of understanding that apparently do not become possible to a human being until he has coped with his share of unwanted experiences—of loss, disappointment, failure, grief and come to terms with these. One chief gift of maturity, in brief, is that of seasoned judgment; judgment that does not confuse the tawdry with the excellent, but which recognizes that the excellent is not always easy to come by. (Overstreet & Overstreet, 1956, p. 25)

Just as our society has too often failed to provide models of mature behaviors, it has also shied away from entering the domain of spiritual development. Even though many of our clients come seeking help with religious and spiritual issues, unless their therapist has been schooled in the Fourth Force or transpersonal theory, they may not have the necessary knowledge and skills to meet that challenge.

Assessing Religious Maturation

Ironically, some of the religious worldviews that have provided solace for many individuals and stability for nations throughout history have now become part of our "social ills of the day"—part

of the problem instead of part of the answer. Mental health workers have even been called to intervene in situations where religious groups have been spiritually abusive to their members (Derezotes et al., 2008). Although unimaginable atrocities have been committed throughout history in the name of religion, it has only been possible in the technologically brilliant postmodern world for terrorists to instantly transmit pictures of the terrible deeds done in the name of religion worldwide to a horrified global audience.

As social workers and other professionals are called to intervene in the aftermath of traumatic, barbarous atrocities attributed to a distorted religious worldview, it becomes increasingly clear that practitioners must develop a knowledge base broad, deep, and high enough to help differentiate between religions that are mature and authentic and those that remain "shallow, pseudomystical rationalizations" that may generate or maintain psychological pathology in their members (Anthony, Ecker, & Wilber, 1987, p. 2). Clearly, the worker dealing with the person-in-situation today needs to understand as much about the client's level of spiritual development as possible. It would be helpful to know how many schools of social work have integrated content on spiritual development into their curricula.

Fowler's (1981) research on the "stages of faith" offers a non-threatening way to approach the topic of faith-based issues. A discussion of how most people experience an evolution of understanding as they develop through a lifetime can normalize the fears and/or guilt that disturbs some individuals. As they begin to think as adults, some people may start to question what they have been taught as a child. It is helpful when workers are prepared to talk with them about Fowler's research and the six levels of faith that he identified:

> Level 0 begins at birth. It is described as primal and indifferent. Faith at Stage l is intuitive and projective in nature. Stage 2 faith has a mythic-literal quality. At stage 3, faith becomes more synthetic or conventional. Stage 4 is a level of individuated or reflective faith. Fowler called Stage 5 faith "conjunctive." At stage 6 an individual has developed an inclusive or "universalizing" faith.

In a time when world peace has been torn asunder by political differences and deeply held religious and sectarian animosities, it may not be easy to make distinctions between the many different levels of spiritual development we are exposed to daily. The word "religion" comes from the Latin "religio," which means "to tie back." Whether religious values edify and lift its adherents to higher consciousness or keeps them fixated at levels unproductive for self, others, or the world at large is a question that needs to be asked and answered. According to Peck (1987), world peace will ultimately depend upon our ability to make such distinctions. Just as Peck has written that we all must learn to accept and celebrate diversity and the contributions of many different cultures, he has also cautioned that acceptance should not imply that all cultures and religions are equal in their levels of maturation.

Peck delineated four distinct stages of spiritual development:

Stage I. Chaotic and antisocial: Spiritual development at Stage l is basically an anti-life position. It includes "people of the lie" whom Peck described as individuals who behave in uncaring, unprincipled, self-serving, and manipulative ways (Peck, 1983). Unsocialized children. and perhaps one in five adults, fall into this lowest level of spiritual development. If Peck were writing today, he might have included in Stage I those who justify terrorist agendas in the name of religion.

Stage II. Formal and institutional: At this more socialized stage of spiritual development, people are attached to the form, liturgy, or theology of their religious institution rather than to its spiritual essence. Because the letter of the law has provided a sense of order to their lives by liberating them from chaos, they feel threatened by the thought of change. The majority of orthodox churchgoers identify with this stage.

Stage III. Skeptic and individual: People at Stage III are independent thinkers. Because they are active truth-seekers, those who are true believers may consider them to be nonbelievers. This level of spiritual development often includes people who are involved with social causes.

Stage IV. Mystic and communal: At this highest level of spiritual development, instead of seeking security, one finds mystics who embrace the unknowable mysteries of life. Consequently,

they do not fear the unknown or resist change. Operating out of the principles of an acceptance for diversity and a commitment to the unity of all life, they are inherently world-centric.

In order to help raise individual and collective consciousness to its highest spiritual potential, there must be some definition of how healthy spirituality would reveal itself. Consider this description offered by transpersonal therapist, educator, and author Frances Vaughan:

> Healthy spirituality acknowledges both our humanity and our divinity, inspires a reverence for life and enhances our capacity for love, peace, and joy. It affects experience in both the inner and the outer world and has far-reaching personal, social, and cultural implications. . . . As a subjective experience of the sacred, authentic, healthy spirituality does not hinge on a particular concept of God or religious observance. It depends, rather, on how we relate to ourselves, to each other, to the earth, and to the cosmos. (Vaughan, 1995, p. 51)

Promoting the ideal of a spiritually connected whole is not an easy or popular thing to do in a world that tends to demean and marginalize the mystical. Sometimes it seems as if too many people in our postmodern society must have suffered a collective lobotomy of the spirit, or what some have described as a "spiritual bypass." Instead of venerating the most spiritually evolved among us, our scientifically oriented culture may treat them as if they were an embarrassment, or at least irrelevant (Cowley, 2014). However, there are some also promising signs that we are not headed away from spirit, but toward it.

Finding Darwin's Lost Theory

Like Freud's, Charles Darwin's work and visionary view of human evolution have largely remained misunderstood. In his book *Darwin's Lost Theory*, David Loye (2007, 2010) tries to set the record straight. Instead of proposing the "survival of the fittest" with the "selfish gene" in control, Darwin wrote about love and moral sensitivity as the vital and prime drivers of human evolution. Darwin sought to correct the prevailing misconceptions of his book *On the Origin of Species Through Natural Selection* (1859) when he wrote *The Descent of Man* (1871). In *The Descent of Man*, Darwin described his original vision about the human species. Darwin believed that the human being had "a desire for good, more compelling even, than our desire for self-preservation" (Loye, 2007, 2010. Commenting on Loye's book, Mihaly Csikszentmihalyi (co-founder of the field of positive psychology) had this to say:

> In times like these a new worldview often arises at the margins of power, at the periphery of the action unfolding on the main stage. David Loye's central insight . . . is in my opinion right on the money. . . . The organizing principle of a new faith—a faith of human beings; about human beings is evolution itself. Not the traditionally taught evolutionary scenario determined by competition and selfishness, but an understanding closer to the original Darwinian one that sees cooperation and transcendence of the self as the most exciting parts of the story. (Loye, 2007, 2010, p. ii)

Many sages, saints, gurus, philosophers, and psychologists support the view that it is nature's biological plan for the human species to have an unlimited potential. Self-transcendence, not a survival mentality, is our innate nature and our ultimate goal.

Spiral Dynamics and Macro Practice

In psychology's quest to make the unconscious conscious, its "reactive stance" to the social ills of the day has served us well. With the development of the Four Forces model, we have theories, models, and interventions that help us move individuals up the "great chain of being" from the "chaotic it" to the prepersonal, personal, and even transpersonal levels where the transcendence of the little self becomes a possibility. Now, in a time when the human species (and even our planet) are perhaps more than ever before "in a race between self-discovery and self destruction" (Elgin, 1981), it is time for us to broaden our area of concern and research from the micro to the macro level, from a basically reactive stance to one that is more proactive.

In the fifth edition of *Social Work Treatment: Interlocking Theoretical Approaches*, Turner wrote that one of his major premises was that we should increase our efforts to use our various theories in a differential manner (2011, p. 576). "Spiral dynamics," arising out of the work of

Graves (l 970), popularized by Beck and Cowan (1995), and embraced by Wilber (2003), is a theory that may hold great promise for providing some of the answers to the person-in-situation in today's world. In spiral dynamics, the evolutionary flow is "up" the ladder of consciousness from the level of mere survival toward the possibility of self-transcendence. It describes the evolutionary journey taken by individuals or an entire culture. This journey spans eight different waves of existence in terms of a value orientation. It is divided into two "tiers."

I have made some alterations to the theory to adapt it for possible use by the social work profession. For example, colors were added to represent each of the eight levels, but I elected not to use them. I have also chosen not to utilize the word "memes," generally used as a label for different value sets. The two tiers of spiral dynamics include:

Tier One

The lowest six waves of development in the spiral dynamics model have been designated "subsistence levels." They are marked by "first-tier thinking." This means that over 60% of the world's population is estimated to operate out of what amounts to a survival mentality. In addition, each of the first six stages believe their worldview is not only the best one, but the only one anyone in the world should have. Thus, it follows that all six waves of development in Tier One are totally exclusive in their interactions with others.

1. Archaic-instinctual values: Life lived at this beginning wave is an existence that basically relies on instincts and habits. The primary goal of life is just to survive, and it's pretty much an "everyone for him/herself" way of living. Members of these primitive groups band together for safety and spend most of their energy searching for food, water, warmth, and sex. Wherever it is found, it is definitely a prepersonal state of consciousness.
2. Magical-animalistic values: The world at wave two is viewed as a mysterious, magical place where superstition and irrationality reign. Curses and spells, voodoo-like practices and blood-oaths abound. Such tribal minds are most commonly found (but are not exclusive to) Third World settings. Anyone who has a tribal mentality only has one concern or loyalty, and that is to the tribe. Anyone outside the tribe is likely to be seen as an enemy and therefore dispensable.
3. Power gods: At the third wave, more distinct selves begin to rise above the masses. Using power and force, egocentric and exploitive values make it possible for those who seize power to provide protection to their underlings in exchange for total obedience and labor. This value set is not just to be found in feudal lords and famous power gods like Attila the Hun, but anytime or anywhere the power-hungry exploit the weak or helpless to serve their egocentric goals.
4. Mythic traditional values: Life at this wave of development has brought order out of chaos. A strict view of what is right and what is wrong brings a sense of meaning, purpose, and direction to members who comply with a prescribed order of conduct that is absolutist in nature. Rewards and punishments are determined by an all-powerful leader. This wave has been called "saintly/absolutistic," but it can also operate in a secular or atheistic setting.
5. Modern/rational/individualistic values: At wave five, the developing self begins to reject the values of the herd mentality and authoritarianism of patriarchal/matriarchal systems for a more rational and objective way of living and thinking. As a modern mindset prevails, the laws of science, politics, and the economy are more likely to be seen as resources that provide opportunities for personal, materialistic gain. Although individuals and organizations at this level utilize a more liberal value set, they are still most likely to be motivated by self-interest.
6. Postmodern/pluralistic values: The last wave in Tier One is often referred to as "green." At this wave, a sensitivity usually has developed that leads to a longing for human equality and human bonding. It often includes the capacity for a sense of ecological responsibility to the earth, or Gaia. Communities of like-minded individuals create networks to work together on projects that go beyond self to benefit pluralistic and equalitarian values. Communication styles emphasize the values

of dialogue and the importance of building relationships. The sphere of concern and caring begins to show a greater proclivity to care for not just the self or one's group, but for the whole. A shift of gigantic importance is coming into view.

Tier Two

In spiral dynamics, the quantum leap of growth that divides First Tier and Second Tier was described by Graves (1970) as "a momentous leap," where "a chasm of unbelievable depth of meaning is crossed." This value set is relatively rare. In a world population of 7.13 billion, it is estimated that 2%, or about 142.6 million, will achieve this leading edge of collective evolution; the transpersonal kind of consciousness that has the capacity to see and appreciate the entire spectrum of development. Those who reach Tier Two understand that each wave of the spectrum of consciousness is vitally important to the whole. Since each wave transcends and includes all that came before, each (according to Wilber) is "instrumental in moving from relativism to holism, or from pluralism to integralism."

The Two Major Waves in Tier Two

7. Integrative/systematic values: This wave's highest priorities include flexibility, spontaneity, and functionality. Knowledge and competence are also deeply valued. The few who operate at this level are so sensitive to the existence of different realities worldwide that they are able to move up and down the spiral dynamically within the global community. Their developmental capacity enables them to facilitate cooperation and mutual acceptance between groups despite the complexity involved and the skill required.
8. Holistic/universal-mindedness values: When an individual's value set develops to this highest state, the potential for self-transcendence is a viable possibility. Wilber estimates 0.1% of the population will ever achieve this level. However, Tier Two individuals are exactly the kind of morally mature leaders the human species is innately intended to be.

Spiral Dynamics and Macro Practice

Research on the spiral dynamics model forces us to ponder an old question: "To be—or not to be?" As human beings in the process of becoming, are we going to continue to devolve, or will we get back on an upward evolutionary course? It seems abundantly clear that the culture in which one is embedded will either lift its members toward self-transcendence and a love of self, others, and the world, or it will act as a regressive force likely to produce members who have little time, interest, or opportunity to spend in self-improvement. A Tier I survival mentality doesn't care about others who are just competitors in a life revolving around staying alive and destroying one's enemies. Surely the human species is destined for more than this.

Pierce (2007) points out that there are many factors that can operate as a "negative field effect" and sabotage development. Consider the disadvantage of being born in a chaotic and unloving family or in a culture with a dominant value matrix that loves death more than it loves life. Pierce is not the only one to assert that "love is evolution's *raison d'être*." Yet, there is so much that we need to learn in order to become loving that is what psychologists call "state-dependent." We must have good models and positive educational encounters, as well as uplifting life experiences, in order to balance each stage of our development in a positive direction. To succeed, the individual's thrust toward his/her highest potential requires the support of a benevolent family, a healthy earth, and a social matrix with virtuous leaders. Each time an individual is able to give up toxic ideas for more healthy ones, to move beyond self-interest toward a reverence for all life, he or she is doing his or her bit to help raise the collective unconsciousness.

> Man is not, as some current motivation theories would like to make us believe, basically concerned with gratifying needs, and satisfying drives and instincts, and by so doing, maintaining or restoring homeostasis, i.e., the inner equilibrium, a state without tensions. By virtue of the self-transcendent quality of the human reality, man is basically concerned with reaching out beyond himself, be it toward a meaning, which he wants to fulfill, or toward another

human being whom he lovingly encounters. In other words, self-transcendence manifests itself either by one's serving a cause, or loving another person. (Frankl, 1977, p. 9)

The Four Forces can offer a fuller understanding of human potential, not only to our social work educational programs, but also to the lay public. Together with others who are concerned about the current quality of life in our postmodern world, we can build coalitions and play a more relevant part in combating the global challenges and social ills of our day, that, if left unchallenged, threaten to destroy us all. Experience has demonstrated that education is our best hope. What happened to the original idea of using public education to promote good citizens, and the intentional use of character education to help build a mature character? (Lickona, 1982). Why has political correctness prevented us from educating the moral and spiritual dimensions of our students? Where is the effort to promote the development of what Erikson (1950) called "virtues"? How many Americans know the characteristics of self-actualized people? Why have we not followed up on Rudolph Steiner's idea that "the heart is not mainly a pump but also a major source of knowledge." or Robert Wolff's studies on "the original wisdom of aboriginals" (Pierce, 207, p. 13). Just imagine what might be accomplished if we trained our innate intuitive gifts and educated not only the brain but also the heart. Ultimately, human beings change through evolution not revolution. We are already using and teaching so much less than we know, and we know so little compared to what we can glean from searching on the margins for hidden treasures about human potential like Loye's book, and models like spiral dynamics that offer so much to our understanding of how macro issues affect local lives. We need to initiate more research that continues the search for the farther reaches of human nature and look for more precise answers to the question, "Who are we capable of being?"

. . . we are basically good . . . we are driven by moral sensitivity. . . . We are also driven by love to transcend selfishness . . . though, of necessity fiercely motivated to survive and prevail, we are also driven by the transcendent need to respect and care for the needs of others. (Loye, 2007, p. 7)

It's a moment of truth time for the planet Earth and all who love it. We need to discover how to lure more of the earth's population "beyond ego" by helping them develop a capacity for caring about the needs of others. So many sages and philosophers have made it clear throughout human history that whether or not we reach our full potential depends on the level of our development in the moral and spiritual dimensions of being. Will we choose to continue to devolve, or will we achieve the individual and collective greatness that Nature intended? Ken Wilber (2003) posited that, even though each individual (and culture) starts at square one and less than 2% of the world's population is at Tier Two of the Spiral Dynamics model in terms of development, "it is an elitism to which all are invited."

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13

Functional Theory and Social Work Practice

Katherine M. Dunlap

Functional Theory

An early, almost-forgotten theory developed by Otto Rank, this stresses personal growth and not determinism, and using agency structure with clients to define the focus, direction, content, and thrust of service

In a dramatic saga that is now mostly forgotten, early 20th-century social work leaders hotly argued over which practice method the profession should adopt. Most followed the medical profession and advocated the psychoanalytic principles developed by Sigmund Freud. A smaller group embraced the functional principles promulgated by German psychoanalyst Otto Rank. The emotional climate was so charged that at least one national convention was disrupted by shouting (Dr. Alan Keith-Lucas, personal communication, circa 1984). In the short run, the psychoanalytic school prevailed; however, the principles of functional social work have survived and now underpin many current methods of practice. Functional theories have had a dramatic impact on contemporary social work, yet most educators and practitioners have had limited exposure to the functional roots of modern methods. This chapter recapitulates the historical conditions from which the functional school emerged, explains its major tenets, reviews its applications, and examines the future of a once-powerful approach to social work practice.

The principles of functional theory were first developed by Otto Rank, a German psychoanalyst and erstwhile student of Sigmund Freud. Functional theory was subsequently adapted for social work practice by Jessie Taft and the faculty of School of Social Work at the University of Pennsylvania. Although only a few schools and agencies adopted this approach, functional methods were applied to individual, group, and community practice as well as to supervision, administration, research, and social work education, particularly on the east coast of the United States.

Functional social work is a therapeutic approach derived from psychoanalytic theory. Three characteristics differentiate functional social work from the Freudian or diagnostic school, which was the only other clearly formulated approach extant in the early 1920s (Smalley, 1971). First, functional theory was predicated on a psychology of growth, not determinism. To this end, the functional school replaced the concept of *treating* patients with that of *helping* clients. Second, functional theory assumed the structure of the agency defines the focus, direction, content, and duration of service. Third, functional theory stressed the concept of *process*, not diagnosis. Within the functional therapeutic relationship, the client and clinician work together to discover what can be done with the help that is offered.

Historical Antecedents

Functional theory was incorporated into social work practice in the United States during the turbulent 1920s and 1930s, but its roots must be traced to three antecedents: the emergence of the field of psychiatry during the first decades of the 20th century; concomitant changes in scientific thought; and the influence of Otto Rank, a disciple of Freud in Germany before the First World War. The following sections summarize the contributions of Freud, review scientific changes, and explore the life and work of Rank.

Psychoanalytic Theory

Sigmund Freud revolutionized the study of human behavior by developing the first systematic, scientific theory of personality. Today, Freud's contributions are well known. When first proposed, however, psychoanalytic theory was considered radical and controversial. Freudian methods were initially rejected by some; however, this theory offered hope to others seeking effective treatment for troubled people.

Freud's work was based on principles of scientific determinism. He and his disciples assumed that present behavior has meaning and can be understood through intense examination of past events. To garner meaning, they focused on the inner world of the self—thoughts, feelings, impulses, and fantasies.

Using case study methods, Freud and his followers engaged in a process of diagnosis. Their primary goal was to discover the cause of present difficulties. They assumed that by removing a cause, they could remove its symptoms, as in medical practice.

One of the keystones of Freud's personality structure was the concept of the unconscious mind, which he claimed to have discovered through his experiments in hypnosis and the study of dreams. To produce "unconscious" material without hypnosis, Freud proposed the technique he called "free association." To elicit material, the analyst was instructed to maintain an attitude of dynamic passivity. Freud declared that these techniques would enable the analyst to uncover the underlying motives that prompt behavior. Tentative hypotheses were confirmed by interpretation, a process through which the analyst shared insights gained "through the careful weighing of evidence and critical comparison" (Aptekar, 1955, p. 9). By analyzing the progress of people treated with these new methods, Freud identified several patterns of predictable responses, including resistance, blocking, and transference. The goal of psychoanalysis was understanding, not change. Freud maintained that rational people who understood their motives could make necessary changes independently of the analyst.

Several of Freud's theories have gained wide exposure, including the epigenetic process of psychosexual development; the organization of personality into three structures that together govern knowledge, emotion, and behavior; the creation and maintenance of defense mechanisms; and the presence of instinctive drives toward pleasure and death. As the following sections indicate, these theories were embraced by the diagnostic school of social work.

A Scientific Revolution

As Freudian theory reached maturity in the early decades of the 20th century, the entire arena of scientific thought experienced what Kuhn (1970) would call a "paradigm shift." Drucker (1959) explained that there was a "philosophical shift from the Cartesian universe of mechanical cause to the new universe of

pattern, purpose, and process" (p. xi). Scientists abandoned the deterministic search for irreversible causes as they faced the realization that the only thing predictable is unpredictability itself. Researchers in diverse fields began to explore the concept of growth as an orderly process with a universally recognizable purpose (Corner, 1944; Sinnott, 1950). Yelaja (1986) summarized four assumptions first articulated during this period: (1) the goal-directed whole of an organism transcends the sum of its parts; (2) despite common patterns, each being is unique; (3) the observer affects the observed; and (4) will and freedom exist and impel individual growth. These presumptions had profound implications, particularly for theorists in the field of human services (Mead, 1936).

Innovations of Otto Rank

Freud was surrounded by an inquisitive, dedicated circle of disciples who worked with him to elaborate and refine "psychoanalytic theory," as the new school of thought came to be called. One of the most dedicated and brilliant of this circle was Otto Rank, and it was Rank who devised the concepts that led to functional social work. Since Rank is less well known than Freud, his life and work are recapitulated here.

Otto Rank was born Otto Rosenfeld in 1884, the third child of an alcoholic jeweler. According to Rudnytsky (1991), the family was economically and emotionally deprived. Rank's older brother Paul received academic training and a law degree, but Otto Rank was forced to attend trade school and work long hours in a machine shop. He still found time to attend the theater, and he read voraciously (Taft, 1958). Rank charted his own intellectual development in diaries and daybooks containing quotations, references, cryptic scribbles, personal notes, and theories. His ambition was to live fully and creatively (Lieberman, 1985).

When Rank was 21, Alfred Adler introduced him to Sigmund Freud. This was a dream come true for Rank (Rudnytsky, 1984). Freud readily accepted Rank into his circle of disciples, for Rank enriched the medical group with his discerning understanding of history and culture. Freud brought Rank to the center of the group by making him secretary, and for many years Rank prepared the minutes of the weekly meetings of the Vienna Psychoanalytic Society (Klein, 1981).

Recognizing Rank's creative capacities, Freud helped him publish his first book, *Der Künstler (The Artist)*, in 1907 (Rank, 1925). Freud also financed Rank's studies at the University of Vienna, where Rank obtained his doctorate in 1912 for his dissertation on the Lohengrin legend. Rank was the first to employ psychoanalytic methodology in a doctoral dissertation, and he was also the first in psychodynamic literature to explore death symbolism and relate it to birth symbolism (Lieberman, 1985).

This was a period of great productivity for Rank. Under Freud's guidance and with his support, Rank engaged in theoretical research, edited journals, wrote monographs, organized the psychoanalytic movement, and practiced lay analysis for two decades (Progoff, 1956). However, as psychoanalysis began to harden into a standardized procedure, Rank reassessed and rejected many of Freud's notions and continued to experiment with innovative ideas of his own (Karpf, 1953).

Rank was surprised by the storm of controversy generated by the publication of *Trauma of Birth* in 1924 (Rank, 1924). Although the book was dedicated to Freud, it posited new, innovative concepts and was not well received by Freud or his followers.

The criticisms of the Vienna circle were sharp and bitter. With his subsequent departure for Paris, Rank dissociated himself from the official psychoanalytical group and continued to formulate his own theory and approach. His physical move to the United States was followed by an emotional breach with Freud that was never repaired. What began as a theoretical disagreement between colleagues grew into a vendetta that persisted for decades (Menaker, 1982). The two met for the last time in April of 1926 to say goodbye. Rank was 42 and Freud was nearing 70.

In *Art and Artist* (Rank, 1932), Rank explained his view of the human condition. Rank was not a feminist, but he respected women's freedom of choice, and he recognized the significant power in the mother–child bond (Sward, 1980–81). Using the metaphor that "life is a loan, death the repayment," Rank presented

life as a series of separations beginning with a painful birth. He focused on the importance of living fully—with creativity, humor, and joy—in the limited time between beginnings and endings.

Rank believed that people oscillate between their need to merge with a larger entity and their desire for separation. To achieve a unique identity and live an abundant life, the individual must exercise personal will (Menaker, 1984).

The concept of will is elaborated in *Will Therapy* and *Truth and Reality*, written in 1928 (Rank, 1928) and 1929, respectively, and translated by Jessie Taft into English in 1936 (Rank, 1936). Rank explains "will" as a complex, organizing element that delineates the total personality of the person, including creative ideas, feelings, and the energy of action. Will arises from "counter-will," or the oppositional stance of "not wanting to," a condition readily observed in young children. Rank maintains that people appropriately use will to adapt situations to their own unique needs. The situation may be external, as in an unhappy childhood, or internal, as in a counterproductive attitude. Regardless, individuation is achieved through active acceptance and adjustment.

As an analyst, Rank viewed each therapeutic hour as a microcosm of life, a time with its own beginning and end. In his therapy sessions, he emphasized the present, rather than the past or future. He encouraged patients to "experience" rather than to analyze the thoughts, feelings, and behaviors arising from the therapeutic process. He focused on recurring interactions and patterns instead of isolated events (Taft, 1958).

Rank is perhaps most famous for setting time limits. He used this strategy to help clients crystallize their conflicts regarding continuation or termination of therapy. Within this context, the conscious use of will becomes a therapeutic agent. For example, Rank noted that people must consciously choose to accept a course of action, even if there appears to be no other choice. By making ambivalence explicit, Rank enabled clients to mobilize their will. In the preface to his last book, *Beyond Psychology* (Rank, 1941), Rank explains, "Man is born beyond psychology and he dies beyond it but he can live beyond it only through vital experience of his own" (p. 16).

Relationship is the determining element in this therapeutic process. Rank rejected the stance of dynamic passivity. For him, the helping relationship is marked by mutuality, as in teaching and learning, but not by reciprocity, as in friendship. The therapist first establishes a setting in which the client can discover and use the strength that arises from vulnerability. Then the therapist becomes the tool that enables the client to explore and expand the will. Finally, the therapist precipitates termination by setting limits so that the client can achieve autonomy and avoid dependency.

Rank saw psychotherapy as an art as well as a science. Since every person is different, every therapeutic encounter will be different. The therapeutic alliance is characterized by spontaneity and creativity, for the analyst must fabricate conditions for growth in every session. It is this intense emotional process that produces change.

Rank frequently lectured in the United States. Although he scrupulously guarded the identity of his clients, it is known now that he worked with many famous individuals, including Henry Miller and Anaïs Nin. He led courses at the University of Pennsylvania School of Social Work, the New York School of Social Work, and the Graduate School for Jewish Social Work (Lieberman, 1985). Until his untimely death in 1939 at age 56, Rank continued to develop and revise his theories about the human condition.

Although he has had a major impact on the development of personality theory and psychotherapy, Rank's list of publications is not large, and his material is not widely read. There are several reasons for this. First, not all of his books are available in any one language. Some, originally written in German, have not been translated into English; others, written in English, have not been translated into German. Second, Rank's complex, Germanic style has made translation difficult. Third, his lack of precision has frustrated many scholars.

The Emergence of Two Schools

In the field of psychology, the two great poles during the 1920s were psychoanalysis and

behaviorism (Lieberman, 1985). In the field of social work, the primary focus was also on the internal problems of the individual (Kadushin, 1959), and there was relative indifference to behaviorism, social problems, or social reform (Meyer, 1970). Instead, the profession became deeply committed to the medical model, which in turn embraced psychoanalytic theory. The pace toward professionalism accelerated as the two factions, labeled the "diagnostic" and "functional" schools, endorsed and adapted psychoanalytic methods.

The Diagnostic School

Like the young Otto Rank, most social workers in the United States were enamored of the theories of Sigmund Freud. As the new theory swept through the profession, a major branch absorbed Freudian methods (Hollis, 1970). This group, first called the "diagnostic" and later the "psychosocial" school of social work, found in Freudian theory "the first great opportunity in history to break through to an understanding of the hitherto hidden mysteries" (Barlett & Saunders, 1970).

The diagnostic school evolved and expanded (Hollis & Woods, 1981), but in its early forms, diagnostic social work was based on scientific determinism, or the assumption that people are products of their past. The emphasis was on the past, for proponents maintained that only an understanding and acceptance of previous experiences can bring relief. The goal of treatment was to overcome blocks to normal, healthy functioning by bringing unconscious thoughts to mind (Hamilton, 1937a, 1937b). Research was conducted through the meticulous analysis of case materials (Hollis, 1939).

This approach assigned well-defined roles to social workers and clients. The client was presumed to be psychologically ill and in need of services. It was the worker's responsibility to collect information through the social history, to diagnosis the illness, and to provide treatment. Usually the presenting problem was viewed as a symptom of a deeper, all-pervading psychological problem (Hamilton, 1936).

The worker treated the client over an indefinite period of time, assuming sole responsibility for the goals and direction of treatment. As Hamilton (1937) explains, "Not everyone is equally capable of self-help, and the amount we must do for people is directly inverse to what they can do for themselves" (p. 171).

To avoid countertransference, the worker operated from a stance of dynamic passivity. The client was encouraged to expose deep-seated emotions that the worker subsequently interpreted. Hamilton (1940) explained that the effect of past influences was irreversible, so that the goal of treatment was not change, but adjustment or mitigation of "the crippling effects of deprivations or pathological exposures" (p. 168). She added, "Case work is less often able to free its clients than to help them live within their disabilities through social compensations" (p. 168).

Treatment rarely reached the termination stage in those early days. Hamilton (1940) recalled,

> When social studies were being worked out, case workers carried on so much investigation that they scarcely got around to treatment. In the twenties, case workers became so interested in the psychogenetic causes of difficulty that long histories were a major activity and often the treatment did not progress, stagnating in a dead center of diagnosis. (p. 141)

The Great Schism

For many years, the diagnostic and functional schools competed for supremacy (Hamilton, 1941). Each group defended its stance with evangelistic fervor, for each believed it had found *the* way to end psychic pain and mental illness. The polemic was public and painful, and the subject of casework became a contentious one for social workers and others. (Kasius, 1950; Murphy, 1933).

In trying to integrate the two disparate schools of thought, Aptekar (1955) prepared a comparison of the primary tenets of each:

Summing up, we might say that the chief conceptions of Freud which have been taken over and widely used by caseworkers as follows:

1. Unconscious mind as a determinant of behavior.
2. Ambivalence in feeling and attitude.
3. Past experience as a determinant of present behavior.

4. The transference as essential to therapy.
5. Resistance as a factor to be dealt with in all helping.

The chief conceptions of Rankian thinking, taken over by the functional school and substituted for the above, are:

- The will as an organizing force in personality.
- The counter-will as a manifestation of the need of the individual to differentiate himself.
- Present experience as a source of therapeutic development.
- The significance of separation.
- The inherent creativity of man. (p. 35)

The principles and presuppositions of functional social work are explored more fully in the following sections.

Path into Social Work

While the majority of social workers espoused Freudian theory, a small group adopted the approach of Otto Rank. Led by Jessie Taft and the faculty of the School of Social Work at the University of Pennsylvania, this group came to be called the Rankians or "functionalists," a term coined by Taft to describe the controls imposed by agency parameters. (The term "functional" in this context bears no relationship to the same term used in sociology.)

A child psychologist by training, Taft attained her doctorate from the University of Chicago in 1913. At the time she met Rank, she was a supervisor of the Foster Home Department of the Children's Aid Society of Pennsylvania. Their first contact occurred on June 3, 1924, at a meeting of the American Psychoanalytical Association where Rank discussed the ideas contained in *The Trauma of Birth*. Two years and many letters later, Taft began analysis with Rank in New York City (Robinson, 1962).

At first, Taft was ignorant of Rank's feud with Freud, but it was not long before she realized that she would have to "face Freudian difference, painful as it was, not merely through Rank but in my own thinking, reading, and use of the therapeutic relationship" (Robinson, 1962, p. 126). Taft immersed herself in Rank's philosophy and methods as she translated *Will Therapy* and *Truth and Reality* (1936). In addition to her agency employment, she concentrated on her psychoanalytic practice, studied the new theories, supervised others, and taught at the University of Pennsylvania School of Social Work. It was through these activities that Taft introduced the ideas of Otto Rank to social work.

Evolution of Functional Theory

Rank was a catalyst. After his break with the established psychoanalytic community, he lectured at the University of Pennsylvania School of Social Work, but he never related his theory to the profession of social work. In his later years, he did not even recognize the term "functional" (Smalley, 1971). The evolution of Rankian theory into functional social work was fostered by others.

Virginia Robinson was one of its leaders. A lifelong colleague and companion of Taft, Robinson participated in therapy with Rank in 1927. At the time, Robinson was head of the casework department at the University of Pennsylvania School of Social Work. She was impressed by her brief experience with analysis. Like Taft, she adopted and applied Rank's ideas.

Colleagues of Taft and Robinson, and those who followed them—including Aptekar, Dawley, de Schweinitz, Faatz, Gilpin-Wells, Hofstein, Lewis, Phillips, Pray, Smalley, and Wessel—elaborated and expanded Rankian concepts into functional social work (Smalley, 1970). Taft (1937) added the pivotal concepts regarding agency function.

While functional theory was predicated on Rankian philosophy, it also incorporates material from George Herbert Mead, W. I. Thomas, James Tufts, and John Dewey—masters whom Taft and Robinson had encountered in Chicago (Robinson, 1978). Functionalism accepted the scientific changes of the time and embraced the proposition elucidated by Corner (1944) and Sinnott (1950), to wit: "human growth expresses *purpose* and constitutes a *process*" (Smalley, 1971, p. 86).

The functionalists read widely in diverse fields, including philosophy, education, science, art, and literature, as a cursory perusal of the *Journal of the Otto Rank Society* attests.

As Smalley (1967) reports, many assumptions were imported from psychology. From Gordon Allport (1955) came the confirmation that people have autonomy, the ability to reason, and the capacity to make choices in a free society. Kurt Lewin (1935) added an understanding of the dynamic nature of change and the importance of environment and context. Erik Erikson (1940) contributed his early notions predicating an epigenetic unfolding of the human life cycle replete with psychosocial crises, or challenges, and opportunities for revitalization. Helen Merrel Lynd (1961) posited a psychology of abundance to replace what she saw as the psychology of economic scarcity.

In addition, Maslow (1937) delineated the concept of self-actualization, and Karen Horney (1939) portrayed anxiety and inner strivings as the positive sign of a continuously maturing individual. Moustakas summarized the contributions of Lecky, Angyl, Goldstein, Rank, and others in *The Self: Explorations in Personal Growth* (1956). All of these theorists were expanding on the same themes: the capacity for positive growth and change, the uniqueness of the individual, and the ability of people to shape their own destinies.

Basic Assumptions of the Functional School

Increasingly dissatisfied with the restrictive, pessimistic Freudian view of people, the early functionalists eagerly endorsed the proposition that people are purposeful, change-oriented masters of their own fate. Biological and environmental forces were not ignored in Rankian thought, but these were relegated to a secondary position.

Optimistic Underpinnings

Robinson's milestone work, *A Changing Psychology in Social Casework* (1930), introduced Rankian philosophy to the broader social work community. Robinson presents a positive and hopeful view of individuals' creatively using inner and outer experiences and resources to determine their own lives. The functionalists replace the psychology of illness with a belief in human growth, and they replace the obligation to treat with a mandate to serve (Lewis, 1966).

Ruth Elizabeth Smalley (1971), dean of the School of Social Work at the University of Pennsylvania, summarized the optimistic underpinnings of the functional approach:

> The functional school sees the push toward life, health, and fulfillment as primary in human beings, and the human as capable throughout his life of modifying both himself and his environment, in accordance with his own changing purposes with the limitations and opportunities of his own capacity and his own environment. (p. 90)

The individual is the "central, active figure" in the process (Faatz, 1953, p. 47). Functional caseworkers embraced the view that basic human nature is inherently good. Consequently, in a move considered revolutionary, they abandoned "judgmental standards of approval or condemnation of behavior" (Faatz, 1953, p. 22). Caseworkers presumed that change was not only possible, but inevitable, since each individual is endowed with an innate push toward psychological growth and a fuller, more integrated self. As Smalley (1960) suggests, the view sees people "as not only responsible for [their] own future evolution but capable of it" (p. 107).

Role of Will

The primary tenet of functional theory is Rank's revolutionary concept of will and self-determination. This new concept established the foundation on which all else rests. As Taft (1932) explained:

> The anxious parent, the angry school teacher, the despairing wife or husband must bear their own burdens, solve their own problems. I can help them only in and for themselves, if they are able to use me. I cannot perform a magic on the bad child, the inattentive pupil, the faithless partner, because they want him made over in their own terms. . . . Here is a beloved child to be saved, a family unity to be preserved, an important teacher to be enlightened. Before all these problems in which one's reputation, one's pleasure in utilizing professional skill, as well as one's real feeling for the person in distress are perhaps painfully involved, one must accept one's final limitation and the right of the other—perhaps his necessity—to refuse help or to take help in his own terms, not as therapist, friends, or society might choose. My knowledge and my skill avail nothing unless they are accepted and used by the other. (p. 369)

Caseworkers realize that even when change is wanted, it comes with a price—the sacrifice of certainty and security. Accordingly, functionalists understand that people resist change even as they reach for growth. As Taft (1950) explains, "Only at points of growth crisis, where the pressure for further development becomes strong enough to overcome the fear of change and disruption, is the ordinary individual brought to the necessity of enlarging his hard-won integration" (p. 5).

The Value Base of Functionalism

As the preceding quotation illustrates, casework implies a collateral relationship marked by mutuality. Furthermore, functionalists maintain that one person cannot change another, for the other is also endowed with will. Early writers did not specifically address issues related to sociocultural or ethnic sensitivity; they considered each person as a unique human being with distinct needs and particular gifts to contribute to the casework experience.

Putsch (1966), recounting her participation in the civil rights movement in Georgia, affirmed this philosophy. Her agency had worked hard to develop an atmosphere in which people of many different colors and convictions could work out a more satisfying way of living together. Putsch reflected, "As I had learned from my own experience, when we know too surely what is right we are impatient of difference and miss the opportunity for attaining full understanding through considering different viewpoints" (p. 95).

Significant others and environmental pressures and resources are considered from Lewin's (1951) perspective; that is, they are elements in the topography of an individual's life space. They are part of the problem if they inhibit growth, and they are part of the solution if they allow or promote change. Although the functionalists accepted the common premise that people are subject to the physical laws of nature, their belief in growth suggests that a harmony with nature is possible and desirable. People were encouraged to use natural resources, but individual responsibility was stressed.

The functionalists always focus on the present time, and this "now" orientation is a hallmark of the functional theory. The past is explored only to the extent that it impinges on current concerns. The future is projected only as a guide for present activities. Aware that the future is always uncertain, caseworkers help people learn to live in the present, making the best of themselves with the resources that are currently available.

The overarching goal of casework is the exercise of free will moderated by responsibility; however, functional caseworkers never speculate on the type of change anticipated or desired, for setting goals is considered the prerogative of the client. The role of the caseworker is to help the client obtain and use whatever tools are needed to forge the future. Recognizing the limitations inherent in the situation, only the client can determine what that future can and should be.

Major Concepts of Functional Social Work Practice

Smalley (1971) summarized three basic assumptions that, when combined with the concept of self-determination, describe functional social work practice. These three concepts, paraphrased below, were derived from Rankian methods, but they have been modified and expanded. They are applicable in private and public settings, with individuals, families, and communities.

Understanding the Nature of Humanity

The functional group works from a psychology of growth, which occurs in the context of relationship. The impetus for change lies with the client, not the worker. Taking social and cultural factors into account, the worker helps clients release their own potential for choice and growth through the power of the relationship. The functionalists use the term "helping" rather than "treatment" to describe this method.

Understanding the Purpose of Social Casework

The agency gives focus, direction, and content to the worker's practice. By so doing, the agency protects both the worker and the client. Casework is not a form of psychosocial treatment; it is a method for administering a specific social service.

Understanding the Concept of Process in Social Casework

Casework is a helping process through which agency services are made available. Workers take the lead in initiating, sustaining, and terminating the process; however, they enter the relationship without classifying the client, prescribing a particular treatment, or assuming responsibility for an anticipated outcome. Together, the work and client discover what can be done with the help offered (Smalley, 1971, pp. 79–81).

Treatment Through Functional Social Work Methods

Functional social work is an insight-oriented therapy. Although its primary method is colloquy, proponents focus on the casework relationship, which offers an opportunity to reject old patterns in favor of new approaches that promote growth. In addition to the basic presuppositions listed above, Smalley (1967) captures the mature tenets of the functional school in the five generic principles, paraphrased here:

Diagnosis should be related to the use of agency services. It should be developed jointly, modified as needed, and shared with the client.

Time in the social work process—beginnings, middles, and endings—should be fully exploited for the use of the client.

Agency function gives focus, content, and direction to social work processes, ensures accountability by society, and engages the client in the process characterized by partialization, concreteness, and differentiation.

Conscious use of structure furthers the effectiveness of social work processes by using a myriad of elements such as application forms, agency policy, and the physical setting to define and delimit service.

All effective social work processes take place within *relationship*. The purpose of the relationship is to help clients make propitious choices.

Functional therapy flows directly from these key tenets. Because they are vital to the helping process, each is described and examined here in greater detail.

Diagnosis

Functionalists eschew diagnosis as an objective of data collection (Austin, 1938). Diagnosis is considered important only when naming a condition helps a client modify it. In the same vein, history is important only as it encroaches on the present, and early childhood experiences are analyzed only when the client and caseworker agree that they may be contributing to the current difficulty. The assessment process is a joint endeavor (Dawley, 1937), and it constitutes the first phase of therapy.

Relationship and the Process of Change

Instead of focusing on diagnosis, the functionalists stress relationship and the process of change. These two are considered to be inseparable, for all change takes place within the context of relationship. The act of giving and taking help is a dynamic process that occurs over time (Hofstein, 1964). Furthermore, the process is "never static, never finished, always chiefly significant for its inner quality and movement, for its meaning to those it engages, rather than for its form or status or outcome at any instance of time" (Pray, 1949, p. 238).

Since every human being is unique, each person develops a distinct pattern for handling critical experiences. The pattern is initiated during the first separation, or beginning, which Rank called the birth trauma; it is reinforced through subsequent opportunities for change. The nature of the relationship with others determines whether an experience will produce or limit growth. For example, when early relationships with the mother are positive and constructive, the will learns to accept the inevitability of separation and to adapt to the limitations of reality. If early experiences with the mother are negative or destructive, the will develops a pattern of refusing to accept separation. This usually results in repeated and futile attempts to complete the self through the other person in the relationship.

To the functionalists, the concepts of will, counter-will, and resistance are not only inevitable but also necessary for "movement," a functional term connoting change or growth. Conflict is considered inherent in human growth as individual wants and needs clash with the wants and needs of other people and with

society. The counter-will, or negative aspect of will, opposes the will of others and resists reality as presented by society. The counter-will carries with it a connotation of guilt. Resistance, a natural attempt to maintain the self, is inevitable in the beginning of the casework relationship. Resistance is not seen as a problem or deficit; rather, it is considered a sign of strength indispensable to new growth.

The term "transference" is rarely used in functional literature. Taft (1933/1962) explains, "Transference, like resistance, is accepted for what it is, a stage in the growth process, in taking over of the own will into the self" (p. 97). Caseworkers assume that clients want to make themselves known, and the only way they can do this is to project their desires, fears, and conflicts onto the worker (Robinson, 1942). A competent worker must be sensitive enough to identify with these projections without getting lost in them (Aptekar, 1941). Throughout the course of therapy, the caseworker establishes and maintains sufficient separateness from the client so that neither confuses the self with the other. The worker's identification with agency function helps preserve this necessary separation.

Regardless of how negative previous experiences may have been, people have an opportunity to embrace growth and attain potential through the casework relationship. The therapeutic process consists of a beginning, a middle, and an ending phase. From the beginning, the caseworker displays a consistent attitude of respect and an unwavering belief that clients can change. The worker also creates an atmosphere in which clients feel safe and free to be themselves. The worker presents both reality and acceptance, creating for the client a "situation so safe, so reassuring that none of his defenses is needed and, therefore, fall away, leaving his underlying fears, loves and jealousies free to express themselves" (Robinson, 1962, p. 113).

During the middle phase of therapy, movement occurs as clients take increasing responsibility for their own actions. Caseworkers offer something new—either a new view of the situation or a new grip on it (Lewis, 1966), and relationships deepen as caseworkers continue to build on client strengths. Clients practice new behaviors with the caseworker and through this rehearsal gain a heightened sense of accomplishment and power.

Endings are both feared and welcomed, for they embody both the emptiness of loss and the pride of accomplishment. During termination, the client and therapist recapitulate goals, assess movement, and summarize gains. When therapy has been successful, endings signal a rebirth of the client, now armed with courage, confidence, and a capacity for other healthy unions. Yet, termination also signals the end of the powerful alliance that gave the client this new life. Thus, the ending is marked by sadness and joy, emptiness and fullness, security and challenge.

Some terminations are established by agency function, as when a patient leaves the hospital. More often, however, endings are introduced by the caseworker to help the client consolidate gains and move along independently. The technique of setting time limits is another hallmark of the functional approach.

Use of Time

Time is a critical element in functional casework, for it is the only medium through which help can be offered and received. Faatz (1953), who has written extensively about the nature of choice in casework, emphasizes the importance of the immediate present—the here and now—as the only setting in which change can actually occur. In this, Faatz anticipates systems theory, noting that emotions and events experienced during the therapeutic hour can influence and change the remainder of a client's life.

As Taft (1932) wrote, "Time represents more vividly than any other category the necessity of accepting limitation as well as the inability to do so, and symbolizes therefore the whole problem of living" (p. 375). Taft elaborated on this precept with examples from therapy. She explained that the person who arrives very early bears responsibility for self and other, while the person who arrives very late is abdicating responsibility. By addressing these problems in the therapeutic hour, the therapist enables the client to live that one hour fully and thus conquer the secret of all hours.

There is no predetermined or ideal duration of treatment. For some people, a few sessions may suffice, while for others, therapy may continue for an extended period of time.

Functional therapists frequently establish time limits in order to facilitate movement, a technique that has been misunderstood. Time limits may be derived from natural time periods, such as a school year or a season. The limits may be recommended by agency function, or they may evolve from therapeutic needs. Regardless of the origin, appropriate limits are never rigid or arbitrary; instead, they are derived from the situation. Appropriate time limits become an incentive to use the present productively and wisely.

Agency Function and the Conscious Use of Structure

The concept that may be the most relevant to social work involves the use of agency function and structure in the helping process. It was Taft (1937), not Rank, who first identified the importance of agency function. Taft viewed therapy as too unreal and public relief as too real. The concept of agency function enabled early caseworkers to find a productive place "between pure therapy and public therapy" (p. 11). Taft's introduction of agency function as the unifying theme in social work practice gave functional social work its moniker.

The principle is simple: the creative, positive acceptance of agency parameters can have significant philosophical and psychological benefits for both caseworker and client (Taft, 1937). In the conscious decision to work within the parameters of a specific agency, the worker accepts a circumscribed area of service. The caseworker's responsibility is mediated by what the agency can and cannot do. Worker attitude is important. The caseworker must not sink into resignation, chafe publically at limitations, revolt, or secretly resolve to overlook rules. When caseworkers recognize, accept, and use limitations, agency function becomes one of their most valuable tools.

Agency function is also a valuable tool for clients. When clients choose to accept agency limitations, they identify with the social purpose of the agency. Personal risk is minimized, for clients need not submit to an entire personality reconstruction. Rather, they can ask with help with specific concerns and know that their request will be respected. Through the casework relationship, clients learn to use limits to deal responsibility with reality in the pursuit of personal goals.

The structure and forms of service arise from the function of the agency. Agency policy is the primary authority that determines all other forms and structures. As we have seen, time is used deliberately. All forms and structures are consciously designed for the maximum effectiveness of all social work processes. Every item—from intake procedures, application forms, and assessment to termination rituals—is planned (Bellet, 1938). Even the setting—the structure of place—is considered important in defining and delimiting agency function. Because change is constant, forms and structures are reassessed regularly to ensure congruence with intent.

The relationship between freedom of choice and agency function is clear when a client voluntarily applies for service and then freely chooses to accept or reject the help that is offered. This relationship is less clear when the client participation is involuntary. Pray (1949), whose experience was primarily in the field of corrections, has written extensively about this apparent dilemma, and he argues that freedom and authority are not mutually exclusive. Pray identifies two conditions essential for success in an authoritarian setting. First, the authority must reflect the will of society, not the will of an individual. Second, within the setting, the captive client must be free to reject the service that is offered. Only by being free to reject can a client be free to accept and find fulfillment within the bounds (Yelaja, 1971).

Principal Applications of Functional Social Work

Functional methods were initially limited to work with individuals. In fact, when the University of Pennsylvania School of Social Work hired its first group worker, Helen Phillips, in the 1940s, the two areas were kept entirely separate (Robinson, 1960). Over time, their similarities became more apparent than their differences (Phillips, 1957). After World War II, the number of opportunities for group work expanded dramatically (Eisen, 1960).

In her definitive summary, Smalley (1967) indicated that functional methods are effective

with many types of groups and a wide variety of problems. Smalley cited case materials from a leisure-time group of adult women being served by a Jewish community center and from a therapy group of chronically mentally ill men in a psychiatric hospital. Although she acknowledged that specific knowledge and skill are required in these applications, she combined these dissimilar examples with case notes from a community organization to illustrate the five generic principles previously described.

Eisen (1960) reiterated the commonalities between group work and casework, adding that the group worker must also possess, not only special knowledge about the impact of the group process on individuals, but also special skill in using group interaction. Eisen underscored the range of services that can be provided in functional groups, listing four types of groups that might be formed in an inpatient unit for the chronically mentally ill. These are special-purpose groups, such as an orientation for new patients; a unit group for patient governance; peer groups for support and leisure activities; and community-focused programs.

The power in the group or community is essentially the same as the power in the individual (Smalley, 1967). Each is in process, striving toward self-fulfillment or purpose. Whether the goal is personal adjustment or social agitation, the worker facilitates the process through a helping relationship that is clearly delimited by agency controls. As Eisen (1960) explained, "Our service should be geared to helping patients overcome their disabilities, enhancing their capacity for group and self-direction. Toward this end, the group process becomes an individual experience" (p. 114).

The earliest writings acknowledge the importance of families (Taft, 1930) and address parent–child interactions, especially as related to abuse, neglect, and incompetence (Mayer, 1956). However, functional principles were not systematically applied to the family as a unit until the early 1960s. The process was initially called "family casework."

Rappaport (1960) was an early proponent of family-focused service. Recognizing that family problems are often rooted in the problems of society, she called for "more vibrant and vital ways of helping" families with multiple problems, and she recommended social action and coordination of resources as well as the application of functional principles to family practice (p. 86).

Berl (1964) also affirmed the relationship between family and society and noted that the major challenges of family casework involve a dynamic balance between the elements necessary for successful functioning, the integration of knowledge and practice, and systematic progress toward health and growth. He recommended the application of functional methods to prevention and crisis intervention, to treatment settings and education institutions, and to society at large. The field of family casework evolved slowly, however, for in 1967, Smalley presented generic principles for functional casework, group work, and community organization, but she did not mention family work.

Whether practiced with individuals, dyads, families, groups, or communities, functional social work is most appropriate for client systems seeking solutions to problems they have identified and embraced. Functional casework is especially effective for people seeking personal growth. It provides an insight-oriented process appropriate for children and adults (Taft, 1930). Neither formal education nor high intelligence is a prerequisite, and individuals with cognitive limitations can benefit if they have the capacity for reflection. The only qualifications needed to benefit from this method are an ability and willingness to engage in the process of self-examination and change.

Because the worker and client explore the process of change together, functional methods are applicable whether the participants have similar or dissimilar backgrounds. The first tasks of the worker are to establish rapport and acquire a rich understanding of the situation from the perspective of the client. Through this exploration, the worker comes to appreciate and value both similarities and differences in racial/ethnic heritage, culture, background, tradition, and experience. The recognition and affirmation of difference is reinforced in supervision, a process that scrutinizes client–worker differences so that workers can maintain appropriate roles and separate their personal needs and goals from those of the client.

Proponents identify few limitations or contraindications; however, functional methods alone are not sufficient for clients who also require medical or pharmaceutical intervention. Functional practice is rarely effective with people who have psychotic disorders; dementia; or antisocial, paranoid, schizoid, or borderline personality disorders. With specific populations or problems, functional methods may require adaptations to be developed by the worker (Smalley, 1971).

Since participation is entirely voluntary, risks are few. When a client's problems lie outside the agency's function, workers are obliged to refer the client to a more appropriate venue where help can be obtained. The functional method can be successfully applied to even the most complex problems, including psychosocial crises, introspective concerns, interpersonal conflicts, environmental issues, and social strife.

Administrative and Training Factors

The University of Pennsylvania School of Social Work developed the first master's program in this method around 1934 under the leadership of Taft (Robinson, 1960). From that point forward, caseworkers were expected to obtain the master's degree before they were allowed to provide therapy to clients. Educators assumed that these professional social workers would become leaders and administrators in their employing agencies (Pray, 1938), but no requisite knowledge or skill—other than the functional method—was identified.

Supervision is a critical element in training students and overseeing experienced workers (Faith, 1960), for before workers can help others, they must become aware of and manage their own inner and outer conflicts. Intrapersonal material, in addition to case content, constitutes the substance of supervision (Robinson, 1936).

The supervisory relationship is considered a special derivative of the therapeutic relationship, for it includes all the controls of the therapeutic alliance plus the needs of a third system. Sometimes the third entity is the agency, and sometimes it is the client (Robinson, 1949). In either case, effective supervision is indispensable, for it binds people to agency function. It also prevents the condition often called "burnout."

Hughes (1938) acknowledged that not all agency employees have professional training. In functional agencies, paraprofessional workers and volunteers are still required to uphold functional principles. As Hughes explained, "Lack of skill in knowing how to use our function helpfully is costly to the agency in time, in money, and in human misery" (p. 73).

Empirical Base

Single case studies have been conducted using agency records, but they often contain only idiosyncratic process recordings. These investigations focus more on product than process, since, by definition, goals are set by the client and can change during the course of therapy. They add little information about the overall effectiveness of functional methods.

Marcus (1966) maintained that functional principles are drawn from a substantive scientific base, and Smalley (1962, 1967) stressed the fact that casework students were consistently trained in research methods. De Schweinitz (1960) urged the university community to collaborate with practitioners. Lewis (1962) exhorted agencies to add the function or research analysis to agency services. Both Lewis and Smalley (1967) suggested engaging a research specialist, as Mencher (1959) recommended. Sprafk in (1964) accepted this challenge but reported on the process, not the outcome. Despite the attempt to embrace the scientific method, functional social work would not meet the rigorous standards of statistical analysis that have been developed during the past 20 years.

Prospectus

This chapter has described the lively and dramatic debate that shaped social work practice during the first half of the 20th century. At its zenith, functional social work was practiced and taught at the universities of Pennsylvania, North Carolina, and Southern California; the Graduate School for Jewish Social Work; and, briefly, at the New York School of Social Work (Robinson, 1978). The 16th edition of the *Encyclopedia of Social Work* devoted 12 pages to the functional method (Smalley, 1971), but

by 1977, that number had already dropped to 11 pages (Smalley & Bloom, 1977). By the 19th edition in 1995, the topic had been dropped completely.

Currently, no graduate schools of social work in the United States teach the functional methods as a unitary approach, and few institutions explore the historical roots of this tradition; however, a few historians and psychoanalysts have rediscovered Otto Rank (Lieberman, 1985; Menaker, 1982; Rudnytsky, 1991; Timms, 1997). With passing reference to functional authors, a number of articles have encouraged a return to relationship as the context for helping and change (Ganzer, 2007; Reupert, 2006; Sudbery, 2002; Trevithick, 2003). Timms (1997) has recommended a reevaluation of functional social work.

In fact, the revolutionary concepts that engendered such controversy have been modified, adapted, and ultimately subsumed into the major theories of social work today. Theorists have incorporated once-heretical ideas—such as freedom of choice and self-determination, the human potential for change, and the use of time and agency constraints as treatment elements—without reference to their stormy origins in the functional school. In the 1950s, Helen Harris Perlman developed the "problem-solving casework model." For some, this approach represented a synthesis of the diagnostic and functional schools. This systematic approach appears today in the form of cognitive therapies and evidence-based practice (Pozzuto & Arnd-Caddigan, 2008).

Carl Rogers (1951), who studied Rank extensively, championed unconditional positive regard and an emphasis on the importance of the authentic relationship in which change or healing could occur. These concepts inform self-help groups, transactional analysis, Gestalt therapy, and group therapies (Berlin, 2005). Reality therapists regularly promote the functional limits of an agency (Glasser, 1965), and the empowerment movement was built on client strengths and capacities for change within the context of community (Saleebey, 1992). Today, few clinicians acknowledge the functional roots undergirding their modern methods.

Economic conditions today resemble those found in the 1920s and 1930s in the United States. As then, economic necessities compel agencies to maintain services strictly within budget realities. Communities wish to avert suffering, especially for children, but they do not have resources. To this end, elected officials are reviewing mandates, setting limits on allotments, and demanding personal responsibility. An understanding and intentional use of agency function can ensure accountability to society and the attainment of social work objectives (Smalley, 1967). A deeper awareness of historical antecedents can enable the profession to meet the needs of a changing environment with greater efficiency and increased effectiveness.

Acknowledgment

This chapter is dedicated to my teacher and mentor, Dr. Alan Keith-Lucas (Feb. 5, 1910–Aug. 5, 1995). A graduate of Western Reserve University in the diagnostic tradition, Dr. Keith-Lucas was brought to the University of North Carolina to "clean up that functional mess." Instead, he joined forces with the functionalists, and for more than 50 years, his ideas and influence shaped social work services and group child care in North Carolina and the Southeast.

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14

General Systems Theory

Nancy Riedel Bowers and Anna Bowers

Systems theory is a broad view which far transcends technological problems and demands, a reorientation that has become necessary in science in general and in the gamut of disciplines from physics and biology to the behavioural and social sciences and to philosophy.

—Ludwig von Bertalanffy, Foreword, *General Systems Theory* (1968, p. vii)

Introduction

For as long as civilization has been evolving, there has been an importance accorded to "systems" and their contribution to survival and progression of societal changes. With respect to current efforts to collaborate in program planning, mental health intervention, and systemic changes, no time is better than now to review systems theory and its application to social work practice. Consideration of the individual, family, and community within the context of the larger system is no longer an option. It is an essential part of ethical and learned practice for the mental health professional.

As Ludwig von Bertalanffy wrote in 1986, "So innumerable problems are arising in production, commerce, and armaments . . . thus, a 'systems approach' became necessary" (von Bertalanffy, 1986, p. 4). Ackoff has supported the need for this theory development, suggesting that "Systems, of course, have been studied for centuries, but something new has been added . . . the tendency to study systems as an entity rather than a conglomeration of parts" (Ackoff, 1959, p. 145). The inception of "general systems theory" (GST) paralleled the trends of the 1950s. This chapter reviews aspects of this theory and its relevance to systems theory, in

order to apply the current trend of *collaboration* in social work and mental health practice.

The concept of systems theory saw its inception, or at least its rise to prominence, with the theory of von Bertalanffy and has now morphed into many variations on the theme, but it is commonly understood as "a general science of wholeness" (von Bertalanffy, 1968, p. 37). The application of this model to the functioning of systems from business designs, medical and mental health planning and implementation, and other entities that involve an interactionary process for survival has been one of the great movements of this last century. It affects virtually everything. However, there is not a single definition that would stand to fully define general systems theory (Smith-Acuna, 2011).

This chapter serves to review explanations of general systems theory and systems theory that have been proposed, including those of Dan Andreae found in *Social Work Theories,* 5th edition (Turner, 2011). An anecdotal history of Bertalanffy and his colleague's work to create the concept of "systems theory" will be discussed. In order to discuss both general systems theory and its contribution to systems theory, the second part of this chapter will provide two contemporary applications of the psychotherapeutic process. Both are applicable to mental health, including social work, practice highlighting a focus on the individual within the concept of the system and community perspectives. The first case example reveals a systems perspective on an intervention with a child with a learning disability within the context of the family and ecosystem, and the second, a narrative approach to family healing within Bronfenbrenner's ecological systems theory, serve to illustrate the current applications of systems theory used in mental health healing today. The chapter concludes by highlighting the application of systems theory to the collaborative approach to mental health.

Of special note, diversity as it pertains to cultures around the world, economic variations, sexual orientation choices, and physical, emotional, intellectual, and developmental challenges are inherent and intrinsic to all aspects of the discussion of systems and their application. Given the evolution of general systems theory and the collaborative efforts seen currently, we are reminded that general systems theory advocates organized unity of the system and speaks to this unity in terms of diversity.

The Evolution of Systems Theory

Interestingly, von Bertalanffy recounts his journey in the development of his observation of "open systems and steady states which essentially is an expansion of conventional physical chemistry, kinetics and thermodynamics . . . and so I was led to a still further generalization which I called 'General Systems Theory'. . . which corresponded to a trend in modern thinking" (von Bertalanffy, 1968, p. 90). The defining of a "system" and its applications are varied and diverse. But it may be defined as a complex of elements with interactions, arguably of both an ordered and a non-ordered nature. In a system, the whole necessarily become *more than the sum of the parts*, and as Andreae suggests, they are in "constant movement with the interfaces between systems . . . constantly in the process of change" (Andreae, 2011, p. 243).

The importance of systems theory was originally grasped by von Bertalanffy (1901–1972), the founder of systems theory, who recognized that a system has holistic properties that are not found separately within the parts. He conceptualized general systems theory as a complex of component parts or interacting elements that may together form an entity. This new synthetic approach to understanding nature can be defined as "an interdisciplinary doctrine elaborating principles and models that apply to systems in general irrespective of their particular kind, elements and forces involved" (von Bertalanffy, 1981, Introduction, p. xv). His concept of the "open system" is based on the hierarchical order of systems, the relationships between and within suprasystems, systems, and subsystems. The utilization of intersystem generalization renders their differentiation and specialization possible.

Following the applications of science discoveries and the relevance of the general system, Gregory Bateson, a cultural anthropologist by training, but a man who had a profound interest of "cybernetics" (the study of methods of feedback control within a system), provided many of the theoretical underpinnings for the

application of systems theory to human relationships. Norbert Wiener, neuropsychologist Warren McCulloch, social psychologist Kurt Lewin, along with G. Bateson and Margaret Mead were considered the "Who's Who" in systems theory. A systems approach was increasingly seen as adding an emphasis on seeing problems in context, looking at how interactions create and maintain problems, and examining the ways that patterns can remain constant or change (Smith-Acuna, 2011).

Application of this concept of perpetual shifting emphasizes the existence of circular causality, which helps conceptualize a family's behavior in current transactional terms, as a network of circular loops in which every member's behavior affects everyone else. People mutually affect one another, even in the absence of a specific behavioral event (Goldenberg & Goldenberg, 1994). Indeed, an essential way in which a system, such as a family, maintains itself as a self-regulating system is through the constant exchange of information "fed back" into the system. This information automatically triggers necessary changes to keep the system fluid and functional. In systems theory, "feedback loops" (circles of response from which there is a return flow of information into the system) are operating, and information is being processed through the system. The concept of feedback loops was developed by Norbert Weiner, a mathematician and pioneer in the field of cybernetics, who defined feedback as a method of controlling systems by reinserting into it the results of the past performance.

The application of this research discovery, albeit through scientific experimentation, has direct application to social work practice. The social work practitioner needs to analyze the various repetitive links that keep the loop locked in place regardless of the system under study (and thus maintain the mutually defeating interaction patterns) that prevent individuals or units who make up the particular system from moving on to more productive and fulfilling activities.

Application of Systems Theory to the Intervention Process

Historically, the major focus in the behavioral sciences prior to the understanding of general systems theory had been on individual functioning as reflected in such approaches as psychoanalytic theory, classical behaviorism, and neo-behaviorism, as well as learning theories. While different in nature, these theories share commonalities, particularly vis-à-vis the concept that the psychological organism is reactive. The principles of general systems theory and their application to the theory often referred to in social work literature and related rhetoric as systems theory are seen as reactive and also potentially learned (Andreae, 2011). Among the applications for various theoretical frameworks applied to the psychotherapeutic process by social workers and other mental health practitioners, systems theory may be applied from a variety of perspectives. Andreae (2011) suggests that social workers are provided a theoretical overview of systems theory, that systems are "interrelated, interconnected and interdependent" (p. 242). Social workers and associated mental health professionals observe any individual within the context of their entire system with consideration given to the effects that various levels and aspects of their systems have on their functioning.

The major roots of systems theory within the field of psychology that have had effects on most aspects of mental health come from three major areas:

1. Gregory Bateson studied psychopathology from a systems perspective, joining with Don Jackson, a psychiatrist from California, in the study of families with schizophrenic members. The Mental Research Institute was created in 1959 with Paul Watzlawick and John Wealand, along with Jay Haley and Virginia Satir.
2. In 1946, Murray Bowen, working with mothers and their schizophrenic children at the Menninger Clinic, expanded this work to include large family groups, including the extended family (Smith-Acuna, 2011).
3. In the 1950s, Nathan Ackerman expanded traditional psychodynamic definitions of relationship problems at the Family Mental Health Clinic in New York.

These three distinct developments in systems theory saw the shifting away from examining

problems in an individual and linear manner to looking more at context and circular causality, as noted by Smith-Acuna (2011).

As is noted and summarized by Andreae (2011), from the perspective of the psychoanalytic therapist, forces that affect a person are likely to result from early childhood experiences. For the behaviorally oriented therapist, causes are more likely to be found in the past and present combined. From the biologically oriented healer, behavior may be seen, in part, as determined by genetic inheritance.

It is the *context* that contributes to the holistic and more accurate understanding of the individual; i.e., the system in which the individual is involved. The systems view is holistic and attuned to targeted interpersonal relationships and stresses the reciprocity of behaviors between people. Circular causality suggests that the causal chain assists in the explanation of the person's life and relationships. The mechanistic view of linear causality is fundamental to the consideration of an individual's psychobiological behavioral with the goal of reestablishing equilibrium (homeostasis) (Andreae, 2011).

As has been suggested thus far, in the early 20th century, an alternative view of human problems and their alleviation began to emerge, along with a growing dissatisfaction with the mechanistic view of linear causality. The concepts of developmental psychology as reflected in Piaget's "genetic epistemology" as well as neo-Freudian developments such as Carl Rogers' "client-centered therapy," Abraham Maslow's "self-actualization" psychology, the personality theories of Murray Allports, and phenomenological and existential approaches such as that of Fritz Perls's Gestalt therapy, all provided a new view of circular causality. "The common features to all of these emerging alternatives is that they did not treat human beings as reactive robots but rather as active personality systems, and recognized that systems are capable of dynamic change and growth as opposed to the homeostatic models of earlier times" (Compton & Galway, 1989, p. 123, as cited in Andreae, 2011).

Bowen concretized the application of the original concepts of systems theory to the mental health and psychology field with his profound thoughts regarding the healthy system's being able to promote differentiation by providing closeness and connection, valuing the unique identities of each group member. These values may be present simultaneously, sequentially, or in conflict, but they are expressed. Ultimately, the more a person feels grounded and accepted in a secure relationship, the more he or she will be able to express and be true to her or his identity (Smith-Acuna, 2011). While Whitaker and Satir focused more on affect than on theories that were perceived as creating distance, a current clinician/theorist, Sue Johnson, uses a current application of systems theory by applying attachment theory, thereby enriching the understanding of human communication. A more recent application of systems theory is that of Daniel Siegel, who employs his attachment research in neurobiology and describes the intricate communication patterns seen between children and their caretakers. He claims that early attachment relationships can be repaired by fostering accurate emotional communication.

With this new understanding of the person–environment interrelatedness, general systems theory and now systems theory have come to provide social work and mental health practitioners with a conceptual framework that shifts attention from the cause-and-effect relationship between paired variables to a person/situation as an interrelated whole. The person is observed as part of his or her total life situation, which is only observable when the entire system is studied. "The social work practitioner must strive for a full understanding of the complex interactions between the client and all levels of the social and physical system as well as the meaning that the client assigns to each of these interactions" (Teevan, 1993, p. 256). Collaboration between the individual and the system provide a new and important addition to the contributions of systems theory.

Case Example 14.1

Systems theory and families of children with special needs (Author: Anna Bowers)

Families function within a complex system in which they impact and are impacted by interrelated components, including characteristics of individuals, the context in which individuals develop, and time

(Bronfenbrenner, 1979). The socio-ecological model of development of Uri Bronfenbrenner, a developmental psychologist, created a model known as the "ecological systems theory." This model considers the entire system in which families are functioning in order to better understand their interactions with the environment. Biopsychosocial characteristics are thought to set in motion a family's ability, experience, knowledge, and skill, that are condusive to effective functioning (Bronfenbrenner & Morris, 2006).

It is widely recognized that a child with a developmental disability is part of a larger family system, with reciprocal interactions occurring between them (Bailey & Simeonsson, 1988). The family affects the child, and the challenges of the child alter the family's functioning and quality of life. Bronfenbrenner's (1994) socio-ecological model of development considers the child to be "nested" within a family, which in turn is nested within a broader community system. This model provides a framework to explore and better understand the interactions that both a child with special needs and the family have with their environment.

The socio-ecological model of development recognizes characteristics that prompt or deter reactions from the social environment (Lerner, 2002). Research indicates that social support improves coping and adaptation for families of children with a developmental disorder (Gray, 2002). Drawing upon Bronfenbrenner's (1994) socio-ecological model of development, the entire system in which these families are functioning and growing must be considered in order to better understand how and why they are interacting with their environment in the way that they are. Thus, the various microsystems that the child participates in influence the seeking of and engagement in therapeutic services. Additionally, the mesosystem in which families function helps dictate the support services that are necessary and available to address the needs of the family. This model provides a framework to explore and clarify the complex factors that families face and the interactions between the child/family and their environment that prompt the need for differentiated services for both child and family.

Professionals working with children assume responsibility for establishing partnerships with families in addition to fostering relationships between school professionals and families, and providing training to better understand the interrelated systems of children's lives (Manz, Mautone, & Martin, 2009). Bronfenbrenner's ecological systems theory proposes that considering the reciprocal components of a child's developmental process facilitates a person-context relational view of the child's functioning (Bronfenbrenner, 1977). As professionals assume the role of catalyst in establishing collaborations, consideration must be given to biopsychosocial characteristics in order to understand how children interact with others in their world and exhibit active agency in their own development (Lerner, 2002; Manz et al., 2009).

Case Example 14.2

Systems Theory and Its Effect on Narrative Therapy (Authors: Alan McLuckie and Melissa Rowbotham; from Riedel Bowers, 2013, pp. 117–119)

Narrative therapy emerged as a mainstream model of psychotherapy in the 1990s (Gurman & Messer, 2003), offering a new paradigm of practice that espouses a social constructionist worldview. Social constructionist thinking within therapy represents a departure from family systems thinking (i.e., that a person's reality, including life's problems, arises from and is sustained by interpersonal interactions within the family environment) and constructivist thinking (i.e., that a person's reality, including life's problems, is created via one's interpretations/perceptions of the world). Simply stated, social constructionist thinkers believe that a person's reality (e.g., the stories we have about ourselves and our world), including life's problems, arises from and is maintained through interpersonal interactions that occur within, and are influenced by, forces within the broader environment. The environment within social constructionist thinking includes the family unit but goes beyond its confines to include broader cultural, historical, and socio-political forces. Morgan (2000) summarizes the important role of broader environmental factors by stating:

> The ways in which we understand our lives are influenced by the broader stories of the cultures in which we live . . . some stories will have positive effects and some will have negative effects on life in the past present and future . . . there is always a context in which the stories or our lives are formed . . . this context contributes to the interpretations and meanings that we give events . . . the context[s]

> of gender, class, race, culture etc. are powerful contributors to the plot of the stories by which we live. (Morgan, 2000, p. 9)

An underlying assumption of social constructionist psychotherapies is that our stories about "who" we are as people are not constructed in isolation, independent of other people's influences and the influences of our social context. Our life stories, including who we are, do not simply arise as a product of genetic materials inherited from our parents nor result solely from our family upbringing. Rather, these stories are co-constructed across time within a developmental context that extends well beyond the parent–child dyad or family system to also include wider sociocultural influences. Brown and Augusta-Scott (2006) describe this co-construction process as follows:

> We do not, and cannot, create our stories by ourselves, as they can emerge only within a pre-existing context of meaning. This context of meaning is always social, as meaning cannot exist independent of social life. The human capacity to produce meaning and to attach it to social events and experiences requires social interaction. (p. xix)

In our opinion, although it is not a social constructionist theory by design, Bronfenbrenner's (1979) ecological systems framework effectively depicts how an individual's story about him/herself unfolds or develops within a nested system, ranging from the broad sociocultural context (i.e., macrosystem) to the inner core of the nuclear family system or the parent–child relationship (i.e., microsystem) (see Figure 14.1). Transactions occurring within each system, such as at the level of the family, are highly influential on an individual's life story. Transactions between systems also have marked influence on the realities of children and families. For example, children and families can be shaped by government policies related to such things as health care (i.e., macrosystem), or by experiences parents have with workplace policies (i.e., exosystem), or by the opportunities children have at school (i.e., mesosystem).

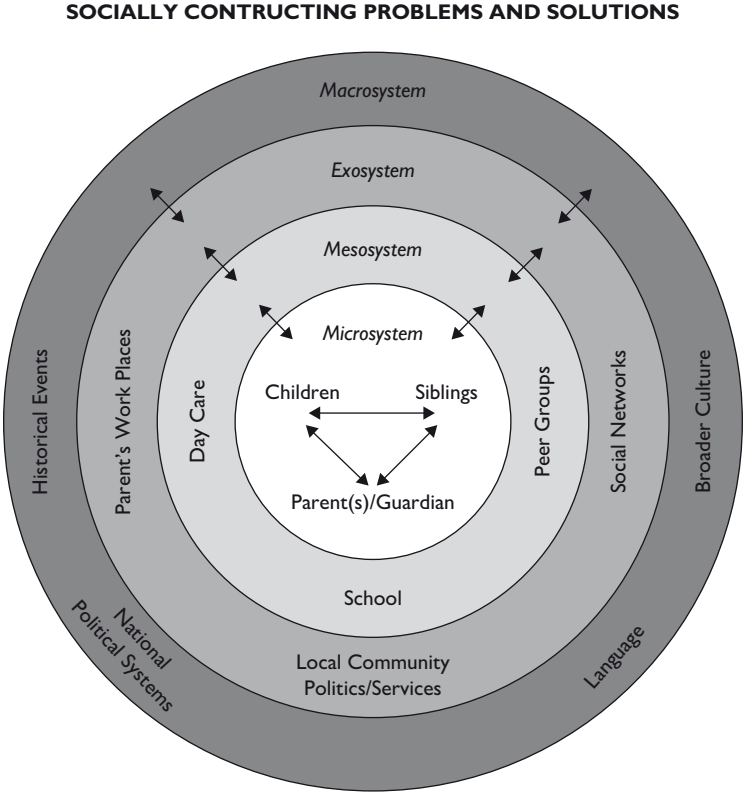

Figure 14.1 Ecological/Nested System

Unfortunately, Bronfenbrenner's model (1979) does not explicitly account for the fact that children and families do not all begin on equal footing within their particular social context. Sociocultural forces are seldom experienced the same way by all children and families. Not everyone has the same power, privilege, and opportunity within the various levels of society, including the broader macrosystem. Social structures are often socially constructed by the dominant group(s) in a fashion that maintains a privileged position within society for the dominant group(s), thereby resulting in oppression of other groups. For example, racism is alive and well in a North American context as well as worldwide. Discrimination due to such factors as race/ethnicity, gender/sex, sexual orientation, age and physical ability/disability, continue to erect barriers to young people and families within major institutions (e.g., school and the employment sector) and society. Real and potential sources of oppression with society must be acknowledged within the therapeutic context because these forces wield a negative influence on the development of children and families.

Conclusion

This chapter intends to review the evolution of general systems theory, the application of this overview for the development of systems theory for the explicit purpose of mental health care, and the current trends in this application. As Bateson (1972) and Watzlawick et al. (1967) suggest, patterns in relationship conflicts are categorized in complementary and symmetrical interactions. The notion of circular causality suggests that complementary interactions can be self-reinforcing and, at times, polarizing, which can lead to role rigidity and inhibit conflict resolution (Smith-Acuna, 2011).

Applying a "systems approach," thereby resolving conflict and tensions collaboratively, the patterns of relationship distance and detachment may be halted, and even reversed. Other variables come into play in this collaborative effort to work within the ecosystem, drawing on the internal resources of the individual, and support from the family, extended family, and alternate caretakers and communities. Following the ecosystemic framework, the uniqueness of the diverse aspects of the context of the person, both challenges and strengths, contributes to a better understanding of the life story of those individuals who seek out social workers and mental health practitioners for insight, and, for some individuals, change.

In summary, the nature of collaborative mental health intervention, whether it be focused on

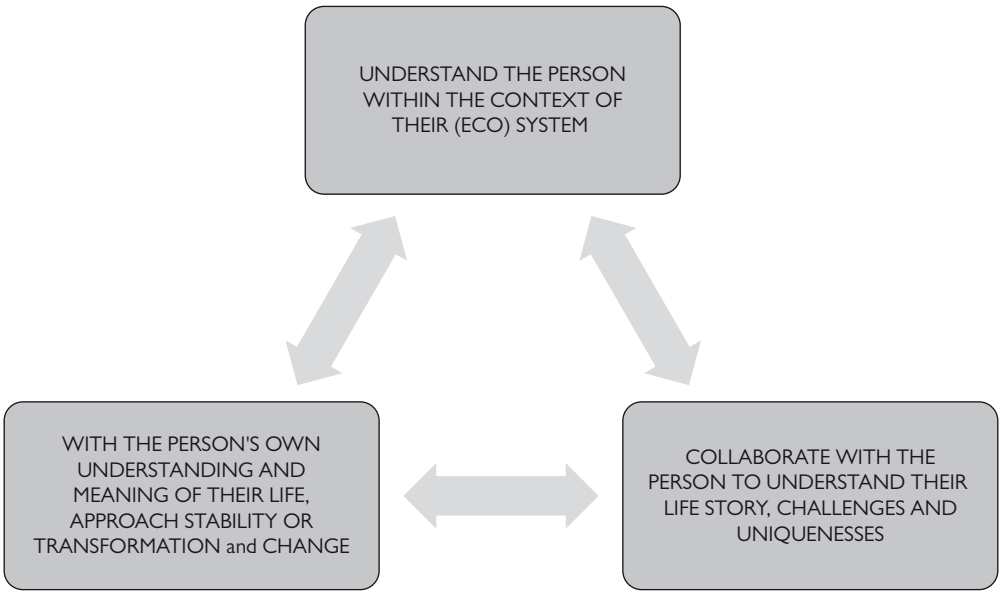

Figure 14.2 Collaborative Mental Health Intervention

the child, adolescent, or adult within the *context* of the family, is affected by the system and its effect on family patterns, equilibrium, and changes.

The original insight of von Bertalanffy, particularly putting forth the concept that the "system is a part of the whole," along with its adaptation by Bronfenbrenner for a better understanding of the ecosystem, the layers, and the interplay between all the parts of the person's unique world have been presented in this chapter. There have been many applications of these models, and there will be many more. The concept of collaboration, though, is not actually unique but a reworking of the obvious need of the person to seek out strengths when available, deal with challenges when evident, and apply such insights for a better world, a skill that clinical and community-based social workers are often skilled to do.

The systemic conceptualization of collaborative healing provides a progressive model of attachment and resilience provided by the ecosystem that surrounds the person in the context of their environment. Von Bertalanffy conceptualized the framework; Bronfenbrenner proposed the importance of the ecosystem; based on the importance placed on the general systems theory and systems theory, new constructions of the same will follow.

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15

Gestalt Theory and Social Work Treatment

Elaine P. Congress

Gestalt

This system aims to produce enhanced self-awareness of inner and outer selves as a unified whole, by focusing on dysfunctional boundaries of confluence, interjection, projection, and retroflection.

Contrary to popular belief, Gestalt theory is much more than a collection of techniques, as this model is firmly rooted in existential philosophy (Perls, 1992). Derived from a German word denoting "wholeness," *Gestalt* refers to the holistic nature of human experience. A Gestalt is seen as much more than its collected parts. Although Gestalt therapy focuses on the "figure," the experience of the individual in current context, there is also consideration of the "ground," the present as well as past background of the individual. While the here and now is stressed, past experiences and relationships are examined in the present in order for the client to gain greater understanding about his or her current situation.

Overview

Historical Origins

First developed in the late 1940s, Gestalt theory introduced a new approach to understanding personality, human development, and therapy that differed from widely accepted psychoanalytic theory. The founder and principal proponent of Gestalt theory and therapy, Frederick ("Fritz") Perls, disagreed with the Freudian lineal approach, which stressed the past, focused on individual pathology stemming from Oedipal conflicts, and promoted a treatment method that fostered dependency on the therapist.

Written over 60 years ago, *Ego, Hunger, and Aggression: A Revision of Freud's Theory and Method* (Perls, 1947) presents the initial development of Gestalt theory. Perls disagreed with traditional psychoanalytic theory and instead embraced existential philosophy and Gestalt psychology. Although traditional psychoanalytic theory was rejected, there have nevertheless been some linkages to the more modern psychoanalytic self-psychology (Jacobs, 1992). Perls was greatly influenced by the existential focus on individual responsibility for one's experience within the present. The Gestalt therapeutic relationship is likened to the I–Thou relationship described by Buber (1958) in which the therapist unconditionally accepts the unique personality of the client. In the I–Thou relationship, the barrier between self and others is minimized, and each person connects on a human level. From Gestalt psychology, Perls derives his focus on the total person as an entity that is much more than a collection of component parts. In contrast to psychoanalytic theory, which presents sex and aggression as primary drives, Gestalt theory proposes that the basic human drive is that of self-actualization.

Gestalt therapy was most popular in the 1960s, and Fritz Perls conducted many workshops and seminars to disseminate his theory during that time. Miller (1989) has suggested that Gestalt therapy, which focused on here-and-now experiential methods, was particularly suitable to the radical revolutionary nature of the Sixties. Gestalt therapy, however, is not only is a collection of dated dramatic techniques designed to bring about rapid personality change, but it also presents a philosophical worldview and a therapeutic method that has continued to have relevance and a following into the 21st century.

Literature on Gestalt Theory and Therapy

Originally, Frederick Perls was the principal author of literature on Gestalt theory. Important books by Perls that outline theoretical and treatment concepts of this model include *Gestalt Therapy Verbatim* (Perls, 1969a), *In and Out of the Garbage Pail* (Perls, 1969b), *The Gestalt Approach and Eye Witness to Therapy* (Perls, 1973), and *Gestalt Therapy* (Perls, Hefferline, & Goodman, 1951). Other authors on Gestalt therapy include Panning (2009), Polster (1992), Smith (1992a), Harman (1990), Korb, Gorrell, and VanDeRiet (2002), Clarkson (1989), Smith (1992a, 1992b), Nevis (2000), and Melnick & Nevis (2009).

Gestalt therapy has been linked to psychoanalytic models in the work of Yontef (1987), to transactional analysis and redecision theory in Goulding (1989), to self psychology in Breshgold and Zahm (1992), to insight-oriented therapy in the work of Scanlon (1980), and to attachment theory (Sternek, 2007). Within the last 15 years Brownell (2008), Houston (2003), Melnick and Nevis (2009), and Yontef (2005) have published books on Gestalt therapy. Many recent publications on Gestalt therapy have originated in Europe rather than in the United States, where Gestalt therapy began.

Recent literature on Gestalt therapy has focused on the use of body movement in psychotherapy (Klepner, 2001) and group supervision with supervisees (Melnick, 2008). *The International Journal of Gestalt Therapy* (renamed in 2002 from *Gestalt Therapy*) is a continual source of current work on Gestalt theory and practice. Applying Gestalt principles to increase understanding of child behavior has been a particular focus for current Gestalt therapists (Arfelli-Galli, 2006; Trombini, 2006, 2007). Trombini (2007) uses focal play therapy based on Gestalt principles to work with children with eating disorders. Currently there is a focus on client groups, such as Wedam's (2007) application of Gestalt principles to clinical work with traumatized refugees in which refugees who have experienced torture must learn through therapeutic relations to develop new structures. In addition to clinical work, Gestalt principles have also been used to understand communication patterns, including audience reactions to media. Members of the audience are not passive receivers of information, but instead actively seek out information they need (Umphrey, 2007).

Much literature on Gestalt therapy has focused on specific age groups: children (Geldard & Geldard, 2009; Botha & Dunn, 2009); adolescents (Williams, 2010; McConville, 2012), and the elderly (O'Leary & Barry, 2006).

Other articles look at the use of Gestalt therapy with different psychiatric diagnoses such as clients with schizophrenia (Arnfred, 2012), bipolar disorders (van Balalen, 2010), and posttraumatic stress disorders (Perera-Dilitz, Laux, & Toman, 2012). A third type of article looks at different problem areas such as those affected by substance abuse (Carlock, O'Halloran, Glaus, & Shaw, 1992; Clemmens, 2005; Brownell, 2012), domestic violence (Little, 1990), clients suffering from bereavement (Cheung & Nguyen, 2012), clients with suicide attempts (Young & Lester, 2002), and cardiac patients (O'Leary, 2006).

Relationship to Social Work

Although Gestalt theory was originally developed by a psychiatrist, Fritz Perls, and his wife, a psychologist, Laura Perls, and the majority of literature has been written by psychologists, there are many tenets that seem particularly pertinent to social work. Both Gestalt and social work focus on beginning "where the client is." What Gestalt therapists describe as the "figure/ground experience" is similar to the social work focus on the "person-in-environment ecological perspective." Social work's concern about the total person, including the physical, cognitive, behavioral, and emotional, and verbal and nonverbal, resembles the Gestalt therapy focus on wholeness. Increasing self-awareness for the therapist, as well as the client, is an important tenet for both the Gestalt and the social work therapist.

Senreich (2014) points out that the principles of Gestalt therapy are very compatible with the National Association of Social Workers Code of Ethics (2008) which stresses social justice and the respect for the worth and dignity of each person. Four major themes of Gestalt therapy (field theory, creative adjustment, the I–Thou relationship, and the phenomenological approach) are seen as particularly relevant for social workers (Senreich, 2014). Just as a Gestalt therapist looks at the total Gestalt affecting a client, the social worker is encouraged to view the total multifaceted environment of family, community, school, work, health and social service agencies, as well as other resources and liabilities. A comprehensive approach is sought in both perspectives. Similar to a Gestalt therapist's not working with patients based upon one factor, a social worker would not use a straight lineal causal approach; for example, parental substance abuse would not be considered the only cause of a child's acting out in school. The I–Thou approach of Gestalt therapy is similar to the approach in social work that sees the therapeutic relationship as less hierarchical, since both therapist and client participate in helping the client achieve greater mental health. This is also similar to the focus in social work research of participatory research. Clients are not just subjects who provide information, but are actively asked to participate in developing pertinent research questions.

"Creative adjustment" is a familiar concept in both Gestalt therapy (Melnick & Nevis, 2005) and social work treatment. For example, in Gestalt treatment, psychiatric symptoms are frequently seen as the way a client deals with life stresses, while social workers also may interpret behavioral symptoms such as adolescent's joining a gang as a "creative adjustment" to lack of attention at home (Senreich, 2014).

Finally, there is a close link between the phenomenological approach of Gestalt therapy that focuses on the subjective experience of the client and the social work approach to cultural competency and, most recently, cultural humility. Social workers are encouraged to learn from clients, especially when they come from different cultural backgrounds.

Extent of Social Work Literature

Social work literature on Gestalt therapy has been limited. In the chapter on Gestalt therapy published in the last edition of *Social Work Treatment* (2011), a review of *Social Work Abstracts* from 1968 to 2009 yielded only 10 journal articles and three dissertations, only half of which had been published in social work journals. A promising sign, however, is that there now are more journal articles on Gestalt and social work in professional journals, as a recent search for journal articles on this topic yielded 16 articles in the last five years. In Levenson (1979), differences between Gestalt therapy and psychoanalytic psychotherapy are considered. Other social work authors have focused on the application of Gestalt therapy

to clinical practice (Lammert & Dolan, 1983), to groups for chronic schizophrenics (Potocky, 1993), to marriage counseling (Hale, 1978), and to training groups in Gestalt therapy (Napoli & Walk, 1989). In an earlier edition of this book, Blugerman (1986) discussed the usefulness of Gestalt theory for social work practice and research. A 2014 article summarized important concepts of Gestalt therapy in relation to social work practice (Senreich, 2014).

Basic Concepts

Gestalt theory presupposes a belief in the wholeness of human experience and the value of each person. The six main concepts in Gestalt therapy are wholeness, awareness, contact, figure/ground, self-regulation, and the here and now (Smith, 1992a, 1992b).

Wholeness: Gestalt theory stresses the wholeness of the person without separation between mind and body, thought, emotion, and action. The problems or symptoms presented by clients are viewed as integral parts of their experience.

Awareness: The Gestalt therapist seeks to help the client become more aware of internal feelings and processes as well as others in the external environment. As children, all human beings have the capacity for awareness and growth, but they are often encouraged to minimize certain thoughts and behaviors as inappropriate. For example, a young girl may be taught that girls should never be assertive and should always be passive and accepting. This may lead to conflicts as an adult when a boss places unreasonable demands on her. A Gestalt therapist would help this client become aware of her feelings of anger, which she had not been able to express as a child. By becoming more aware of both inner and outer experiences as a child and now as an adult, she can move toward developing more appropriate assertive behavior in the here and now.

Contact: The focus of Gestalt therapy is to expand the range and scope of contact between a person's inner and outer self and environment, as well as between client and environment. The Gestalt therapist views transference as a contact boundary disturbance and tries to increase the client's awareness of this distortion (Frew, 1990).

Figure/Ground: This concept, which stems from Gestalt psychology, alludes to the human being in relation to the environment (Perls, Hefferline, & Goodman, 1951). A Gestalt therapist helps the client to increase awareness of "figure" as a unified personality at the point of contact between the external and internal world, while the "ground" becomes everything that is not the focus of attention at the experienced moment.

Self-Regulation: Pursuant to the existentialist focus on personal responsibility, Gestalt therapists believe that each person has the capacity to regulate his or her own actions. Contrary to Freudian-determined drives of aggression and sexuality, Gestalt therapists believe that human beings can self-regulate their own needs, as well as self-support and self-actualize. This process is enhanced when clients increase self-awareness at contact points and view themselves in a more unified way.

Here and Now: The Gestalt therapist's focus on the here and now represents the most radical departure from psychoanalytic theory. While a Gestalt therapist is primarily concerned with increasing a client's self-awareness at the current contact point between client and external environment, it is assumed that the past does affect the present experience of the client. The Gestalt therapist, however, does not dwell on past experiences and instead is more likely to use exercises to help clients understand past experiences in the context of the here and now. When the client is able to assume new roles or become aware of previously unarticulated feelings, the client learns how past experiences impacted the here and now and can begin to work through "unfinished business" from the past.

Gestalt Definition of "Personality"

Gestalt theorists define *personality* as "the relatively stable or predictable ways in which one person will behave differently from another, under the same external conditions" (Wheeler, 1992, p. 115). This theory of personality departs markedly from psychoanalytic theory, which postulates that all people progress through certain well-defined developmental stages. The diversity of individual personality is stressed. Also in contrast to the Freudians,

Gestalt therapists stress the unity, the total Gestalt of personality. Freudians emphasize the structural theory of personality, and psychodynamic therapy focuses on helping clients gain insight into different structural parts and making the ego dominate. While Perls in early Gestalt writings spoke of the ego, superego, and id, and in *Gestalt Therapy Verbatim* (Perls, 1969a) even added an "infraego," Gestalt therapists in general focus, not on the divisions of personality structure, but rather on the totality and integration of different parts of the personality.

Nature and Process of Change

Unlike most other psychotherapies, the focus of Gestalt theory is not to produce change in the client, but rather to produce increased awareness. Consistent with an existential approach, the Gestalt therapist accepts the client as a unified whole without judgment or criticism (Cole, 1994). The therapist does not seek to change the client according to the former's evaluation of the client's problems and/or pathology. Therapeutic change is defined as increased awareness of inner self and outer self as a unified whole. The client has the capacity to change, grow, and self-actualize, while the therapist serves only as a facilitator in this process.

Role of Significant Others

Gestalt therapists minimize the role of significant others in contributing to a client's move toward change and self-actualization. In fact, the Gestalt prayer, "I do my thing, and you do your thing. I am not in this world to live up to your expectations and you are not in this world to live up to mine," which Perls includes in the introduction to *Gestalt Therapy Verbatim* (Perls, 1969a), stresses the focus on the individual without regard for either support from or hindrance by others. Other Gestalt therapists, however, have recognized the importance of significant others, and Gestalt techniques have been used in marital counseling (Hale, 1978). With Gestalt marital therapy, each partner is encouraged to develop basic awareness of the other and of the effect of the partner on the self during each here-and-now moment.

Role of Resources

Similar to other psychological theories, Gestalt theory focuses primarily on the person of the client, rather than on environmental resources that may or may not be available to the client. Although Gestalt therapy may not concentrate on concrete resources in the client's environment or teach the client skills to access them, a Gestalt therapist does acknowledge the importance of the totality of a client's experience, which includes environmental resources as well as psychological resources.

Values Base of Theory

Time Orientation

The focus of Gestalt theory is most clearly on the present, the here and now, yet Gestalt therapists acknowledge that past experiences often influence the perception and behavior of clients in the present. Past relationships with significant others, especially parental figures, are often reenacted in the present to help clients develop greater understanding of how the perceptions and distortions of these relationships are affecting the here and now. Contrary to the Freudian deterministic belief that the past has inextricably influenced the present, Gestalt therapists believe that a client can revisit the past to reshape the present and future. Neither the future nor the past is the primary focus of Gestalt therapy.

Unlike many current therapy models, such as cognitive behavioral theories, Gestalt therapy is not goal-directed. The existential moment is the most important, the way the client experiences the world with increasing self-awareness. The future in terms of client or therapist goals is unknown and not considered as important as the current process of Gestalt therapy.

Basic Human Nature

Gestalt theory presents an optimistic view of human nature. Each person is viewed as capable of self-actualization and increasing self-awareness. Each has the ability to see himself or herself as a unified whole. People are viewed as neither bad, vulnerable, nor sick. Consequently, focus on social problems and/or psychological dysfunction is minimized.

Relationship

A key relationship within Gestalt theory is the therapeutic relationship between therapist and client. This relationship resembles Buber's I–Thou relationship in which power differentials do not exist. Other positive relationships within a person's here and now should follow a similar format. The nature of activity for Gestalt therapy is primarily emotional experience rather than behavioral change. The goal is to help the client understand his or her Gestalt rather than change behavior. Gestalt theory views people as existing in harmony with nature rather than in conflict or as dominant. By increasing self-awareness, a human being can become more aware of the impact of nature on the total Gestalt.

Social, Bi, and Ethnic Sensitivity

Perls nor other Gestalt theorists do not have a primary focus on cultural and ethnic differences. Most of the early Gestalt clients were from white, middle-class, American, or Western European backgrounds. Gestalt therapy is thought to foster an American individualistic perspective (Saner, 1989). Yet the focus on self-actualization, acceptance of diverse perspectives, and concentration on the whole person seems particularly relevant for work with ethnically and culturally diverse people. Recent articles have focused on systems of oppression and privilege (Billies, 2005), cultural issues (Fernbacher, 2005), a Gestalt approach in a Brazilian *favela* (Neville, 2008), and on Gestalt treatment with Asian clients (Cheung & Nguyen, 2012). Gestalt therapy has also been suggested as an effective form of treatment for those affected by violence in religiously divided Ireland (Keenan & Burrows, 2009) or Israel (Bargal & Peled, 1986).

Gestalt Therapy

Principal Therapeutic Goals

Although Gestalt therapists avoid specific goal-setting with individual clients, the following general goals are relevant to Gestalt therapy:

1. Increase the variety of behaviors used by clients: Often clients have a very limited repertoire of behaviors. Gestalt therapy encourages them to expand their use of different behaviors.
2. Encourage clients to take more responsibility for their lives: While clients may initially blame others for their life situations, Gestalt therapy helps clients accept their own roles in creating their current situation.
3. Maximize experiential learning: Gestalt therapy encourages clients not to rely only on cognition, but to integrate this type of thinking with their emotions.
4. Complete unfinished business from the past and integrate these experiences into their present: Gestalt clients with disturbing past experiences that detrimentally affect their current functioning are encouraged to bring these experiences into the here and now. By reliving and reworking through these experiences, clients become more receptive to new life experiences.
5. Increase opportunities for clients to feel and act stronger, more competent and self-supported, with conscious and responsible choices, thereby facilitating good contact (Korb, Gorrell, & VanDeRiet, 2002).

Principal Therapeutic Concepts

Gestalt therapy's goals are achieved through the nature of the therapeutic relationship and the variety of techniques employed by the Gestalt therapist. In Gestalt therapy, the focus is always on the client. It is assumed that clients have all the tools required to make any desired personal changes (Korb, Gorrell, & VanDeRiet, 2002). The therapist functions as a facilitator who aids in the client's discovery of what the client is doing and how the client is doing it, and explores the underlying processes that influence the behavior. The client is helped to accept responsibility for his or her behavior, not for the situation or other people's actions. The therapist enables the client to explore and take responsibility for his or her actions.

Nature of Therapeutic Relationship

The nature of the therapeutic relationship is crucial in Gestalt therapy. The most important quality for a Gestalt therapist is

authenticity—that is, to have achieved good self-awareness and to be open and honest with the client. The therapist must be able to enter into the client's world. Gestalt therapists must develop a close, personal relationship with clients, rather than have a distant and objective connection (Korb, Gorrell, & VanDeRiet, 2002). The Gestalt therapist minimizes the power differential that occurs between therapist and client. The establishment of an authoritarian relationship between therapist and client (in which the therapist knows what is best for the client) is avoided, as the Gestalt therapist respects the client's desire to change, as well as desire to remain the same (Cole, 1994). The client's reality is considered paramount, and the client is seen to possess the capacity to grow and change with minimal assistance from the therapist. The therapeutic relationship is likened to Buber's I–Thou dialogue, which implies complete acceptance and respect for the other.

Unlike psychoanalysts, the Gestalt therapist does not foster the development of a transference relationship. Yet Gestalt therapists acknowledge that clients come into therapy with expectations that the therapist will relate to them in ways similar to what they experienced in childhood. The I–Thou position of the therapist, however, "chips away at the client's expectation of trauma in the client relationship" (Cole, 1994, p. 84). The Gestalt therapist may present himself or herself as the "good parent," but only to facilitate the growth and change of the client. Transference in Gestalt therapy only functions as a means to an end, not as an final goal as in psychoanalytic treatment.

Perception of and Importance of History

Although the main focus of Gestalt therapy is on the here and now, it is a mistake to think of Gestalt therapy as ahistorical. A person's history is crucial, as all that is unfinished from the past manifests itself in the here and now (Huckabay, 1992). In contrast to the psychoanalytic model, which encourages clients to talk about past experiences, the Gestalt therapist uses exercises to help clients relive past events and relationships in the here and now.

Perception of and Importance of Assessment

A Gestalt therapist's assessment of a client differs significantly from a social worker's psychosocial assessment. Neither a discussion of the physical, psychological, intellectual, cognitive, and emotional characteristics of the client nor an analysis of familial, social, and environmental resources can be found in the Gestalt therapist's assessment of a client. In terms of diagnosis, Gestalt therapy does not focus on pathology. Diagnosis according to symptom descriptions in *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2015), defense mechanisms, and even client "problems" are not relevant to a Gestalt therapist's "assessment" of a client (Yontef, 1987). Statements such as, "This is a manic-depressive, single parent, or welfare recipient" are avoided. While psychoanalysts see the defense mechanism of resistance as a negative force to be eliminated, Gestalt therapists see the need "to enliven the resistances to awareness, so as to give them new flexibility and contact with the realities of the self and the social world" (Cole, 1994, p. 72).

While Gestalt therapy does not recognize assessment and diagnosis according to the psychoanalyst, psychiatric DSM-5, social work psychosocial model, problems that occur at the point of contact, dysfunctional boundary disturbances, introjections, projection, and retroflection can be identified in clients and become the focus of treatment. Even the word "disturbances" has been considered too judgmental for Gestalt therapists; it has been suggested that "processes" would be a better descriptive word (Swanson, 1988).

Specific Therapeutic Definitions

The four disturbances (processes) that occur between person and environment can be described as follows.

Confluence involves the denial of differences and an unrealistic focus on similarities. It is similar to the psychological phenomenon of accommodation and generalization. For example, if one places a hand on a wall, at first one is very aware of temperature and tactile differences, but these

differences blur within a short period. Similarly, in some marriages, differences between the partners are denied and a false sense of togetherness ensues. Gestalt therapy helps couples examine their ambivalent feelings about each other, as well as the "shoulds" and expectations of their relationships (Hale, 1978). Couples become more aware of individual needs apart from their confluent relationship.

A second contact disturbance, *introjection*, refers to the inappropriate intake of information from others, especially significant historical figures. Often parental messages become internalized, with the result that the client is plagued by commands of "I should," "I ought to," or "I have to." When introjection is a client's disturbance, the Gestalt therapist may encourage the client to assume a voice apart from the introjected parent and carry on a dialogue in the here and now. The purpose of this exercise is to help clients differentiate themselves from the parental introject. While psychoanalysts would assess introjection as an ego defense against anxiety, Gestalt therapists perceive introjection as a disturbance between person and environment that can be readily be remedied in the here and now.

A third contact disturbance, *projection*, describes the process of disavowing parts of oneself and projecting these parts onto others. Ego psychologists consider this phenomenon a defense mechanism in which unacceptable parts of one's own personality are rejected and attributed to another. This defense mechanism is considered a lower-level type of ego defense that is used most frequently by the severely mentally ill. Gestalt therapists, on the other hand, do not consider that clients who use this process are more mentally ill, but rather that these clients have lost a significant part of themselves. This behavior takes away power from them and gives the environment more control than warranted. Gestalt therapists would help clients reclaim lost parts of themselves. For example, a client who thought all men were angry at her might be helped to acknowledge her own feelings of anger toward significant men past and present.

A final disturbance of contact, *retroflection*, describes the process during which individuals do to themselves what they would like to do to someone else or to have someone else do to them. This behavior sometimes is a very healthy response, as when an angry mother very actively cleans the kitchen rather than abusing her child, or a woman rejected by a boyfriend buys herself a new suit (Polster & Polster, 1973). Retroflection can be overused, however, and a person may not be able to function in the current here and now because of powerful forces from the past. For example, clients rejected by their parents as children may not reach out to others as adults and may depend only on themselves for support. A Gestalt therapist would work with clients to help them understand that they no longer have to be the primary source of their support and that they can connect with others in their current environment.

The assessment of contact-point disturbances occurs at the very beginning of treatment. Assessment is not viewed as a prerequisite to treatment. The integration of assessment and treatment from the very beginning serves to bring the Gestalt therapist and client together immediately, thus avoiding the professional distance created by a more formal, diagnostic assessment process.

Specific Techniques and Strategies

Gestalt therapists often use a variety of strategies or techniques in working with clients. Respect for the personhood of the client and flexibility are main principles that govern the choice of specific techniques to use with clients. The choice of techniques depends on the health and readiness of the client. Therapy often creates the safe emergency in which the client learns that it is acceptable to be angry, elated, or unhappy (Stevens, 1975). Translating this safe emergency into action is often accomplished through the use of an experiment (Polster & Polster, 1973). A Gestalt experiment has been described as "an attempt to counter the absolutist deadlock by bringing the individual's action system right into the room" (Polster & Polster, 1973, p. 234). In general, experiments help clients understand themselves better through acting out problems and feelings, rather than only talking about them.

While an important role for the Gestalt therapist is facilitator, the therapist often assumes the role of director in introducing and carrying through the following experiments. Some of the

main classic experiments can be summarized as follows (Korb, Gorrell, & VanDeRiet, 1989).

Dialogue, the best-recognized of Gestalt therapy techniques, is commonly referred to as "the empty chair technique." Although this technique is often criticized as being overly dramatic, it should be remembered that it was originally designed to teach others about Gestalt therapy, as well as to facilitate growth in an individual client (Blugerman, 1986). When a client has conflict with another person, past or present, or with a part of his or her personality, the Gestalt therapist asks the client to imagine that this person or personality aspect is in the empty chair. By promoting this separation, the client is often able to achieve greater understanding of, and insight into, what is frequently an area of conflict. For example, a client who is very demanding and a perfectionist in his behavior may benefit from the experience of having his imagined father sit in the empty chair and having the opportunity of "talking" with his father about the latter's multiple demands for perfection.

Enactment of dreams often permits clients to become aware of issues and conflicts they are unaware of. In contrast to psychoanalytic theorists, who encourage clients to discuss their dreams to provide greater understanding of the unconscious, Gestalt therapists see dreams as "existential messages" about the current situations in the client's life (Latner, 1992, p. 51). While psychoanalysts stress interpretation of dreams as most important, Gestalt therapists encourage clients to act out their dreams as an expression of their current Gestalt.

Exaggeration occurs when the Gestalt therapist asks the client to exaggerate some motion or speech pattern. This exercise may help the client get in touch with feelings about which there was no previous awareness. For example, a Gestalt therapist noted that a client frowned when she discussed an impending visit by her in-laws. After the client was encouraged to exaggerate her frown, she became more aware of her negative feelings about her in-laws' visit.

Reversal involves suggesting that a client reverse a statement that has been made. Polarities are common in human experience, and encouraging clients to state the opposite often leads to greater awareness and acceptance of integrated feelings toward significant others. For example, a mother who was having a difficult time separating from her ten-year-old son stated that she did not want her child to go to summer camp as he was too young to take care of himself away from home. When the client was asked to reverse the statement, she became more in touch with part of herself that really wanted to encourage her child to be more independent.

Rehearsal serves to prepare the client before seeking any change. Clients often lack a self-support system and fear there will be dire consequences if they try a new experience. Practicing words beforehand often gives the client confidence to approach a new situation. For example, the client who is fearful of asking the boss for a raise may benefit from the opportunity to rehearse this experience with the therapist. Many cognitive behavioral therapies also make use of this rehearsal technique.

Making the rounds is a Gestalt group work technique that provides an opportunity for the client to rehearse and receive feedback from other group members. By introducing the environment of other members, the client is helped to become clearer about his or her own experience. For example, a group member struggling with his plans to separate from his wife was asked to rehearse this discussion within the group and hear group members' reactions.

Exposing the obvious is a technique in which Gestalt therapists are encouraged to follow up on a client's initial statements and movements, which are often indicative of deeper processes. This technique is familiar to social workers, who learn it to follow up on both verbal and nonverbal communication. An example of this occurred in Gestalt therapy when the therapist noted to the client that he had been yawning repeatedly since he came into the session.

Directed awareness experiments help clients establish contact with different inner and outer experiences. Gestalt therapists use these techniques to help clients gain a clearer picture of sensory as well as internal body sensations.

In *Creative Process in Psychotherapy*, Zinker (1977) outlined the following steps in a Gestalt therapy session:

1. Laying the groundwork
2. Negotiating a consensus between client and therapist

3. Grading (assessing that an experiment is challenging, not frustrating)
4. "Surfacing" the client's awareness
5. Locating the client's energy
6. Generating self-support for both client and therapist
7. Generating a theme
8. Choosing an experiment by mutual process
9. Enacting the experiment
10. Insight and completion

Reorientation is necessary after the use of a Gestalt experiment (Heikkinen, 1989).

Length of Treatment

Gestalt therapy, like other therapies, delineates the following four stages: (1) establishing a relationship, (2) exploring a problem in depth, (3) determining steps for the client to take, and (4) providing support and encouragement for growth (Egan, 1986). Gestalt therapists believe that, for some clients, all four stages may occur in the first session, whereas with other clients the process may span several years. The average client often falls somewhere in between (Korb, Gorrell, & VanDeRiet, 2002). Flexibility in duration of treatment is consistent with Gestalt theory, which supports a client-centered focus on treatment. The client, not the therapist, makes decisions about the length of treatment. Allowing the client to make decisions about the length of treatment seems to contradict both the traditional psychoanalytic model, which favors long-term treatment, and the current managed-care model of brief treatment. In general, however, Gestalt therapy is not usually considered a long-term model.

Because the focus is on flexibility and the acceptance of each client, Gestalt therapy is often short-term. This factor increases the usefulness of Gestalt therapy for those who practice in a managed-care environment.

Importance of Specific Methods

Work with Individuals and Groups

The founder of Gestalt therapy, Fritz Perls, was primarily an individual therapist. Even when he led groups, he worked primarily with one individual at a time, with little interaction from other group members (Nevis, 1992). Groups were seen to provide an excellent opportunity to demonstrate Gestalt theory and practice to others. An early Perls group would consist of placing one individual in the "hot seat" and exploring a particular topic, with the other group members as spectators. Other members might be asked to contribute in a structured way about the client in the hot seat. A client usually stayed in the hot seat about 10 to 30 minutes, and in a two- to three-hour session, two to four participants would take the hot seat (Korb, Gorrell, & VanDeRiet, 2002).

Currently the most frequently used Gestalt group therapy model is the Gestalt group process model (Huckabay, 1992; Zinker, 1977). With this model, the therapist continues as the director of experimentation but is more receptive to interventions from other group members (Korb, Gorrell, & VanDeRiet, 2002). Group interaction and the development of cohesiveness are encouraged. With this model, one group member may express awareness of a particular theme, which is shared by other group members. The group leader may lead the group in an activity related to this issue.

Although Gestalt therapy began as an individual model and is still used as an individual model, four features of Gestalt therapy are particularly suitable to working with groups: self-regulation, contact and the contact boundary, awareness, and an emphasis on the here and now (Frew, 1988). Groups, like individuals, demonstrate their own tendency to self-regulate and seek wholeness. The possibilities of contact between different group members, different subgroups, and the group leader are manifold in a group process. Awareness or focused attention is even more important in group work than in individual work. Finally, a focus on the here and now is paramount in group work. With this focus, Gestalt group therapy is short-term, which is particularly advantageous in the current managed-care mental health environment.

Work with Dyads

In addition to individual and group work, Gestalt therapy has also been applied to working with couples. Treatment of couples, however, may be difficult for the Gestalt therapist who has been trained to focus on the individual

and his or her boundary in relation to the external world (Zinker, 1992). The Gestalt therapist must focus on the couple as a system, a Gestalt, and the boundary of the couple as they relate to the outside world. Couples' therapy consists of prescribing certain exercises for the couple to increase their awareness and interaction with each other (Hale, 1978; Zinker, 1992).

Work with Families

While not initially developed as a family therapy model, Gestalt theory has been used in family therapy. Kempler, a Gestalt family therapist, applied Gestalt theory and techniques in his work with troubled families (Kempler, 1974). Other family therapists, including Satir, adopted an experiential, existentialist approach in working with families and developed Gestalt-like family therapy techniques such as family posturing and family sculpture (Satir, 1983).

Work with Community

Gestalt therapy as it was originally developed was intended primarily for micro-practice with individuals and other small systems, including couples, groups, and families. Although not directing change efforts toward the community, Smith, a contemporary Gestalt therapist, writes, "My power to influence social change resides in my person and the effect of my person on others through intimate contacting" (Smith, 1992a, p. 294). Others have seen Gestalt therapy as being more socially and community-focused, in contrast to American individualism (Brown, Lichtenberg, Lukensmeyer, & Miller, 1993). Gestalt therapy has been used to study macro-organizational patterns (Critchley & Casey, 1989) and has also been used in therapeutic milieu settings such as psychiatric hospitals, group homes, day treatment centers, and sheltered workshops. More recently, Maurer (2005) and Neville (20080 have applied Gestalt treatment to macro-practice.

Principal Applications

Social Work Practice

Gestalt therapy was first developed for use with depressed, phobic, and obsessive clients with adjustment to neurotic disorders. Most clients are and have been from a white, middle-class background. Yet the existential focus of Gestalt therapy, which stresses the uniqueness and value of each client's experience, seems particularly well suited to the diverse economic, social, cultural, and racial clients with whom social workers work.

Gestalt therapy has been used primarily with young and middle-aged adults, but it has also been applied successfully in work with children (Oaklander, 1992) and older persons (Crouse, 1990; O'Leary & Barry, 2006). Other clients who have benefitted from Gestalt therapy include battered women (Little, 1990), abused children (Sluckin, Weller, & Highton, 1989), amputees (Grossman, 1990), people with AIDS (Klepner, 1992; Siemens, 1993), clients with family members who have committed suicide (Bengesser & Sokoloff, 1989), and those with substance abuse problems (Brownell 2012; Clemmens, 2005).

Risks of Gestalt Therapy

A prevailing belief has been that Gestalt therapy is inappropriate for clients with severe personality disorders or psychoses (Shepard, 1970). Clients who have difficulty differentiating reality from fantasy may become more disoriented during guided fantasies, a frequent experiment used in Gestalt therapy. It has been suggested that Gestalt therapy can be modified for work with people who have been diagnosed as having borderline personalities (Greenberg, 1989), groups of people diagnosed as chronic schizophrenic (Potocky, 1993), and individuals hospitalized for psychoses (Harris, 1992). There is greater risk, however, in using Gestalt therapy with people who have a tenuous grasp of reality and sense of self, as they may not be able to return easily from fantasy to the real world.

Limitations of Gestalt Therapy

While Gestalt therapy presents risks for many clients with severe psychotic disorders, this model of therapy also may not be appropriate for poor clients for whom environmental advocacy and securing of resources is needed. Most successful with middle-class or working-class clients with neurotic or adjustment disorders,

Gestalt therapy seem to differ from case management, a current treatment model for work with the chronic mentally ill and others who require therapist activity in securing and coordinating community resources.

Administration and Training

Training for Gestalt Therapists

Gestalt therapy is often briefly covered in graduate social work or psychology programs, and most Gestalt therapists receive their training in postgraduate training centers located in many large cities. There are three major Gestalt therapy associations: the Association for the Advancement of Gestalt Therapy (AAGT), which is based in the United States; the European Association for Gestalt Therapy (EAGT), founded in 1985; and Gestalt Australia and New Zealand (GANZ).

There are no universal guidelines for the extent of training, but most educators in the Gestalt therapy field believe that the three main areas to be covered in Gestalt training are (1) theoretical grounding, (2) intense personal Gestalt work, and (3) extended supervision (Korb, Gorrell, & VanDeRiet, 2002). Educators believe that beginning students must study extensively the theoretical orientation of Gestalt therapy in order to have an understanding of this method that is more than a collection of techniques. Because of the importance of the therapeutic relationship in Gestalt work, the therapist must have a good understanding of herself or himself as explored through his or her own Gestalt therapy. Finally, ongoing supervision is considered essential for students studying the Gestalt method.

Importance and Function of Recording

Recording for Gestalt therapists focuses on the verbal and nonverbal process of the interview, similar to the process recordings of social work students. Diagnosis, history taking, and psychosocial assessment are usually absent from Gestalt recordings because these areas are not part of Gestalt therapist work with clients. Instead, Gestalt literature on practice with clients often focuses on the initial awareness contact phase with clients. What is stressed is the process that occurs between therapist and client.

Role of Setting

Although the agency context is certainly part of a client's total Gestalt, Gestalt therapists minimize the role of the agency setting. Most Gestalt therapy occurs within Gestalt training institutes or in private practice, although many professionals may use some Gestalt techniques with their clients in a variety of mental health settings.

Case Example 15.1: Individual Gestalt Therapy

Susan, a 25-year-old married woman, had been referred for therapy because of recurring symptoms of depression characterized by feelings of low self-esteem and crying spells. The therapist introduced herself as "Nicole Smith." Immediately the therapist noted that Susan seemed to sink into the chair and did not make any comments until asked. In this first session, the therapist asked Susan to describe how she was feeling, to which Susan responded "terrible," but she did not understand why she felt this way as her husband was very supportive, and she had a good job and a nice home. The therapist was careful to stay with the original feeling Susan had expressed and asked her to describe in more detail the experience of feeling terrible. After some encouragement, the client indicated that she felt like a piece of garbage. The therapist asked the client to explore what being a piece of garbage felt like. The client described herself as feeling dirty, unclean, and rejected. She remembered that once as an adolescent she had cooked dinner and her mother had said the food tasted like garbage, and that her room had been compared to a garbage dump. It became apparent that Susan was very angry at her mother for such criticism, but had turned this anger inward.

As a Gestalt therapist, Nicole saw that her client was suffering from *retroflection*, a process by which a client turns back on himself or herself what he or she would like to do to another, and Nicole decided to use the Gestalt exercise of the empty chair to help Nicole get in touch with and verbalize some of her previously unexpressed angry feelings toward her mother.

(With Gestalt therapy, the past is not ignored, but brought into the present.) Susan was able to express angry feelings toward her mother (sitting in the empty chair) and after the exercise reported that she felt better than she had in a long time.

Case Example 15.2: Group Gestalt Therapy

The second case example focuses on Gestalt work with a group whose members had recently been diagnosed as HIV-positive. This group followed a Gestalt group process model, rather than the original Perls individual-in-group model. This group consisted of six homosexual men ranging in age from 20 to 35 who had learned of their HIV status within the past month. Group members were each asked to introduce themselves and tell what they expected to get out of the group. Most group members were in a state of denial about their illness. Several made no reference to having HIV; one said he was sure he was misdiagnosed; another indicated that once he took medication he would no longer have the diagnosis. The Gestalt group leader was supportive of where each member was. When one member mentioned how hopeless and helpless he felt, the group leader again was able to support this member's awareness. The focus was on the here-and-now feelings of group members, not historical events.

In the beginning, the group leader related to each member individually, but was very encouraging when another group member reported that he, too, had felt powerless when he learned of his diagnosis. He reported that he had last felt this powerless when his mother died when he was 16. At this point the client started to cry; the other members were very supportive, as was the group leader.

The group leader tried to facilitate this interaction by asking if others had experienced losses. Reliving this loss in the here and now was an important experience because it allowed the client to work through issues of loss that had never been completely resolved. This interaction also served to promote group cohesiveness, as many group members reached out to this client, while before they had all been quite isolated. Also, this sadness over a past loss led to a discussion about current losses, health and impending disability, and fears of future losses (that is, death). Finally, this incident demonstrated a Gestalt therapist's concern about the whole person—that each person in the group was not only just a person who was HIV-positive but also had a history and current Gestalt, of which HIV was only one part.

After each member had the opportunity to express himself and some initial group cohesiveness was developed, the group leader introduced a Gestalt experiment. Group members were asked to imagine that they had a treasure box in which they could store all that was most precious to them. One member spoke very concretely, saying that he would use this box to store T-cells for a time he might need them in fighting his illness. Another expressed concern about his younger brother and visualized that he would store him in this box to prevent him from being harmed. Another would store in his box all his successes in life, such as when he was selected to give the graduation address in college and when he was named director of his division at work. A group member saved sunsets and the first day of spring. This exercise served to create connection between the men and helped them begin to confront the present reality of their illness.

Empirical Base

Extent of Research Base

Because Gestalt theory focuses on the experiential rather than the empirical nature of treatment, single-subject case studies greatly outnumber large research studies on Gestalt therapy. Some of the many reports of clients who benefitted from Gestalt therapy can be found in Harman (1989), Smith (1992a, 1992b), and Nevis (1992). There has been clinical research on Gestalt methods (Clarke & Greenberg, 1988). "Good moments in psychotherapy," including extra-therapy behavior change, acceptance of a problem, and increased general well-being, have been linked with specific Gestalt treatment methods (Mahrer, White, Howard, & Gagnon, 1992). Research on Gestalt therapy has demonstrated its effectiveness in resolving decisional conflict (Greenberg & Webster, 1982), in groups (Anderson, 1978; O'Leary & Page, 1990), and in teaching (Napoli & Walk, 1989).

Gaps in Research

In general, empirical research on Gestalt therapy has been limited, and there is a need for more research to substantiate its effectiveness

as a treatment method. There are difficulties, however, in conducting empirical research on an experiential, highly individualistic form of treatment, and most Gestalt therapists minimize the need for research of this type.

Present Status and Influence on Current Practice

While in the political and social climate of the Sixties Gestalt therapy focused more on a individualistic model of self-actualization, more recently there has been a focus on relational Gestalt therapy promoted by Fritz Perls's wife, Laura Perls (Senreich, 2014). Many Gestalt therapy institutions exist around the country, and the *International Gestalt Journal* continues to publish articles of current interest to Gestalt therapists. While Gestalt therapy has frequently been accused of relying too extensively on techniques, current Gestalt therapists have argued that Gestalt therapy is more philosophical than technical (Perls, 1992), and that creativity, not technical skill, is essential for Gestalt therapists (Zinker, 1991). Also, Gestalt therapy groups have changed over the years from the therapist's focus on individual clients in the group to the current emphasis on increasing clients' interactions with each other (Frew, 1988; Frew, 1992; Harman, 1989).

Contributions to the Social Work Profession

Many aspects of Gestalt therapy are particularly pertinent for the social work profession. First, the Gestalt focus on the point of contact between person and environment suggests social work's attention to person-in-situation. Also, the Gestalt figure/ground concept relates to the profession's use of the systems approach. While Gestalt stresses the I–Thou relationship, social work speaks to the importance of developing an empathic helping relationship with the client. Both Gestalt therapist and social work professionals see much importance in increasing self-awareness and use of self.

Gestalt therapists, as well as social workers, focus on clients' strengths. Also, Gestalt therapists and social workers agree on self-actualization as a primary treatment goal. Finally, the Gestalt therapy's concern with the total Gestalt resembles the social work focus on the total person, including physical, cognitive, behavioral, emotional, verbal, and nonverbal dimensions.

Implications for Practice

Current social work practice includes clients from very different social, economic, and cultural backgrounds. Gestalt therapy, which begins with the acceptance of the client and his or her Gestalt, would seem very useful for social workers in working with very diverse clients. Now more than ever, social workers work with clients from diverse cultural and socioeconomic backgrounds. A psychotherapeutic theory that speaks to the importance of accepting and valuing each person as he or she is seems particularly relevant to social workers.

Gestalt therapy, however, may not be an effective treatment modality for all social workers in all settings. Social workers who treat clients with severe psychiatric or socioeconomic problems may not be able to use this model. Also, the I–Thou relationship of Gestalt therapist and client may be difficult for social workers who define their primary role as that of professional experts. Furthermore, the Gestalt therapist's lack of emphasis on history taking, diagnosis, psychosocial assessment, and goal setting may not be acceptable to social workers and their agencies who have been schooled in a more psycho-dynamic or psychosocial approach.

Connection to Other Models

In terms of treatment modalities, Gestalt therapy, which stresses the here and now, resembles current treatment modalities of brief treatment, problem solving, and crisis intervention, which are often used by social workers. Also, since most Gestalt therapy is brief, this treatment modality works within a short-term, financially mindful treatment environment that introduces many time constraints into treatment.

Future of Gestalt Theory for the Profession

Currently, many social workers are enrolled in Gestalt training institutes. Social workers often

learn little about this treatment modality during graduate education, and those who wish to develop their expertise in this area usually attend a Gestalt therapy institute for postgraduate training. For social workers interested in this model, Gestalt therapy will continue to be a significant practice method for use in social work treatment.

Gestalt therapy's focus on and acceptance of the individual person-in-environment points to its current, as well as future, value in social work treatment. The clients we serve are becoming increasingly diverse. The applicability of this model in working with clients from different cultural and socioeconomic backgrounds suggests that social workers can make greater use of Gestalt theory and therapy in their understanding and treatment of clients.

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16

Hope Theory and Social Work Treatment

Alexander T. Polgar

Hope is so much a part of our daily vernacular that we hardly take notice of it or concern ourselves with what, exactly, this concept means. Even when we become mindful of hope as a critical aspect of life, we lapse into using the concept imprecisely. Often we assume a shared understanding of the word and most often use it to state the blatantly obvious, saying, for instance, at our child's wedding, *I hope they will be happy*. Almost the same can be said of the extent to which counselling professionals attend to how clients experience hope and how hope is used in the therapeutic process. For the most part, counselling professionals interpret a client's presence as indicative of hope that their lives can be improved upon by the assistance they are about to receive.

While many have thought about and studied hope, it remains a rather obscure area of knowledge and skill among professionals in all human service disciplines. Moreover, there is no discernible evidence of hope being a core topic of study in any undergraduate or graduate curriculum, including in schools of social work. When it comes to hope, it is safe to say most of us simply do not know what we do not know. Most assuredly, however, there is much more to hope than meets the proverbial eye of the beholder.

This chapter will explore the long history of hope being thought about and studied across a broad range of disciplines. Based on a synthesis of the broad range of views about hope, the premise will be argued that hope is an innate propensity that develops over time as a function of interaction between the individual and the environment. Because hope is argued to be a cognitive developmental phenomenon experienced differently at various stages of life, the

occurrence of which is environmentally determined, it is of particular relevance to the biopsychosocial perspective of social work. The challenge for the profession, therefore, is to transform the common use of hope into a mindful, deliberate focus that is persistently applied. When the use of hope becomes fully informed, the argument is that outcomes of interventions with individuals, couples, families, groups, and communities will proportionally improve.

Historical Background

The experience of *hope*, a positive expectation for the future, has been a central theme of human thought since the beginning of recorded history. Periodically, hope has been formalized into systems of belief for the explicit purpose of shaping or prescribing behaviors, with the promise of a better future for all. Most notable of the formalized systems are the messages of the prophets. Without exception, each prophet conveyed a positive expectation of the future dependent on and determined by prescribed behaviors. Arriving at the Promised Land, achieving nirvana, or gaining access to the kingdom of God are all messages of hope for a better future. Notwithstanding subsequent secular distortions of the prophets' original messages as to how the better life could be achieved, the message of many religions is one of hope. It is noteworthy that there are theologians of hope (Moltmann, 1967; Marcel, 1962) and that more has been written about hope in a religious context than in any other field of thought.

The other major formalizations of hope into systems of belief and prescribed behaviors are political ideologies. The message of all political ideologies, also without exception, is hope for a better future once its proponents are elected and mandated by the majority of voters to implement their policies and practices. In response to messages of hope, the primary reason for casting a vote is one of hope. Ernst Block (1954, 1955, 1959), a Marxist philosopher, for example, considered communism to be the only ideology with a full and consistent positive view of humanity's future. Of course there were and continue to be contrary political views on the means by which to achieve a better future.

In parallel to religious and political ideologies, all of philosophical thought has been grounded in hope, an expectation of a better future derived literally from *figuring things out*. The education of youth for the purpose of creating a better future through a better informed, more capable and knowledgeable populace also was first a philosophical notion. Most notably, Socrates, some 2,500 years ago, engaged young men in a process designed to develop their reasoning abilities. For his troubles, he was accused of corrupting their minds, was found guilty, and given the option of exile or suicide by drinking hemlock. He chose the hemlock. In spite of this inauspicious beginning to formal education, it could not be curtailed, and it eventually evolved into what many believe to be humanity's greatest purveyor of hope. As various academic disciplines emerged, hope for a better future was and continues to be the primary goal of their focus.

The Place of Hope in Key Theories About the Human Condition

Imagination is a wonderful human attribute and it is alive and well, especially in academia. Not surprisingly, academic theoreticians and researchers have explored and continue to explore the various manifestations of how we think about the future. *Expectation theory* is an area of study concerning how people behave when they formulate a belief about the future based on any number of factors. Robert Rosenthal and Jacobson (1966) of Harvard University conducted a study of how teachers behave when provided specific information about their students. They demonstrated that teachers behave significantly differently and produce predictable results, depending on what they are told by credible people. In this seminal experiment, equally capable students were randomly assigned to two groups in one classroom with the same teacher. One group was described to the teacher as gifted, and the other as not. As predicted by *exception theory*, the group described as "gifted" objectively performed significantly better at the end of the academic year than the group described as "not gifted." Needless to say, no academic ethical review board would allow such an experimental design

today. While subsequent researchers have been challenged to devise better and fairer ways of studying this powerful phenomenon, expectation theory closely linked to hope continuously demonstrates that where you end up is significantly determined by where you start.

Hope also is an integral component of *oppression theory*, which emerged out of several different ways of seeking to understand the dynamics of power, discrimination and prejudice, and systemic ways in which the status quo is maintained. Marsiglia and Kuklis (2009) capture the core definition of "oppression." For oppression to occur, two basic elements are required: *a group that is being oppressed and an oppressor who benefits from such oppression*. Given the key element of one benefiting from oppressing the other, it is no wonder that incidents of such relational dynamics are global and exponentially growing as evidenced by wealth becoming concentrated in the control of an increasingly smaller group of people.

In the context of this discussion, oppression is the creation of what is referred to in the literature as *hopelessness*. In this subtly insidious process, often those being oppressed are not aware of it. When oppression is pervasive and optimal, the status quo prevails because focus on survival predominates and overshadows any hope for a better future. Without hope, it is uniformly reported, planning and working for a better future become very rare. The victims of oppression, those without hope as described in the literature, are negatively affected in ways that range from the tyranny of materialism, to which all cultures are being socialized, to systemic discrimination against groups of people because of some discernible difference.

Oppression is closely associated with the absence of *social justice*. What constitutes social justice has been explored since Plato's *Republic*, written some 2,500 years ago, and more recently conceptualized by John Rawls (1971) as that which is chosen behind a veil of ignorance. Both views constitute hope for a better future. Social justice, in particular, is a belief that all people should have the same rights, equal access to the resources of society, and receive fair treatment regardless of their circumstances (Heinonen & Spearman, 2001). Social work embraced this idea at the beginning of the 20th century in relation to advancing the settlement house movement, intended to improve the conditions of poor immigrants. Advocating and seeking measures for social justice, while an enlightened idea, did not, however, enjoy continuous support nor prominence over time. It was and continues to be a revolutionary idea that threatens the status quo, which even the oppressed inadvertently protect. Moreover, since social work practitioners were and continue to be largely institutionally based, without being fully aware, have strayed into advocating social policies and practices that support at least some discriminatory, unfair practices (Reisch & Andrews, 2001). In response to blatant and progressively unjust practices, the focus on social justice reemerged in the early 1960s and is currently most prominent in anti-oppression movements and many schools of social work.

In summary, it would not be unreasonable to conclude that the notion of hope, always in the context of creating a better future, is an integral component of key theoretical frameworks dealing with the human condition. Even the dismal view of human nature, that people are nothing more than flesh and blood machines as described by Thomas Hobbs (1909), is hopeful, if no other reason than once it is understood and accepted for what it is, coping with life becomes easier.

Hope and Social Science

It would be safe to say that the first social scientists were educators. The science and art of teaching, shaping the minds of young and old, have evolved through trial and error as well as excellent research to test methods of instruction. There is a considerable body of research on how best to build on the hope with which a child enters the educational system.

There is also considerable research on how best to instill hope in the *unfortunate* ones who as children already are without hope (Freire, 1994; Webb, 2010). It is noteworthy that in this literature, hope is conceptualized in a rather curious way. There is a focus on how to build on hope, which implies some semblance of it exists, and there is a focus on instilling hope where there is none. The implication that hope can be enhanced is an important one.

While hope has been a focus of considerable attention in philosophy, religion, politics, and education, it had not been extensively studied in the social sciences until the middle of the last century. Sigmund Freud (1905–1968) the best-known proponent of psychoanalytic theory, considered the benefits of the approach to be creation of *expectations, colored by hope and faith*. Not much later, Karl Menninger (1959) urged all mental health practitioners to study hope, which he characterized as a *basic but elusive ingredient in our daily work*.

As if in response to Menninger's urging, psychologists began to study hope, at first as an essential motivation to implement a plan with which to achieve a predetermined outcome. In short order, other disciplines began to study hope from their respective perspectives. As could be expected, there is not yet a consensus about what hope is and how it is experienced by different people at different times. For example, Beavers and Kaslow (1981) are of the view that hope constitutes an emotional state, whereas Drahos (2004) takes the position that hope represents a psychological process. Capps (1995) posits that hope is a matter of perception or intuition. Others have defined hope as positive expectations that include both cognitive and emotional factors (Miceli & Castlefrachi, 2010). In spite of their differences, all agree that hope is related to optimism about what is possible.

Recognizing the importance of hope, social scientists interested in facilitating the occurrence of positive outcomes have mostly concerned themselves with hope-enhancing strategies. Snyder (2002) a psychologist, like hope theorists in general, believes that a positive expectation for the future is learned in a variety of ways, including through a therapeutic process. From his perspective, loss of hope, despair, and hopelessness, therefore, also are learned through various life experiences. Later life events such as personal losses, divorce, and death (Steinbock, 2004) are sited as antithetical to a positive expectation of the future. Not surprisingly therefore, high-hoping individuals are reported to cope better with life's vagaries than low-hoping ones; this justifying the interest in and testing of hope-enhancing strategies.

In search of objectivity, social scientists and researchers like Snyder (1995, 2000) have developed self-report standardized questionnaires to measure the intensity of people's hope (Obayuwana et al., 1982). Such tools can be extremely useful for research purposes, as long as their internal validity correlates with how investigators chose to define the hope that they are studying. It is noteworthy that much inconsistency exists, even about fundamental issues such as whether hopelessness means the absence of hope, or hope is present but at a very low degree of intensity. Nevertheless, such tools have been used to study how hope can be enhanced in the terminally ill (Dufault & Mortocchio, 1985) and those suffering from the death of a loved one (Cutcliffe, 2004). While less is written and studied about hope in social work, what does exist concerns mostly settlement work (Yohani, 2008; Yohani & Larson, 2009).

Given the volume of literature and research in this area, Weis and Speridakos (2011) conducted a meta-analysis of hope-enhancement strategies in clinical and community settings. They found no overall effect with respect to the hope-enhancing strategies alleviating the psychological/emotional distress of individuals. Nevertheless, at the very least, the reported studies serve to underscore just how powerful and important expectations or hope for a better future are when it comes to shaping the behaviors in which human beings engage.

A Cognitive Developmental Perspective

A synthesis of what has been written and discovered about hope supports a conclusion that it is not a zero-sum phenomenon. Hopelessness does not exist. The data support a conclusion that there is always hope; it is innate and undergoes a developmental process that is environmentally determined. As such, hope is not learned in the traditional way of reinforcement-supported acquisition of a behavior or thought pattern. Hope develops over time and is experienced differently until it reaches its full potential. Hope, like other developmental potentials, can be and often is obstructed from its evolution by adverse environmental conditions.

The premise of this treatise also is that the notion of the conservation of neurons as it concerns some areas of human innate propensities

is inappropriately applied to hope: in other words, the "use it or lose it" notion that if a propensity is not activated by a critical time, such as the ability to speak several languages flawlessly or to behave cooperatively, it is lost forever (Chugani, 1998; Huttenlocher & Dabholkar, 1997; Katz & Shatz, 1996).

This hypothesis about hope being an innate developmental cognitive process, always with an emotional overlay, parallels other processes that evolve over time. Lawrence Kohlberg (1969), a Harvard psychologist, after experiencing the inhumane treatment of one group by another, full of hope, sought to understand how people justify their behavior. Building on the work of Jean Piaget (1948), J. Dewey (1930), and G. H. Mead (1934), Kohlberg described a cognitive moral developmental sequence about how people reason out what is the fair or right thing to do when faced with a situation of competing claims. In addition to describing stages of development that occur in an invariant hierarchical sequence and that the underlying structure of a stage is universal, developmentalists like Kohlberg and Piaget also reveal the unique essence of being human. The essence of being human, which also applies to hope, is an innate lifelong propensity for growth and development unless it is obstructed by adverse environmental factors.

When environmental conditions are conducive to fostering the human developmental potential, there is harmony with being human. When the innate propensity for hope is fostered, most likely other developmental potentials also are activated. When the newborn cries out in discomfort and in response is comforted, the innate propensity for hope is activated. When the toddler in distress raises both arms in need of comforting and in response is affectionately hugged, hope also is activated. In brief, every time a child's expectation of a primary need is met, hope is activated to progress along a hierarchical sequence.

Insofar as development cannot occur in a vacuum, the quality of the environment is a critical factor in the human condition. The environment not only determines the rate and extent to which development occurs, the environment also determines, in this discussion, whether innate hope flourishes or becomes stagnated at its earliest stage of being experienced.

The Biopsychosocial Perspective

The *biopsychosocial* perspective, that which defines social work perspective in particular, is that individuals are born with an array of innate developmental potentials, which are environmentally activated. The sum total of the activated, or not, potentials then combine to define an individual's personality. If indeed hope is a developmental process experienced differently at each stage, it is not learned or instilled by life experiences as Beavers and Kaslow (1981) contend. If hope is learned, an infinite number of ways of experiencing it would be required for the complexities of life.

Instead, the premise of this chapter is that hope evolves in stages with an underlying structure that is relevant across a myriad of situations. In other words, hope about life in general is experienced in stage-specific ways, and the evolution of how hope is experienced is environmentally determined.

The importance of one's environment is nothing new to social work. It emerged out of the 19th century charity organizations; Mary Richmond (1917) was the first to define the benefits of a combined focus on people and their environment. This person-in-situation focus continued to evolve and now more than ever underscores the critical importance of one's environment on how an individual functions and to what extent individual potential is actualized.

While learning in its various forms shapes behavior, emotional reactions, values, and beliefs, developmental preconditions are required before certain types of learning can occur. In order to achieve the prerequisite developmental gains, environmental conditions must be conducive to them. The absence of such conditions obstructs development and is a factor in explaining an individual's dysfunctionality. For example, the same conditions that create failed attachment also obstruct the development of various innate propensities, including hope. Later life events such as divorce, the loss of a loved one, or how one is treated in one's physical and mental decline also have a deleterious effect on how hope is experienced. The danger of negative life events often is that they precipitate regression to earlier stages of reasoning and feeling about the present and future.

Social Work's Challenge

So far, social work, like other areas in the social sciences, has restricted its conceptualization of hope to either having it or not. Efforts to enhance hope not surprisingly have failed to produce stellar results, although it is unclear whether the efforts were to instill it as opposed to enhance it. There is a difference. On close examination, it would not be unreasonable to conclude that it would be more accurate to interpret the reported therapeutic strategies as efforts to instill hope where there was none. In fact, however, the premise being advanced here is that there is always hope, but it is either stagnated at a very early-in-life way of experiencing it, or there has been a regression because of adverse environmental conditions. Regardless, the prevailing variable is the environment.

Seldom acknowledged, in spite of its crucial importance, is that there are not only micro- but also macro-environmental factors that impact the lives of those served by social work. Specifically, there are deliberate and inadvertent macro- and micro-environmental forces in play that maintain the status quo (Polgar, 2009), including conditions that negatively influence hope. The insidious and pervasive nature of these forces parallels or even exceeds the oppression that social work is committed to eradicating.

From this perspective, social injustice is not only perpetrated on vulnerable individuals or groups; the forces of status quo maintenance impact virtually everyone. Addressing this interplay between individuals and their environment has been and always will be the lot of social work. As we build knowledge, the challenge for the profession is increasingly more complex, especially when we have to also look within.

Since most social work practice is institutionally based, the very organization that is the employer and the provider of services also could be an inadvertent protector of the status quo. Recognizing environmental barriers when immersed in them can be a difficult task, especially when there is a vested interest, such as continued employment, involved. Social work, therefore, has the demanding task of carefully addressing systemic institutionalized barriers to sustainable change as well as individual specific environmental factors that compromise how hope is experienced by clients or the group to which they belong. Sometimes, both can be addressed simultaneously in the context of building a therapeutic relationship. Before exploring the hope component in social work intervention, further reflection about hope being environmentally determined is required.

Most, if not all, who avail themselves of social work services live under siege conditions. By definition they are constantly under attack and as such are too busy trying to survive to engage in reflective activities, the necessary ingredient for development to occur. Under siege, people's experience of hope is quite basic. At best, hope is experienced as an expectation that there is a tomorrow but never a better one. All too often, this limited and narrow way of experiencing hope is intergenerational. These are the clients who do not follow through with the best planned actions with which to achieve a desired outcome. Why would they, if how they experience hope precludes a better tomorrow?

The unique biopsychosocial perspective about which social workers are educated and into which they are socialized is ideally suited to addressing the environmental and individual factors that obstruct innate development and rob individuals of a quality of life for which they have the potential. To fully implement the social work perspective, however, requires a lifelong commitment to learning and a functional dissatisfaction with the status quo. In the context of this discussion, the status quo includes how hope is conceptualized and how hope is incorporated into everything that social workers do.

A significant advantage of the cognitive developmental conceptualization of hope is that it mirrors an axiom of operant learning. Specifically, the axiom is that it is easier to increase the strength and frequency of an existing behavior than it is to teach a completely new one. The same should be true of advancing how hope is experienced, as opposed to instilling hope where there is none.

The intent of conceptualizing hope as innate and developmental is not to suggest that focusing on hope should become a new intervention strategy. Social work does not need a therapy of hope-intervention modality. What social work does need to do is to incorporate a focus on hope in everything that practitioners do, when

building therapeutic/constructive relationships with individuals, couples, families, groups, or communities. When a therapeutic relationship does not evolve into what it could, most likely missing in the encounter is a sufficiently mindful and skillful focus on hope. This is not to say that hope is not addressed, this is to say that greater focus on it could greatly improve outcomes.

Facilitating the evolution of how hope is experienced is not a simple task, nor should its challenging nature be underestimated. Its evolution, however, must be facilitated, and its facilitation must be interpreted, discussed, and explained at every opportunity. Moreover, the obstructed way in which hope is experienced must be challenged. Without the cognitive conflict this creates, the active construction of a better way of experiencing hope cannot develop. Concomitantly, social work's challenge is to keep an equally focused eye on the complex environmental factors that obstruct how hope is experienced. The environmental factors can include intergenerational ways of experiencing/talking about hope, or systemic social obstacles such as restricted educational or employment opportunities. Once the environmental factors are identified, the next challenge is to address them. Sometimes social work can take on an advocate role and literally run interference for a client. The opportunity for this is rare. Most often, it is the client who must take on the environmental factors with guidance and better-informed strategies. If the client's experience of hope is not addressed, even the best laid plans will not be acted on. Mistakenly, then, the client becomes labelled as noncompliant. An alternate, better conclusion is that the social worker had not addressed adequately how the client experiences hope. To state the obvious, the task begins with building a therapeutic relationship that incorporates a focus on hope.

At this point, it will be useful to interpret with a different view what goes into building a therapeutic relationship. The more the process is understood, the more likely it is that the practitioner will do it better.

Listening

Active listening serves to invoke different hope because it counters previous obstructive experiences when reaching out was dismissed, ignored, or even ridiculed.

Validating

When trauma, singular or continuous of any and all kinds, is compassionately acknowledged, this serves to validate the person's experiences as significant and thereby invoke different hope because someone finally understands.

Genuinely Curious Engagement

Being genuinely curious serves many purposes, not the least of which is to invoke a different hope that, through this relationship, change is possible because, as people explain their circumstances, glimmers of alternative interpretations emerge.

Acknowledging Siege

To acknowledge that being in constant survival mode it is virtually impossible to solve problems, let alone strive for a better future, is markedly liberating. It frees up energy consumed by having to rationalize failure, and it invokes a different hope that help will come from someone who understands.

When it comes to addressing hope, therefore, no new strategies are required. As noted earlier, the premise of this argument is that better results can be achieved if a focus on hope is incorporated into everything the social work practitioner does. Perhaps the only new strategy is to draw attention to how hope is being experienced and how else it could be thought about.

Case Example

People primarily are a product of their past as well as their current situation. Joshua, a 30-year-old with considerable cognitive intelligence, grew up in a markedly impoverished environment void of empathic nurturance. Secure attachment failed to emerge, and this relationship trauma began to manifest itself early in a variety of negative ways. After numerous psychiatric hospitalizations, instances of cutting himself, and suicide attempts, he was granted a permanent disability status. While on probation for a minor criminal

offense, he was referred for social work services as a condition of his sentence. At intake he reported living in deplorable conditions. He slept on a cot in an unfinished basement without a refrigerator or even a hot plate. As well, unpredictably the sewer backed up, covering the floor with feces. By his bedside, he kept rubber boots so that he would not in the dark step into raw sewage.

Joshua's clinical presentation was that of a person in the process of disengaging from the unbearable and inescapable reality of his circumstances. His experience of hope was limited and stuck at the expectation that he was going to be alive tomorrow and that he was not going to step into raw sewage in the dark.

Acknowledging that his despondence was an appropriate response to his circumstances served to release his hope from survival mode to hoping for a better future. Once he could hope differently, he was able to explore and seek out options available to him. A plan was formulated with small, easy to accomplish steps that culminated in Joshua moving into markedly better accommodations. As he settled into his new home, treating it as his sanctuary, his need to escape into his head discernibly diminished.

The case of Joshua illustrates that, in the midst of all that goes on in the lives of people, hope is at the core. When hope is obstructed from its development, people languish in their state of dysfunctionality, which can include escaping their reality by a variety of means such as self harm, or withdrawing into their self-created world. In contrast, when the experience of hope is facilitated by building a therapeutic relationship, the seemingly impossible can and does happen.

Future Research

Since no one has yet fully entertained the notion that hope is an innate, environmentally activated, cognitive developmental propensity with variable emotional overlay, it is unknown how hope is experienced at different developmental stages. Knowing this is important at several levels, not the least of which concerns building a therapeutic relationship by engaging clients at a conceptual perspective close to how they experience hope; a closer, more adaptive perspective of hope a client can relate to more easily than a markedly divergent one.

There are various existing methods for discovering and describing how an innate propensity develops over time as a function of interactions between an individual and the environment. Nancy Eisenberg (1976) expanded on Kohlberg's (1969) stages of moral reasoning to define the development of prosocial reasoning. She described a parallel sequence of prosocial reasoning, each stage being qualitatively different from other stages, each representing a total way of thinking, not just an attitude toward a particular situation. June Tapp (1971) similarly extrapolated from Kohlberg's scheme to describe how a sense of law and legal justice develops over time as a function of environmental conditions. As could be expected, the building of knowledge about how innate propensities develop continues. Martin Hoffman (2000) described an empathy-based sequence of moral reasoning. Empathy, according to Hoffman, is a predisposition that eventuates in mature prosocial behavior. This predisposition he postulates is actualized through three key factors: biological basis, cognitive development, and socialization, a perspective remarkably similar to the biopsychosocial perspective of social work practice.

If indeed hope is an innate propensity that is environmentally activated, it is incumbent on a discipline that is concerned with the context in which people live and function to, not only discover the hierarchical stage structures of hope, but also to discern what environmental factors are conducive to its development. Fortunately, there are existing methods for doing so that have served well other researchers interested in other innate domains of developmental propensities.

The fact that even the so-called hopeless can alter their lives gives credence to the premise that hope cannot not exist. There is no hopelessness, only hope that is obstructed. Nevertheless, even obstructed hope finds expression, as in the case of Joshua placing the rubber boots by his sleeping cot hoping to avoid stepping into backed-up raw sewage.

Conclusion

General systems theory (von Bertalanffy, 1968) introduced into our lexicon the concept of *isomorphism*. It refers to the transferability of principles or laws from one discipline to another. The intent of demonstrating this was to avoid the time-consuming process of discovering the

same principles in different fields isolated from each other. The purpose was to enhance and expedite knowledge-building in each discipline as its work became informed by that of all the other disciplines. Alas, this lofty ideal has fallen short of its intent, as different disciplines strive on their own to discover for themselves the importance and relevance of hope to their focus of interest. This chapter is essentially a beginning effort at synthesizing from various disciplines the relevance of hope theory for social work practice, now more than ever, firmly grounding it in a biopsychosocial perspective. Instead of considering this to be a value-based, idealized perspective, the preceding postulates hope to be an innate propensity of the same order as the propensity to develop various other innate propensities. Insofar as hope is the precursor to any and all actions, positive or negative, it is critically important therefore that all interventions begin and continue with a focus on hope. Moreover, it is critically important that the focus on hope become optimally informed, starting with available objective measures and an awareness that hope probably is experienced, not only in different magnitude, but also differently at each developmental stage perspective. Perhaps the lack of these considerations has been the critical missing link in optimally facilitating motivation to action that is progressively adaptive. Given the critical importance of hope, *hopefully* its theoretical foundation and means by which to facilitate its growth and development will become part of the core curriculum of every graduate faculty of social work and subsequently better inform how graduates practice.

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17

Hypnosis and Clinical Social Work Practice

Elayne Tanner

A Perfect Fit

Social work is now a recognized, regulated profession with a unique body of knowledge. Because of social work's holistic perspective that combines the biological, psychological, and social aspects of an individual's life, while also recognizing the impact of community, culture, social positions, gender, sexual identity, race, and age, to name a few (Mullaly, 2010), many aspects of social work theory originate in other disciplines. That said, a social work perspective always draws on multiple standpoints while applying a systemic lens to knowledge. "Social work pioneers were among the first to address the significance of deeply connected relationships that constitute the social context of people's lives. Out of this rich heritage, social work is recognized for its familiar 'person-in-environment' perspective" (CASW, 2000, http://www.casw-acts.ca/sites/default/files/attachements/Scope%20of%20Practice_August_08_E_Final.pdf). This multifaceted and holistic view invites social workers to explore many modalities of service delivery and use whatever theory or methodology works best for each client. This opens the door for the use of hypnosis in a clinical social work practice.

What Is Hypnosis?

Hypnosis is a physical and mental state of highly focused concentration. A person under hypnosis can respond to questions and is very susceptible to suggestions from the hypnotist (James, 2010). While hypnosis's legitimacy has been questioned, we do not question the brain's ability to enter an involuntary dissociative state. "Clinical

hypnosis uses naturally occurring states and behaviours and amplifies them" (James, 2010, p. 4). We frequently see examples of these naturally occurring states in our daily life. Driving the same route that we follow daily to our workplace, we realize that we have arrived but really have no idea of what we passed along the way, unless it stood out as a stark variance from the norm. The brain uses this same ability as a tool to help individuals avoid remembering incidents of physical or psychic pain that would overwhelm their coping capacity. Victims of child sexual abuse will often use this skill of involuntary dissociation to block memories of the abuse until they have reached adulthood and are more able to deal with the trauma and process the knowledge (Winsor, 1993).

While these are examples of the involuntary use of trance, hypnosis is the intentional use of this trancelike ability. Although sometimes used in popular media for fun and entertainment, hypnosis can also be utilized as a very powerful therapeutic tool. As described by the American Psychological Association (2000), hypnosis is a therapeutic technique in which therapists use suggestions and imagery to guide individuals. These individuals have been encouraged to enter a relaxed state where their minds are focused. When in this focused, relaxed state, hypnosis can be very effective as a technique to provide to relief for many different issues, including pain, anxiety, mood disorders, childhood trauma, post-traumatic stress disorder (PTSD), performance anxiety, dissociative identity disorder, and a variety of obsessive and habitual behaviors. Although a therapist usually initiates the hypnotic trance, individuals can also be taught self-hypnosis so that therapeutic responses can be utilized in settings other than the therapist's office.

Common Myths About Hypnosis

Now that we have an idea of what hypnosis is, it is important to also recognize the common myths surrounding hypnosis and note what hypnosis is not.

1. *Hypnosis is not mind control*. The therapist is not able to control the client and make them agree to do or say anything that the therapist suggests. The client is always in control of their mind.
2. *You cannot "get stuck" in hypnosis*. Because the client is always in control of their own faculties, they are also always able to come out of hypnosis at any time. Hypnosis can be compared to the moment just before you fall asleep. If you hear an unfamiliar noise, you may choose to get up and investigate, or you might decide to not bother. The client always *can* come out of hypnosis but generally does not want to until they are told to come back to normal consciousness.
3. *The ability to be hypnotized does not signify a weak mind*. The ability to be hypnotized indicates that the client has the ability to hear suggestion and relax adequately. It also suggests that the therapist has found a good induction and approach that has captured the attention of the client.
4. *Through hypnosis, every past memory is accessible*. Sometimes some new memories are accessible through hypnosis, but these are generally memories that were already there but not acknowledged. The process of hypnosis does not open up the mind to be read like a book.
5. *With hypnosis, you can find your past lives*. Although I cannot disprove this theory, I have never experienced it occurring.
6. *A good hypnotist can hypnotize anyone*. A good hypnotist can hypnotize anyone who wants to be hypnotized and who is ready to be hypnotized. The client has to have an understanding of the process so that they are not afraid to allow themselves to relax and go into hypnosis, and the client cannot consciously be resisting hypnosis. Remember myth number one—the client is always in control.
7. *You can be made to do things you would not normally agree to do*. While under hypnosis, you are still in control of your mind and your body. Your ethics, values, and knowledge of right and wrong do not vacillate. You cannot be talked into something that you would not agree to if you were not in a trance.
8. *If the therapist leaves or dies, you will stay hypnotized for life*. If for some reason the therapist stopped the process, you would either wake up naturally or fall asleep and then wake up.

Hypnosis as a Clinical Tool

Hypnosis is a powerful clinical tool. James (2010, p. 5) states that hypnosis provides five fundamentals that increase the client's "capacity to enhance what is already present." She notes that as a clinical tool, it can be used to amplify abilities, focus attention on the task in hand, help create a goal to work towards, reduce stress or anxiety, and rehearse events in order to alter autonomic responses. Hypnosis can also be used as an adjunct to other methods of psychotherapy. For this discussion, the uses are grouped into three categories.

Hypnosis for Symptom Reduction

When hypnosis is used for symptom reduction, the client is put into a trance, and a hypnotic suggestion is made that is designed to reduce the symptom. For example, a client who fears needles is told that the injection site is numb and insensitive to pain. The client who fears dental work may be told that the dentist's chair is a cloud that will take them to a beautiful place where they feel no discomfort, and that any pressure felt in the mouth will intensify the relaxation and deepen the trance. Other areas of aches and pains may be treated with the suggestion of an analgesic tap attached to the client's body that can be turned up as needed, so that a stream of numbing, relaxing, analgesic liquid can flow through their body, or it may be suggested that they possess an absorbent sponge that will "wick up" all their pain. Since pain is often intensified by stress and is always felt through the brain, altering the brain's perception of the pain can effectively eliminate any discomfort. In this way, hypnosis can persuade the brain to alter and disregard the psychological experience of pain, as well as modify the brain's processing of the pain.

Hypnosis to Amplify Abilities

Hypnosis has proven very useful for amplifying abilities. In the relaxed state, the client is able to hear the positive suggestions for personal growth. This can be to enhance relaxation techniques, focus on goals, install ego strengths, or visualize completing a stressful activity, to name just a few. Many of these uses of hypnosis can also be seen as working with other psychotherapeutic methods, and will be discussed later in this chapter.

Hypnosis as an Adjunct to Other Methods of Psychotherapy

Hypnosis is a powerful adjunct when used as a psychotherapeutic tool with cognitive behavior therapy (CBT). Research suggests that using both hypnosis and CBT together, rather than either technique alone, improves outcomes for approximately 70% of patients (Kirsch & Lynn, 1995). Hypnotic trances can enhance the process when used in conjunction with progressive relaxation techniques and with guided imagery to reduce stress and manage anxiety. Anger responds well to these hypnotic techniques, and there are many scripts written as examples of how to both diminish and positively express anger. The intensity of obsessive-compulsive disorder (OCD) can be lessened through a hypnotic trance that changes the obsessive behavior and compulsive thinking. PTSD, victimization, and childhood trauma all respond well to hypnotic suggestions. The intensity of phobias and debilitating fears can be reduced with hypnotherapy. By preceding the CBT technique with a hypnotic induction and continuing to present the CBT technique with the cadence and tone of hypnosis, the benefits of both approaches are seen to support each other. Hypnosis used in this way also ensures that the CBT directives are presented and received in a very gentle and soothing manner.

It is important to note that, while the hypnotic trance can be used to install many positive and helpful suggestions, hypnosis has also been implicated in "false memory syndrome." False memory syndrome, popular in the Nineties, suggested that some memories of child sexual abuse were falsely induced, resulting in court cases for hundreds of people wrongly accused of abuse (Yapko, 1994). While the issue of whether false memory syndrome is a true concern or a fabricated condition designed to provide reasonable doubt on behalf of those accused is still disputed, the Supreme Court of Canada in *R. vs. Trochym*, 2007, has deemed evidence obtained under hypnosis to be inadmissible (Judgements of the Supreme Court of Canada, 2007).

Overview of the Hypnotic Process

The hypnotic process can be broken into three segments: preliminary activities, the hypnotic phase, and the awakening. We will consider each of these stages individually; however, there are some common features of each of the phases to look at first.

Styles of Hypnotic Suggestion

Throughout the hypnotic process, the therapist orchestrates all the activity. Therefore, the therapist assumes a particular stance that suits the therapist, the client, and the stage and development of the process. Some therapists may consistently use the same posture, while others will alter their stance as suits the moment. Therapists are encouraged to "individualize hypnotic suggestions to the unique personality, expectations, motivations and problems of the patient" (Hammond, 1990). Hypnosis consists of hypnotic suggestions and metaphors, and how these suggestions and metaphors are presented can best be understood by considering the three following approaches.

Directive or Authoritarian Suggestion

When the hypnotherapist adopts an authoritarian stance, phrases such as "You will feel . . ." or "You will notice . . ." are used. The authoritarian approach is useful when the therapist wants to direct the process so that the client knows what is expected of him or her. In the hypnotic induction, for example, phrases such as "Your muscles have all relaxed" or "Your arms are heavy" are common. An authoritarian stance is also useful when bringing the client out of the trance and the therapist wants to be very firm in getting the client back to an awake and alert state. A directive may be given such as "You are emerging from hypnosis. You will notice that the room is getting lighter. Move your fingers and toes." These are times when the therapist does not want to give the client a choice. While a directive approach can produce dramatic and quick responses, Brown reflects that using this approach exclusively is effective for less than 10% of the population (Brown, 1986).

Ericksonian or Indirect Suggestion

Ericksonian suggestions are delivered in a manner that is "nonspecific, indirect, ambiguous—often disguised" (Brown, 1986, p. 53). This indirect approach frequently uses phrases such as "You may": "You may notice that the room has become darker" would be one such indirect comment. "Some people notice that they feel a tingling in their fingers, but whether you do or not does not matter" is another. These are times when the therapist does not need the client to feel or experience the things being suggested but wants to keep the client's attention focused on the tone and the words that are lulling them further into the trance. An indirect approach may reduce resistance and allow the client to feel that they are still in control, while still allowing the therapist to guide their thoughts. The phrase "Do not think of pink elephants" is an example of an indirect directive that in fact captures the listener's attention. An indirect approach as described by Erickson uses metaphors and confusion to hypnotize anyone, whether with or without their knowledge (Brown, 1986). According to Erickson:

> You provide a multiplicity of suggestions: the more suggestions that you give, and the more simply you give them, the greater the possibility of getting some of them accepted. Your task isn't to force a patient to accept suggestions. Your task is to present a sufficient number of suggestions so that he will willingly take this one and that one. (Hammond, 1990, p. 2)

While an indirect approach is commonly used as described here, true Ericksonian hypnosis as elucidated by Erickson is rarely adopted and is seen as being suitable only for specialized patient populations (Brown, 1986).

Permissive Suggestion

To add to the confusion of the various approaches, there is a great deal of overlap in them; also, many theorists will use the same term differently or call the style something other than what is noted here. The permissive approach is at times referred to as "indirect," while the Ericksonian approach is sometimes perceived as "permissive." That said, it is up to the reader and the student to establish their own style while being aware of the various approaches.

The permissive style of hypnotherapy is one that may resonate with social workers, as it appears to maximize client choice and involvement. While there are times when it is beneficial "to phrase suggestions in a more permissive and indirect way" (Hammond, 1990, p. 12), it is also important to recognize that, no matter which approach the therapist adopts, the client is always in control. Using a permissive role, the therapist will remark, "One of your hands is getting lighter. Look, your hand has become so light that it will float up. Lighter and lighter . . . it *will* float." It is essential that the therapist using a permissive style differentiate between being permissive and lacking confidence or conviction. If, rather than saying "your hand will float," the therapist continues to repeat "your hand might float up" or "perhaps you will develop a numbness in your hand," there is a chance that the comment can be misconstrued as lacking in confidence and experience. That will confuse the client as to the therapist's expectations (Hammond, 1990) and can be counterintuitive. Hammond implores the therapist to "make the distinction between being confident and authoritative versus authoritarian and dominating" (Hammond, 1990, p. 12).

A permissive stance is especially useful in applications such as guided imagery, where the client is encouraged to "imagine" a favorite scene or possibly a series of colors, or is given a choice between an analgesic tap or a pain-absorbing sponge as noted previously. Ego-strengthening techniques or anxiety- and stress-reduction skills are examples of appropriate uses of a permissive approach. The therapist guides the client to accept a new way of viewing aspects of their life. The language is often still directive, but there is a supportive and permissive component to it. The therapist may say, "You are feeling stronger and calmer every day. Every day you will feel more confident and more able to deal with the concerns in your life." Used in this way, hypnosis is both empowering and strengths-based. Imagery used in hypnosis allows the client to build an image that they will later be able to draw on for self-hypnosis. Relaxing gardens, waves on a beach, floating clouds, or staircases are often used for imagery. The therapist may be completely permissive and vague in this process or they may suggest a number of various scenarios, asking the client to adopt the ones that seem to be the best fit for them. Frequently, multiple images are used within the same hypnotic trance to accomplish different goals. For instance, the image of going down stairs, or descending in an elevator, or counting numbers in descending order are all techniques often used to deepen the hypnotic trance. Colors are often suggested to both deepen the trance and highly focus the attention. Specific images are most effective once the client has entered a deep trancelike state. That would be the time to plant suggestions regarding the termination of habitual behaviors such as smoking or hand-washing.

Preliminary Activities

Establishing Rapport

When hypnosis is considered as a therapeutic tool for a client, a therapeutic alliance must first be established in order for suggestions to be received effectively (Hammond, 1990). If the client does not trust the therapist to be warm, caring, ethical, and honest, they cannot let their guard down enough to enter into a trancelike state. As has been noted, the client is always in control, so they must be willing to go into a hypnotic state. Ask the client what image they feel might work to eliminate or reduce the problem. Explain what hypnosis is and is not. Taking the time to build this relationship may be the most critical piece in the success or failure of the hypnotic process.

Assessing Suggestibility

While building this relationship, the therapist will assess for suggestibility and find the imagery that will help the client. A suggestibility test can be something that suggests movement. The therapist can tell the client that his or her arm is attached to a helium balloon and being lifted up, and the therapist notes the amount of movement the client shows; or it can involve the lack of the ability to move such as would be achieved by telling the client that his or her arms are so heavy and limp that, like a wet rag, they cannot be lifted.

If the client is especially skeptical, it may be necessary to use a number of suggestibility tests

to assess the speed with which the therapist can move towards hypnosis. By finding the areas of resistance that can be anticipated, the therapist can attempt to address them prior to hypnosis. Simultaneously, it is important to find imagery that the client can truly relate to. Asking what their ideal safe place would look like is often a good way to get details that can be used as needed in the hypnotic process to calm any agitation or to strengthen the hypnotic process.

At this stage is also a good time to discover the client's interests so that the induction is one that is easy for him or her to relate to. Using a gently rocking boat analogy is not relevant to someone who has never been on a boat and may be anxiety-producing to someone who has had a traumatic boating experience.

There is, for example, an induction script that asks the listener to imagine drawing and erasing letters on a chalkboard. I find this to be a very useful hypnosis-induction method for some schoolteachers.

Contraindications

It would be at this stage that the therapist would look for contraindications to the use of hypnosis. Erickson and those who adhere to Ericksonian philosophy believe that everyone can be hypnotized if the therapist is adequate. Erickson advised the therapist to weave monologues and metaphors into the trance, and said that confusion captured the client's attention (James, 2010). But others recognize that some clients will not always allow themselves to be hypnotized. A client who cannot relax in the office setting, or one who is unable to process the words of the hypnotic trance and suggestions, would be two examples of where hypnosis would not be a suitable technique until these issues are dealt with. A client who has been severely traumatized would be another case where hypnosis would not be appropriate until the therapist is acutely aware of the triggers that may reactivate the trauma, placing the individual into a potentially vulnerable state. Using hypnosis without the prior work in such cases could be retraumatizing and unethical.

It is imperative to note, however, that before using hypnosis for any type of physical ailment or pain management, the client must be advised to seek medical attention to ensure that hypnosis is not being used to inadvertently cover up symptoms of an untreated medical condition.

Setting the Stage for Success

After a relationship of trust and awareness has been built, the physical environment must be considered. Bright lights, loud noises, and any other intrusions will all interfere with the success of the hypnotic process and must be accounted for. Seating must be comfortable and supportive, and the therapist must strive for a soothing, calm, and controlled voice, delivered in a manner that projects to the client at a slow and deliberate pace.

The Hypnotic Phase

Inducing a Hypnotic Trance

After all the preparatory work is done, it is time to begin the hypnotic process. First, the therapist will teach the client how to effectively take a deep, cleansing breath. This deep breathing is useful for many reasons. With each deep breath, the client becomes more relaxed and goes deeper into hypnosis. If the client becomes agitated, a deep, cleansing breath calms them while it also distracts the client from the stressor. Lastly, if the client appears to be falling asleep, asking them to take a cleansing breath lets the therapist know if they are still listening, wakes the client up if necessary, especially if their name is used, and helps the therapist evaluate the depth of the trance.

The Induction

The trance is the stage of ultimate relaxation and least conscious awareness. As discussed before, this is the state in which the client is hovering between sleep and wakefulness, able to hear everything and take direction, yet unlikely to initiate conscious action.

The therapist will begin the trance by using an induction script, speaking in the future tense in order to advise the client regarding what is about to happen: "You will begin to feel very sleepy." The same induction will then be repeated but in the present tense: "You are feeling very sleepy. Your eyes have gotten heavy."

The therapist then becomes directive, making statements such as "Now close your eyes and go down into a very deep and relaxing hypnotic state. You will go deeper and deeper." The therapist will give the client permission to question the process by noting that going into hypnosis is a gradual process and they can go into it at their own pace, as they are ready. This appears to stop much of the internal questioning of whether the client is "doing hypnosis right" or not. The therapist creates a positive expectation (Hammond, 1990) at this stage with comments such as "You feel wonderful" and "You are deeper than you have ever been before."

While the client is in the trance, the observant therapist will often notice changes in their skin color, suggesting lowered blood pressure, and changes in breathing rate as the client begins to breath slower and deeper. It is the therapist's responsibility to remain aware and visually monitor the client's wellbeing. The induction is delivered in a musical manner, paying strict attention to the cadence and ensuring a lulling, soothing rhythm. This makes the difference in the success of the hypnotic trance, but it can be very difficult for the therapist, as the controlled tones can be straining on the voice.

Once a desired depth of trance is attained, the therapist, if the client agrees, can add therapeutic suggestions and ego-strengthening. The ego-strengthening uses a firmer, more authoritarian and motivational tone of voice, emphasizing the positive messages.

There are many scripts available to induce the initial trance state or to attain any of the desired goals of hypnosis, such as smoking cessation, ego-strengthening, or pain management. These scripts are readily available online or in books such as *Handbook of Hypnotic Suggestions and Metaphors* by D. Corydon Hammond (1990) or *Hypnosis and Suggestion in the Treatment of Pain: A Clinical Guide* (Barber, 1996).

Although these scripts are available, it is imperative that a therapist who wants to add hypnosis to their repertoire of skills find a reputable hypnosis-training program so that hypnosis is not used haphazardly but recognized and respected as the powerful tool that it is. Although the therapist never has control of the client's mind, the client is put into a position of vulnerability where fears and memories are generated and are frequently charged with the same horror as they originally carried. The therapist has a responsibility to know how to contain and manage said emotions and fears while soothing and guiding the process in a healthy and empowering manner.

The Awakening

The purpose of awakening is to bring the client to full, conscious alertness, with any physical limitations that may have been suggested now removed. So, for instance, those arms that had earlier become as limp as a wet rag now must be returned to full feeling and movement. Any post-hypnotic suggestions should be repeated at this point. The client should be reassured that they feel wonderful and are fully alert. The tone of the awakening is more upbeat and moves from the quiet, soothing tones that went down deeper in tone back to the normal speaking tone, and the speed more closely approximates that of the normal speaking voice. The messages presented to the client are in the present and state the facts such as "You are starting to emerge from hypnosis," "You are waking up," "The room is getting brighter," "The feeling has returned to your fingers and toes—begin to move and feel them again," "You feel wonderful in every way," "Take your time as you open your eyes." These awakening messages are accompanied by a counting that goes up in tone. The client is told how long they have and what number the therapist will count to. They then have the sense of control. It is important to not do the awakening in a manner that startles the client. Any post-hypnotic suggestions should again be repeated.

The therapist should then debrief with the client after they come out of the trance, answering any questions, reassuring them that all was done correctly, and ensuring that the client is alert prior to leaving the office. The therapist must clarify that the client is awake and alert enough to be able to get home safely.

Hypnosis as a Legitimate Psychotherapeutic Tool

As noted earlier, hypnosis as a legitimate therapeutic activity has been challenged and questioned. However, many highly regarded and

reputable research institutions and individuals do recognize and support the significant contribution that hypnosis makes as a therapeutic adjunct to psychotherapeutic techniques. Both the American Medical Association and the British Medical Association have long recognized the validity of incorporating hypnotic suggestion into medical treatments in order to alleviate pain. Corydon Hammond (1990), Joseph Barber (1996), and Michael Yapko (1994) are just some of those who have written extensively on the many uses of hypnosis to relieve symptoms of psychic and physical pain. Hypnosis has proven to be a very powerful tool, but it must be used as such—as a therapeutic adjunct and not as a method in and of itself. The practitioner must be knowledgeable in appropriate counselling techniques and relevant topical knowledge in order to not potentially cause further harm to the client.

Reamer, highly respected for his work on ethics and social work practice, touches on this topic when he refers to hypnosis as a nontraditional and unorthodox intervention. He recognizes that the legitimacy and validity of these unconventional methods is based on the social worker's receiving the appropriate formal training, certification, or supervision necessary to appropriately apply the technique. He furthermore states that lack of adequate training "in the use of widely accepted clinical innovations—such as . . . hypnosis . . . may exacerbate clients' emotional condition because of their unskilled application of these approaches" (Reamer, 2006, p. 191). Reamer emphasizes the need for following the procedural standard of care when using innovative and nontraditional approaches, including hypnosis—"the steps that an ordinary, reasonable, and prudent social worker should and would take in deciding whether to use [this] technique" (Reamer, 2006, p. 194). He includes consultation and supervision, informed consent, awareness of current relevant literature, and proper documenting and evaluating as steps that the social worker should follow to avoid ethics complaints, malpractice claims, and even criminal charges. Thus, while hypnosis is accepted and recognized as a beneficial tool, the social worker still has an obligation to exercise the ultimate standards of care to protect both the therapist and the client. Nontraditional methods do not mean sloppy practice.

Hypnotic Induction and Suggestion

A hypnotic induction has been included here as an example to illustrate the techniques that have been discussed. It must be again emphasized that, prior to using hypnosis, the social worker must receive proper and adequate training in this technique. This script is not intended to replace that training and skill-building.

The following script is taken with thanks from *Clinical Hypnosis Textbook: A Guide for Practical Intervention* (James, 2010, pp. 19–22). It should be read in its entirety in a soft and calming voice as discussed. The headings, which are included in the original script, are for the convenience of the reader and not to be read aloud.

Inducing Hypnosis

Make yourself comfortable . . . place your feet flat on the ground . . . and . . . let your hands rest comfortably on your thighs . . . rest your head back . . . you can relax now . . .

and just close your eyes . . . let them close . . . and. . . . you can relax your eyes now . . . so comfortably relax them . . . that they won't bother to open at all . . . hey will remain . . . comfortably closed . . . comfortably closed throughout . . . and . . .

Deepening the State

I would like you to focus in on your breathing . . . take three deep . . . relaxing breaths . . . let them out in your own time . . . that's right . . . and as you do . . . I would like you to notice that your breathing has become deep and even . . . and . . . in a few moments' time . . . I would like you to take control of the process . . . and you will start this by deciding how relaxed you choose to go . . . you can go deep enough to access any information which will help you to make the changes you want in your life . . . deeply relaxed . . . you are in control . . . so ready . . . continue to pay attention to your breathing . . . and as soon as you wish you can take control of the process . . . you can begin a countdown . . . silently and mentally . . .

using your out breath to time the numbers . . . you can start when you wish . . . with the number 100 . . . and with each breath out you count down to the next number . . . and with each descending number between 100 and zero . . . you go deeper and deeper into hypnosis . . . more and more in control . . . ever closer to the memories which can help you today . . . you are in control . . . completely in control . . . and as you count . . . you may wish to see the numbers written on the screen of your mind's eye . . . some people hear their own inner voice repeating the word . . . it is entirely up to you . . . you can allow yourself to experience this process in any way you wish . . . because you are in control . . . and I want you to know that the more control you take of the process . . . the more you will relax . . . and the more you relax the more easily you can access the part of your mind which will help you . . . it is time for you to take control . . . complete control of the process . . . and you will find . . . that when you do . . . there may be times when you focus so hard on counting . . . that you forget to listen hard to the words that I say . . . and there may be times when you forget to count . . . and that will be fine . . . just fine . . . you will pick up at the next number which occurs to you . . . or not at all . . . it really doesn't matter . . . what does matter is that you will hear and remember everything of importance for you to hear and remember . . . whether this is your own inner voice . . . or the sound of my voice relaxing you . . . you are in control . . . and as you count ever deeper and deeper . . . going more and more relaxed . . . you may even notice that the sensations in your body are changing . . . there may be times when you notice that you feel as if you are drifting or floating . . . but that will be fine . . . it is a very pleasant experience . . . similar to the moments between waking and sleeping . . . your body warm and comfortable . . . completely at peace.

Give the Following Post-Hypnotic Suggestions

And . . . now you are deeply relaxed . . . I am going to teach you how to take yourself into this fully relaxed state . . . whenever you need it . . . whenever you want to take time out . . . and . . . you will find that the more deeply you can go . . . it is very simple . . . all you have to do . . . is find a time and a space where you can make yourself comfortable . . . a place where you can make sure that there is nothing which can disturb you while you practice . . . but I want you to know . . . that if . . . for any reason you need to be immediately alert and aware . . . you will be . . . you are completely in control . . . so for now . . . you can relax . . . knowing that you are able to go as deep as you like . . . when you do this for yourself . . . first of all . . . decide how long you want to be in hypnosis . . . five minutes . . . ten minutes . . . fifteen . . . it is entirely up to you . . . your internal clock will tell you when it is time for you to wake yourself up . . . ten . . . all you have to do . . . is sit down or lie down . . . and close your eyes . . . take three deep breaths . . . and . . . on the last one . . . hold your breath for a count of three . . . and . . . let that breath go . . . and . . . as you do . . . allow every muscle of your body to relax . . . continue to pay attention to your breathing . . . noticing your chest rising and falling . . . and be aware that any sounds or sensations around you can just fade into the background . . . just as they do when you drift off to sleep . . . you can now notice your thoughts . . . and let your thoughts . . . connect themselves to your breathing . . . so you can start to allow your thoughts to fade in . . . and out . . . as if connected to your breathing . . . and . . . you will soon notice . . . that some of those thoughts fade away completely . . . while others take a while . . . but it doesn't matter either way . . . as you are going into a state of self-hypnosis . . . you are controlling it . . . and . . . you can now begin to count yourself deeper into this state . . . by using the numbers between ten and one . . . count on your out breath . . . this will help you to relax even more deeply . . . more and more relaxed . . . and . . . as you count down . . . any tension in your body fades away . . . any feelings you want to release . . . you can count down to letting them go completely . . . so by the time you reach the number one you will find that you have let go of any stress or tension . . . and can just relax . . . relax and think clearly . . .

Pause for 5 Seconds

. . . and . . . once you reach the number one . . . you can use this time to give yourself a positive suggestion . . . something simple . . . something that will come in useful for the next 24 hours . . . you may wish to focus . . . or to be

more motivated . . . or to have some extra confidence . . . keep it simple . . . you can do this now if you want . . .

Pause for 5 Seconds

. . . then just let your mind drift . . . enjoy the peace . . . enjoy being relaxed and focused . . . after a little while . . . your internal clock will tell you it is time to wake . . . and to wake yourself up . . . all you need to do is count slowly up from one to ten . . . and . . . with each number you become more aware of your surroundings . . . and feel more alert . . . you will wake refreshed and relaxed . . . and . . . these benefits will increase . . . the more often you take time to do your self-hypnosis . . .

. . . and . . . so it is easy for you to fit this into your day . . . you can do it just before you go to sleep at night . . . you can give yourself suggestions to let go of any tension or frustration from the day . . . so that you can fall asleep and sleep deeply and will . . . taking all the benefits from your sleep that you need . . .

. . . and . . . if you want to . . . you can do it in the morning . . . just before you are fully awake . . . to give yourself positive suggestions for the day . . . suggestions on how you are going to be confident . . . energized and in control . . . you can even walk yourself through a situation which you know you have to deal with that day . . . and imagine yourself and completely in control . . . confident and at ease with yourself and your surroundings . . .

. . . you can do your self-hypnosis whenever you need it . . . to give yourself a rest . . . a boost . . . or positive suggestions . . . and the more you practice . . . the better you get at it . . . the more you improve . . . the more easily you will take on board the positive suggestions for change . . .

General Ego Strengthening

And . . . before I wake you . . . I would like you to know that when you wake you will be able to notice how much better you feel . . . and you will feel more relaxed . . . more focused . . . and more at ease with yourself and the world around you . . . you will be aware that you feel stronger . . . and clearer in your mind . . . more able to make decisions . . . more capable, too . . . and . . . you will find that these positive feelings continue to grow . . . as the days go by . . . and . . . from now on . . . just before you sleep . . . you will be able to allow your unconscious mind to work through any of your problems as you sleep . . . so that you can . . . and you will . . . sleep deeply and well . . . and wake feeling refreshed and more positive . . . so positive that you will find that you can feel in control throughout the day . . . helping you to cope better . . . and to be stronger . . . and more able to deal with anything . . . anybody . . . any situation . . . and as a result of this you will feel more motivated . . . to make the changes suggested to you today . . . more focused . . . more confident, too . . . confident that you can change . . . you can take control . . . you can feel and be different . . . altogether more positive, too . . .

Awakening

In a few moments in time I am going to slowly count up from one to ten . . . and . . . as I count . . . you will become more aware of your surroundings . . . more aware of the sensations in your body, too . . . all healthy . . . appropriate and normal sensations will return to your body . . . and every healthy . . . normal . . . and appropriate part of you will be back here in the present . . . and at the count of eight your eyes will gently start to open . . . and you can start to stretch your body . . . and at the count of ten you will be fully awake . . . feeling alert and focused . . . your body relaxed . . . your mind refreshed . . . so ready . . . one . . . two . . . three . . . becoming more aware now . . . four . . . five . . . six . . . more alert . . . seven . . . eight . . . open your eyes now . . . starting to stretch . . . nine . . . and ten . . . fully awake . . . alert . . . feeling refreshed and relaxed. . . .

Conclusion

Hypnosis can be a very powerful, yet gentle, tool. The client is able to passively listen to the therapist and enjoy the beautiful images and the relaxing and encouraging messages. Most clients report enjoying the experience and awake feeling relaxed and invigorated. But at those times when the client remembers horrific abuse or re-experiences a punitive or embarrassing life episode, the social worker must know how to respond and remedy the situation so that the

client feels nurtured and safe. As Reamer (2006) notes, unscrupulous and unethical practitioners can exploit clients for self-serving purposes. It is imperative that all who would like to use this very effective method learn the appropriate techniques so that clients can benefit from its very many applications. As social work continues to build its unique body of knowledge, hypnosis properly used is an excellent fit and a wonderful way in which to enhance the social work skills.

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18

Life Model of Social Work Practice

Alex Gitterman

The first edition of *The Life Model of Social Work Practice* (Germain & Gitterman, 1980) represented a beginning effort to conceptualize and illustrate an integrated method of practice with individuals, families, groups, organizations, and some aspects of neighborhoods and communities. Two conceptual mechanisms (degree of choice and problems-in-living) were formulated to describe and illustrate integrated practice. Beyond conceptualizing an integrated method, distinctive knowledge and skills such as are required for forming groups or influencing organizations were also presented. Ecological theory provided a conceptual framework that offered a dual, simultaneous focus on people and environments. In the first edition, the underlying theories and distinctive knowledge at various system levels—individuals, families, groups, communities, organizations, and social networks, as well as the properties of social and physical environments, were also differentiated. In the first edition, a beginning effort was also made to explicate the connections between "private troubles" and "organizational issues." These emerging ideas were placed within historic and philosophical perspectives.

During the next 16 years (1980–2006), dramatic changes took place in our society and profession. Social workers had been increasingly working with profoundly vulnerable clients, struggling to survive the economic and psychological consequences of poverty and discrimination. Practitioners were dealing with the devastating impact of AIDS, homelessness, substance abuse, chronic mental disorders, child abuse, and family and community violence. Clearly, the miseries and suffering in the 1990s were different in degree and substance

from those encountered from the 1940s through the 1980s. With "safety net" resources being dismantled, for many clients it was difficult to endure (Gitterman, 2001).

Facing these bitter realities, social workers have been expected to do more in less time with decreasing resources. More than ever, professional courage, perseverance, creativity, and a widening repertoire of professional methods and skills are indispensable elements of contemporary practice. In response to these contemporary challenges, a revised and more fully expanded edition of *Life Model* responded to these pervasive social changes through four major elaborations (Germain & Gitterman, 1996). First, to be responsive to oppressed clients, social workers must develop competence in community, organizational, and legislative influence and change as well as in direct practice. The second edition of *Life Model* specifies methods and skills to move back and forth from helping individuals, families, and groups, to influencing communities, organizations, and legislative bodies.

Second, to effectively respond to people's varied needs, social workers must practice at whatever levels a particular situation begins and wherever it may lead. The expanded *Life Model* conceptualizes and illustrates methods and skills distinct to various modalities, as well as continues to describe and specify the common base of social work practice.

Third, people cope with oppression and scapegoating in many different ways. Practitioners must be careful about blaming oppressed people for their troubles. People's coping styles, strengths, and resilience must be understood and supported. In the first edition, the concept of "problems in living" organized ideas about professional assessment and interventions. Unwittingly, this formulation may have implied a deficit in the individual and collectivity. In the second edition, a more neutral stressor-stress-coping paradigm was substituted.

Finally, social workers must be sensitive to people's diverse backgrounds. Stage models of human development assume that social and emotional development follow in fixed, sequential, and universal stages. In subsequent editions, a "life course" conception of human development replaced the traditional "life cycle" models (Germain, 1990).

In the 19 years since the publication of the second edition, further dramatic changes have taken place in society, and, consequently, in the profession. The third edition (Gitterman & Germain, 2008) takes into account these pervasive changes and presents a more fully developed "life-modeled" practice. While retaining and refining the core of the previous work, new concepts and new content are presented. This edition provides social work practitioners and students with the necessary knowledge base and practice guidelines to deal with the many professional, societal, theoretical, empirical, and ethical issues they face. In this edition, a new chapter traces social work practice and its historical traditions from its roots in the charity organization societies and settlement house movement, to the development of professional methods, to the current social context that affect people's lives (global economy, immigration, the role of the federal government, new legislation, and cultural and technological changes). The chapter also explores current professional developments such as managed mental health care, practice outcomes and evidenced-based practice, and their respective influences on contemporary practice (Gitterman & Knight, 2013). Another new chapter, "Assessment, Practice Monitoring, and Practice Evaluation" discusses assessment tasks common to all practice approaches as well as a few underlying distinctive ideas to life-modeled practice. The chapter also examines the tasks and skills of practice monitoring as well as the strengths and limitations of different research designs used to evaluate practice outcomes. *Ecological theory* continues to provide concepts that illuminate the continuous exchanges between people and their environments. In this edition, people present new concepts from deep ecology and eco-feminism.

Human Ecology

In the revised *Life Model*, the ecological metaphor is broadened and deepened and continues to provide the lens for viewing the exchanges between people and their environments. Ecology, a biological science, examines the

relationship between living organisms and all the elements of the social and physical environments. How and why organisms achieve or fail to achieve an adaptive balance with their environments are the major questions of ecological inquiry. Deep ecology and ecofeminism deepen and enhance our understanding that all phenomena are interconnected and interdependent as well as dependent on the cyclical processes of nature (Besthorn, 2012; Besthorn & Canda, 2002; Besthorn & McMillen, 2002; Bloodhart & Swim, 2010; Drengson, Devall, & Schroll, 2011; Gitterman & Germain, 2008; Kopnina, 2014; Mack-Canty, 2004; Norton, 2012; Putney, 2013; Phillips, 2014; Stephens, 2012; Stephens, Jacobson, & King, 2010; Twine, 2010; Ungar, 2002). Ecological theory, with its evolutionary, adaptive view, continues to provide the theoretical foundation for life-modeled practice (Germain & Gitterman, 1986, 1987, 1995; Gitterman, 2008a, 2013).

Person: Environment Fit

Over the life course, people strive to improve their *level of fit* with their environments. When people feel positive about their own capacities and hopeful about having their needs and aspirations fulfilled, and when they view their environmental resources as responsive, they are likely to achieve a reciprocally sustaining condition of *adaptedness*. Adaptive person: environment exchanges reciprocally support and release human and environmental potentials.

However, when perceived environmental and personal limitations are fueled and sustained by oppressive social and physical environments (e.g., racism, sexism, homophobism, ageism, unemployment, pollution), consequences range from heroic adaptation to impaired functioning, to parasitic exploitation, and to individual and collective disintegration. In coping with toxic environments, some people mobilize inner strengths and resiliency to steel themselves against non-nurturing environments—to be survivors rather than victims (Gitterman, 2001, 2014). Others internalize the oppression and turn it against themselves through such self-destructive behaviors as substance abuse and unprotected sex. Still others externalize the oppression, strike back, and vent their rage on others less powerful than they through such behaviors as violence, crime, and property destruction. Readily accessible targets often include family members, neighbors, and community residents. *Dysfunctional* person: environment exchanges reciprocally frustrate and damage both human as well as environmental potentials.

In dealing with environmental demands, people appraise the adequacy of their environmental and personal resources. *Stress* is the outcome of a perceived imbalance between environmental demand(s) and one's ability to manage it with available internal and external resources. To relieve the stressful situation, the level of person: environment fit must be improved. This is accomplished by an active change either in people's perceptions and behaviors, or in environmental responses, or in the quality of their exchanges.[1]

The Environment

Person–environmental exchanges are dynamic rather than fixed processes. Ecological theory emphasizes the reciprocity of person–environmental transactions through which each influences and shapes the other over time. People need to receive from their environment the resources essential for development and survival. Reciprocally, the environment needs to receive the care necessary for its evolution.

The environment consists of *social* and *physical* layers. The former consists of the social world of other human beings, ranging from intimate social networks to bureaucratic institutions. The physical layer consists of the *natural* world inherited by human beings and the constructed/built world of human structures, the *space,* which supports, contains, or arranges the structures, and the *temporal rhythms*, fluctuations, and periodicities of environments and of human biology (Gitterman & Germain, 2008; Gitterman (2008b, 2015).

Complex *bureaucratic organizations*, a salient feature of the social environment, are prevalent forces in contemporary life. Health, education, and social service organizations profoundly affect most people's lives. In order to carry out its social assignment, an organization develops

a mission and evolves structures (e.g., division of labor, chain of command, policies and procedures) to carry out its operations. While organizational mission and structures are essential to service delivery, they simultaneously create tensions and conflicts for professionals and service recipients. For example, an organization's division of labor integrates roles, minimizes duplication, maintains accountability. At the same time, these differential role assignments create vested interest in protecting one's own turf, and other mischief. Organizational and client needs can be held hostage by turf interest.

Political, economic, and cultural forces affect organizational missions and structures. Economic, social, and bureaucratic forces conspire to block access and quality services for vulnerable and oppressed people. Politicians redefine the failures of the economy as behavioral and personality defects of public assistance recipients. Funding sources expect mental health agencies to diagnose and pathologize community residents rather than to view and assist them as residents experiencing life stressors.

Social networks, also a salient feature of the social environment, consist of kin, friends, neighbors, work mates, and acquaintances. Supportive linkages provide essential instrumental (goods and services), expressive (empathy, encouragement), and informational (advice, feedback) resources. They serve as essential buffers against life stressors and the stress they generate.

Not all people are able or willing to use available social supports. Some minimize, negate, or deny their difficulties or their need for assistance. Others, while aware of their life stressor(s), are unable to ask for assistance. Self-esteem issues and shame from negative social comparisons may account for their reluctance. Still others are inhibited by their needs for privacy.

Not all networks are able or willing to provide available social supports. Loosely knit networks may be unaware of members' difficulties. Lacking sufficient contact, a member's difficulties remain invisible. Some networks have insufficient resources to meet their members' varied needs. Their resources are too stretched out to incur additional instrumental burdens. Still others withhold available resources for such reasons as selfishness and punishment (Gitterman & Germain, 2008).

Some networks provide resources, but have a negative impact on recipients. Some reinforce deviance, such as drug and gang networks, by supporting dysfunctional behaviors and sabotaging more functional coping behaviors. Networks may also scapegoat and reinforce negative self-esteem. Exploitative and parasitic behaviors undermine a member's sense of well-being.

Life events such as sickness and death, job mobility and loss, marital separation and divorce, dissolve linkages to significant others. Social and emotional isolation are devastating experiences. Without viable networks, people are deprived of life-sustaining instrumental and expressive supports. Widowers who lose social ties maintained by their wives, and people suffering from chronic mental illness, suffer from impoverished networks.

The ecological concepts of habitat and niche are particularly relevant for understanding the environment's impact on us (Gitterman & Germain, 2008). *Habitat* refers to places where organisms are found, such as territories and nesting places. People's spatial behaviors are mediated by the texture of space, and by their age, gender, sexual orientation, culture, socioeconomic status, and experiences. The exchanges between people and their habitat take place within the context of personal space, semi-fixed space, and fixed space.

Personal space refers to an invisible spatial boundary that we maintain as a buffer against unwanted physical and social contact and to protect our privacy. Since the boundary is invisible, two or more people must negotiate a mutually comfortable distance. When less distance is transacted than desired, people experience crowding and intrusion and react either with subtle physical gestures or with pronounced withdrawal, or with aggression. When more distance is transacted than desired, people feel the unpleasant state of disengagement and either withdraw or pursue greater intimacy. Since the amount of desired space is influenced by many individual and social factors, it carries the potential for misperception, misunderstanding, and stress.

Semi-fixed space refers to moveable objects and their arrangement in space. Furniture, floors, curtains, paint, decorative figurines, paintings, and lighting provide spatial meanings and boundaries. People rely on environmental props (doors, locks, gates, fences, signs) to regulate interactions with others and to protect their territory within their living dwelling and with the outside world. In families, for example, whose members share limited space, the degree of interpersonal coordination required and the structural limits to privacy create stress. The close proximity, social overload, and spatial constraints are potential sources for interpersonal conflict.

The design of immovable objects and their arrangement in space, *fixed space,* have a profound impact on the quality of life. The high-density (i.e., limited space with a large number of people using it) structure and design of high-rise low-income housing, for example, creates unpredictable and indefensible spaces. With limited control over such public areas as elevators, hallways, and lobbies, these spaces represent dangerous threats to survival and are associated with feelings of withdrawal, alienation, and dissatisfaction.

Habitat also consists of the *natural world* of climate and landscape, water sources, quality of air, and animals and plants. The natural world provides the resources essential to the survival of all species. However, lack of attention to preservation of the natural world and careless, destructive abuse of our natural resources endanger us. Exploitative power by dominant groups creates technological pollution by corporations and government agencies of our air, water, soil, and food. Toxic materials are tolerated in disadvantaged neighborhoods, workplaces, and schools. Beyond supplying resources essential to survival, the natural world also lends special meaning to everyday life. Human beings have a need for a sense of kinship with nature, arising out of our evolutionary heritage. The kinship is expressed in our joy of pets and plants, our pleasures from walks in the park and swims in the ocean. Pets, for example, serve numerous functions such as companionship and protection.

In ecology, *niche* refers to the status occupied in a community's social structure by its individuals and groups. Because dominant groups discriminate on the basis of personal or collective characteristics such as color, gender, sexual orientation, socioeconomic status, physical or mental condition, many people are forced to occupy niches that limit their opportunities, rights, and aspirations. Dominant groups coercively use power to oppress and disempower vulnerable populations, creating and maintaining such "social pollutions" as poverty, chronic unemployment, lack of affordable housing, inadequate healthcare and schools, institutionalized racism and sexism, homophobia, and barriers to community participation by those with physical or mental disabilities. Communities of people are placed in marginalized, stigmatized, and destructive niches such as "welfare mother," "ex-addict," "ex-con," "the underclass," "homeless," "borderline," and so on.

Individuals, Families, and Groups

Over the *life course*, individuals, families, and groups experience unique developmental pathways.[2] Diverse human experiences create distinctive transactional processes that occur and recur at any point in the life course. These developmental processes take place within the context of historical, social, and individual time. People born at the same period of time—birth cohorts—experience common formative influences, which have a profound effect on their opportunities and expectations. Because birth cohorts live through a different *historical time* and social forces, they undergo developmental processes of growing up and growing old differently from other birth cohorts. For example, the Depression of the 1930s, World War II in the 1940s, the civil rights movement and War on Poverty of the 1960s, the Vietnam War of the 1970s, the terrorist act of September 11th, wars in Iraq and Afghanistan, and the dramatic economic changes of the 2000s differently shaped the experiences and expectations of the respective birth cohorts. Each birth cohort was deeply affected by its generational events.

The timing of collective life issues in a family, group, or community also influences individual bio-psycho-social development; i.e., *social time*. For example, in contemporary society,

less predictable timetables exist for beginning and completing school, leaving home, remaining single or marrying, having a child, beginning a new career, retiring, etc. Similarly, family cultures may have different timetables for male and female developmental expectations. These collective experiences also affect people's experiences over the life course.

Within the context of historical and social time, people construct their respective meaning from life experiences. Personal constructions or narratives, *individual time*, also profoundly influence human development. Essentially, a life course view emphasizes understanding the impact of historical, social, and individual perspectives and sensitivity to the differences in human development.

Over the life course, individuals, families, and groups deal with external *life stressors* and their associated demands (Lazurus & Folkman, 1984). A life stressor(s) (e.g., job change or loss, separation and divorce, death and dying, chronic and acute illness, interpersonal conflict, etc.) creates demands for the individual as well as the collective. When we appraise a stressor(s) as exceeding our external and/or internal resources to deal with it, we experience *stress* (manifested physiologically and/or emotionally). Stressful reactions and feelings range from unpleasant, to disquieting, to immobilizing. Intensity is determined by dimensions of the actual stressor(s), its meaning to the individual and the collective, and the availability of environmental supports.

When confronting a life stressor, a process of conscious or unconscious *primary appraisal* takes place by which people ask themselves, "What's going on here?" "Can I deal with it?" "Is this a challenge I can manage or is it a current or future threat of serious harm or loss?" (Lazarus, 1980). People appraise a life stressor as a challenge rather than a threat when they believe they have sufficient personal and environmental resources to master it. Although a perceived challenge might be stressful, feelings of excitement make adrenaline flow, and anticipated mastery prevails. In contrast, an appraised threat of harm and loss creates feelings of vulnerability and risk. One person's threat is another person's challenge. The interplay of cultural, environmental, and personal factors as well as past experiences affect primary appraisal processes.

When a life stressor is perceived as a threat, a process of *secondary appraisal* takes place when people ask themselves, "What can I do about this situation?" At this moment, they launch their efforts to cope with the stressor. Coping measures primarily consist of efforts to manage their feelings and/or to use personal and environmental resources to manage the stressor(s). Personal resources include problem-solving skills, flexibility, motivation, belief systems, resilience, optimism, and self-esteem. Environmental resources include informal social supports such as family, friends, neighbors; public and private social agencies, and various institutions; and the build and natural dimensions of the physical environment. The two interrelated functions of coping—*problem-solving* and *management of feelings*—have an interesting reciprocal relation to each other. In many coping responses to stressful person–environment encounters, the two functions may proceed together. However, in the early, acute phase of very severe stressors in particular, it may be difficult to proceed with problem-solving until intense negative feelings are brought under some degree of control. Otherwise the feelings are apt to immobilize problem-solving efforts. But such feelings may be difficult to control until the person has experienced some degree of progress in the beginning steps of problem-solving. A saving grace in this seeming paradox is an ability to cope with the life stressor by unconsciously blocking out negative feelings temporarily in order that some problem-solving can begin. This is frequently seen in the unconscious denial (defense) of people who have suffered a grievous loss or harm.

When their coping efforts are effective, people experience a sense of relief. When coping efforts fail, physiological and emotional strains are intensified, which can lead to augmented coping efforts, immobilization, or dysfunctional physical, emotional, and social responses. Dysfunctional responses generate more stressors in a downward spiral toward deterioration and disintegration. For example, a terminated romance may trigger a reactive depression. To cope with feelings of abandonment and hopelessness, a person may turn to alcohol to numb the pain. The dependence on alcohol may then

create additional stressors at the workplace and with other relationships.

The Life Model

Professional Function

Direct Practice Level

The professional function as defined by the Life Model is to *improve the level of fit* between people's (individual, family, group, community) perceived needs, capacities, and aspirations and their environmental supports and resources. Through processes of mutual assessment, a social worker and service recipient(s) determine the practice focus, choosing to:

1. Improve a person's (collectivity's) ability to manage stressor(s) through more effective personal and situational appraisals and behavioral skills;
2. Influence the social and physical environments to be more responsive to a person's (or collective's) needs; and
3. Improve the quality of person: environment exchanges.

When people are helped to change their perceptions, cognitions, feelings, or behaviors, their ability to manage a stressor(s) is improved, or its adverse impact may be reduced. By effectively influencing environmental responsiveness, people gain access to desired support and resources, and, in turn, they develop greater control over their lives. Finally, when the exchanges between people and their environments are improved, both actively adapt to the needs and demands of the other.

Community, Organizational and Political Levels

Social workers in practice today deal with profoundly vulnerable populations, overwhelmed by circumstances and events they feel powerless to control. On a daily basis, social workers are bombarded and reminded of the devastating assault on our clients and the dismantling of entitlements and services. The poor (particularly of color), the sick, the children, the immigrants are blamed for their plight and held to pay for the excesses of the affluent in our society. The anger, the alarm, and the despair intensify as people anticipate the suffering that lies ahead and the inhumanity that permits such injustices.

Corporate and other special interest lobbies assure a widening gap between the poor and the wealthy, as the poor become poorer, the wealthy become wealthier. The gun lobby and polluters reign supreme. While influential voting blocs receive government subsidies, the "safety net" established to mitigate and cushion economic forces is being brutally reduced. Martin Luther King, Jr., mordantly observed that our society preaches socialism for the rich and rugged individualism for the poor.

When community and family supports are weakened, social deterioration increases the risk of personal deterioration. The task of providing direct services to vulnerable and oppressed populations becomes progressively more difficult to fulfill. Within this social context, our professional function must include involvement at the community, organizational, and political levels. In Life-Modeled practice, professional function includes: mobilizing community resources to improve community life; influencing organizations to develop responsive policies and services; and politically influencing local, state, and federal legislation and regulations.

In this way, the historic polarity of cause versus function (Lee, 1929) is replaced with a contemporary melding of cause and function as an essential part of Life-Modeled practice (Schwartz, 1969). Historically, the profession experienced interpersonal and ideological conflicts between those who emphasized bringing about social change in behalf of social justice, the "Cause," as the primary characteristic of social work, and those who emphasized "function" as the primary characteristic of social work practice; that is, the technologies used by practitioners to bring about individual change. In reality, however, a cause won requires a function (technology, services, and programs for individuals, families, and groups) to carry it out. A further and specific technology (organization and political advocacy) is required for successfully winning a cause. Clearly, both cause and function must be hallmarks of practice and education for practice if social work is to ready itself for the new century.

Problem Definition (Person: Environment Exchanges)

How a stressor is defined largely governs what will be done about it. If, for example, the source of a painful life issue is believed to be internal and defined in psychological terms, a disease model will psychologically guide social work interventions. Goals will refer to internal change through gaining psychological insight.

For example, Billy does not pay attention in school, and the school threatens to transfer him to a special school. Organic disability has been ruled out and the life issue is defined as an emotional disturbance. This emphasis on psychopathology leads to a linear, dichotomized view of the child and his environment. He has an internal disorder that requires psychological "excision." He and his mother might be viewed as having symbiotic difficulties in separating, so Mother is added to the treatment program. Different therapists might treat the mother and child. Help exclusively focuses on psychological processes. Little or no attention is given to school, social networks, and neighborhood conditions that might contribute to the life stressor.

Similarly, if Billy is viewed through a cognitive behavioral lens, the emphases will be on teaching and rewarding more adaptive behaviors and extinguishing maladaptive behaviors. This view will also encourage a dichotomized child-and-environment association. The entire responsibility and burden for change is placed on the child.

If life issues are defined as rooted in social pathology, then intervention is likely to be conceived in social-institutional terms, on a social action. Goals will refer to external change, and the practice method will be primarily case or class advocacy. In advocating for Billy, his right to stay in school may be won. He can stay in school, but the life issues that had kept him from learning in school may still remain. However, in Life-Modeled practice, the social-pathological definition does not preclude individual attention to Billy and his mother as well as to advocacy.

If life stressors are defined as disharmonious *person–environment exchanges*, then interventions are likely to be conceived as improving the *level of fit* between Billy and his environments. Goals will refer to reducing or eliminating the life stressor if possible, strengthening coping skills, and acquiring environmental instrumental and emotional resources.

Psychologically oriented skills will be directed to progressive forces in the personality or their development. These include sensory-perceptual capacities, positive emotions, and thinking and problem-solving abilities. Supports in the organizational and network fields and physical settings will be mobilized and used. If needed, the work will include increasing the responsiveness of the organization affecting the client, including the worker's own agency.

In Billy's situation, depending on the source(s) of the stressor(s), several separate or joint entry points into the person–environment field might be possible for effective help:

1. If the stressor arose from Billy's difficulty with the life transition of adapting to a nourishing school environment, help is directed to improving his coping skills through individual or group (other boys in a situation similar to Billy's) modality (Gitterman & Shulman, 2005).
2. If the stressor arose from the family's dysfunctional patterns, help is directed to modifying those patterns with the family or a few families experiencing a similar stressor (Wise, 2005).
3. If the stressor arose from dysfunctional exchanges between Billy and family and school, help is directed on an individual, family, or group basis toward removing barriers in their communication and stimulating mutual problem-solving.
4. If the stressor emerged from the social structure and climate of Billy's classroom, the social worker and teacher could undertake classroom meetings. Such meetings are designed to help the children (and teacher) learn to express their feelings and ideas about their shared experiences. Such an approach would not only help Billy, but on a preventive level it could be helpful to all the children and to the teacher by reducing scapegoating by the children, biased responses and expectations held by the teacher, or other dysfunctional exchanges.
5. If the stressor came forth from a lack of afterschool resources, the worker could try to help the school obtain a grant and develop a program.

6. If the stressor converged from Billy's concerns about overcrowded classrooms, unsafe school bathrooms, or fears of walking past the neighborhood drug users and dealers or assaultive teenagers on his way to school, his parent(s) could be helped to join with other concerned neighborhood or community parents in approaching the school, police, and local legislatures, in order to improve school conditions and to gain safe school routes.

This analysis is purposively oversimplified to highlight the varied practice options emerging from the Life Model's broad focus on person–environment exchanges. In reality, Billy's stress most likely arose from multiple sources. Sometimes effective work on one stressor supports coping with others. Other times, work is directed to two or more stressors (guidelines for appropriate focus are discussed later).

The major point is: a social worker using a Life Model conceptual lens is more likely to "see" diverse points of entry into a complex situation and less likely to fit a client into a narrow theoretical construction. Our practice theories and models must be responsive to people and their situations rather than fitting their life issues into our own theoretical and practice preoccupations and biases. Similarly, a worker's specialization in individual, family, group, or community practice should not determine what service is provided, but rather the received service should be based on applicant/client needs and preferences.

Life Stressors Schema

Over the life course, people must cope with three interrelated life issues: difficult life transitions and traumatic life events, environmental pressures, and dysfunctional interpersonal processes. Although these three life stressors are interrelated, each takes on its own force and magnitude and provides focus to practice with individuals, families, groups, communities, organizations, and politics.

1. *Difficult life transitions and traumatic life events*: Life transitions include biological as well as social changes. The physical and biological changes of infancy, childhood, puberty, adolescence, adulthood, and advanced age are universal. While these changes are universal, social expectations and patterns associated with the changes vary across cultures. For example, puberty is a biological condition; adolescence is a social status.[3] Biological factors associated with pubertal changes elicit changing responses and demands from the environment of family, school personnel, and peers.

People also experience stress from entering new experiences and relationships and leaving familiar ones. Beginnings (entrances) generate stress. Entering a new neighborhood, school, relationship(s), or job; having a baby, or acquiring a new diagnostic label are filled with ambiguity, new role expectations, and challenges. Leavings (endings) are usually more stressful than beginnings. Ending an intimate relationship through separation or death, losing a job, leaving a school, separation from a child or parent are characterized by painful loss and change. Unexpected life transitions are more stressful than expected ones. Similarly, when life entrances and exits come too early or too late in the life course, they are likely to be stressful. For example, a young adolescent who becomes a parent, and an older grandparent who has primary responsibility for parenting, may find that the timing of the experience creates additional stress. The abruptness, enormity, and immediacy of traumatic life events cause personal crises and long-lasting residue of pain. Unexpected death and illness, the violence of rape, displacement caused by natural disasters, loss of a cherished home or job can be overwhelming and immobilizing. Severe physical, psychological, and/or social loss is a primary characteristic of trauma.

2. *Environmental pressures*: The social and physical environments provide essential instrumental resources and emotional support to the tasks of daily living. They also create significant troubles and distress. For some individuals and collectives, organizational and informal network resources are available, but they are unable to access or use them. For others, organizational and network structures and functions are unresponsive to their personal styles and needs. And for still others, important organizational and network resources are unavailable, and their basic

needs remain unmet. Similarly, the physical environment's natural and built resources may be available, but some people are unable to use them. For others, available physical resources are unresponsive to their styles and needs. And for others, basic natural and built resources are extremely minimal.

3. *Dysfunctional interpersonal processes*: For conceptual clarity and consistency, interpersonal processes apply only to when the social worker is involved with a family/group system or subsystem. If a social worker, for example, is working with an abused woman, but not with the partner, the focus is on life-transitional concerns (e.g., separation, grief) and/or environmental concerns (e.g., linkage with community resources, negotiating with her partner, securing a court order of protection). In contrast, a focus on dysfunctional interpersonal processes requires joint work with both partners and/or the children.

In responding to life-transitional and environmental stressors, the family and group serve as resources and buffers. However, problematic internal family or group relationships and communication patterns exacerbate existing stress and/or become yet another painful stressor in people's lives. Dysfunctional family and group processes are expressed in such behaviors as scapegoating, rigid alliances, withdrawal, and hostility. While dysfunctional for individual members and the collective, these behaviors may maintain an illusion of functioning and the collective's continued existence. For example, scapegoating may stave off disorganization in the family or group at the expense of the individual member. These behaviors become fixed and obstruct potential for mutual support.

Similar dysfunctional processes arise between social workers and clients in the form of discrepant expectations, misunderstandings and misperceptions, value conflicts and differences in backgrounds (Gitterman, 1983, 1989, 2012). These processes interfere with the helping process and create additional stress for clients.

Case Example

A life stressor often generates associated stressors. When it or they are not successfully managed or resolved, additional stressors erupt (the "spread phenomenon"). For example: Ms. Northern, the manager of a single mothers' residence, referred Marcia, a 23-year-old African American single mother of a two-month-old daughter, Denise, to Family Services. Marcia had been living in the residence for the previous six months, and remaining there was made conditional on her accepting the referral to the agency. In the first session, she expressed anger at Ms. Northern for forcing her to come to the agency and blaming her for all the arguments and fights in the residence. At the same time, she wanted help with the stress in her life—particularly being a single parent and her new role as a mother. She said that at times she was overwhelmed and even angry at Denise "for being so needy." People mutually agreed to focus on three interrelated stressors:

1. She haCh the life transition from living with a partner to living as a single parent;
2. She had to deal with problematic environmental transactions with the residence manager and the other residents; and
3. She had to secure permanent housing.
4. A fourth stressor evolved from our work; namely, her distrust and testing of me (and my reactions).

The life-transitional stressor centered on Marcia's entry into motherhood and becoming the sole caretaker and responder to the unrelenting demands of a young infant. Marcia's history fed ambivalence about her single-mother status and its associated roles. She was placed in foster care at age seven, moved from home to home, and lost contact with her mother at the age of 13. While she felt rage at her mother for not wanting her ("I'll probably forgive my mother someday, but right now I'd like to kill her even though she's already dead"), she was trying to forgive her because she recognized that her mother was a "victim of the system." Soon after giving birth, she looked for a job and child care with minimal success. She stated, "I feel stuck, isolated, like I have no life of my own. . . . I can't get off welfare without a job; I can't get a job without child care; and I can't afford child care while on welfare." Marcia felt caught in a "vicious circle" that made her want to "throw off all responsibility."

Marcia's ambivalence was evident in her vacillation between poignantly questioning whether Denise's needs exceeded her ability to give; and vehemently asserting that she would sell her body, if she must, to keep Denise happy, safe, well-fed, and with her. When Marcia perceived herself to be

a capable mother, she was responsive to Denise. However, when the urgency of Denise's needs conflicted with Marcia's needs, Marcia became overwhelmed with the depth of her own unmet needs. Marcia's pain became more intense and intolerable. At these moments, she impulsively responded to Denise with anger and impatience. Incidents the worker observed during a couple of sessions illustrate life-transitional stress:

> 1/11: Denise started to fret a little bit. Marcia responded by talking to her in a non-stop, repetitive manner. Denise tried to follow her mother's erratic cues, but looked helpless and confused. She began to cry, and Marcia jammed a bottle in her mouth, which began to leak all over. Marcia swore and her anger became overt. Denise began to choke on the milk, and Marcia, trying to control her anger, set Denise on her lap, vigorously patting her back. When Denise regurgitated, Marcia scolded her. She seemed really furious and made a few half-hearted attempts to smooth her rage away by calling Denise by various pet names, and telling her that she was loved.
>
> 1/25: At the end of the session, Marcia yelled at Denise, "What the fuck?! . . . What did you do now? . . . I can't believe this! . . . Guess what, smarty pants, I brought another set of clothes—na! na!" Marcia continued to swear and became increasingly agitated, bordering on rage, that Denise had soiled her diaper. She was again talking to Denise non-stop, finally yelling, "And that fucking bastard of a father you have is a good for shit." She continued talking to Denise as she angrily unsnapped her clothes, saying "stinky, stinky, stinky. . . ."

Marcia felt that Denise, like the rest of the world, was unfair and taking advantage of her. With unresolved feelings of being abandoned by her family and by Denise's father, pressures of being a single parent ("I'm tired . . . I'm hungry . . . I hardly got to wash my face today"), and insufficient environmental supports and resources, Marcia was unable to be predictable and consistent with Denise. With so many of her own needs unmet, Marcia's had difficulty viewing Denise as a separate human being with separate needs.

Severe environmental pressures exacerbated Marcia's difficult life transitions. Marcia lived well below the poverty line, receiving Aid for Families with Dependent Children (AFDC), Medicaid, and food stamps benefits. She considered herself homeless—having a maximum of six months left at the residence before she must leave. She further stated that Ms. Northern "kept holding it over me that she can kick me out." She added with bravado, "I am a survivor—I am not going to take shit from anybody," least of all Ms. Northern and the other "girls" in the residence. With neither sufficient income nor the necessary child care to support herself and Denise, Marcia was feeling increasingly hopeless about getting off welfare. Her relationship to her last foster parents represented the single most enduring relationship in Marcia's life. She described them as "my friends when I need them." Outside of her ties to her foster family, her social network was negligible. She complained that she had no friends, that she pushed people away without realizing it. Finally, she had severed all ties with the remainder of her biological family, many of whom lived nearby, because "I can't forgive them for refusing to take me and my sister and brothers in when my mom caved in."

Marcia's environment was fraught with severe limitations: chronic racial prejudice and discrimination, lack of affordable housing, limited employment opportunities, unavailability of childcare services, Denise's father's heroin addiction, cohabitation with several other young women and their babies, demand for conformity to house rules, a limited social network, and finally, the unceasing and ever-present responsibility for being the sole caretaker of an infant. These environmental stressors combined, and acted independently, to lessen significantly Marcia's ability to tolerate the demands of new motherhood, which had radically changed her life. The social environment only served to exacerbate Marcia's emotional and social neglect and profound sense of despair and worthlessness with which she probably had struggled with since childhood.

In working together, *interpersonal stress* also developed between Marcia and me, the social worker. Marcia vacillated between viewing me as a supportive listener and advisor, and as an authority figure not dissimilar from Ms. Northern, who "sat in judgment" of her. In the second session, she commented, "I've got to do the political thing, and that's why I'm here—I've got the picture. . . ." Beyond the obstacle posed by a mandated service, Marcia's and my differences in race, social class, and level of education contributed tension in our communication.

Assessment

Throughout the helping process, social workers make decisions about such issues as points of entry in the person–environment field, goals and tasks, practice modality, methods, time arrangements, and life stressor(s) focus. Professional judgments are made *at any moment in time* about which messages to explore (probe, chase) or when to respond with information and advice, or when to point out contradictions between verbal and nonverbal communication. Similarly, *during and after each session*, social workers make decisions about focus and next steps. These professional judgments must be based on disciplined reasoning and inferences within the context of sensitivity to differences related to values, beliefs, and perceptions derived from one's social class, race, ethnicity, religion, gender, sexual orientation, age, and mental and physical states.

Valid and reliable decisions rest on three assessment tasks: collecting, organizing, and interpreting data. First and foremost, professional judgments are based on *collected data*. To help an individual, family, or group with life stressors, workers and applicant(s)/client(s) examine available salient information. Salient data include: the nature of the life stressors and their severity; the person(s)'s perceptions of and efforts to deal with the stressors; the person(s)'s perceptions of the role of family, networks, organizations, and features of the physical environment in cushioning and exacerbating the stressors; and expectations, if any, of the agency and social worker. *Mutuality* in stressor definition and collection of other relevant data actively engage applicants/clients in developing with the worker a common focus and direction. These data are collected from the person(s)'s verbal accounts, the worker's observations of nonverbal responses, significant others' verbal and nonverbal responses (obtained only with applicant's/client's informed consent), and written reports (also obtained only with the person(s)'s informed consent).

Many applicants/clients are affected by overwhelming life stressors. Harsh environmental realities, multiple stressors, and the associated pain understandably overwhelm practitioners. A schema helps a practitioner to *organize data*. The life-stressor formulation (i.e., difficult life transitions and traumatic life events, environmental pressures, and dysfunctional interpersonal processes) provides a tool for grouping and organizing data (see the case example of Marcia).

The life stressor schema also provides moment-to-moment assessment guidelines for professional interventions. For example, at an early moment in the third session, Marcia complained about her loneliness. At this moment, the social worker had to assess whether Marcia was asking for help in exploring her grief associated with developmental transition and losses. Or was she focusing on the lack of social connections in her life and asking for help with reaching out to organizations and social networks? Or was she at this particular moment indirectly voicing some degree of dissatisfaction with the worker's pace or style of helping? At each moment, the worker had to assess with Marcia whether she was asking for help with life-transitional, environmental, and/or interpersonal stressor(s). From moment to moment, Marcia might change her focus and the social worker must skillfully follow her cues.

The final professional assessment task is to *interpret* the collected and organized data. To be valid, professional inferences must be rooted in disciplined inductive and deductive reasoning rather than in personal values and biases. Using inductive reasoning, social workers engage applicants/clients in patterning and developing hypotheses about their person–environment exchanges, particularly the *level of fit* between personal strengths and limitations and environmental supports and obstacles. Deductive reasoning is more of a professional and less of a mutual process. The social worker applies relevant theory and research findings to person(s)'s life situation(s). For example, knowledge about post-traumatic stress disorder may help a social worker better understand a person's reactions to an unexpected life stressor.

The assessment tasks of collecting relevant information, its systematic organization, and the analysis of data are common to most practice approaches. However, several beliefs and goals are distinctive to the Life Model.

1. Engaging participation of applicant/client in the assessment process and developing *mutual* understanding,
2. Understanding the nature of person(s)–environment exchanges and the *level of fit* between human needs and environmental resources is the core assessment task,
3. Using the life *stressor schema* to organize and assess data, and
4. Emphasizing *moment-to-moment* assessment.

Intervention (Modalities, Methods, and Skills)

In helping people with their life stressors, the social worker may be called on to intervene at the individual, family, group, community, social network, organization, physical environment, or political level(s). Social workers must competently work within all modalities, moving from one to another as situations require. In life-modeled practice, mutual assessment of life stressors and the level of person–environment fit determine the selection of modality, rather than professional specializations and preferences.

Based on a belief that many professional methods and skills are common to most modalities, the Life Model emphasizes an *integrated perspective on practice*. A few formulations are particularly helpful in presenting common practice methods and skills. Life-Modeled practice is, like life itself, *phasic*. Its processes constitute three phases: the initial, ongoing, and ending. These phases provide a structure for conceptualizing and illustrating common professional methods and skills. However, in actual practice, these phases are not always distinct; they often appear, recede, and overlap. For example, in brief and episodic work, the temporal limits collapse the phases. Similarly, all beginnings are affected by past endings.

In the initial phase, the auspice of the service rather than the modality differentiates common professional methods and skills. Thus, a person(s)'s *degree of choice* (whether the service is sought, offered, or mandated) integrates practice modalities. For example, when a service is offered, the social worker begins by identifying her/his organizational auspice and role and presenting a clear offer of service, which takes into account people's perceptions and definition of their needs. The skills of offering a service are common to work with all modalities. Similarly, the life stressors schema supports an integrated practice related to assessment of, and interventions in, life-transitional, environmental, and interpersonal issues.

While emphasizing the common base of social work assessment and interventions, the Life Model also examines the methods and skills specific to each practice modality. For example, in offering a group service, the practitioner must have distinctive knowledge and skill in group formation. Forming a group requires achieving compositional balance; developing appropriate time arrangements related to number, frequency, and duration of sessions; deciding on group size; and developing organizational sanctions and supports. Distinctive knowledge and skill is identified for each respective modality.

While the Life Model presents practice principles, methods, and skills for integrative practice as well as for specific modalities, they are not prescriptive. This is so because practitioner style and creativity are indispensable. A mechanical "professionalism" expressed by projecting an impression of neutrality and impersonality is not helpful. Professional skills must be integrated with a humanness, compassion, and spontaneity. The social worker's genuine empathy, commitment, and willingness to become involved speak louder than assuming the "correct" body posture, saying the "right" words, or making the "appropriate" nonverbal gestures. Effective practitioners are "dependably real" rather than "rigidly consistent" (Rogers, 1961, p. 50).

Conclusion

This chapter is dedicated to Professor Carel Baily Germain. She died on August 3, 1995, just when people were editing the final manuscript of our second edition. She had a profound impact on my intellectual development as well as that of many others. A brilliant, internationally acclaimed scholar, she left a lasting gift to the profession. A creative and intellectual explorer and discoverer, she roamed the globe of ideas and discovered their relevance for a profession she deeply loved. Never satisfied with the intellectual status quo, she leaped forward

into uncharted theoretical territory, found new concepts from ecology, psychology, anthropology, and sociology, and made them available to us. Her ideas and words resonate throughout this chapter. More than a collaborator, she was a close personal friend whom I loved and miss.

Notes

1. Ecological theory perceives "adaptedness" and adaptation as action-oriented and change-oriented processes. Neither concept avoids issues of power, exploitation, and conflict that exist in the world of nature as well as in the social world of human beings. Adaptedness and adaptation are not to be confused with a passive "adjustment" to the status quo.
2. In the Life Model, "life course" replaces the traditional "life cycle" stage models of human development. Human beings do not experience universally fixed, sequential stages of development. Race, ethnicity, culture, religion, gender, sexual orientation, social class, and historical context have profound influence on individual and collective development.
3. Among some groups or classes in our society, a fully independent adulthood may not be recognized until the twenties. Furthermore, "adolescence" is not recognized in all societies. In some

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19

Meditation and Social Work Practice

Thomas Keefe

Meditation

This centuries-old methodology aims to teach people the ability to observe interactions and responses, and to make compassionate choices; self-observation reveals problems past and present, and ways of dealing with them.

Meditation is an ancient discipline wedded to several major psycho-philosophical systems arising from diverse cultures. Among others, American Indian, Central Asian Sufi, Hindu, Taoist, widespread Buddhist, and some Christian traditions have cultivated forms of meditation as sources of spiritual enrichment and personal growth.

Over 70 years ago, meditation began to attract Western psychotherapists, and eventually the scrutiny of the rational-empirical tradition of Western science (for a brief history of mindfulness meditation, see Germer, Siegal, & Fulton, 2005). In recent years, it has been operationalized, stripped of its mystical trappings, tested in a variety of contexts, and enriched with empirical understanding. Currently, it is becoming clear that one form of meditation that enhances mindfulness or undifferentiated awareness is being adopted by psychotherapists, including clinical social workers, and has been increasingly researched regarding its effectiveness and applications.

Meditation is a method that is adjunctive to social work practice. It is a mechanism for self-regulation and self-exploration. It can help reduce stress and aid coping. Its effectiveness in treating particular problems and persons is finding empirical support. It has the potential to be valuable in work with clients from diverse cultures. Yet meditation as a method continues to demand much from, and occasionally challenges, some theories underlying social work treatment for its full description and explanation. This chapter will track the origins, relevance, development, and application potential of meditation. Meditation, especially mindfulness meditation, has inspired a large and growing volume of needed research, and while a comprehensive review is beyond the scope of this chapter, reference will be made to founding and contemporary studies.

Description and Explanation: The Mind as an Open Hand

Meditation is a set of behaviors. Some of the consequences of meditation are directly observable; others can be indirectly inferred. For the purposes of this chapter, *meditation* does not refer to the mind's wandering and floating in fantasy or to the mind's laboring along a tight line of logic toward a solution. In contradistinction to these common notions, meditation is the deliberate cultivation of a state of mind exclusive of both fantasy and logic. While there are several varieties of meditation, they all share some common characteristics.

In essence, meditation is the development—or discovery, depending on one's orientation—of consciousness independent of visual and verbal thought. It is the deliberate cultivation of a mental state conducive to intuition. Meditation usually pairs a relaxed state of the body with either a concentrated or merely attentive focus of the mind. A brief description of this common process in meditation will help orient us to the method.

Method

One meditates by focusing attention on a single thing while physically relaxed. This focus of attention may be a sound (mantra), a design (mandala) (Kapleau, 1967), an object, a part of the body, a mental image, the breath, or a prayer. This ostensibly simple task is seldom immediately mastered. Noises, bodily stimuli, internal dialogues, monologues, images, and emotions can constantly interrupt the task to break one's attention. Meditation then becomes a task of first, continually noticing or being mindful of a distraction; second, recognizing or naming the loss of attention—e.g., "thinking," "feeling," "remembering," etc.; and third, letting go of any resulting chain of associations to return to the meditation focus. Releasing attention to a distraction, easily refocusing attention, and cultivating an attitude of noninvolvement in the distracting chains of association constitute meditation for the beginner. A perhaps useful analogy would be: "The mind becomes like an open hand. Nothing is clung to. Nothing is pushed away."

Some theorists and practitioners distinguish between two prominent forms of meditation. One is a concentrative form in which the meditator's attention is riveted to the meditation object to the exclusion of other stimuli. In contrast, insight or mindfulness meditation, described in more detail later, stresses the examination of these randomly occurring mental contents, often with a naming of each, such as memory, fantasy, fear, etc. There are many variations on these two themes. Interestingly, studies of electroencephalographic changes accompanying representative variations on these two themes indicate changes in brain activity that parallel the form of meditation underway (Anand, Chhina, & Singh, 1984; Kasamatsu & Hirai, 1984). For advanced meditators, easy attention to the meditation object actually facilitates the examination of randomly occurring internal and external stimuli when they adopt the mental attitude of an open hand.

Mindfulness

In the past two decades, one branch of meditation has been identified as a salient and relatively easily accessed adjunct to various psychotherapeutic approaches (see, e.g., Hick & Bien, 2008; Germer et al., 2005; Roemer & Orsillo, 2009) and useful in coping on a daily basis (Germer, 2009; Williams, Teasdale, Segal, & Kabat-Zinn, 2007). The mindfulness meditation—described previously and at the end of the chapter—is further subdivided into "formal" and "informal" activity, with the meditation being the formal endeavor and mindfulness being the informal application of mindfulness skills in daily life (Germer et al., 2005; Roemer & Orsillo, 2009).

Hick (2008) describes the current interest in mindfulness:

> Practitioners such as psychotherapists, social workers, psychiatrists, family therapists and other mental health professionals, as well as medical doctors, are showing extraordinary interest in mindfulness and how it affects practice, both for themselves and their clients. There is unparalleled interest in mindfulness-based interventions and approaches for a range of issues such as addictions, suicide, depression, trauma, and HIV/AIDS, to name a few. (p. 4)

Several definitions of mindfulness can help triangulate the mental activity involved

in mindfulness meditation. Undifferentiated or unconditioned awareness is certainly an aspect of mindfulness. Definitions by researchers, psychotherapists, and others provide a fuller picture. A succinct definition comes from Gunaratana (2002), who tells us that, in meditation, "We train ourselves to see reality exactly as it is, and we call this special mode of perception mindfulness" (p. 33). While discussing mindfulness and psychotherapy, Germer et al. (2005) refine the definition of mindfulness as having three components: "All components of mindfulness—awareness, present-centeredness, and acceptance—are all required for a moment of full mindfulness" (p. 8). Under the influence of mindfulness, a particular attitude of mind and comportment is seen to develop over time. This was seen as the "approach" side of the hard-wired approach–avoidance construct by Williams, Teasdale, Segal, and Kabat-Zinn (2007): "Mindfulness embodies approach: interest, openness, curiosity (from the Latin *curare*, 'to care for'), goodwill, and compassion" (p. 67). Finally, Hick (2008) reports a definition from Lau and his associates, who combined definitions from multiple authors rendering mindfulness as "a nonelaborative, non-judgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is" (p. 5).

The Experience

A fuller understanding of meditation can be derived from a description of the experience. Most initially find that their attention is disrupted by a stream of thought. Distractions by the stream of thought may present themselves in a hierarchy of personal importance. The incidents of the recent past evoking the most anxiety or anger intrude first. These are followed by memories or anticipations of decreasing concern. Thoughts, images, and feelings well up, momentarily distract the meditator, and if not clung to or elaborated upon, burn themselves out. When paired with the relaxed state of the body and followed by refocusing upon the pleasantness of the meditation object, a global desensitization (Goleman, 1976) of cathected thoughts and images occurs. Increasing equanimity and objectivity secure the meditator in an attitude of observation of the thoughts and feelings that make up the symbolic self and its constituent concerns.

The meditation behaviors of focusing attention, recognizing when attention is interrupted, sometimes naming the nature of the interruption—e.g., "thinking," "feeling," "remembering," etc.—and deliberately refocusing attention are forms of *discrimination learning* (Hendricks, 1975). Perceptions, thoughts, and feelings are discriminated from the meditation focus. Slowly, the capacity to discriminate thoughts and feelings from any focus of attention is amplified. The meditator discriminates memory and anticipation, fear, and guilt from the immediate focus of attention. He or she cultivates a present-centeredness. This is operationalized in research as *time competence*, a component of self-actualization (Brown & Robinson, 1993). As this learning to discriminate among the ingredients of consciousness or contents of mind becomes easier, an *observer self*, also called the *watcher self* (Deatherage, 1975) or *witness* (Goleman & Schwartz, 1984), emerges. The observer self is helpful in a variety of areas of functioning.

The observer self is not characterized as an alienated, depersonalized, or neurotic self-sustained by disassociation processes or suppression of thought and emotion. It is, instead, a secure subjectivity that, at its most refined level, allows mindfulness of internal experience without judgment, defense, or elaboration. In the cultivation of this observer self of meditation, several helpful capacities emerge that are taken up later and elaborated on as we examine meditation as a technique in personality change.

Capacities Learned in Meditation

For those of us involved in social work treatment, examining the postulated lessons transferred from meditation practice into the psychosocial functioning of the meditator may prove valuable. Some of the things learned from meditation can be termed "capacities," and there are several of them.

Focus and Inner Direction

The capacity to focus the attention on a single thing or task in present time is enhanced. This is called "one-pointedness of mind" in some traditions. When carried over into everyday life, tasks undertaken with this state of mind are completed with less distraction and with the expenditure of less energy. The Buddhists call this state of mind, carried into everyday life, *right mindfulness* (Burt, 1955).

Consider the snow skier: Skiing requires concentration. As her speed increases and the slope becomes steeper and the surface more varied, her concentration must intensify. If the skier suddenly becomes preoccupied with a distant drop-off, a concern with her appearance or relative performance, or with an intruding and distracting fear of falling, her concentration is broken and the possibility of falling is more likely. The "clutched" athlete, the self-conscious speaker, the ego-involved attorney, and the over-identified social worker are all momentarily distracted from their intended focus, and this is experienced as loss of inner control. Brown and Robinson (1993), in a study of the relationship between meditation, exercise, and measures of self-actualization, found that meditation alone or in combination with exercise significantly increased subjects' inner direction beyond that of both subjects who only exercised and control subjects who did neither.

Discrimination Learning

The capacity to discriminate among internal stimuli, such as memories, fears, anger, etc., provides a measure of enhanced self-awareness that may be useful in empathic relating and communicating one's responses in social situations. Coupled with a present time focus, the capacity to view these internal processes with a degree of objectivity and non-attached concern allows enhanced performance in complex behaviors.

Receptive Perception

Finally, the capacity for an altered mode of perception is cultivated in meditation. The passive–receptive phase of perception, wherein one allows the senses to be stimulated, delaying cognitive structuring and allowing the things perceived to speak for themselves, is enhanced. Sidney Jourard (1966) and Abraham Maslow (Goble, 1970) both described this form of perception as necessary to supplement the more active, structured, need-oriented perception. Nyanaponika Thera described the Buddhist view of this perceptual mode generated in meditation as *bare attention*. Thera (1970) elaborated:

> It cleans the object of investigation from the impurities of prejudice and passion; it frees it from alien admixtures and from points of view most pertaining to it; it holds it firmly before the eye of wisdom, by slowing down the transition from the receptive to the active phase of the perceptual or cognitive process, thus giving a vastly improved chance of close and dispassionate investigation (pp. 34–35).

In sum, we see the results of meditation behaviors as including such global experiences and capacities as relaxation, desensitization of potentially charged stimuli, concentration of attention, inner direction, intentional present centeredness, enhanced discrimination, self-awareness, and augmented perceptual modes. Some of these theoretical and subjectively observed capacities have been addressed in clinical social work literature (such as Turner's review, 2009), as a mindfulness skill set: attention, affect regulation, attunement–neurological activation related to interpersonal relationships, and empathy.

While these capacities have implications for generally enhanced personal and interpersonal functioning, meditation is used to counter specific responses or behaviors seen as symptomatic or problematic for clients. As will be seen later, those supported by research include most prominently anxiety and stress, some forms of depression, substance abuse, phobic reactions, and interpersonal difficulties. Generally arising from traditions that are unhampered by notions of health and illness in relation to human behavior, meditation has been used in the personal growth and consciousness development of both the average lay person and the select initiates of particular religious orders. Used as a tool to extend the potential of its practitioners, meditation has been oriented toward the possible rather than the merely adequate or healthy

in human functioning. Consequently, there are several ramifications for social work treatment. Meditation has, as shall be seen later, potential for the social work practitioner as well as for the client. It requires no predisposing diagnosis for its use, although there are empirically supported indications for its use and definite contraindicators. It has potential for use with individuals, families, groups, and in community settings.

Origins and Paths into Social Work Treatment

As indicated earlier, meditation comes to us from diverse cultures and traditions. Yet the various forms, whatever their source, express a common origin in humankind's intuitive modes of thought. As an example, the *zazen* meditation of Zen Buddhism has its origin with the intuitive enlightenment of Siddhartha Gautama, "Buddha," in about 544 B.C. (Burt, 1955). Siddhartha was said to have led a life of wealth and indulgence and then a life of asceticism in his quest to find the cause of suffering in the world. After relinquishing these extremes of self-preoccupation, his answer and enlightenment came. His Four Noble Truths together with his Eightfold Path served as vehicles for transmission of insight into his wisdom. The Buddha's Eightfold Path includes meditation as one of the routes to freedom from suffering (Beck, 1967). Thus it is a central practice in all branches of Buddhism, although characteristic variations have developed in each tradition. Buddhism is thought to have been carried from northern India of Siddhartha to China in A.D. 520 by Bodhidharma (Kennett, 1972). There the Indian *dhyana* became the Chinese *Ch'an*. Influenced by Taoism in China, meditation was transmitted to medieval Japan, where it is referred to as *Zen*, which literally means "meditation." Zen found its way to the West by several routes and has been popularized by D. T. Suzuki (1964), Allen Watts (1961), and others.

But Zen is only one form of meditation that has ancient and divergent cultural origins. In fact, meditation has been an important practice in the major world religions: Hinduism, Confucianism, Taoism, Buddhism, Judaism, Islam, and Christianity.

For centuries in India, meditation was taught in the oral traditions of the Hindu Vedas. Then, sometime before 300 B.C., some of these traditions of meditation were written in the Yoga Sutras of Patanjali (Wood, 1959). The techniques used in yoga include mantras, visualizations, breath control, and concentration on various postures or parts of the body. The purpose of yoga meditation is to unify the body, mind, and spirit, allowing an individual to become whole, integrated, and functioning as *Atman*, a godlike higher self (Prabhupada, 1972). Ultimately, union with Brahman, or God, is achieved. The *Bhagavad Gita* (200 B.C.) suggests meditation as one of the three main ways to achieve freedom from karma (Prabhupada, 1972), or the world of cause and effect.

In China, Confucius recommended meditation as a part of one's personal cultivation. Later it became the central feature of the Lu Chiu-Yuan school of Neo-Confucianism. Taoists during the same period in China also used meditation to facilitate mystical harmony with the Tao (Welwood, 1977).

Some types of Jewish mysticism incorporate meditation to achieve metaphysical insights. Philo of Alexandria (15 B.C.–A.D. 50) and other Jewish scholars in the Middle Ages used this type of meditation.

Since the 12th century A.D., Sufism, a popular folk Islam, has encouraged various types of meditation as well as other techniques such as whirling to induce trance. Meditation is considered to be an important remembrance of Allah. It is also used to facilitate perceptions of inner reality (Al-Ghazzali, 1971).

Christianity, too, is rich in traditions using a variety of meditative techniques, from the early Christian Gnostics to the medieval monasteries to 18th-century Greek Orthodox teachings. Some original training manuals include *The Philokalis* (Greek Orthodox) and *The Way of Perfection* by St. Theresa of Avila (Jourard, 1966). Recently, the origins of Western forms of meditation have been traced to early Christianity, including meditation's decline as a Western tradition in the 17th century (Schopen & Freeman, 1992). Driskill (1989) observed that the Christian tradition once recognized the therapeutic as well as the religious value of meditation.

The more recent work of clinicians and researchers such as Kabat-Zinn et al. (1992), with their *mindfulness-based stress reduction* used in pain management, and Huss and Baer (2007), with their integration of mindfulness and cognitive therapy, *mindfulness-based cognitive therapy*, have helped inform the knowledge base for clinical social work. The work of Turner (2009) and Birnbaum and Birnbaum (2008) on mindfulness meditation should contribute to the flow of theory and findings into social work.

Form Follows Philosophy

Interestingly, the philosophies of the Yogic and Buddhist meditators are reflected in their contrasting meditation behaviors. For example, most Yogic meditators seem to cultivate a habituation effect (Ornstein, 1977) to the object of meditation and experience a loss of perception of the object or a "blending" with it. This subjective experience of habituation corresponds with the brain's production of electromagnetic alpha waves that accompany relaxed awareness. These Yogic meditators reduce their awareness of outside stimuli and experience a blissful indifference sometimes called *samadhi*. For the Yogi, *samadhi* is a high state of self-transcendent consciousness, a link with the Godhead or universal consciousness to be attained through rigor and single-minded devotion.

Advanced Zen meditators undergo the habituation effect and record increased alpha wave productivity. However, when exposed to outside stimuli while meditating, they respond with sharp, momentary attention, as evidenced by corresponding short bursts of beta wave productivity. These meditators seem to be able to respond repeatedly to external stimuli without habituating to them. Psychologist Robert Ornstein (1977) suggests that they are responding without constructing a visual model or verbal label for the intruding stimulus, perceiving it clearly each time. For the Buddhist, the state of *nirvana*, analogous to *samadhi*, is attained but rejected by the protagonist in favor of an act of compassion. This act is to enter the world in a state of wisdom, or *prajna*, there to undertake the work of bringing other sentient beings—or aspects of the larger consciousness—to enlightenment. In interesting ways, then, the internal responses of meditators parallel the doctrines of their traditions. Given these parallels found in other traditions, it seems natural that meditation should become a part of Western therapeutic traditions. The reciprocal influences between meditation and social work should be exciting.

Relevance for Social Work

While meditation comes to the West by several ancient paths, it has far from penetrated to all parts of our industrial culture. Professional social work, a byproduct of the industrial market system, is itself relatively new in humankind's endeavors. Meditation is new to social work. It comes to the profession at a time when variety, diversity, and eclecticism are the norm. As the instability, contradictions, and stresses of socioeconomic change generate a search for relevant modes of treatment, meditation will perhaps be another technique to be taken up in the interest of more effective practice.

This vision of the reasons for the profession's potential interest in meditation rests on a common contemporary human experience: stress. Basically because of the contradictions and instability of the economic system, we live in an age of anxiety. Meditation may fill a symbolic and practical need in our personal and professional psyches. To face the fragmentation and contradictions of our lives, a safe and quiet place to recollect, sort out, and relax is a natural balm. Moreover, if meditation is not only a clinical adjunct technique but also a facilitator of other social work skills, and a precursor to action as well, it has relevance for the profession as a whole.

Meditation is used or discussed by various psychologists and psychiatrists. Engler (1984) notes that techniques from all the major meditative traditions have been incorporated or adopted for use in psychiatric treatment settings. Psychologists using a biofeedback apparatus are naturally drawn to meditative techniques, and their work influences social work colleagues. Psychologists do the lion's share of research on meditation (Shapiro & Walsh, 1984).

Meditation as an aid for psychotherapists themselves (Keefe, 1975) and in the development of empathic and other therapeutic skills (Germer et al., 2005; Hick & Bien, 2008; Keefe,

1976, 1979; Roemer & Orsillo, 2009) has been proposed and examined clinically (see, e.g., Sweet & Johnson, 1990) and by research, with mixed results (Pearl & Carlozzi, 1994). Both endeavors have generated interest among clinical social workers and social work educators. Other workers have had experience with meditation, especially Transcendental Meditation (TM) (Bloomfield & Kory, 1976), and have incorporated it into their work. Finally, integrating mindfulness with cognitive and dialectical therapy has been clinically developed in treatment of people with borderline personality disorder (Huss & Baer, 2007). While getting a good fix on the extent of its use is difficult without a study, one can assume that as more findings are reported in the literature, more interest will be generated in the social work profession.

Cross-Fertilization and Diversity

As noted in the discussion of the historical origins of meditation, the technique has been refined for personal growth and positive behavior change in several cultural traditions (e.g., Shapiro, 1994). In each of these traditions, meditation is linked to conceptualizations that can help explain for practitioners the subjective experiences of meditation and their behavioral and psychosocial outcomes. Each culture has placed meditation in its own context. To use meditation as an adjunct to psychotherapy and social work treatment is to place it within a rational, technological cultural context. In so doing, we can refine and extend meditation techniques and at the same time enrich our own traditions.

Because meditation has its origins in diversity, it has a naturally diverse appeal. In the author's experience, clients and practitioners whose cultures have longstanding meditative traditions have found the contemplative aspects of meditation compatible with their values and self-development. Others' reactions have ranged from very receptive to wary, depending on their particular backgrounds. While these observations are from limited clinical and teaching experience, a reasonable generalization is that people from cultures and subcultures that value contemplation and intuitive modes of thought have good potential to be receptive to meditation as a treatment technique.

Meditation, the Personality, and the Conditioned Self

The experience and outcomes of meditation related to the organization and dynamics of the personality extend Western psychodynamic conceptualizations. They modify or extend psychodynamically and cognitively oriented social work treatment.

The ego or symbolic self in traditional Freudian theory develops out of the need to symbolically represent in thought the real objects that meet our needs. Our capacity to symbolize allows for deferred gratification in keeping with the physical and social reality. Thus, symbol formulation is seen as necessary to the creation of meaning and social interaction. Meditation experience does not refute these perspectives, but it does challenge certain assumptions underlying them.

Observing the Self

Observing the Self and the Five States of Mindfulness

It may be that an observer requires an object or circumstance to be aware of in order to exist at all. An *observer self* and a *being self* are two designations for the core of awareness that all conscious beings share. Insight meditation—identifying each new thought or event as it arises—facilitates the recognition of this constantly churning aspect of self. The recognition provides the basis of a core identity with all "sentient beings" as the Buddhists name it: "If I have a core of awareness, so must all sentient beings." Recognition of this shared spark of consciousness as being within all sentient beings is a basis for empathy, compassion, and loving kindness toward those beings. "I see the you in me, and you see the me in you. Alas, we are the same."

Several possible sources of suffering—also called "difficulty" by DAS, 1997—were identified above as resulting from an imbalance or exaggeration of more moderate coping behaviors. This lack of balance might be seen as a cause of suffering, but also as the source of strategies to cope. It can be identified as *coping* in

that it involves making choices about mindfulness states. While meditating, the Buddha had a profound insight rendered as the Four Noble Truths.

One notes how various forms of stress and coping are similar (for a discussion of the various origins of the teachings, see Das, 1997; Watts, 1957). 1. *There is suffering.* 2. The *cause of suffering* is attachment (craving and revulsion) in a world of change. 3. *There is a way* to cope. 4. Walk the eight-fold path (the Middle Way). This is advice to maintain, in eight sectors of life, a balance between the extremes, such as self-indulgence at one extreme and self-denial on the other.

In the eight-fold path reflects some of the values and potential shortfalls that are encountered in everyday life that can be defined as stressful and addressed with particular states of mindfulness. Here is a brief list of the path from Lama Surya Das, who provides an accessible analysis in *Awakening the Buddha Within* (1997, p. 93).

Right view—Truth and love and no dysfunctional myths
Right intent—Many meanings, one is a compassionate way of life
Right speech—Kind words, includes no lies or gossip
Right action or conduct—Compassion driven
Right livelihood—One's one true calling
Right effort—Among others, self-discipline in goodness
Right mindfulness—Insight into thoughts and actions in everyday life
Right concentration—Focus energy

While set out as developmental guidelines to liberate the mind from suffering, the steps can be read as various forms of coping with stressful memories or fantasies.

The Mind Like an Open Hand

Mindfulness can be used as a means to avoid extremes that will ultimately cause suffering (stress). There are various strategies in meditation and informal mindfulness that help focus attention on the present. In this perspective, memory and fantasy are products of the past or future that may be acutely or chronically stressful and that can be addressed in states of meditation. We see mindfulness-living as a form of coping in the traditional stress-coping paradigm. However, mindfulness provides a perspective that other coping skill sets do not. This perspective has been described as stepping back from one's life and gaining a new view from which one can make choices more objectively and in keeping with one's values, while avoiding either craving (neurotic addiction, infatuation, etc.) or revulsion. Keeping mindfulness in mind, practicing one or more of its components can be facilitated with the image of the simile, *"Become like an open hand, cling to nothing, push nothing away, give what is needed."* Together with states of meditation discussed later, this simile—like an open hand—may provide some structure for mindfulness living and meditation.

Process States of Meditation Mindfulness

As the research suggests, meditation is a process that can include becoming *aware, attending, accepting, anticipating*, and, depending on the circumstance, *acting.* Each of these states in meditation can be a part of the meditation process. Different forms of meditation might include one or more of these states. There is a likely ordering of the states that begins and ends with states that interact with the flow of change:

Awareness, beginning, and *Action*, ending. Discovering and then choosing from the five states of mindfulness is a form of *coping.* "How shall I address the reality of change mindfully?" Here are intentionally brief definitions of five states (five A's) found in the meditation process:

1. *Awareness:* to know of the existence of something, cognizant. "Awareness helped these social workers perceive the connection between their clients and themselves and their clients and communities" (Brenner & Homonoff, 2004, p. 265).
2. *Attention:* to focus perception. "Bare attention is the clear and single-minded awareness of what actually happens to *us* and *in us* at the successive moments of perception" (Thera, 1970, p. 30).
3. *Acceptance:* openness to the reality of something, not approval or disapproval or passive acquiescence. Meditation allowed social

workers to "keep an open mind and an open heart" (Brenner & Homonoff, 2004, p. 265).

4. *Anticipation:* curiosity drive in primates. Planning as coping skill vs. hypervigilance or stilted.
5. *Action:* one-pointedness of mind. Focus. Doing. Perception in keeping with values and acting directly.

The five A's are states of consciousness associated with the meditation process.

Different forms of meditation, such as concentrative or mindful, emphasize different states. A meditator may discover one or more of the A's as he meditates. Choosing states consciously is a form of coping, essentially identifying the mental process and making deliberate choices among them as needed (see Figure 19.1).

In clinical uses and operationalization of variables, clarity about which of the five states are "at play" can refine approaches and provide specificity as to what is being measured. For example, sometimes "attention" (to focus perception) is used instead of "awareness" (to know the existence of something). Consequently, a phrase such as "awareness with focus" used to define awareness could lead to difficulty in understanding what, exactly, is being used in a therapeutic process or what is being counted in research. To be aware does not require attention, but attention usually requires awareness.

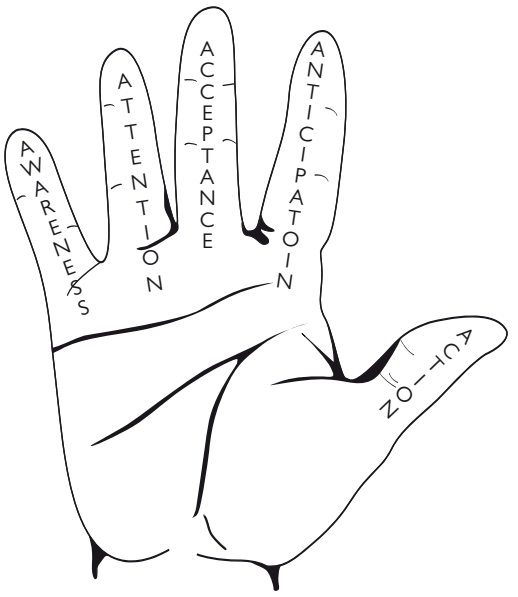

Figure 19.1 Mental Processes in Meditation

Stresses can be addressed in one or more of the states of mindfulness (awareness, attention, acceptance, anticipation, and action). Each of these states can itself be observed from a state of bare attention. Conscious selection of states is a form of coping.

Personality Change

While Welwood's particular definition of "ground" is very different from traditional concepts of the unconscious, it is descriptive of the way in which the meditator experiences the aspects of awareness that are not labeled as "conscious" in traditional psychodynamic terms. In meditation, the ego or symbolic self does not dissolve. The meditator does not become "ego-less."

Meditation instead facilitates the realization of the socially conditioned nature of the self. That each person has a history of conditioning by the interpersonal context of his world, that he can attend to or be conscious of only a small part of his own social programming at a given time, and that meditation is a means of discovering his potential apart from his social conditioning, are realized in meditation. These are the sources of personality change in meditation.

From the perspective of meditation, then, the personality is not structured into static conscious–unconscious components. Rather, it is a web of interlacing symbolic meanings, each rooted in the changing social world. This symbolically constructed self is like an eddy in a stream. In a sense, it is illusory.

Conscious Control

In cultivating an observer self, the meditator grasps the illusory nature of the symbolically constructed self. Conflicts, anxiety-arousing ideas, rumination, and repetition compulsions are some of the experienced components of this symbolic self. Seen from the vantage of an observer self, their power and control seem less ominous. This is because the advanced meditator discriminates the sources of problems and decides, with a degree of neutrality, alternative lines of action. As her anxiety or anger related

to particular incidents or situations is desensitized in the relaxed state of meditation, their power and control are further diminished as her capacity for intentional decision about such behaviors and responses is increased. This perspective can enhance treatment. As Deatherage (1975) puts it: "By becoming aware of the intentional process, one can then intercept and cancel unwanted words or deeds before they are manifested in behavior—something many patients find useful since it places control of their own behavior back at the conscious level" (p. 136). Not surprisingly, meditation is a component in the field of inquiry and treatment of behavioral self-control (Shapiro, 1994).

These experiences and outcomes of meditation, therefore, extend and modify traditional psychodynamic and cognitive perspectives, particularly with regard to the nature and function of the unconscious. They can also give rise to issues of spiritual and social perspectives.

Social Conditions

The traditional cultural contexts of meditation universally interjected myths to explain what exactly makes up the conditioning of the psychosocial self. Communication science, ego psychology, symbolic interactionism, and other Western perspectives augment traditional views of the processes that condition the self. However, even Western psychologists and therapists who have taken up the practice and systematic study of meditation sometimes fall back on philosophical musings when the parameters of the interpersonal ground are defined. Some use the language of mysticism and speak of the larger self or cosmic consciousness to which each small ego is linked and of which each person is a small manifestation. This language is very global and may fit with the beliefs of a given client or therapist. Such interpretation of the meditation experience has the potential for individuals to relinquish social responsibility and to retreat into a passive acceptance of social conditions that cause physical suffering and oppression. A more precise and critical view of the social realities should not be abandoned for a mystification of social realities. So, without disparaging the potential and wisdom in this view, we need not misuse it to gloss over social conditions. Indeed, those concerned with spiritual development and compassion for those suffering may be among the first to acknowledge the inhibiting aspects of social conditions.

Social work, with its particularly broad orientation toward human behavior and the social environment, has a special contribution to make toward an understanding of this larger ground of the self. Social workers are cognizant of the extent to which social conditions interact with the individual psyche and condition its nature, prospects, and levels of awareness. Briefly extending this orientation, Marx (1966) and other materialists postulated that the economic organization or structure of society conditions or shapes the social and ideological life of a society. We might caution, then, that the global language of mystical traditions need not supplant critical analysis of the experiences of meditation, for these experiences are behaviors that may carry over into daily functioning with positive benefit to the meditator's personality and social functioning.

Personality and Specific Applications

Self-awareness, physical relaxation, stress reduction, desensitization of anxiety-arousing thoughts, self-regulation of problematic behaviors such as substance abuse, discrimination of feelings and thoughts from other stimuli and self-exploration, and management of mild depression are specific applications of meditation in the treatment of problems. A thorough review of the bourgeoning literature, especially mindfulness meditation, is beyond the scope of this chapter, but some foundation studies will be noted.

Self-Awareness

First, learning to be more self-aware (aware of feelings and motivations) can inform one's responses to interpersonal situations. As we shall learn later, the self-awareness or mindfulness meditation facilitates sensing and then communicating one's responses to others; both behaviors conducive to empathy. Glueck and Stroebel (1975), in their study of the effects of meditation and biofeedback in the treatment of

psychotherapy patients, made detailed observations of the physiological changes occurring during meditation. They found that TM generated recordable electroencephalographic changes in the brain that parallel relaxation. They think that the repeated sound, or mantra, is the vehicle of relaxation that eventually involves both the dominant and non-dominant hemispheres of the brain. This response is functional to self-understanding and psychotherapy by allowing repressed material to come into consciousness more quickly. This has the potential of permitting more rapid recovery of patients than standard therapeutic treatment would allow.

Relaxation and Stress

Second, learning to relax through meditation is conducive to managing anxiety-related problems. For example, Shapiro (1976) found Zen meditation, combined with behavioral self-control techniques, effective in reducing anxiety and stress in a client experiencing generalized anxiety and a feeling of being controlled by external forces. A three-year follow-up study showed lasting benefit of mindfulness-based stress reduction in the treatment of anxiety (Miller, Fletcher, & Kabat-Zinn, 1995). Several studies have now demonstrated significant results in the use of meditation or meditation as a supplement to reduce trait and state anxiety as well as physiological correlates of stress (e.g., Alexander, Swanson, Rainforth, & Carlisle, 1993; DeBerry, Davis, & Reinhard, 1989; Kabat-Zinn, Massion, Kristeller, & Peterson, 1992; Pearl & Carlozzi, 1994; Snaith, Owens, & Kennedy, 1992; Sudsuang, Chentanez, & Veluvan, 1991). In overcoming insomnia in patients, Woolfolk, Car-Kaffashan, McNulty, and Lehrer (1976) found meditation-derived attention-focusing techniques as effective as progressive relaxation exercises in reducing the time to onset of sleep. Both meditation and relaxation were effective in improving patients beyond controls on six-month follow-up (Woolfolk et al., 1976).

Third, traditional therapy for anxiety-related problems has been broadened in recent years to encompass the domain of ordinary stress. Stress, as a field of inquiry, promises to enrich our ability to prevent more serious symptoms and mental disorder. Stress is the physical and psychosocial response of a person who perceives external and/or internal demands as exceeding his capacity to adapt or cope (Fried, 1982). Some stress, of course, challenges us or piques our interests. Overstress, however, is a common problem in our industrial society.

Meditation and various forms of relaxation training have been studied for their potential in reducing the physical effects of stress and in helping people self-regulate aspects of their behavior or consciousness related to stress. In the early 1970s, research conducted by Robert Wallace, Herbert Benson, and Archie Wilson (1971) suggested that meditation might produce unique physiological and other changes. Later, other studies suggested that relaxation and various relaxation strategies and hypnosis may have effects similar to meditation's (Beary & Benson, 1974; Fenwick, Donaldson, Gillis, Bushman, Fenton, Perry, & Serafinovicz, 1984; Morse, Martin, Furst, & Dubin, 1984; Walrath & Hamilton, 1984). Some studies are clear in indicating that meditation is at least as good as relaxation strategies in helping relieve stress and in lowering autonomic indicators of stress (Goleman & Schwartz, 1984; Marlatt, Pagano, Rose, & Marques, 1984). For example, in their study, Woolfolk, Lehrer, McCann, and Rooney (1982) compared meditation, progressive relaxation, and self-monitoring as treatments for stress. Meditation and progressive relaxation significantly reduced stress symptoms over time. More study is in order in this area.

Coping and Substance Abuse

The advantage of meditation as a strategy in helping clients deal with stress lies in the cognitive domain. What causes a person stress is determined in large part by the perceptions of an event or situation. Events viewed as threats are more stressful than those viewed as challenges in which one will grow. Meditation allows the individual to discover the symbolic meanings, the subtle fears, and other internal stimuli evoked by the event. Strategies, opportunities for coping, calm decisions, and previous successes can be distinguished in the mental contents and consciously enlisted in coping strategies. Moreover, one case study and

some theorists support the aforementioned idea that meditation behavior may be transferred to other aspects of life and consciously enlisted to meet stressful events as they occur (Shapiro & Zifferblatt, 1976; Woolfolk, 1984). Maladaptive coping occurs when stress is responded to in ways that cause more problems for the stressed individual than they help solve. Meditation may help prevent these maladaptive responses, such as substance abuse, which relieve immediate stress but generate long-term physical, psychological, and even interpersonal problems.

Indeed, there is some evidence that meditation can help treat these maladaptive problems once they have developed. Several recent empirical studies indicate significant beneficial effects of meditation or meditation-assisted treatment in recovery and relapse prevention for substance abuse (Denney & Baugh, 1992; Gelderloos, Walton, Orme-Johnson, & Alexander, 1991; Royer, 1994; Taub, Steiner, Weingarten, & Walton, 1994). Finally, an analysis of mindfulness applications in relapse prevention with an information-processing orientation (Breslin, Zack, & McMain, 2002) should open new lines of inquiry in the substance abuse field.

A fourth outcome, combining self-awareness and the capacity to relax intentionally, permits an individual to transfer behaviors learned in meditation to other realms of life where there is stress or excessive stimulation that would hamper objective or reasoned functioning. The results of some studies suggested that meditation may be useful for alcohol and drug abusers to reduce anxiety, detect stimuli that evoke the problematic habits, and cultivate an "internal locus of control" (Benson & Wallace, 1984; Ferguson, 1978; Marlatt et al., 1984). One might reason that anxiety-arousing stimuli are less likely to become self-perpetuating in the symbolic system if they are discriminated and desensitized in the meditative process. For example, some individuals have associated worry over coming events with positive outcomes of those events. Worry, intermittently rewarded, is likely to persist, complete with fantasized negative outcomes, anxiety, and preoccupation (Challman, 1975). Meditation enables the individual to discriminate worrisome fantasy and to observe its impact upon the body and overall functioning. Desensitization and a secure observer self enable the individual to recognize worry, limit the duration, and allow worrisome thoughts to burn themselves out, with lessened physiological consequences. As the observer self is cultivated, the not-uncommon state of consciousness of modern Westerners, complete with split attention, worry, preoccupation, and anxiety, can be sharpened to a mindfulness in which attention is voluntarily riveted to the action at hand. Preoccupation with oneself and how one is performing, worry over consequences, and wandering attention will then interfere less in the tasks one has decided to do. In a sense, the symbolic self is lost in the activity.

Fifth, observation and discrimination of one's thoughts in meditation enable the meditator to use thoughts and images more as tools to represent reality, to communicate, and to serve as intentional guides to action, rather than as illusory and unintentional substitutes for real circumstances. Symbols and cognitive constructs interfere less with clear present-time perceptions.

Depression

Finally, meditation as discrimination training may have specific usefulness in helping to manage depression. In her article "Learned Helplessness," social worker Carol Hooker (1976) reviewed literature suggesting that reactive depression is dynamically similar to experimentally induced states of learned helplessness in experimental animals. This stems from extrapolations to humans from the works of M. E. P. Seligman (1974, 1975) and others that suggest that subjects may learn, in effect, *not* to learn when repeatedly subjected to noxious circumstances over which they can achieve no mastery or control. Under such conditions, subjects learn that there is no escape, no solutions other than unresponsive withdrawal, with little or no mobility, eye contact, or normal need-fulfilling behaviors. Hooker (1976), drawing on the work of Beck (1967), sees this learned helplessness as having cognitive components in humans wherein all known avenues of mastery and solution have been tried or rehearsed to no effect. Action and effort have no effect on circumstances. Beliefs about one's

lack of effectiveness sustain a depressive reaction. Loss of a loved one to death, for example, is an insoluble trauma. Repetition of guilt-evoking thoughts, self-deprecation, and beliefs that there is no future without the deceased may in some cases sustain a depressed mood for extended periods.

Meditation may help the depressed person regain a sense of self separate from the dilemma, partially sustained in the symbol system. In this scenario, traumatic thoughts associated with a traumatic event are desensitized, and one learns increasing mastery over the contents of one's depression-sustaining ruminations. Eventually, thoughts that constitute new tasks and new opportunities for mastery and rehearsal of new roles to play can be sustained intentionally and used as guides for action and mastery. A groundbreaking study of the effects of a meditation-based stress-reduction program found that, not only anxiety and panic symptoms, but also depression were reduced, and results were maintained in the three-month follow-up (Kabat-Zinn et al., 1992). In another important study, "Prevention of Relapse in Major Depression by Mindfulness-Based Cognitive Therapy," patients with three or more episodes of depression were significantly less likely to relapse (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000).

Similar processes, used with both caution and close, informed supervision, may be therapeutic for persons with thought disorders. In other words, observation of thinking, not building upon associations and becoming "lost in thought," is the intent of meditation for enhanced discrimination.

Combining the findings and expertise of four researchers and clinicians—Williams, Teasdale, Segal, and Kabat-Zinn—in their book *The Mindful Way Through Depression* (2007), have broadened and deepened our understanding of depression and our approach toward helping those beset by it. They formulate their approach on mindfulness and point out the nuances of mindfulness in everyday life that can liberate individuals from the attachment of depression.

In summary, research indicates that meditation is an effective adjunct to treatment of a potentially wide variety of problems. Shapiro (1994) summarized research on meditation in self-regulation and self-exploration, observing that the meditation has been stripped of the original cultural and religious contexts to avoid dilemmas and divisiveness. He makes a strong case, however, for reintroducing the context of meditation, which fits the social work perspective of valuing cultural diversity and working with the whole person. With this idea in mind, we must recognize that some clients and workers will find meditation an alien endeavor, even when it is isolated from its original context. Furthermore, there are certain problems that should not be approached with meditation, except with close supervision by workers skilled in treatment of the problem and in meditation. While a preponderance of definitive studies show that direct contraindications for the use of meditation are few, some guidelines are emerging.

Cautions and Contraindications

Some people find meditation more suited to their temperament and culture or beliefs than others do. Also, certain severe disorders make the correct practice of meditation difficult or impossible.

Attitude

Anxious but organized people seem to take to meditation quickly. Relaxation and learning control over focal attention is rewarding and rather immediate. With very anxious, driven people, however, a caution is in order. Meditation of the Zen type, which requires a continued refocusing to the breath or another object of attention, or of those Yogic types that require strict postures and attention, can become a "do-or-die" endeavor for these persons. Individuals may incorrectly feel compelled to suppress thoughts and emotion, or they may force their breath in an unnatural way rather than following their natural breathing rhythms. Often this response is not unlike their lifestyle, in which they constantly push themselves to perform or conform without paying attention to their own desires and physical needs. The attitude of wakeful awareness is misinterpreted as rigid attention where all interruptions are excluded before their full perception. Sometimes the body is

not relaxed, but held rigid and tense. With such people, the point must be made clear that they are to let go of interrupting thoughts, not push them away or compulsively follow them. The analogy of the mind as an open hand, neither pushing away nor grasping, helps in cultivating the correct mental attitude. In any case, the social worker/therapist must make sure that the client is in fact meditating and not magnifying anxiety, building anxiety-provoking images, or obsessing along an improbable chain of associations about hypothetical, destructive interpersonal events or outcomes.

Ensuring the above attitude may help the meditator avoid some of the experiences discussed by Turner (2009), such as frustration, boredom, and irritability. Clinical profiles including dissociation or post-traumatic stress may indicate a need for gradual introduction and an emphasis on a nonjudgmental attitude and acceptance.

Severe Problems

Two authors have discussed use of meditation by persons who suffer severe mental problems or who are labeled psychotic or schizophrenic. Deatherage (1975), in discussing limitations on the use of Buddhist mindfulness meditation in psychotherapy, cautions,

> While this psycho-therapeutic approach is extremely effective when employed with patients suffering from depression, anxiety, and neurotic symptoms, a caution should be issued regarding its use with patients experiencing actively psychotic symptoms such as hallucinations, delusions, thinking disorders, and severe withdrawal. . . (p. 142).

He goes on to note that the particular meditation technique for self-observation requires "an intact and functional rational component of mind, as well as sufficient motivation on the part of the patient to cause him to put forth the effort to do that observation" (p. 142). Arnold Lazarus (1976), discussing psychiatric problems possibly precipitated by TM, cautions that his clinical observations have led him to hypothesize that TM does not seem to be effective with people classified with hysterical reactions or strong depressive reactions. He warns that some schizophrenic individuals might experience an increase in depersonalization and self-preoccupation (pp. 601–602).

As an activity derived from religious traditions, meditation is associated with notions of self-transcendence. This context may be either culturally congruent or very alien for a client. Good judgment and sensitivity to the client's culture are very much in order when introducing meditation techniques for this reason alone.

Observation of the conditioned self or ego from a perspective of dispassionate neutrality can be confused with several problematic behaviors. Engler (1984), for example, cautions that borderline personalities and others without a well-developed self may be attracted to meditation. Also, persons in developmental stages struggling with identity may find meditation an unfortunate substitute for dealing with their developmental tasks or discovering who they are (Engler, 1984). Persons with very fragile identities, symptoms related to depersonalization, and inadequate ego development are not good candidates for meditation except under close supervision.

In general, therefore, clients or patients with fragile self-concepts or those with severe disorders, whose reality testing, perception, and logical thinking are such that they cannot fully understand meditation instructions or follow through with actual meditation under supervision, are poor candidates for its successful use in treatment. Just as the anxious client may build upon anxiety-arousing associations or the depressed client may ruminate on ineffectiveness and despair instead of actually meditating, clients with severe thought disorders and problems with reality testing may substitute hallucinations, delusions, withdrawal, depersonalization, and catatonic responses for meditation, thereby aggravating their problems.

Glueck and Stroebel (1975), however, found TM effective as adjunctive treatment with a sample of 96 psychiatric patients who would have been expected to have the kind of difficulties outlined here. Preliminary investigation indicated that the higher their level of psychopathology, the more difficult it was for these patients to produce alpha waves. Testing TM against autogenic relaxation and electroencephalogram (EEG) alpha-wave biofeedback training, Glueck and Stroebel found TM to be

the only one of the three experimental conditions that patients could persistently practice. Consequently, the authors match-paired their meditation sample with a comparison group and found their meditating patients to have higher levels of recovery than both their "twins" and the general patient population. Despite these findings, treatment of severely depressed and psychotic patients with meditation is experimental, and without close supervision and immediate post-meditation checks, it is contraindicated until further research is done.

One phenomenon occurring in most forms of meditation is the intrusion of the memory of events in the meditator's life into the meditative state. Meditators employing concentration techniques experience mental images of significant and emotionally intense events replayed before their relaxed mind. Desensitization of these memories has been discussed. But intentional use of meditation to allow the emergence of significant facts and events of the psychosocial history is possible. Requesting the client to record these memories following meditation, for use in the context of treatment and for rounding out a more complete psychosocial history, may be helpful to workers with psychodynamic and psychoanalytic orientations and those helping clients with family-of-origin work.

The diagnostic value of meditation, implicit in earlier discussions, lies in the nature of the difficulty that the client has in meditating correctly. Elsewhere, the author has discussed optimal psychosocial functioning based on Eastern conceptualizations related to and developed from meditation (Keefe, 1978). Briefly stated, the capacity to attend to activities one is about without interference by irrelevant ideation and worry suggests a positive level of functioning. Meditation evokes memories and worries that intrude upon the meditation task. Repetitive anxiety or guilt-associated thoughts will indicate to the meditator and the worker or therapist the areas of conflict or unfinished business that hinder the client's functioning. Repetitive self-destructive images will indicate disturbed role-rehearsal or depression. Conflicts from pushing or driving oneself will manifest themselves in forced breathing or lack of relaxation in meditation.

The Therapeutic Relationship

There are several behaviors learned in mediation that could theoretically contribute to enhanced empathic functioning on the part of the social worker who meditates. First, learning increased voluntary control over one's attention permits one to shift from attending to the various verbal and nonverbal communications of the client to one's own emotional responses to the client. This ability to sense one's own emotional reactions from moment to moment facilitates sensing and verbalizing feelings that parallel those of the client. Accurate reflection of these feelings to the client, of course, is a major component in therapeutic empathy (Rogers, 1975), a worker skill conducive to positive behavior change for the client.

Second, learning to discriminate internal or cognitive stimuli from perceptual stimuli in meditation and enhancing voluntary control over cognitive processes can enhance empathic functioning in another way. The worker can hold complex cognitive elaboration in abeyance and allow herself to perceive the client as he is, without premature diagnosing or other cognitive elaboration coloring her bare attention to the client as he is. This intentional slowing of the perceptual process that allows the client to speak for himself holds the worker in the present time—where emotions are felt, where the worker can be fully with the client, and where behaviors are changed.

Third, the meditating worker is likely to have cultivated a strong centeredness or "observer self" not easily rattled by stresses or emotional interaction. Therefore, staying with the client in her deepest feelings, as Carl Rogers (1975) described high-level empathy, becomes more likely. And because such a worker has a perspective on his own reactions, countertransference responses may be more accessible.

Supervision would naturally include sharing of meditation experiences to help in refocusing. Dubin (1991) recommended meditative techniques in psychotherapy supervision to help learn theory and case management and to deal with countertransference. Meditation can assist the worker sharing about and dealing with countertransference or other issues of problematic attachment.

Meditation as an adjunctive technique to treatment has a virtue common to all profound and shared experiences. It is an experience a worker can teach and then share with the client that may serve as a basis for communication, trust, and mutual discovery when other bases for relationships are less productive. In this sense, meditation can be a common ground of mutual experience that can strengthen a therapeutic relationship.

Teaching Meditation: One Technique

There are several techniques for meditation that are useful as adjuncts for treatment. Among the more prominent are Yogic mantra techniques, Benson's relaxation technique (Glueck & Stroebel, 1975, p. 314), TM (Bloomfield & Kory, 1977), Zen techniques, and the commonly described mindfulness meditation (Birnbaum & Birnbaum, 2008; Kabat-Zinn, 1994; Turner, 2009). The technique to be briefly detailed here is derived from Zen.

The general instructions are readily found in a variety of texts. Expert instruction and a good period of time meditating are recommended for workers considering meditation as an addition to their repertoire of techniques.

The client is instructed to meditate half an hour each day in a quiet place where she is unlikely to be interrupted. The client is asked to record briefly in a log her meditation experiences for later discussion with the worker. The meditation posture, as suggested by Kapleau (1967), is as follows:

1. A sitting position with the back straight
2. Sitting cross-legged on a pillow is ideal for some
3. If uncomfortable, sit in a straight chair without allowing the back to come to rest against the back of the chair
4. The back must be straight for comfort since slumping causes cramping
5. The hands should be folded in the lap
6. The eyes may be open or closed; if open, they are not to focus on any particular thing
7. Loose clothing around the waist is suggested

The client is instructed to focus on the breath manifested in the rising and falling of the abdomen and to begin the first session by counting each exhalation up to 10 and beginning again. The attention should be focused on the surface of the center of the body about an inch below the navel. Thereafter, the client may simply follow the natural, unforced, uncontrolled breathing for the duration of each session.

The client is told that there will be frequent intrusions of thoughts, feelings, sounds, and physical responses during her concentration. The response to these is in every case an easy recognition that attention has wandered and refocusing to the breath is necessary. Relaxing the muscles around the eyes and the tongue and throat is helpful in letting go of visual and verbal thoughts.

Repressed material will usually emerge as insights. These are automatically paired with a relaxed state. The client should be instructed that if the meditation becomes upsetting or frustrating, she should stop and resume the following day or wait until the next appointment with the therapist. Particular cautions with special clients were enumerated previously. Generally, if the experience is not pleasant and rewarding, it may be evidence the client is pushing rather than allowing mental content to flow.

Settings and Levels of Intervention

Meditation is a worldwide phenomenon. It is practiced in settings as varied as Japanese corporate offices, quiet monasteries in all parts of the world, downtown apartments, and mental health centers. Most physical settings where social workers practice would be conducive to meditation. While each agency has its own major theoretical orientation or admixture of orientations, few would preclude meditation as an appropriate technique if thoughtfully and systematically introduced. While a psychodynamically oriented worker would define and describe meditation behavior and results differently than a behaviorist or an existentialist, the technique is not tied to a single system or culture. Therefore, agency acceptance hinges more upon tolerance for innovation, interest in research, and openness to new ideas. Meditation as a social work technique was thought to be well out of the mainstream and esoteric a few years ago, but it has gained wide acceptance

in related disciplines and promises to become a more common technique in work with individuals, families, and groups.

Because meditation tends to be an individual activity, it is naturally thought of as a mode for individual treatment only. However, in addition to its use and ramifications for individual treatment, meditation can be useful for certain kinds of groups, including families.

Receptivity to meditation a few years ago was largely restricted to young people and the religiously or spiritually oriented. But over the years the various forms—TM (Bloomfield & Kory, 1977) and mindfulness-based meditation in particular—have crossed class and age barriers. Increasingly, meditation can be introduced into group work with a variety of people. In the author's experience, group meditation can enhance group processes. Beginning and ending a group with a meditation session can enhance group feeling and "mellow out" intense feelings enough to allow their sharing, analysis, and discussion. A group meditation sets the atmosphere for constructive interaction. Meditation to end a group meeting can have similar effects and can support solidarity and identity within the group. The author has used individual meditation to begin and group chants to end treatment groups for college-age youth and for sex-role consciousness-raising treatment groups for married persons ranging in age from 22 to 45. Meditation for family treatment may help to reduce conflict and give the family a positive, common experience to share and discuss.

The use of meditation to facilitate family-of-origin history-taking suggested here could be a part of an actual family treatment session. Sometimes the level of conflict and individual anxiety is such that constructive communication in a treatment session is hampered. Some minutes of meditation may allow sufficient calming to enhance communication. Except for young children and the contraindications already discussed, family members may be helped regardless of their age. The particular phenomenon of *enmeshment*, or very dependent adult members without a secure sense of self apart from the family, may be helped through meditation. Just as with individual clients, sensitivity to the receptivity and experiences of each family member would be essential. While not a substitute for other techniques, meditation may be useful as an adjunct to family treatment, and systematic use and assessment may support its utility.

Claims of increased harmony and lower crime rates have been made as resulting from certain percentages of people engaged in meditation in given communities (Bloomfield & Kory, 1977, pp. 283–284). These findings require some critical assessment, in the judgment of this author. But, obviously, if meditation contributes to personal functioning, certain aspects of community life will be enhanced.

Much research must be done to determine the long-term effects of the various forms of meditation on individuals, groups, families, and communities. Optimal personal and group functioning does not lead directly to more harmonious community life if the social order is fundamentally exploitive and contradictory. As with many forms of treatment techniques, the gaps in our knowledge about meditation, as an adjunct to treatment at different levels of intervention, is growing, yet more research is still in order.

Implications for Research

Meditation is a widely studied behavior. Nevertheless, our understanding of it is incomplete. As a treatment technique, it has been found valuable in a variety of situations. Yet meditation is more than a technique. While review of the growing abundance of research is beyond the scope of a single chapter, some positive and some negative signposts are evident, especially in studies that discern patterns and provide guidance (Melbourne Academic Mindfulness Interest Group, 2006; Ospina et al., 2007). There is growing knowledge of the appropriate forms of meditation, contraindications, the relative value of meditation and other relaxation techniques, and even the effects of meditation upon stress and anxiety, substance abuse recovery and prevention, depression, the nervous system, the psyche, and social life. Although there is much clinical evidence and intuitive exploration, more research concerning subset meditation phenomena is needed. These include the desensitization, discrimination, and observer

self mentioned earlier. Clinicians must begin to refine the appropriate use of meditation for particular kinds of clients and particular kinds of problems. Together with researchers, we must deduce where it helps and where it does not. The articles "Mindful Social Work: From Theory to Practice" (Birnbaum & Birnbaum, 2008) and "Mindfulness: The Present Moment in Clinical Social Work" (Turner, 2009) provide insightful discussions, suggest directions, and contribute to the theory base of clinical social work. Researchers also have rich opportunities to follow the differential effects of meditation used with various clinical problems and various personalities.

In a study that surveyed many available studies, "Meditation Practices for Health: State of the Research," Ospina et al. (2007) reported some health effects, such as lowering blood pressure; however, their overall conclusion ended with, "Scientific research on meditation practices does not appear to have a common theoretical perspective and is characterized by poor methodological quality. Firm conclusions on the effects of meditation practices must be more rigorous in the design and execution of studies and in the analysis and reporting of results" (p. v.). Their conclusion could possibly have been anticipated, given the rapid growth of interest and clinical application of meditation. It can serve as a motivator to continue research that has a sound theoretical base and uses quality methodology.

Another study (Melbourne Academic Mindfulness Interest Group, 2006) surveying the research studies into mindfulness-based psychotherapies more optimistically concluded,

> This group suggests, based on this review, that the combination of some well-developed conceptual models for the therapeutic action of mindfulness and a developing empirical base, justifies a degree of optimism that mindfulness-based approaches will become helpful strategies to offer in the care of patients with a wide range of mental and physical health problems (p. 285).

The hope expressed in the earlier version of this chapter remains relevant. Being a technique of potentially great value for social work, meditation must continue to be examined empirically. Hopefully, it will not be picked up 'whole hog' and incorporated into practice without continued critical evaluation. This would render it, like some other techniques, a passing fancy, soon discarded in favor of new approaches. Nor should meditation be disregarded as the esoteric product of some foreign and bygone cultures. Despite barriers that exclude the wisdom of other cultures and other lands from our consideration, a critical openness and valuing of diversity in the treatment domains is in order. We must try out, test, and incorporate meditation as an adjunct to treatment where it benefits our clients, our practice, and ourselves.

Conclusion

Meditation is, of course, more than just an adjunct to social work treatment. Meditation and its potential for better understanding ourselves and our functioning may flourish in our culture independently of the helping professions and their practice. If we in social work and others in related professions find it a powerful adjunct to treatment, we should not attempt to subsume it as ours alone. Indeed, Shapiro (1994) argues a strong case for reintroducing the cultural contexts of meditation where it is used. Such an endeavor would enrich the diversity of the cultural and philosophical basis of the treatment where meditation is used. It may even help us reach clients from particular cultures with strong meditation traditions. It gives us new perspectives on the development of the self, amplifies our understanding of subjective experience, provides insights into what constitutes optimal psychosocial functioning, and is an empirically supported tool for dealing with stress, anxiety, and maladaptive coping such as substance abuse.

Meditation is at once a vehicle of consciousness and a portal to individual potential. It can be used to liberate, to extend individual functioning, and thereby to help to create social change in the democratic interest. It could also be used to mystify, to distract people from their social concerns related to their personal problems. How the technique will be used by social work is related to the conscience, wisdom, and position of the profession in the years of profound social change ahead.

This chapter began by identifying meditation as a set of behaviors. Meditation is, of course, the embodiment of a larger theory of self, coping, and change. For this reason, it has begun to take interesting routes in the social work profession. It is a part of the field of stress management and finds frequent mention in that literature (e.g., Nucho, 1988). But it is also naturally linked to mainstream social work literature (Carroll, 1993; Cowley, 1993; Smith, 1995). As social workers openly discuss addressing the "whole person" or the spiritual aspects of client's experience, the understandings of that experience can be enhanced by familiarity with meditation-related phenomena such as global desensitization and an observer self. This perspective does not require adoption of a theological stance or the introduction of religion as a component of treatment. It does have the potential to help us understand our clients more fully. As long as social work is concerned with helping people secure themselves and make good choices, meditation and its body of related theory should have a role to play.

Finally, deep in the heart of meditation lies the insight that is the root of both compassion and social action: to help others is to help ourselves. Whether a clinician, a social activist, or both, this is a message every social worker can hear.

Case Example: The Use of Meditation in the Treatment of Functional Bowel Disease

A 36-year-old woman, married and the mother of three children—ages three, seven, and 12—living in California was referred by her physician. She was suffering abdominal pain. Extensive physical examinations and tests had all been negative, although she had recently had an increase in pain when she was under stress. She wanted to understand why she was having these troubles and how she could control them.

She had been experiencing an increase in pain over the past year. She had gone on special diets, consulted several healthcare professionals, and taken many different medications, but there was no change in her distress, which was becoming overwhelming. She said she was becoming increasingly depressed, anxious, and overly self-critical as her symptoms continued and there seemed no hope for any change in them. Psychological tests completed at the time of the initial evaluation confirmed that she was indeed severely depressed, with little energy. There seemed to be an emotional overlay to her pains.

The client was quick to agree to short-term outpatient treatment of eight weekly sessions. The goals would include developing some understanding of her emotions, the stresses in her life, her coping skills and difficulties, and learning various types of relaxation techniques. It was also agreed that the results of the psychological tests would be fully reviewed with her in the third session. In addition, she was helped to work through some unresolved feelings from earlier years that were related to her parents' divorce and the death of her first husband. She explored how she could utilize some of her past coping skills with some of her present difficulties.

The client was experiencing many stressful and unstable living conditions at the present time while her husband was building their new home. This necessitated their living in a series of different friends' homes. Her husband had been so involved in building their dream home that he had not involved her in the process. He was included in one of the outpatient sessions in order to increase communication between them and to help them to reinstitute their previous level of positive interactions, which had been present in the year previous to all of these changes.

In the second treatment session, the client was taught a passive, modified hypnotic, relaxation technique that was tape-recorded for her daily use at home. She was quite pleased with her ability to immediately relax and experience a definite decrease in her abdominal pains. She was instructed to listen to the tape recording of the relaxation four times a day and to record her responses each time in a "Relaxation Log" that she was to bring with her to each session.

The following week, the patient had several days without any pain until she would forget to use the technique because she felt "so good." The patient continued with the passive therapist-directed relaxation techniques by listening to the tape recording daily. The worker was very directive with this technique. The client was slowly encouraged to try the relaxation technique on her own, without using the tape. She quickly became able to do this.

After the fourth treatment session, the client was introduced to a new technique designed to help her relax on her own, to become more comfortable with her own body, and to learn how she could

help herself on an ongoing basis. It was presented to her as a new coping skill that she could continue to utilize after the termination of treatment. Since the client was now feeling much better, she was eager to increase her skills in this area. She was therefore given oral and written instructions for meditation. She was asked to take the instructions home and read them and to try to implement them into her daily routine. Initially she had some difficulty in being totally comfortable with the technique, so she continued listening, once a day, to the relaxation tape. However, she found less need to rely on the tape recording as she increased her ability to relax with the meditation. After one week, the client found that she was able to relax just as fully as she had with the tape recording. Furthermore, she felt quite proud of her ability to do it on her own. By the last session, she was able to relax without any reliance on the tape. She found that if she meditated once a day, she had no pain, and could reduce any stresses that arose by short relaxation techniques, which she would go over in her mind. At that point she had been totally pain-free for three weeks. Follow-up contacts with the patient one month after formal termination of treatment showed that she continued to do her daily meditation, was pain-free, felt much more confident in her abilities and coping skills, and felt that all aspects of psychotherapy, relaxation, and finally meditation had been quite beneficial to her. She recognized the benefits of continuing to practice what she had learned, and her family was quite supportive.

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Annotated Listing of Key References

Germer, C. K., Siegel, R. D., & Fulton, P. R. (2005). *Mindfulness and psychotherapy*. New York: The Guilford Press. This text begins with sound definitions and discussion of Buddhist and Western psychology. The therapeutic relationship and clinical applications are presented in readable style. Invaluable for practice.

Hick, S. F., & Bien, T. (2008). *Mindfulness and the therapeutic relationship*. New York: The Guilford Press. Integrates mindfulness into the therapeutic relationship, with many insights into the connections.

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Williams, M., Teasdale, J., Segal, Z., and Kabat-Zinn, J. (2007). *The mindful way through depression*. New York: The Guilford Press. Grounded in research and clinical perspectives, this accessible and valuable book extends meditation and cognitive approaches, addressing a sound model of depression and ways to relieve it.

20

Mindfulness and Social Work

Kirstin Bindseil and Kate Kitchen

We are leading a mindfulness workshop for social workers. We begin with the question, "When we say 'mindfulness,' what ideas come to mind?" and list the answers on a flip-chart. "Relaxation, attention, a body scan, eating a raisin, letting the mind go blank, the breath, yoga, the present moment." The responses come with some hesitation. They are not sure if they have it right. They are curious and excited about mindfulness but also a little skeptical. Is there really anything new here? Is this just a restatement of what they already know and practice? A mindfulness workshop weaves information with experience and encourages participants to find out for themselves. In addition to the discussion, they will learn mindfulness practices: body scan, sitting and walking meditations, yoga, and awareness of sight and sounds. Over time they will connect with the present moment, and in observing this connection, find that thoughts become less concrete. They often find that they enjoy the stillness and taking some time for themselves. They often describe the experience as worries melting into the moment and say that they gain a firsthand experience of how this can be helpful for themselves and the people they care for.

Introduction to the History of Clinical Applications of Mindfulness

Meditation and contemplation are found in most cultures and religions; however, this modern adaptation of mindfulness arose out of Western interest in ancient Buddhist practices developed by Siddhartha Gautama (the Buddha), who shared his understanding of how to increase

one's happiness and to free oneself from suffering 2,600 years ago in India. This wisdom has had a secular adaptation into clinical practice with what has been called the "Third Wave" of psychological treatments. Linehan (1993) with dialectical behavioral therapy and Hayes et al. (2011) with acceptance and commitment therapy were early adopters of incorporating mindfulness into clinical treatments. Mindfulness as a treatment for healing has been most popularized by Jon Kabat-Zinn (1990) who developed mindfulness-based stress reduction.

Jon Kabat-Zinn developed the mindfulness-based stress reduction (MBSR) program at the University of Massachusetts Medical School over 30 years ago. It uses the principles of mindfulness meditation to treat patients with both medical and emotional problems. It is generally taught in an eight-week program that teaches mindfulness meditation practices that participants also practice daily. Participants are provided with recordings of the led practices to facilitate their home practice.

Mindfulness-based cognitive therapy (MBCT) was adapted from MBSR by cognitive psychologists as an addition to cognitive-behavioral therapy (CBT) to assist in preventing relapse for those with recurrent depressions. It interwove the practices of MBSR with the philosophy of cognitive therapy. Just like MBSR, MBCT helps people to be in the moment. In addition, MBCT adds specific exercises to enhance awareness of negative thoughts with the goal of practicing letting them go. At the core of MBCT is learning the concept of decentering (relating to thoughts, feelings, body sensations and impulses as events passing in the mind and body, rather than identifying with them) Segal et al., 2013, p. 91). The Three-Minute Breathing Space, as taught through the program, highlights the importance decentring throughout the day. Like, MBSR, MBCT emphasizes the importance of learning with others in a group format.

Since this innovation, mindfulness has been added to treatments for a wide variety of problems treated by social workers, such as eating disorders (Kristeller et al., 2014, MB-EAT), and addictions (Bowen, Chawla, & Marlatt, 2011, Mindfulness-Based Relapse Prevention). This has led to an ability to combine best practices of the specific diagnostic profiles within the structure of an eight-week mindfulness psychoeducation group.

Evidence from Studies of Mindfulness

Scholarly contributions for applications of mindfulness have exploded over the last decade. Today, on average, a new article is published for every day of the year. The literature is filled with case examples, illness-specific studies, studies exploring cultural adaptations, and testing constructs showing the differing capacities of mindfulness. In a series of literature reviews by Baer (2003) positive effects have been found for mindfulness treatment in chronic pain, cancer, fibromyalgia, depression, anxiety, panic, generalized anxiety disorder, eating disorders, general clinical populations, inner city populations, and medical and nursing students, with moderate to large effect sizes, large psychological symptom reductions, and maintenance of benefits over time.

In a series of meta-analyses, mindfulness has been shown to have some moderate effects that improve a variety of symptoms and diagnoses. Grossman et al. (2004) found, in an analysis of 20 studies, that mindfulness enhanced general coping skills with distress and disability symptoms in everyday life. Most benefits were related to physical health symptoms. In an analysis of 10 studies of mindfulness-based stress reduction for patients with cancer, mindfulness was found to have some effects with mental health symptoms, and suggested that there was a need for further research on the physical effects (Ledesma & Kumano, 2009). A more recent analysis of 39 studies for cancer found improvements for generalized anxiety disorder, depression, and other psychiatric or medical conditions. Eberth and Sedlmeier (2012), in an analysis of 29 studies of nonclinical populations, found mindfulness-based stress-reduction groups to have a significant effect on changes in stress reduction, mindfulness, well-being and trait anxiety. Moderate effects have also been found for mindfulness in addressing symptoms of anxiety or mood (Hofmann et al., 2010). Overall, with the abundance of studies, the meta-analyses have shown promising overall effects on how mindfulness can improve health-related symptoms.

Randomized controlled studies have also been conducted showing the efficacy of mindfulness with an assortment of clinical populations. One of the first randomized control studies showed how mindfulness practices can dramatically (four times compared to usual treatment) increase the healing process for psoriasis (Kabat-Zinn et al., 1998). With the development of MBCT, mindfulness has been shown to have positive effects for individuals who suffer from depression, with improved scores in anxiety, distress including depression, empathy, spiritual experiences, and depression relapse (Teasdale et al., 2000; Ma & Teasdale, 2004; Segal et al., 2010). Oncology patients have been found to show improvements in mood disturbance, fatigue, and stress (Speca et al., 2000; Bower et al., 2015) and stress, quality of life, and social supports (Carlson et al., 2013; Monti et al., 2006). Mindfulness-based stress reduction groups for 117 men who were HIV-positive demonstrated increased positive affect and state mindfulness as well as decreased avoidance after six months compared to control participants (Gayner et al., 2011). A reduction in depression symptoms was found for patients who had fibromyalgia without severe functional impairment (Sephton et al., 2007). Medical students during their exam time showed better results in trait and state anxiety and measures of distress, as well as enhanced empathy and spirituality responses after taking an eight-week mindfulness course (Shapiro et al., 1998). Female medical and psychology students from Norway had reduced mental distress and study stress and increased subjective well-being after taking a seven week MBSR course compared to a randomized control group. This was not found to be true for male students. The authors also found higher participation in class and homework were responsible for the improvements (de Vibe et al., 2015). One hundred and thirty-six medical patients with heterogeneous diagnoses showed improvements in quality of life and physical symptoms, and a reduction in psychological distress after an eight-week MBSR group (Reibel et al., 2001). The scholarly literature in mindfulness is quite varied. There have emerged a series of randomized controlled studies emphasizing improvement beyond stress reduction to include medical, psychiatric, and social symptoms.

What Does Mindfulness Mean for Social Work?

Before it was used as a clinical term, *mindfulness* was mostly thought of as a way to pay attention and be careful. *Mindful* was used to mean "to be more focused on the topic at hand."

Over the past three decades, there has been a change, and "mindfulness" has taken on a slightly different meaning. In popular culture, it has taken on a meaning that might be closer to *relaxing* and *slowing down*. In the media, images depicting mindfulness are often pictures of serenity: a beautiful flower, a difficult yoga pose done serenely, or a facial expression of bliss. It all gives a sense that if we can practice mindfulness, all of our difficulties will melt away; with the image of someone sitting, eyes closed and a gentle smile.

As social workers, we want to think of ourselves as being mindful, especially when relating to others, and may think of it as something we already do. Attending to the present moment in caring for others is a strongly held value, but we also know that there are real limits to this when there are so many tasks that we are attending to all the time. Sometimes this means that moment-to-moment awareness feels unattainable; a goal for a future time when we do not have such busy lives. Someday we will figure it out.

So, if mindfulness is not a guilt-inducing admonishment to pay more attention or to manage multiple tasks with a serene ease, what is it, and why has it gained such importance for social work? With the increasing interest in a mindful approach to the profession, social workers have discovered how mindfulness can enhance our ability to be present, to remain connected, to listen and be kind to ourselves and our clients as we see them in the individual and group settings.

Social Workers' Experience of Learning Mindfulness

With the many mindfulness groups we have led over the years, with populations coping with chronic pain, depression, anxiety, addiction, or the experience of being a new immigrant, it has been very important to give words to what

mindfulness is very early in the group. There is not just a single definition among mindfulness practitioners. Jon Kabat Zinn (2005) is most often quoted, stating, "Mindfulness is paying attention on purpose, without judgment, in the present moment." Germer et al. (2005) writes that mindfulness is "awareness, of the present experience, with acceptance." The *Oxford Dictionary* (2015) says it is "A mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations, used as a therapeutic technique." According to *Wikipedia* (2015), mindfulness is "the intentional, accepting and non-judgmental focus of one's attention on the emotions, thoughts and sensations occurring in the present moment, which can be trained by meditational practices."

Participants take several weeks of practice before the meaning truly comes to life, and the facilitator can help clarify and shape the meaning of what is and what is not a mindful approach to the present moment, while honoring group members' experiences. Often participants come to mindfulness groups looking for relaxation and serenity, and they find it; however, they also find help with their problems by practicing returning to the present moment over and over again, and observing how they are relating to that experience. At first, it can seem counterintuitive to pay attention to one's problems, usually physical or emotional pain, but because we tend to avoid painful experiences, we also tend to know little about them. To practice connecting with one's world in an intentional way, without getting caught up in avoidance or the judgement that comes with rumination, leads to insight and self-acceptance. This practice helps our patients and clients and ourselves to tap into internal resources. Jon Kabat-Zinn describes this as the experience of "falling awake."

An example of this occurred in one of our groups. Following a sitting meditation practice, someone described a moment in the meditation when she felt the same sensations as when she was unwell. Her next overwhelming experience was of an intense fear that she would get sick again. During the discussion of the meditation, or "inquiry," she was invited to expand on these sensations and experiences. As leaders, we saw this as an opportunity for her to learn more about her internal experience and understand the effect that the fears of getting sick again have on her day-to-day life functioning and even on judgments she makes about her own worth.

She and the group began to appreciate that this is a new and innovative way of working with their problems so that they can gain a better understanding of the situation, but even more importantly, take away the mystery that has kept them feeling fearful and stuck. This allows for greater choices in working with the difficulty and leading to greater confidence in their skill and agility in trying out these choices.

If we stay with each moment, all the experiences (emotions, thoughts, sensations) in our lives will come to mind at some point. If we spend our energy working with what is here in the present, where we actually live, we will have the best ability to address each need with more agility and skill.

This phenomenon of understanding also happens in our professional training. The course we teach to professionals is scheduled over three weekends, approximately four weeks apart. Participants start the course on day one absorbing and understanding the simplicity of the program; they see how it can enhance their day-to-day lives. The course validates the importance of self-reflection and self-care. By the second day, questions are fast and furious, as their meditation experiences take them to places they may not have explored within themselves. This leads to an intense experience of seeing themselves as vulnerable. They question how they will work with their own experiences, and experience doubt that they will be able to learn what is needed to be able to teach mindfulness and work with what comes up for those they are trying to help. "If I am struggling with some of the difficulties and questions that are coming up for me, how can I guide others to experience their difficulties? How will I know what to say?" As the practices continue, something remarkable happens as they explore new experiences of mind and body, moment to moment, while coming out of their automatic responses. These professionals are amazed at what is actually happening at each moment and at the unique choices and options they have when they awaken to their own experience.

Mindfulness in the Social Work Field

The explosion of mindfulness-based treatments is so vast that it is hard to think of where it has not had some sort of impact on our understanding of healing and well-being. Although it would be difficult to create exact numbers, Cullen (2011) recorded that individuals from 35 countries around the world have participated in teacher trainings at the Center for Mindfulness in Massachusetts, and this number is trending higher. Mindfulness practice and teaching seem to transcend one's profession. Every profession is represented in the mosaic of mindfulness teachers and practitioners. As mentioned earlier, we have worked with many different helping professions, including physicians, psychologists, occupational therapists, recreation therapists, private counselors, and, of course, many social workers. In our minds, mindfulness does not belong to one profession over another, nor is one profession more aligned to mindfulness teaching.

Although we have learned to emphasize the importance of a professional foundation in providing competent and ethical mindfulness care, we have also learned from our own teaching and attending trainings and conferences that a mindful approach to one's work is highly personal. The journey we are on as teachers and students of mindfulness is parallel to that of those to whom we provide care. We are all on a path to learn to live more fully in each moment. Our meditation helps us connect further with ourselves and with others. In this way, we are much the same. This is the wonderful paradox of clinical practice; as we enhance our skill and ability, we are better able to learn from those we are engaged in helping, and in turn provide more thoughtful, intentional care.

Although it has been embraced by all the helping professions, there is an emerging literature on the impact of mindfulness in the social work field. In clinical practice, the emphasis has primarily been on how mindfulness can enhance the therapeutic relationship. Turner (2009) discusses how mindfulness assists in enhancing one's therapeutic presence, which helps to develop the "core mental processes" of the practitioner. He says this helps us deepen the therapeutic relationship with our ability to attend more accurately to our clients' viewpoints and needs. This enhancement of our attention can lead to better perception and connection to the client/patient. In social work psychotherapy, one is often working with individuals with extremely vulnerable histories. This can lead to intense feelings for both clients and social workers. Having one's own mindfulness practice can help workers self-regulate and remain present, even with painful content. Enhanced attunement and empathy can be an outcome of a mindfulness practice for the psychotherapist who engages in a mindfulness practice. This can help reduce stress on the therapist and support a creative and authentic clinical experience, providing more safety and opportunities for exploration.

Béres (2009) suggests that mindfulness can help the social work clinician take a step back from the Western discourse of the role of professional as one who tries to end suffering in clients; that, at times, the therapist's need to be helpful may prematurely cut off beneficial therapeutic processes. This is seen as a "reflexivity" of the practitioner's own thoughts and feelings about the clinical process. Mindfulness is seen to be able to help the clinician become more aware and possibly let go of the reflexive responses, noting when the approach to care is more related to the thoughts and feelings of the clinician than the client's. Furthermore, a mindful practice helps the clinician develop a better awareness of her own thoughts and feelings and be better able contemplate whether there would be benefit to sharing these personal thoughts with the client in the hopes of co-constructing the client's narrative. "Rather than noting and then letting go of the emotion or thought without refection, it may be possible to note the emotion or thought, make a decision as to whether it would be useful to mention, and then let it go if it would not add anything useful to the discussion" (p. 62). One critically important aspect of a mindful approach according to Béres is that this process of reflection happens more often in the moment of the clinical session instead of after the clinical encounter or during supervision time.

A second area of inquiry into mindfulness and social work has been to consider mindfulness

as a way to enhance education practices. One approach has been to examine the role of the educator and the use of mindfulness to support the complexities in the social work classroom. Mishna and Bogo (2007) discuss how, within the social work classroom, there are often discussions of "diversity" and "oppression" as a part of the curriculum, and conflicts will arise as individuals bring their own values and experiences to the classroom. Educators will try to set up a "safe" learning environment. The expectation of "safety," where conflict will be avoided and all expect a certain level of comfort, is not only unlikely in discussions of these value-filled topics but also creates an atmosphere where disagreement is considered a problem. This atmosphere sets the students up to see conflict or discomfort as an annoyance or mistake. This can inflame the classroom discussion and leave the educator unprepared to adequately address the difficult interactions in the moment.

> As the topic of diversity and oppression in the social work classroom is inherently fraught with risk and is, thus, inevitably unsafe to some degree it is not feasible in post-secondary and graduate education to aim for safety. Rather, instructors must strive to be prepared to deal with and attend to interactions and conflict in a manner that facilitates social work learning. (Mishna and Bogo 2007, p. 535)

Traditionally, educators may have felt they have prepared the class by setting ground rules based on respect and understanding in an attempt to create a safe environment; however, the authors argue that this approach unrealistic, flat, or two-dimensional and is likely to be insufficient to effectively facilitate learning an emotionally complex curriculum. Mindfulness, according to Mishna and Bogo, is seen as a way to assist the educator to reflect on the classroom discussion in the moment and be more responsive and less reactive. With this awareness, one can bring forth an opportunity to explore the challenges with the class while creating an atmosphere of openness. Judgments or conflict can then arise, and there will be an opportunity to clarify the differing perspectives with a nonjudgmental approach and explore the significance of all perspectives right in the moment. This approach is seen to develop through a practice of mindfulness in daily life that better equips the educator to assist with this level of deep learning and understanding. Furthermore, the increase of mindfulness and self-compassion offers permission for situations to not always "go well" and allows for an opportunity to further reflect after the fact with colleagues who support the dynamic needs of classroom learning.

Others have written about how mindfulness can add to the social work student experience. Mindfulness strategies can help students increase awareness of their body sensations and thoughts as well as attend to difficult feelings and judgments (Lynn, 2010). Paré et al. (2009) describe how they have used concepts of mindfulness to help students learn the art of engaging in a therapeutic conversation in a way that supports one's ethical practice. They emphasize that, in the clinical relationship, there are many areas of focus in each moment. They provide their students with exercises such as one where they begin an in-person mock clinical discussion and then continue the session online. While they are responding online, they are also typing "offline" on their word processors to help them record their internal dialogue simultaneously. The intention of this exercise is to "slow the process down." While using this process, some students found that they could reflect on the differences within and outside of oneself, while enhancing their awareness of thoughts and emotions. Others found that it was too difficult to maintain awareness of both processes and reported feeling overwhelmed and disconnected. These authors point out that in any clinical discussion, many different "strands" or "trains" of content may be coming forward from moment to moment, along with the student's own emotional responses. The learning process, therefore, helps the students become more aware of the existence of the different trains of content and become better able to focus on a path that facilitates healing.

> These are distinct "trains," and they lead to very different outcomes. A therapist who is not mindful will "board" on one or the other without the experience of having chosen to do so, in much the same way that the mind can latch onto discursive strands during meditation practice and drawing us away from attention to the breath. (Paré et al., 2009, p. 82)

As students enhance their mindfulness practice, they become better able to notice and attend to

these "trains" of thought and focus the clinical discussion in a way that leads to a more comprehensive and intentional practice.

Birnbaum (2008) followed seven first-year social work students who attended a series of two-hour group sessions over eight weeks, where the group participated in mindfulness practices and had an opportunity to journal and share the experiences of their work both in the classroom and at their placement. The themes from the qualitative analysis highlighted the benefit of having a safe place to explore their experiences; expanding and observing the "self"; containing and regulating emotions (i.e., fears); exploring relationships with professors and field supervisors; and discussing how the mindfulness practice changes the student in unexpected ways that at times were even unwelcome and overwhelming. The group allowed for a rich opportunity to discuss some of the more nuanced aspects of learning about oneself and managing stress while learning about the profession. An earlier study by Birnbaum (2005) offered 40 students one mindfulness workshop, and a smaller number of students in this group attended three additional sessions. The focus was to help students develop their "inner guidance." Interviews, observations, and student's notes were used to develop themes. The mindfulness sessions were a mixture of practices of mindfulness, relaxation, and attending to the student's internal wisdom. After these sessions, the students were better able to talk about themselves and others in the clinical experience, and they had developed more skill in deciding when they could be more open to their experience in the moment and when to be more protective and maintain a narrower focus. These students said that they were better at recognizing their inner needs with the experience of the mindfulness sessions and had an improved ability to explore their choices for responding in the moment.

Gockel et al. (2013) studied how social work students responded to a ten-minute mindfulness session followed by five minutes of discussion in the 28 classes of their clinical interviewing course. These responses were compared to the experience of students in other sections of the course who did not get the mindfulness component. The group that received mindfulness training showed an increase in counseling self-efficacy compared to the control group. The mindfulness group was also found to have carried the skills into their clinical practice three months after the study. There was not a difference in well-being between the groups, and the authors speculated that this might be because there was such a small "dose" of mindfulness.

These studies highlight how mindfulness in social work education has provided a strong contribution to the literature and our understanding of how a mindful approach can assist our students and professors. A third area of exploration of mindfulness and social work has been with the discussion of how mindfulness can better support social work in the realm of social justice. Wong (2004) writes about her experiences in teaching her social justice class. The first time she offered the course, the discomfort in discussing the societal difficulties was overwhelming for students, and they reacted in ways that tended to close the discussion. The students were confronted with intense feelings and ideas; judgments of good, bad, right, and wrong came forward and ultimately led to a few students blaming the teacher for the unpleasant experience. Wong relied on her mindful practice to stay grounded with her own feelings of teaching this difficult course. She decided to prepare students differently when she taught the course for the second time. In this second version, she prepared the students by normalizing the possibility of difficult and contradictory feelings arising and offered them ways to embrace the difficulty, slow down their process, and reflect internally on their own experience within their social context. The mindful approach led to a very different experience: students were able to stay with their feelings, explore how their preconceived ideas could change in a way that was exciting and new instead of threatening their sense of self.

Hick and Furlotte (2009) also speak to their personal experience of finding how their own mindfulness practices help inform their work in social justice. With social justice, one is to explore the layers of difficulty, looking into oneself and looking at the injustices of others. Tensions, discomfort, and strong judgments often arise with this type of exploration. The mindful practice can provide a spaciousness in

opening to the difficult so that even opposing ideas can be faced without judgment. The social worker is challenged to reevaluate entrenched ideas without creating further barriers or divides between themselves and others.

> Mindfulness introduces a skilful means for cultivating and sustaining awareness about ourselves, our everyday experience, and our experience in the world. Taken together, they can enable social workers to consciously know their inner and outer experience, the dialectical relationship between the two, and how this plays out in society. (Hick and Furlotte, 2009, pp. 20–21)

These are some promising ideas about how mindfulness can positively contribute to the work of social justice. Our mindfulness practice allows us to see more of what is happening in each moment, and in the case of social justice, be better able to hold internal and external ideas at the same time without demanding that these ideas be completely aligned. It is the ability to be with the misaligned ideas that allows for further exploration and understanding to enhance social justice.

Social work scholars are beginning to write about mindfulness in a variety of ways within the context of the profession. Mindfulness and social work practice offers a unique perspective in the literature, with discussions of how to be present with oneself and with others. As more become familiar with the benefits of working with a mindfulness lens, this literature will be able to further contribute to our understanding of social work practice in countless ways.

Accessing Mindfulness

Throughout both of our careers, the question of how we can teach mindfulness and tap into its riches in a way that is accessible and meaningful frequently comes up, with students and with peers. How can we be sure we are teaching mindfulness? Are there risks of picking up relaxation instead of mindfulness? One example of this occurred many years ago when we were teaching an MBCT course that was part of a research study. It was comparing the benefits of mindfulness versus relaxation. It was decided that once the relaxation group had finished their group, they could be invited to come into the mindfulness group. We were curious about their perspectives. Interestingly, those who attended the relaxation group did not stay. Relaxation offers a different set of skills—quite often focused on avoidance of difficulty and instead to connect to the pleasant. So participants found it difficult to switch to a new set of skills so quickly. We are not judging relaxation—it is an equally useful skill. Mindfulness is less known to us in our Western culture, so confusion can often occur. Mindfulness works with whatever comes up. Someone may become relaxed and enjoy any experience in the present moment, but when one has a difficult experience, mindfulness offers alternative choices to be present with the difficulty. For new practitioners, understanding the difference can be confusing because there are opportunities in the mindfulness practice to settle into the present moment, and at times a release can come. The difference is that it is not our goal to create or hold onto the pleasant, we simply look to embrace whatever emerges in our practice.

What we have observed is that all of us who are on the journey as healers, including social workers, are searching for ways to ease suffering and enhance happiness. How can we best access mindfulness for others and ourselves? First, we have found the group format to be quite beneficial. The group provides a multitude of learning possibilities in each moment. One person will feel warm, another cold, someone will notice a sensation of happiness, whereas another might feel pain, anger, or resentment. In the group environment, all of us are experiencing the same practice at the same time but relating to experiences differently. This helps us to realize the contrast between ourselves and others and see firsthand that all of the experiences of daily life can show up at any time. There is also a greater opportunity for the facilitator to respond to the different experiences without valuing one over another. The group quickly sees how we "walk the walk" in that we can "be with" the difficulty discussed in the group, knowing at times we are all looking for a way to "fix" this moment by grasping what feels good or trying to push away what we judge to be difficult.

What we do instead is emphasize the importance of choices. The most rewarding feedback we hear when we teach is that participants

believed that they could choose what was best for them in the class and in their home practice. In guiding or leading practices, it is key to invite people to explore different ways of being or working within a guided meditation. Many of us automatically do what we are told, especially when the health "expert" is giving the instruction. So, we like to think that we offer many instructions and choices, and the participant is welcome to explore with us or tune into their own wisdom that says "I am going to try something different right now," or "This does not feel quite right, I think I will let this go." We try to reinforce this message when we talk with the group after the meditation practice. We emphasize how participants are welcome to consider other options if they are overwhelmed or become disconnected in any moment. There is a wisdom in tuning in, and saying no, and acting from their own perspective.

Like all of the mindfulness programs for clinical populations, we teach that different practices or meditations will speak to each participant. Some will connect to mindfulness more through the poetry or a sitting practice. Others are better able to connect to their present experience through the body scan or walking meditation. This also can change over time. A common experience in the eight-week group is to have participants do the body scan on the first and last days of the group. Participants cannot help but notice how this moment eight weeks later is so different from where they started.

Practices to Access Mindfulness

The following practices are intended to offer some ideas of how to connect into one's own mindfulness practice and begin to explore ways of helping others develop some skill and understanding of the properties of mindfulness. At every session, at least one formal practice focuses on either the body, breath, movement, thoughts or feelings/emotions, and these are from 30–45 minutes long.

Body

Practices that tune into the body have been seen as foundational. Many of us are unaware of many of the sensations in the body. And when we do connect with our body, we can make very negative judgments about our body that lead us to try to avoid these sensations. The avoidance of the body, the lack of awareness makes it difficult to receive the signals from the body that can warn us about ways we are injuring ourselves and triggering pain. Practices such as the body scan, where one gives attention to regions of the body as if following an actual map, can help us connect with how the body is functioning in the moment. This practice is often done lying down, but it is quite versatile and can be done sitting or standing. The practice is often done without moving (although moving is "allowed") in order to notice what sensation is occurring in the region of body in each moment. Some participants will note that there are parts of the body where they do not notice sensation, which allows for a curiosity of the lack of awareness. Another common practice is body movement of some sort stretching, yoga, or tai chi. These all give opportunities for connecting to the body as it is moving and to thoughts and feelings that arise.

Breath

Attending to the breath is often seen as a prestep into mindfulness. Most see attending to the breath as a concentration exercise and not really a mindfulness practice. The breath is with us at all times and provides a very available focal point. Focusing on the breath can also teach us a nonjudgmental approach to the present moment, particularly if we have an idea about how one is "supposed" to breathe. The practice here is to notice where one can feel the sensation of breathing and the properties of breath such as shallow or deep, long or short, etc. For this reason, the breath is a very useful place to begin. It can also be a very helpful practice to return to if someone becomes overwhelmed during meditation.

Feelings, Emotions

Quite often when we become still for any period of time, feelings will emerge in the practice. We can mindfully practice simply observing the feelings when they arise. Invite

participants to explore the feeling by exploring the qualities of the emotion, such as its intensity or whether it seems to be associated to a particular area of the body. When one can settle into the feeling, one can notice how it changes from moment to moment, even if it is something as intense as a craving. Instead of trying to "fix the feeling," we can explore it, even if briefly. At this point, one may notice the power in realizing that feelings cannot "hurt" or harm us but instead simply be a short experience. This is further explored when we talk of acceptance, even of the difficult emotions. Acceptance is not resignation but simply allowing the feeling to be present, where it does not need to be hidden or changed. One of the helpful practices developed in MBCT is to work with a difficulty (often a feeling of depression) and invite participants to simply breathe with the feeling—breathing in saying "soften," breathing out saying "open." The participant can be reassured by offering the participant to say "It is okay, whatever it is, let me feel it." (Segal et al., 2013). It is equally important to explore the pleasant feelings as they arise and offer ourselves the opportunity to settle into these feelings. These are also an important part of fully experiencing our lives.

Thoughts

Thoughts are an area of exploration where we do not have to go far into the practice before they emerge. A very common reason for people to say that they cannot meditate is because they feel that they must be able to be void of thoughts. Although it is unclear exactly how many thoughts one has in a day, most have reported that it is somewhere in the tens of thousands. Not only do we have all these thoughts constantly coming forward, but they also combine with emotions into stories that take us out of the present moment. Our stories can be about past events, planning for the future, or simply developing a series of fantasies to "check out" of the present moment. With all of the thoughts and stories coming forward in the silence of mindfulness practice, there is an opportunity is to notice them and even work with them as they arise. Noticing without judgment allows the practitioner to experiment with refocusing on breath or body, as suggested in the practice. Alternatively, one can decide to notice that a story has shown up, follow it with curiosity, and explore what might be learned from the experience. Here we see the choice and an opportunity for the individual to explore thoughts or thinking. It is a common experience to judge oneself for "allowing" the mind to fall into stories. A frequent guidance is to allow the realization that the mind has been pulled into the story, and once this is realized, one is reconnected to the present moment. Then we can practice connecting the attention to the next moment with the suggestion of kindness or success of reconnecting into the present.

Another common practice is to focus on thoughts as they emerge in the present moment. This can be guided in many ways. This may be something as seemingly simple as "seeing" thoughts as if they were clouds forming in the sky, passing by and then dissipating as they move out of view, or perhaps as a projection in the mind's eye where a thought comes on a screen or a stage and then falls away to be replaced by another. This helps us see thoughts as discrete, but transient, events occurring in each moment, instead of as static, unchangeable stories. It can take some practice for practitioners to be able to see these thoughts as emerging and falling away. For this reason, this way of working with what comes up in meditations is not taught until several weeks into the mindfulness group.

Poetry

Poems are often incorporated into meditation practices, often at the end of a practice. Poems by Rumi, Mary Oliver, or Galway Kinnell are frequently recited because they speak to aspects of mindfulness. Our experience is that many find that the poetry speaks to them in a way that has deep meaning and connection as the mindfulness practice deepens. In contrast, others find the poetry to be a distraction and are annoyed by it. This is an opportunity for the social worker to reinforce that different mindfulness practices and experiences speak to different people, to notice what shows up with the poetry, explore it, and let it go if it does not seems helpful.

Informal Practices

For many, there is a tension about whether a formal mindfulness meditation practice will be helpful or if they can even do it on their own. Our perspective is that everything helps. Exploring the informal meditation practices offers a wealth of experiences as one slows down and allows the riches of what is happening right now to unfold. So much of our day can be lived without awareness. Inviting people to practice daily activities such as brushing one's teeth or doing the dishes mindfully becomes a reminder that life is to be lived in each moment no matter how small the task.

Three-Minute Breathing Space

One short form of meditation that was developed from MBCT is the three-minute breathing space. It was developed to help practitioners develop the habit of doing brief (three minutes or less) practices throughout the day and to make use of them when something difficult arises. Our experience has been that this practice, although simple, takes practice to be able to do by oneself. It has three steps: The first is to attend to the experience in the moment—thoughts, body sensations, and feelings. The second step is to move ones awareness to the rise and fall of the breath. The last step is to expand from the breath into the body as a way to reintegrate the present moment. Once the method is learned, taking the brief time to check in with experience, breath, and body can be helpful when someone is feeling overwhelmed, and regularly throughout the day.

Inquiry

During a group, leaders will guide discussion about members' experiences during the formal practice. This is a rich opportunity to clarify any misconceptions about mindfulness and support what is being learned. Although technically we are looking back into the past moments of our meditation, such inquiry helps participants to become more aware of the multiple layers of experience that are occurring in every moment. Inquiry most often occurs in a group where the facilitator helps to explore experiences that the participants volunteer. We are encouraging participants to notice thoughts or feelings related to some portion of the practice. There is a very strong thread of acceptance here.

After a sitting meditation practice, the group is invited to share their experiences of this practice. Here is a small example of inquiry within the group:

Jean: "I was feeling a lot of pain in my back while I was sitting."
Facilitator: "What part of the back did you experience the pain?"
Jean: "I felt it in the middle of my back" (now pointing to her back).
Facilitator: "Did you notice any thoughts or feelings associated with the pain?"
Jean: "I feel this back pain all the time."
Facilitator: "Mmm. And did you notice if anything next?"
Jean: "I began to focus on the breath and I began to feel my spine move as if it is an accordion moving up and down, the pain eased while my spine was moving up and down and I just became aware of the movement."

This is an opportunity for the group to hear how one can stay with the experience, and the facilitator can encourage Jean and the group to attend to their wisdom to be with whatever is arising in each moment. Inquiry can be fostered in the group or perhaps written in a journal to help expand our awareness in our practice.

Conclusion

Mindfulness has made a remarkable addition to clinical work and within a relatively short period of time—beginning in 1979 with the secular adaptation of mindfulness meditation for stress reduction by Jon Kabatt-Zinn and his colleagues at the Center for Mindfulness at the University of Massachusetts; continuing through the significant work of Segal, Williams, and Teasdale in the development of MBCT for prevention of depressive relapse in 2000; and through the present as clinicians and researchers continue to study its effectiveness as an adjunct to work with a multiplicity of physical and mental disorders.

With this work it seems to us that the most natural match for mindfulness within the helping professions is social work. Like social work, a deeply held value for mindfulness is starting

with the individual's experience in relation to the context of the person's life. Mindfulness is both realistic and optimistic in its approach and, like social work, there is value in both self-care and self-acceptance. Being nonjudgmental is a hallmark of both social work and a mindfulness approach.

This can be seen clearly in the significant research into how mindfulness can be useful for, and even improve, social work practice. Social workers explore how to improve the individual, community, and social conscience in our society. Mindfulness is an approach that can help the social worker reflect on all of the layers of experience in any situation—even if these layers are contradictory. Social workers are also keenly exploring how to use mindfulness practices at the beginning of learning. Our students and faculty can struggle with the challenges in the classroom and in the placement setting. Social work educators are seeing the benefits of mindfulness during this challenging phase of professional development.

With the embracing of humanist values, mindfulness is a natural fit with social work. There are many ways to enhance skills and abilities in mindfulness practice. The multitude of choices or opportunities in this approach is not a mistake. To be able to stay present, grounded and aware, one needs a variety of options to work within each moment. Sometimes it is the individual noting what practice or area of awareness is needed or is worth exploring. Sometimes it is the situation that brings forward a different way of being with one's experience. For social workers, there is value in having expertise in mindfulness experience and practice to draw upon while working with the complexities of vulnerable populations and acknowledging the challenges of our societal realities. Seeing where these opportunities go for the social work profession in the future is very exciting prospect.

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21

Narrative Theory and Social Work Treatment

Patricia Kelley and Mark Smith

This chapter is dedicated to Michael White (1949-2008), who with David Epston co-founded narrative therapy.

Narrative therapy was developed in the late 1980s and rose to prominence in the 1990s, especially in the fields of family therapy and social work with individuals, families, and communities. In this chapter, narrative therapy is described, its historical and theoretical base explored, and how it fits into existing social work practice theory and values addressed.

The Narrative Approach

The narrative approach described and discussed in this chapter draws mainly on the works of White and Epston (1990), family therapists from Australia and New Zealand, respectively (both originally trained in social work, and Epston also studied community organization). They developed this approach in the 1980s, but it became popularized in North America after their book, *Narrative Means to Therapeutic Ends*, was published on this continent in 1990. While some elements of their approach were fairly unique at that time, their work emerged and co-developed in relation to theoretical and practice developments concurrently occurring in North America and Europe. Their approach falls under the general rubric of constructivist and social constructionist theories, from which several models emerged at about the same time, which all developed in relationship to the post-modern movement that crossed many academic disciplines (see Carpenter & Brownlee, Chapter 6 of this volume, for further discussion of constructivism). In the 1980s, Anderson and Goolishian (1988) in Texas; Boscolo and

Checchin of Milan, Italy; Penn and Hoffman of the United States, who worked with the Milan group (Boscolo, Cecchin, Hoffman, & Penn, 1987); and Tomm (1987) of Alberta, Canada, who had also studied with the Milan group, all wrote about these newer constructivist/constructionist approaches. Freedman and Combs of Chicago (1996) further popularized the ideas by clearly outlining the theory and practice of narrative therapy in their book, *The Social Construction of Preferred Realities*.

Early on, Hoffman, a social worker and prominent family therapist, described the shift of family therapists away from the emphasis on an intra-psychic focus to systemic views, as swinging back to a greater emphasis on ideas, meanings, beliefs, and myths (Hoffman, 1990). While systems approaches are based on cybernetic thinking, a mechanistic theory of control that Hoffman declared had lost its usefulness, constructionist therapies are based on "second-order cybernetics," which renders observations as being dependent upon the observer. Like some behavioral and cognitive approaches emerging in the same period, systemic therapies were based on a modernist view of objectivity, rationality, and knowing through observation. The postmodern view holds that many realities and truths coexist and sees reality as being socially constructed rather than a given (Neimeyer, 1993).

Relationships to Other Theories

Constructivism and social constructionism both fall under the postmodern movement. Narrative approaches borrow from the constructivists in the field of literary criticism, where narratives are taken apart and analyzed for meaning, and from the social constructionists in the field of social psychology, where reality is viewed as co-constructed in the minds of individuals in interaction with other people and with socio-cultural beliefs. Neimeyer (1993) characterizes constructivism as a "meta-theory that emphasizes the self organizing and proactive features of human knowing" (p. 221) and as a view of humans as "meaning making agents" (p. 222). The roots of constructionist therapies can be traced to many sources, especially George Kelly's "personal construct theory," first articulated in the 1950s (Kelly, 1955). Kelly himself cited semanticist Korzybski (1933), who was also drawn upon by cognitive (Ellis, 1962) and systems (Watzlawick, Weakland, & Jackson, 1967) therapists, and by Moreno (1937), who developed psychodrama. Constructivist-based therapies have been compared to and contrasted with cognitive therapy (Neimeyer, 1993), and to systems approaches (Kelley, 1994), and its emphasis on meaning connects it to the existential approaches (see Krill, Chapter 10). In the development of their narrative therapy, White and Epston (1990) state that they drew on the works of French philosopher and historian Michel Foucault (1980), as well as psychologist Jerome Bruner (1986) and anthropologist Gregory Bateson (1972); system thinkers also drew on Bateson. On one hand, narrative therapy became a new paradigm for viewing human change; while in other ways it can be seen as evolving out of existing practice theories.

The narrative postmodern approaches to practice can be useful for social workers who search for the meanings of events and behaviors as preconditions for action. The emphasis on understanding and meanings is useful as we work with the diverse clients of today's practice settings. White (2007a) discussed narrative therapy as focusing on the expression of peoples' life experiences; that life, meaning, and experience are inseparable. The implications of postmodernism for practice have been discussed by social work scholars and others, who found these approaches useful for multicultural practice (Holland & Kilpatrick, 1993; Kelley, 1994; Waldegrave et al., 2003); persons facing adversity (Borden, 1992), family violence (Rober, Eesbeek, & Elliot, 2006) and trauma (Denborough, 2006); adolescents (Kelley et al., 2002; Zimmerman & Dickerson, 1996); sexual abuse victims (O'Leary, 2004); grief and loss (Hedtke, 2014; Neimeyer et al., 2009); eating disorders (Weber, Davis, McPhie, 2006); and health care (Wynne, Shields, & Sirkin, 1992). Narrative therapy has also been applied to group work (Dean, 1998; Laube, 2004) and community work (Epston, 2003; Kelley & Murty, 2003; Vodde & Gallant, 2003). International conferences on narrative therapy and community work, are held at various centers and institutes around the world, and *The International Journal*

of Narrative Therapy and Community Work has continued quarterly publication since its inception in 2009.

Basic Assumptions

Knowledge is power, and self-knowledge can empower people. White and Epston (1990; White, 2007a) believe that we all "story" our lives to make sense out of them. We cannot remember all of our lived experience; there is too much material and too many experiences unrelated to each other to retain it all, so our narrative structuring of experience is a selective process. We arrange our lives into sequences and into dominant storylines to develop a sense of coherence and to ascribe meaning to our lives. As we develop our dominant storylines, we remember events that support it, and forget (White and Epston say "subjugate") other life experiences that do not fit into the dominant storyline. The meanings we attribute to experience are influenced and shaped by cultural beliefs and practices (Bruner, 1986). Certain events may be imagined or exaggerated to fill in the gaps of a story. White and Epston's concept of subjugated knowledge is different from the psychodynamic concept of the unconscious, in that "subjugated knowledge" refers to life experiences not remembered because they do not fit into the dominant story, whereas the psychodynamic idea of "unconscious" refers to memories that are repressed because they are painful.

Narrative therapy is similar to postmodern literary criticism, where the storyline is "deconstructed" as the plot, characters, and timelines are reassessed. Many times, presenting problems of clients fall within a dominant storyline, with clients authoring stories of their lives that are problem-saturated. These stories limit the clients' views of themselves and others and can immobilize them from action. Their problem-saturated stories have been co-constructed with others around them, including employers, social service workers, and other helpers, and are influenced by dominant cultural norms. For example, social service agencies working to help multi-need families can do too much for them (Imber-Black, 1988), giving the message that they are incompetent, and their dominant narrative becomes that of a "multi-problem" or "dysfunctional" family. Similarly, Wynn et al. (1992) discuss how, for chronically ill people, the life of the illness may become the dominant storyline, as the family and professional helpers gradually become more involved with the patient, and the co-constructed reality is that the patient is the illness, as opposed to being afflicted with it. A goal of narrative therapy is to help the client see more realities, which offer more alternatives for them, and help them to self-empowerment. As Neimeyer has noted (1993), such therapy is more creative than corrective and is more reflective and elaborative than persuasive or instructive.

Role of Social Worker/Therapist

The role of the social worker is collegial. As narrative therapy helps clients "rewrite " their lives through seeing other truths and other possible interpretations of events, the role of the therapist is to listen, wonder, and ask reflective questions. Clients are invited to assess other realities, which are not necessarily truer, but are "also true." For narrative therapists, the harsh realities of many clients' lives, such as poverty, racism, or violence, are not denied as constructs of the mind, but the power given to these adverse events and the control they have over clients' lives are challenged. Clients are also challenged to question some "truths" accepted by family and the larger culture, which have affected their views and held them back. Narrative therapists pose reflective questions in order to generate more experientially vivid descriptions of life events, especially descriptions not currently included in the problematic story. These questions help clients assess other ways to view a situation, analyze for alternative meanings, and find other aspects of their lives, often involving strengths and coping, which may have been lost in the over-focus on problems. In this postmodern view, the therapist is not an outside, objective observer, but is part of the change system, and there is reciprocal influence between client and clinician as both engage in the construction and performance of preferred identities. Thus, the therapist does not just hear the client's story, but co-creates it with the client, hopefully with the client creating some new stories. History is not a collection of facts to be remembered, but

is "created" in the telling. The therapist's role is non-hierarchical, especially compared to that of psychodynamic or systemic therapists. The therapist is not the expert on the problem or the client's life; the client is. The therapist takes a "not knowing" position (Anderson & Goolishian, 1988), which invites the client to do more exploring.

Cultural Sensitivity

Among narrative therapy's signature contributions is its cultural sensitivity because it does not presume a way of being, but aims to understand and enrich the client's reality. The therapist listens for ways in which ethnicity, physical ability, gender, sexuality, culture, and social and economic context may shape the client's worldview and view of self. Clients are encouraged to take action on their behalf, to become their own change agents. Discussions of social justice, poverty, gender, and power are part of social constructionist approaches. At the Family Centre in New Zealand, Waldegrave and colleagues (2003) have developed "just therapy" (meaning "socially just"), where therapists and clients together weave webs of meaning where political as well as clinical responses are invited, and where cross-cultural consultants are used on the therapy teams. Narrative therapists in general have taken on these social-activist views and practices.

Narrative therapists often engage clients in recognizing how their relationship to problem-saturated stories occurs at the expense of preferred, alternative stories and how these dominant, disabling storylines serve to marginalize or subjugate other discourses. Examples of these subjugating cultural narratives include practices of patriarchy, heterosexism, racism, Eurocentricity, and binary constructions such as healthy/unhealthy; normal/abnormal; and functional/dysfunctional.

View of Human Nature

The view of humanity underlying this approach is that humans are complex and multifaceted, not simply good or bad. Underlying pathology is not presumed. Rather than listening for underlying "root causes," the social worker listens for other aspects of the client's life that may also be true and involve strengths to be mobilized. These "unique outcomes" (White & Epston, 1990) exist outside of the client's problem story, and may involve identity descriptions that have been subjugated. Here similarities can be seen to solution-focused therapy, which also looks for "exceptions" to the problem and was developed by de Shazer and colleagues (de Shazer et al., 2007). However, differences between solution-focused and narrative therapy need to be noted. In narrative work, the clients are not asked for the "exceptions" to problems; instead, the therapist carefully listens for these times and brings them out, co-constructing new realities with the client. In addition, instead of ignoring problems to focus on solutions only, problem descriptions are carefully listened to and deconstructed, and the past is not ignored. Borden (1992) discussed the importance of helping the clients assess the past, experience the present, and anticipate the future as specific life experiences are incorporated into the ongoing life story. While attention is paid to the past, the focus is on helping the client not to be stuck in disabling descriptions of the past but to develop a progressive, forward-looking narrative.

Narrative therapists see clients in context, that is, as part of a cultural whole, where views of self and the world are co-constructed in dynamic interaction with cultural and societal norms. Clients are invited to assess the truths they have assumed, and to challenge views that have not been useful. In this way, they may empower themselves to work on their own behalf or for social change. Further, as needs are assessed with client and clinician working together, the client may be made aware of other resources available.

Social Work Treatment

The goal of narrative treatment in social work practice is for clients first to understand and then to broaden and change the stories around which they have organized their lives, and to assess and challenge the socio/cultural/political sources that have influenced them. This work may involve helping the client to challenge the problem-saturated dominant story as the only truth, and to find other aspects of

his or her life that may also be true. The discovery of more realities and more truths can free clients to see more alternatives and ways out of an impasse. Through dialogue between social worker and client, these problem-saturated stories are gradually deconstructed as the worker introduces questions that challenge the client's "thin" descriptions of reality and draw out facets of the client's life that have previously been ignored. Narrative therapists recognize that not all stories are seen as equally useful and they help clients challenge those that are disabling or not useful.

The narrative model offered by White and Epston (Epston, 2004; White and Epston, 1990; White, 2007b) is helpful for teaching and for practice because it names specific practices and outlines stages of the process without being too prescriptive or technique-driven. Constructionist therapists in general do not distinguish between the "assessment" and "treatment" stages of practice, for they view assessment as an ongoing and ever-changing process, and hope that all sessions are therapeutic. All clinicians know, however, that there are some elements of the helping process more appropriate in earlier stages, and some are more useful later in the process. For this reason, White and Epston's (1990) discussion of their narrative approach as consisting of two main stages, "deconstruction" and "reconstruction," is useful.

Deconstruction Stage

In the deconstruction stage, the clients' existing stories are heard and then deconstructed. It is important not to deconstruct or "challenge" the client's problem story too soon. Most people need to have their problem stories heard or witnessed before they can move to examining them and their relationships to them. First, the clinician carefully listens to the "client's story of an experience" that illustrates the problem's impact on the client's life: What does he or she define as the presenting problem? How does the client experience it? What meaning is ascribed to it, and how is it viewed in light of historical events and social contexts? This process is similar to the joining or relationship-building process of any good therapeutic endeavor. Asking questions to elicit the full meaning here is important, as is helping the client to see how most problems are relationally constructed. Who else is involved in this problem? What events in the past have contributed to its development? How did this problem evolve over time? What has been tried to fight the effects of the problem? How has this problem affected other aspects of the client's life? As in any good therapeutic encounter, the development of an empathic relationship is important. This empathy is important for developing trust, but is also important in helping the clinician understand the client's reality more fully. While the careful listening and reflecting is similar to most therapeutic approaches, the way the questions are worded is specific to the narrative approach.

In this beginning stage, the therapist listens to how the client describes his relationship to the problem and helps the client develop a "map" of the various ways the problem story has had influence on the client's experience. Externalizing the problem, a key idea in narrative therapy, begins in the joining stage and continues throughout the treatment process. The purpose of this externalization is to separate the person from the problem, to view it, not as intrinsic to the person, but as something that has interfered with the person's life and needs to be challenged. Thus, at the early stages, where the client's story is being heard and understood, the nature of the reflective questions gradually shifts the view as to where the problem resides. "When did you first notice that depression began to interfere with your work?" "How did it happen that Andy's temper took over so much of his life? Who first noticed it? Who has been affected most by it?" It is important to distinguish between viewing a problem as not intrinsic to the person and not taking personal responsibility for one's actions and the consequences of those actions. Clients are encouraged accept responsibility for fighting the effects of the problem and for their own behaviors, but to not see themselves as the problem.

Even the effects of physical illness can be externalized through questions about the effects of the illness on the person's life, and about the process by which it took on so much power over the person's life, and about how it has interfered with other aspects of the person's life, including

relationships. As the client is able to separate from the problem, it becomes more manageable, and the problem, not the person, becomes the target for change. The client and therapist unite to fight the effects of the problem and to enlist others in joining the client in this resistance to the problem's effect. At this early stage, even before deconstruction, the clinician listens carefully to the client's definition of the problem and begins to objectify the problem through the use of metaphors, through summary, and through the nature of the reflective questions.

The importance of language in sharing meaning has been discussed by many theorists and therapists over the years (Anderson & Goolishian, 1988; Bateson, 1972; Ellis, 1962; Watzlawick et al., 1967), including narrative proponents (Epston, 2004; Freedman & Combs, 1996; White, 2007a). The way questions are worded is an important aspect of this work. A client may be asked to imagine what their struggle with a particular problem might say about them. Clients are encouraged to establish their own evaluation or judgment about an interpretation of an experience. Specifically, clients are led to recognize that they can choose their own interpretation of an event or experience according their own intentional stance. White (1989) has described the way in which he helped a family with a 12-year-old son with behavior problems to "escape from trouble." He asked family members to describe the ways in which "John's" problems had "plagued" his life and "influenced" their lives. White also asked the parents how they had coped with John's troubles and how they had become involved with them.

Narrative therapists, unlike those from some other schools of thought, do not assume that clients "need" the problem or that it symbolizes a deeper problem, as do some psychodynamic therapists, nor do they believe that it "serves a function" for the family unit, as believed by some systemic proponents. It is assumed that clients want the problem solved or remediated, but that they have gotten stuck in finding ways to do so. Thus, words like "unmotivated" or "resistant" are not considered useful. This belief in clients and what they say is very respectful, and consistent with social work values. While it is not presumed that clients need problems, it is recognized that they and family members, friends, and helpers may have helped maintain the problems, possibly through their efforts to solve them. Thus "relative influence" questions are useful in bringing about discussion on that matter. For example, family members may be asked how they were recruited into and influenced by the client's problem, and how cultural forces may have influenced them.

After the first part of the deconstruction stage, where the clients' views are heard, understood, and acknowledged, the therapist gradually begins to help the client deconstruct the dominant story through continued summarizing and questioning. It is important to note here that the client's view is not disputed or seen as not true, for that would not be respectful, and the client would not feel validated. Instead, the story is fully discussed and analyzed for meaning, and other interpretations and other meanings can be assessed, bringing about alternative truths that are also valid. Questions help the clients identify two distinct "landscapes" for their stories: (a) the landscape of action (what has happened, who was there, where things seem to be at present); and (b) the landscape of identity (what the situation says about the client, what meanings can be inferred, how it fits with the client's preferred views or intentions). At this point, the relative influence of the problem's effects on the individual or family is mapped across time and across spheres. How has this problem affected the client in the past, present, and anticipated future across intellectual, personal, interpersonal, and social spheres?

For example, in the White case of helping the family "escape from trouble" mentioned above, it became clear through discussion that John's "trouble" had interfered with his life at school, academically, and with classmates, and at home in his relationship with his parents. To what degree the school had come to view him as the problem, and the degree to which he had taken on that view were examined. In addition, how the problems had "crept into" his parents' lives and affected their relationship with each other as well as their own work productivity was assessed. Ways in which "trouble" had caused guilt in John and feelings of helplessness in his parents were discussed. Questions were introduced to John to speculate about what would

happen if he were to further "succumb" to trouble, and to his parents about what might be the possible effects of their continued participation in the problem. Should they accept John's invitation to join him in participating in trouble, or should they renounce it and escape from it? This careful dissection of the effects of the problem across all spheres of life and the assessment of what might happen in the future if it was allowed to dominate, and to challenge the family to find new ways to handle the problem. The family now could work with the clinician to explore ways to defend itself against the effects of trouble and to fight it when necessary. Since the problem was externalized, the family does not need to define John as the problem, but can join with John and the clinician to find ways to defend against this problem that is interfering with his and their lives.

As the problem stories are gradually deconstructed through a dialogue between client and clinician, the clinician obtains a richer description of the problem. The client discusses events that he or she believes led up to the problem's formation. Not only events, but thoughts, beliefs, and the social environment around the events are assessed for influence in the past, present, and possible future. Clients might be asked to ponder how the same events may have been viewed by others, or even how they might view it themselves if they were not involved. For example, a victim of childhood abuse may have blamed herself or himself, but may now begin to see that being a child in a helpless position, the choices were limited. Alternative futures are also discussed: How would it be if things were different, and who would do what? Who would first notice the difference? What would a better future look like? Here, again, similarities to de Shazer and colleagues' (2007) solution-focused therapy may be noted. This "visioning" of a desired future helps clients begin to think about ways in which they might get there. Different from solution-focused therapy, however, is the fact the narrative therapists also look at what might happen if things do not change.

Reconstruction Stage

In the reconstruction stage, other truths are found that are also true but may have been subjugated because they did not fit into the dominant theme. It is a knowledge-expanding, more than knowledge-changing, experience. This subjugated knowledge is brought out through careful listening for "unique outcomes" or "sparkling events" (White 2007a) as clients tell their stories. These are events or outcomes that cannot be explained by the dominant story. For example, a man has described his problem as being a bully, stating that he has always been mean and has had a temper problem most of his life. He discusses how his experience with bullying has interfered with his relationships with peers and colleagues, both as a child and as an adult. He describes how it has caused a breakup of his marriage (the precipitating problem) and interfered with his relationship with his children. The client and worker also examine how his pattern of bullying has also hurt him, causing powerful feelings of guilt and lowered self-esteem. Looking to the future, he sees a lonely existence if this problem continues to dominate his life. It is important to obtain his view of this situation, not to assume that he sees it as "bad" or that he wants to stop it. The purpose of helping him to separate from the problem is not to alleviate him from responsibility for his actions, but to help him assess its effects on himself and others, make a decision as to what he wants to do about it, and then develop ways to manage and control it (the problem). In fact, responsibility was implied here, as the client was asked about how temper had taken over his life, and did he want it to control his life?

Here the unique outcomes were not easy to find at first, but careful listening helped to uncover some. If he is such a "tough guy," where did he find the gentleness to visit his grandmother in a nursing home? How was he able to muster enough caring to take care of his dog so well? Again, the similarities to de Shazer and colleagues' (2007) solution-focused therapy can be seen, but instead of asking for "exceptions," which the client may not see, the therapist carefully sorts through the conversation like a detective to find the evidence. Just as the dominant story has been deconstructed to find out who was involved in the construction of the tough-guy identity, now the client is asked to think about who may have helped him develop this gentler side. Gradually, a discussion of

a relationship with a caring grandfather was brought out, and a gentle but manly teacher is also remembered. In addition, the cultural message in the media of needing to be tough to be a man is also compared to the conflicting social message about the honorable gentleman treating women and children well. Knowing there is another side to him helps the client find ways to fight the effects of his tough-guy side, allowing him to keep some aspects of that side, while exploring and developing his other, gentler, side.

In another situation, a family was viewed by others in the community, as well as themselves, as being a poor and "out of control" family with "violent" adolescent boys. This view was challenged regarding its narrow definition of itself. They began to see how they were also a resourceful family that had coped with poverty. They had found a way for the mother to be home with the young children by day and earn money holding an evening job with the cooperation of the adolescent boys who babysat for their younger siblings after school. This discussion also challenged the "violent boys" idea, although the fact that they sometimes acted violently in school was not ignored. Seeing other aspects of themselves helped them to see that they had alternatives as to which side of themselves they wanted to develop and in which situations. Here, the social worker did not tell the boys what they must do, but helped them see options and potential outcomes of the options. Both the family and the school reported a marked decrease in violent behavior over the school year.

In another example, a social worker facilitating a coping skills group for chronic pain patients helped the patients find ways in which they were already coping with the illness and see that there were times when they could fight the effects of the illness and identify when the pain was not as bad. At first, most of the patients believed the pain was always there and there was nothing they could ever do. Through careful listening by the worker and each other, they found that there were times when things were better, and they all found ways in which they were already coping (Kelley & Clifford, 1997). The illness was externalized by the social worker's asking them, "If this illness were a member of the family, how would you treat it?" The group members began to discuss this question with great interest. Some found ways they would fight the illness and reject it, while others said that, since it was there to stay, they would look for ways to accommodate it and learn to live with it. The social worker did not teach them ways to cope, but instead, helped them identify times when the patients were already coping, challenging the view that they were totally helpless. At the end, they reported feeling empowered.

At this reconstruction stage, then, clients are helped to reconstruct their views of reality, not by substituting a different story, but by broadening and enriching the story through inclusion of unrecognized or unacknowledged perspectives. A depressed woman, who remembers her childhood as one deprived of maternal care because her mother was critically ill and eventually died when the client was 11, was asked if she remembered any times that her mother had the time and energy to give comfort to her. The client remembered her mother combing her hair every day and how good it felt. The tragedy of her mother being so sick that she only could manage basic tasks was never minimized, but the client was also helped to remember other aspects of her childhood. She reported that she finds it comforting when she feels depressed now to think about how good it felt when her mother combed her hair. Dolan (1991), in her work with sexual abuse survivors, noted that having clients tell their stories over and over can re-victimize them if corrective experiences are not infused into the process. Helping clients broaden their life stories, rather than "polishing" their problem-saturated stories, is a corrective experience.

The last step under the reconstruction stage is what White and Epston (1990) called "Spreading the News." Central to narrative practice is the recognition that problems and problem stories are not just "private" but exist within social and relational contexts. Similarly, construction and maintenance of new and less disabling narratives also relies upon their being shared among important social connections and community. After finding alternative views of self and others, it is important for people to notify others of their changes, to reinforce them. At the Dulwich Centre, White and his

colleagues often had groups where members shared experiences, sang songs, and told stories about their new selves. In another situation, a group of adolescent "girls in trouble" (Kelley et al., 2002), group members drew pictures of their new selves and shared the pictures and stories with other members. These "performances" of new identity stories have a function similar to that of the "definitional ceremonies" described by Myerhoff (1982) that establish community connection and meaning and can lead to the initiation of collective social action.

Length of Treatment

Because of the philosophical nature of constructionist treatment, it is often assumed that the process is a long-term one, and questions have been raised about how such a long process can be applicable in today's social work practice arena. An interesting aspect of the narrative approach of White and Epston (1990) is that they use relatively few sessions, often as few as six or seven, although there is no set idea as to the best number. Clients are usually asked at the end of each session if they would like to return, and if so, how soon. Unlike some constructionist therapists, narrative therapists may ask the clients to do some activities between sessions. For example, in helping the family and boy "escape from trouble," already discussed, White (1989) encouraged the family to plan "escape" meetings where all the family members reviewed the progress of their escape. The meetings were formal in structure and even had minutes taken.

While the number of sessions is usually few, they are usually spread out over a longer time period than every week, to give families time to think about and try new things. Playful ideas and metaphors are often used with families to encourage them to try new things. In addition to asking clients to try something different between sessions, White and others used many forms of writing to expand the impact of each session. These "therapeutic letters" summarize notes on how the therapist heard the client describe the problem and also record any solution knowledge obtained in the session. The therapist requests client corrections, deletions, and additions to make the statements more accurate. Clients report that each letter is worth about four sessions (White, 1992). While some might question the time involved in this process, these letters can also be used as case notes. White also finds taking notes in session helpful, not distracting, and he uses these notes to read their statements back to clients to check for accuracy. Morgan (2002) even suggests copying notes taken in session to give to clients. Other forms of writing may add to the value of sessions, too, such as client writing to self or therapist, art or poetry, or charts and checklists (Kelley, 1990). White and Epston use certificates and documents, such as an "Escape from Guilt Certificate" (1990, p. 199), or a "Diploma of Special Knowledge" (p. 201), which are especially useful with children.

White (1992) also reported other strategies he used to reduce the number of sessions but expand their power. In addition to the letters and documents, he used "ceremonies of redefinition" (e.g., parties for children) where victory over the problem is celebrated, or he may encourage the family to use "consultants," who are people in the clients' lives whom they can talk to for enlightenment about a problem or solution. Epston, early on, used the idea of accessing the expert knowledge of communities of people facing similar challenges to support clients in their change, such as his anti- anorexic/bulimic league. White also subscribed to this idea. At first, White utilized Tomm's (1987) ideas about "reflecting teams" of co-therapists and trainees behind a one-way mirror who traded places with clients, and reflected back their ideas about what they heard. Later, White had the team in the room with the clients, and often used former clients who had faced similar problems to reflect what they heard. Either way, clients report that these teams expanded the impact of each session and reduced the number of sessions.

Principal Applications in Social Work Practice

At first, a primary application of narrative work had been in family therapy and social work with individuals and families. However, its usefulness in group work has been explored also (Dean, 1998; Kelley & Clifford, 1997; Laube,

2004). White and others began to move into community work in the later 1990s, and major efforts of narrative work have been in communities (Dulwich Centre, 2009). Waldegrave and colleagues (2003) pioneered this work at their at the Family Therapy Centre in Auckland, New Zealand, where community work and social action went hand in hand with the family therapy in their "just therapy." White also began to focus more on community action and social justice issues and developed the international conferences on narrative therapy and community work, and the *Journal of Narrative Therapy and Community Work* noted previously. Epston edited an issue on the subject of narrative community work in the journal *Social Work Review* (of New Zealand) in 2003 (Epston, 2003).

Potential Problems and Counter-indications

While there is a wide range of applications of narrative-type approaches in social work, some questions have been raised regarding their use with specific populations. Some might fear that the de-emphasis on "reality" and the focus away from the problem story together could minimize clients' problems, especially in cases of sexual abuse, family violence, or severe mental illness. This is a real problem if the social worker deconstructs the story too quickly or denies the client's reality, but it should not be problematic if the client is carefully listened to and attended, and if referrals are made for complementary services if needed. In a related concern, some might see this approach as superficial because it does not get at "root" causes or underlying pathology in deeply disturbed individuals. Since these ideas do not fall within the constructs of postmodern theory, narrative therapists would not see such concerns as relevant. Some social workers might fear that the process of externalization could reduce a perpetrator's responsibility for violence or other crimes, and its usefulness with mandatory clients could be questioned. White and Epston (1990, p. 65) spoke directly to this matter and noted that helping people separate from the problem and assess it objectively can help them assume more responsibility for it. Social workers and other professionals express the idea that talking is not enough for some clients, that concrete services and possibly even medication may be required for the amelioration of some problems facing clients. Narrative therapists agree, and believe that their approach can facilitate complementary services. In addition, care needs to be taken in externalizing problems with persons experiencing serious emotional problems, who may already have trouble differentiating between themselves and outside forces. Finally, there is a practical concern that, without the use of labels, cross-disciplinary discussion may be impeded and that reimbursement for services may be denied. These are concerns to ponder and are not completely solvable. It should also be noted that labels may not have to be discarded in some situations, but the power given the labels can be challenged.

Because the narrative approaches are relatively new and there is less empirical research to support its efficacy, it is difficult to say at this time which populations may or may not be well served by this approach. While narrative therapists report case studies with successful outcomes with a wide range of clients, future work needs to be aimed at determining which clients are best served by such approaches. Managed-care companies rely on evidence-based services, and using narrative therapy may require combining it with a more accepted approach, such as cognitive therapy, since narrative therapy also deals with cognitions (Kelley, 1998).

Administrative and Training Factors

Narrative therapy is used mainly by clinical social workers, family therapists, and psychologists with graduate degrees. It involves more than storytelling; it involves story-changing through intensive listening and questioning in a specific manner, which is usually learned in special post-degree training. The "conscious use of self" and transference/counter-transference issues discussed by psychodynamic social workers are also considered important by narrative social workers, although they do not use those terms. Narrative social workers need to be very clear about their own issues, views, and experiences, to separate them from those of the clients. Since the client's history and reality are

co-constructed through dialogue, the social worker cannot be an outside observer but is part of the change system through reciprocity. Great care must be taken to hear and understand the client's reality, and to join with each client as an individual as well as being part of a community. Thus, there is no set of techniques or prescriptions; each client is viewed differently, and treatment involves whatever fits his or her particular situation. A great deal of self-awareness and willingness to set aside one's own world view is required to work in such a manner.

Although narrative approaches are infused into some academic social work programs (Kelley, 1995; Vodde & Gallant, 2003), most training is conducted at family therapy training centers or at some social service agencies. In addition to the training centers already noted in Australia and New Zealand, there are several in North America, too. Freeman and Combs offer one in the Chicago area; Zimmerman and Dickerson in the Bay area, California; and Madigan and colleagues in the Yaletown Family Therapy in Vancouver, British Columbia, Canada. In Toronto, The Hincks-Dellcrest Center offers frequent trainings and supervision, while Angel Yuen and Ruth Pluznick co-founded the Toronto Narrative Therapy Centre. In these centers, discussions and clinical work go hand in hand. As noted by Freedman and Combs (1996), narrative therapy is more a way of thinking about people and their situations than specific techniques.

Empirical Base

As noted, little empirical research has been conducted testing narrative approaches. Postmodernism, by definition, denies the possibility of objectivity, which is at the core of empiricism. For this reason, postmodern approaches have been criticized for keeping social work out of the scientific field where it should be placed (Epstein, 1995). While social constructionists are uncomfortable with the assumption of linear relationships among variables needed for most statistical procedures, Neimeyer, Burke, MacRay and van Dyke (2009), a psychologist, has pointed out that there are several research methods that are appropriate to assess outcomes in constructionist therapy. He notes several examples, including the use of repertory grids, transcript analysis of developmental levels, task analysis of change events, stochastic modeling, and time series studies. He also notes, as have others, that more conversational ways of inquiry and of understanding personal meanings need to be explored, too. He stresses the need for diverse approaches to research for fuller understanding. Besa (1994) reported using single-subject design with some success. Ethnographic qualitative research approaches and transcript analysis have been found useful in studying constructionist approaches (Kelley & Clifford, 1997; Kelley et al., 2002); and White and Epston (1990) and others use the case study method in assessing outcome, noting symptom relief in clients. Finding new ways of measuring outcomes in narrative therapy and then conducting more research on these newer approaches are important objectives for the future.

Prospectus

Narrative therapy fits into social work values and practices with its emphasis on respect, individualization, and collegial, client-centered approaches. Its focus on social and cultural forces as important in formation of problems, and its emphasis on social action and political discourse, increase this fit with the profession. In addition, narrative work bridges the gap between micro- and macro-practice, as it works with all levels. Because this theory is part of a cross-disciplinary trend, and because the approaches are useful with a wide variety of clients, it is appreciated by many social workers. There are problems using such approaches with clients in clinical practice, however, because of managed-care setting parameters, and because of the demand for evidence-based practice in the field. More research needs to be conducted and new ways of conducting research will need to be found, however, before these approaches are fully accepted in the profession. Social worker and family therapist Hoffman (1990) expressed the hope that this movement will facilitate a return of therapy as an art of conversation as opposed to a pseudo-scientific activity. She also expressed beliefs that the aesthetic metaphors are closer to home than the biological or machine metaphors, as we work with

our clients, and she expressed the hope that these metaphors will also create an "emancipator dialogue" (p. 11) that is socially and politically sensitive to our clients' needs. Indeed, the aim of narrative approaches of understanding and individualizing each client in his or her social context, and the emphasis on mobilizing strengths, is in the best tradition of the social work profession.

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22

Neurolinguistic Programming Theory and Social Work Treatment

G. Brent Angell

Overview of Theory

Since the inception of the profession, social workers have drawn upon the knowledge, wisdom, and skill from a great many disciplines and experts in order to aid, and lessen the challenges faced by, the people they serve. Our individual and collective ability to adapt this information and use it effectively in our active roles as helping professionals reflects the depth of our compassion and creative capacity as social workers. We are collaborators with clients in the translation and transformation of ways of knowing, believing, and behaving. In this chapter, we look at *neurolinguistic programming* (NLP), which is an innovative practice approach that examines how thoughts and beliefs are socially constructed as expressions and behaviors that shape people's exchanges with the world as it is known and experienced.

Founded on how people make constructs of reality, NLP takes into account the ways in which firsthand and vicarious experiences are arranged, encrypted, and deciphered. Much like travelers, everyone makes sense of what they come into contact with, or learn about through their sensory experiences, and juxtaposes this with what they know, imagine, and have experienced. Framed as neuropsychological patterns, or maps, this understanding guides exchanges with others in the bio-psycho-social-spiritual-physical environment. Recognizing that each person's relationships with others, as well as with the environment, are one-of-kind renderings, social workers using NLP are able to theoretically explain how people formulate their feelings, thoughts, and behaviors and make predictions about how they will feel, think,

and behave in the future. As an approach, NLP practitioners engage clients in a here-and-now exchange using emotions, thoughts, and bodily sensations to discover the sensory data to construct "*maps*." These maps in turn are therapeutically helpful in understanding and foretelling the challenges faced by clients. Through a process of deconstruction, maps can be edited and replaced and used to overwrite conflicted, unpredictable, and impracticable personal ways of feeling, thinking, and behaving.

NLP was created by co-founders Richard Bandler and John Grinder (Bandler & Grinder, 1975; Grinder & Bandler, 1976) following their examination of the writings and observations of the practices of some of the era's foremost theorists and therapists. Included in this group were Gestalt's Fritz Perls, experiential family therapist Virginia Satir, metaphor-based hypnotherapist Milton Erikson, and cybernetic-anthropologist Gregory Bateson. The common thread between these thinkers and doers was their understanding and use of the sensory-based maps of feelings, thoughts, and behaviors developed by people for use in communicating with others and the world around them. Appreciating that a map is not the "territory" of experience, but a representation or construction of it, Bandler and Grinder observed how these thinkers and practitioners worked with the narratives and sensory expressions of clients to help them make sense of what they were experiencing and to make changes in how they felt, thought, and/or behaved.

As an approach, NLP appeals to social workers because it provides a common-sense connection between the cognitive, affective, and behavioral aspects of self and how these in turn are expressed in ways that debilitate clients, or help them cope or make changes for the better. NLP also helps practitioners clarify their role as collaborators in the therapeutic relationship. It calls on social workers to have a self-awareness of their own maps and how these in turn can affect the helping process. Having this insight allows practitioners to meld their maps with their practice wisdom in a way that maximizes their differential use-of-self in collaborating with clients to find solutions. Starting where the client is, and winding up where the client wants to be, NLP is an ideal interlocking theoretical practice approach for finding alternative neuropsychological patterns forged from an effective, collaborative, and authentic therapeutic alliance (Angell, 1996, 2001, 2011; Field, 1990; Ignoffo, 1994; House, 1994; Mercier & Johnson, 1984). Appreciating this, it is easy to see how social workers can make use of NLP as a stand-alone approach, or use it concurrently or combined with other treatment approaches.

As mentioned, the fabric of NLP is woven from the thoughts and techniques of purposely selected thinkers and practitioners in the fields of psychology, philosophy, transformational grammar, and cybernetics. Arising out of this synthesis, social workers are provided with practical ways of working in partnership with clients in establishing a meaningful therapeutic alliance, assessing the concerning circumstances, and finding choices, or patterns to bring about resolve. From the outset, social workers using NLP appreciate the ease of fit it offers in bringing together the theory and application of the approach founded on thought-based language and behavioral change. Together, practitioners and clients are then able to use a common and understandable linguistic template to communicate what is being felt, thought, and enacted, which in turn directs the course of therapy in terms of the selected specialized technique. As Ignoffo (1994) and McDermott and Jago (2001) point out, practitioners of all ilks interested in solution-focused and client-centered approaches will discover the power and precision of NLP. This being said, theory and the techniques only go so far, but they can and do set the stage for effective treatment. To help understand this better, authors Lambert (1992) and Duncan, Miller, Wampold, and Hubble (2010) tell us that the theory behind a high-quality psychotherapy and the therapeutic techniques that arise therefrom account for roughly 15% of the helping process. Used well, the structure of the theory and the processes of treatment lead to the formation of an effective relationship, which represents around 30% of the change process. Having confidence that the approach will work, the expectancy effect, adds yet another 15% to the equation. How this plays out for the client in the environment is an extra-therapeutic factor, which is the largest single influence at 40%. Conceding that what

happens outside of the office can be and often is unpredictable and uncontrollable, it is vital that the social worker engage the client in understanding the theory and toolbox of techniques as part of forming a strong therapeutic alliance and belief that the approach will work outside of the session, translating to multiple settings and circumstances. This bridge between theoretical knowing and practical doing provides clients with a sense of being able to overcome adversity and deal with a wide range of bio-psycho-social-spiritual-physical challenges (Andreas, 1992; Field, 1990; House, 1994).

Origins

Provocative and unconventional from the beginning, NLP is both an art and a science of what works in therapy (Dilts, 1976; Lankton, 1980). Defying the mainstream trend towards evidence-based practice, NLP has persisted in gaining ground, although skeptics assert that it is pseudoscientific and not worthy of consideration. Putting this to the side for the moment, let us take a look at where NLP comes from, what it has to offer, and why it is worth considering as a treatment approach for use by social workers, who ultimately will be the judges of the merits and efficacy of NLP in their work.

Drawing from Noam Chomsky's (1957) study of the biological structure of language, NLP's Bandler and Grinder's developed of their linguistic typology in the early 1970s (Bradley & Biedermann, 1985). Adding to the mix, Bandler and Grinder incorporated phenomenologist Edmund Husserl's (Welton, 1999) constructionist contrasting of the real world with that of perceived human experience. Combined with Wilhelm Wundt's (Rieber, 2001) biopsychology of mental function, which looked at the thoughts, images, feelings, and beliefs that compose the deep unconscious of the inner-mind and emerge to affect the conscious expression of the outer-mind, Bandler and Grinder had the ingredients to further explore and explain how subjective experience was transformed into linguistic and behavioral patterns.

To confirm what they had found intellectually, Bandler and Grinder methodically observed and then deconstructed the work of the some of the period's most prominent psychotherapists. They noticed similarities in how these experts used communication to interpret and change people's thinking and behaviors. Deducing that what they were observing were the "ah ha" epiphanies that brought about change and led to client empowerment, Bandler and Grinder structured their "magic" for psychotherapy using a language-based meta-model. By way of the meta-model, they were able to provide helping professionals with a means of untangling the dysfunctional affective, cognitive, and behavioral communication constructs of clients and to rebuild or replace them with functional and nurturing narratives.

Applicability in Social Work

Let us now look at how NLP as a practice approach aligns with the professional values and ethics of social work. In considering what works in psychotherapy, we must consider what brings clients to seek help in the first place. A common theme with every client is a feeling or thought of being vulnerable, oppressed, or somehow at risk. The social worker's chief goal, therefore, is to help clients discover what impedes them from moving forward and to find a way ahead by making new maps or alternative patterns of feelings, thoughts, and behaviors. This is obviously not an easy task, but with NLP's focus on collaboration, clients come to understand the theory and techniques of the approach (its language), and learn to anticipate results from the therapy. Delivering the "goods" is made more doable by the social worker's focus on forming a meaningful and trusting relationship with the client, and a dogged determination, embedded in NLP, that resolutions to problems are not only possible, but inevitable. The focus of treatment is on helping clients discover their existing strengths in solving problems, and, where indicated, collaborating with them to create healthy choices in handling stressors and enhancing empowerment. Knowledge and skill are shared goals and responsibilities of the worker–client experiential relationship. It is a purposeful process aimed at personal change, which impacts interpersonal and environmental transactions.

Getting at the origins of client problems, from an NLP perspective, involves drawing out

the resource-rich lived sensory experiences, which will form the building blocks for new patterns or maps. The past is not viewed as a place of focused concern as in other therapies, which can be retraumatizing for clients, but as a source of information. Often formulated as narratives, client experiences contain content on coping and resiliency on which NLP practitioners base their understanding of how people construct affective, cognitive, and behavioral communication. The approach's use of metaphors to positively enhance change suggests to clients that they can and will find resolution to their problems and are in control of the treatment process.

NLP has long been taught to and used by social workers interested in clinical practice (Angell, 1996, 2002, 2011; MacLean, 1986; Zastrow, 2009; Zastrow, Dotson, & Koch, 1987; Zastrow & Kirst, 1994). From student to seasoned practitioner, the fundamentals of NLP have played an important role in teaching helpful communication and interviewing skills. One need only look at texts by Ivey, Ivey, and Zalaquett (2013) and Cournoyer (2013) to appreciate how the approach has infused the curriculum of a broad range of helping professions in the preparation of students for both internships and professional practice. The work of Ivey et al. (2013) on intentional interviewing and counseling draws from NLP to provide an interdisciplinary audience with an orderly set of practice skills and methods. From a social work perspective, Cournoyer's (2013) influential text has long served as the standard in social work education and incorporates many of the ideas conceptualized by NLP's Bandler and Grinder (1979, 1982).

Presuppositions of Neurolinguistic Programming

Internal Resources

Practitioners using NLP believe that each and every person has the internal resources to make changes to how they feel, think, and behave (Yapko, 1984). What are "resources"? They are the stored neurolinguistic bits and pieces of data received from lived and vicarious experiences, which enter thoughts and memories, inspire imagination, are expressed as personal narratives, and impact feelings and actions. They shape the personal patterns, or maps, that people operate from and are understood to be unique worldview constructions, which are constantly being reworked as new information is received. Resources are the ingredients for how people make sense of experience and function bio-psycho-socially and are the building blocks for change. Challenges to functioning, therefore, are not seen as limitations per se, but rather as the unsuitability and/or inflexibility of current ways of knowing and doing in addressing client-identified concerns, which are emotionally distressing.

The first step for the social worker is to locate resources already held by the client, which have been used to handle other, not necessarily similar, challenges and to bring them to the surface of perception and to explore how they have been or could be used. Resources, and the patterns or maps that arise from them, are reviewed in terms of how they can and should be used to address issues in the here and now. Moving away from a limitation, or deficit perspective, NLP looks at what the client has to work with in terms of resources, the resiliency of those resources in terms of being adequate, relevant, and adaptable, and how they can be reconfigured linguistically to bring about preferred affective, cognitive, and behavioral change. As such, this strengths-based point of view does not view the client as inadequate, deficient, and/or dysfunctional, but rather as someone with limited choices who nevertheless possesses the creative capacity to revise and create alternative patterns or maps to make desired differences in how they feel, think, and behave. Thus deconstructing the narratives of past experiences provides the linguistic components for alternative and new ways of handling present conditions, which enable clients to better determine how to deal with future situations (Angell, 1996, 2002, 2011; Ivey, Ivey, & Zalaquett, 2009; MacLean, 1986; Pesut, 1991).

Sensitivity to Difference

From the perspective of NLP, social workers understand and accept that each and every person is unique and experiences, learns, and

makes sense of their world in distinctive ways. In saying this, practitioners of the approach appreciate that people are social, and that they share, teach, and learn cultural patterns, or maps. This includes language, values, faith, food preparation, art, and other ethnic practices and traditions. Being sensitive to culture, and its impact on personal development and neurolinguistic processing, provides useful insight for both the social worker and the client with respect to each other's way of life. Why is this important? Well, culture being a multilayered social construct, it aids in understanding, validating, strengthening, and steering the client's lived and expressed experience. The starting point for sensitivity is, accordingly, an intentional channeling of communication between the therapist and the client on the role that culture plays and the value that is placed upon it. Culture is part of how everyone makes sense out of the world and is the connection between the self and others in terms of what is considered acceptable and what is not. It is a collage of feelings, thoughts, behaviors, and beliefs used to shape patterns or maps, which provide reference points for interacting with and viewing others. Thus, taking a nonjudgmental stance on culture from the beginning is critically important. However, to do so requires an appreciation that, although cultures may be constructed similarly, they do differ, and no one culture is any better or worse than any other—they are simply different. Respecting this, NLP practitioners can work with clients and their maps, steeped in culture, to create new acceptable patterns to deal with their bio-psycho-social-spiritual challenges (Angell, 1996, 2002, 2011; Ivey et. al., 2009; Ivey, D'Andrea, Ivey, & Simek-Morgan, 2006; Sandhu, Reeves, & Portes, 1993).

Deep and Surface Structure

Most people are to some extent familiar with how cell and smartphones work and what they can do in terms of sending and receiving voice, text, and video messages. How they do what they do is another thing for most of us to understand. We simply make/send or receive a call or message. Of course, we realize there is more to it than that, but we usually only become more interested in how our devices work, or should work, when something goes haywire and we cannot make, get, read, hear, or view our calls and messages clearly or at all. Much like making or getting a call or message, NLP accepts that receiving and sending information requires the ability to take in, process, and transmit information.

NLP is a compound lexeme of three relational concepts—*neuro-linguistic-programming*. The body's neurological system receives, sorts, and stores data received from the environment in the unconscious deep structure. This is the *neuro-* part of NLP. The actual formulation of thoughts into patterns, or maps, that can be enacted requires the initiation of a retrieval system of sorts that draws upon and organizes needed sensory-based data into a communicable format, which can be used at the conscious surface structure level. This is done in a *linguistic* and/or *paralinguistic* (nonverbal) way using the patterns, or maps formed from lived and learned experiential data. The communication of these *linguistic* and/or *paralinguistic* patterns, or maps requires encoding, or programming of the data in a way that incorporates the necessary content required to acquire to achieve the intended outcome with the greatest probability of success. For this reason, "programming" refers to how decisions are made, problems solved, and results obtained. It reinforces for people patterns that work and guides them in editing their experiences in ways that lead to more preferred outcomes (Zastrow, 2009).

Sensory data that are received and transmitted are kept and processed in the unconscious and are referred to in NLP as the "deep structure." It is the mind's internal archive of experience from which data are drawn for everyday use in creating emotions, thoughts, and behaviors. The level at which these messages consciously emerge is known as the "surface structure." Using the cell/smartphone analogy, neurolinguistic "radio waves" of sensory stimulating energy are constructed from deep structure data and are emitted at the surface structure by way of affective, cognitive, and behavioral "frequencies" from one person's "antenna" to another. How the messages are put together, sent, and received depends on the ability of the sender to compose a clear message from the resources at their disposal, and

the aptitude of the receiver of the communication to be able to decode and make sense of the intent of the message.

The process of receiving, formulating, and sending communication is really quite remarkable when you think about it. We are constantly exposed to and barraged by stimuli in our bio-psycho-social-spiritual-physical environment. Fortunately, handling and making sense of this sensory information is at the heart of NLP, which provides practitioners using the approach with an important advantage (Bandler & Grinder, 1975). Employing a three-part framework for how people sort and select received unconscious information for use in creating patterns or maps, which in turn contribute to the person's conscious presentation of emotions, thoughts, and behaviors, provides social workers with a valuable means of understanding, assessing, and treating the challenges presented by clients. Depending on how the deep structure data are put together and used, the patterns on the surface can vary, depending on the situation. They can be calming, soothing, and clarifying, or they can be destabilizing, disquieting, and distorting.

Deletion is one part of this trio. It involves the omission of bits and pieces of sensory data "files" stored in the unconscious, which are superfluous to functioning, and the creation of manageable, abridged patterns used at the surface structure in the form of patterns or maps. The process of deleting information allows the mind to keep what is needed and to rid itself of information not needed for daily living. Unlike sorting, "deletion" relates to the removal or erasing of data. If deletion did not occur, individuals would be overwhelmed by the plethora of information present in the deep structure coming to the conscious surface. In turn, this would cause sensory overload and make messages incredibly challenging to understand, if not nonsensical. So, discarding information is important to functioning and communicating. It is an automatic deep structure response to what is being experienced bio-psycho-socially in the environment, and it can be purposefully altered at the surface structure by sorting and selecting information to fine-tune the pattern if the individual determines that the construction of information does not, or is anticipated not to, achieve the desired end.

Let us consider an example of how deletion functions. Imagine that you are in a busy restaurant where the patrons are all conversing and there is music playing on the sound system. One customer is arguing with the maître d'hôtel about a reservation. Servers are taking orders from customers at several tables throughout the room. A busboy is rattling dishes, cups, and glasses as a table is being cleared. Suddenly, you hear the crashing from the kitchen as something metallic hits the floor. After a momentary hush across the room, everything returns to its noisy normal. On top of the obvious, there is a host of subtle things happening around you. Phones are being used; texts are being sent and received; cars and pedestrians are passing by outside; traffic signals are flashing and beeping; people are reaching into pockets and purses; eyebrows are being raised; faces are smiling and frowning; lipstick is being applied; itches are being scratched; and so much more. Somehow, you manage to filter out most of this so that you are able to focus on the conversation you are having with your companion. A choice was already made from all the available sensory data available to you and previously experienced, which allowed you to focus on your friend and incorporate what is needed to be attentive. This is deletion at work. You did not choose what to keep and what to dispense with, you simply responded using the pattern that works best for you in crowded, busy, and noisy places.

Distortion is another method of transforming sensory data in the deep structure. If you think of smart technology for modulating the intensity of a light or volume of sound, you can get a sense of how you can magnify or decrease the level of distortion. The same holds true when sensory data are engineered in the deep structure. By assigning more or less significance to sensory data stored in the deep structure, resulting patterns can be intensified to achieve desired surface structure outcomes. It is a creative, reflective process involving abstracting and/or fantasizing about what resources are needed and how they need to be put together to achieve a preferred goal. In the right situation, distortion can have a wonderful result. All genres of authors and artists use distortion to convey their messages through words, sounds, and images. We, too, use it

regularly to emphasize meaning in day-to-day communication.

Returning to the restaurant example: Let us suppose that since starting a new job in sales you have not seen your friend for quite a while. Your motive for inviting the person to dinner at this high-end place is twofold. You want to renew your friendship on one hand, and on the other, you are hoping that they will become a customer. You desperately need and want to achieve both goals. The ambiance, service, and menu seem perfect for setting the stage to accomplish what you are after. So, you contour your presentation-of-self in a way that emphasizes how great you are doing. You state in no uncertain terms that you are so busy at the office that you have hardly had any time to do anything else but work, or see anyone outside of workplace. You tell your friend that you miss them very much, but blurt out in the same breath a pitch for your product and suggest to them that they might be interested in buying it. You are expecting an understanding nod and smile from your friend, but instead you receive a puzzled look of confusion as they try to guess your true motivation for the dinner meeting. As you backtrack and try to make amends by saying that of course your friendship is more important than work, your friend pushes back in their chair and folds their arms. The frown on their face tells you that your plan is not turning out the way you had hoped. The distortion in this case was a double-edged sword and has alienated an important support for you from someone you wanted to be close to, due to the skewed focus. The pattern lacked accuracy and fell outside of what was acceptable to your friend.

Generalization is the third filter. It is useful in drawing together sensory experiences housed in the deep structure to formulate patterns, which can be used across situations when presented at the surface structure. The process involves drawing conclusions, which are used in making determinations about what "things" are alike, or what triggers certain emotions, thoughts, and behaviors. A "generalization" is a particular deduction drawn from specific events about a group, classification, or category, which by inference is used to form an archetypal pattern. This pattern is used to examine sensory experiences and is expressed as all-encompassing emotions, thoughts, and behaviors. Generalizations are helpful in maneuvering our way in and through the bio-psycho-social-spiritual-physical world. Problems can arise, though, when using generalizations one-sidedly as rigid positive/negative, good/bad, and/or right/wrong all-or-nothing dichotomies. If used so, the ability to differentiate where and when to use a certain generalization can be compromised or lost.

Taking a last look at the restaurant illustration, the failed attempt to reconnect with your friend and to make them a customer has proven problematic. You are feeling fairly frustrated. You are thinking, "What just happened?" You review everything, and the whole thing looks perfect for reconnecting and making an impression, but for some reason the whole evening has fallen flat on its face. You wonder why every time you get ahead in one area of your life, the people who should be there for you abandon you. You are beginning to think that reaching out to people is not worth the effort. In this scenario, generalizations abound. The idea that one group of people—friends, can be lumped together with another group of people—customers, and that they should respond to your pitch in the same way seems rather absurd. Yet this does happen and is a prime example of a generalization that did not work out the way that was hoped. The dining experience was a useful generalization as a means to connect with people, but the assumption that all people, whether they are friends or customers, would respond the same way was not. Certainly, lumping the two together in this example proved disastrous.

In summary, distortions, deletions, and generalizations are valuable deep structure processes for filtering sensory data into constructions geared towards improving effective functioning. This being said, they can have an adverse effect and at times do degrade performance by not offering the type of patterned response needed to deal with a full range of environmental issues. What happens in the deep structure does not stay in the deep structure and emerges in the surface structure as patterns that are either need fulfilling or are deficient in some way. It is safe to say that all experiences consist of components with changeable meanings and as such can be reconstructed to create new patterns. How well this is done indicates

the individual's resourcefulness in being able to mold the elements of sensory experiences into multipurpose maps made up of thoughts, feelings, and actions for understanding and functioning in the everyday world.

Treatment's Principal Therapeutic Goal

The basic premise of NLP is founded on personal ability and capacity-building. In principle and practice, social workers using the approach accept that if someone has been able to overcome a challenge, then, in theory, anyone can. It moves client reasoning and believing from the impossible to the possible by focusing on what resources are available to the individual, or need to be introduced, to solve struggles in the here and now. Founded on a sensory perception/processing model of communication, NLP provides practitioners and clients with an understandable cause-and-effect explanation of how emotions, thoughts, and behaviors come about. It also provides adherents to the approach with concrete skills to construct alternative ways of coping with and overcoming obstacles to well-being. Collaboratively, social workers and clients build on the principle that change is achievable, by analyzing the therapeutic goal from the perspective of the client and their bio-psycho-social-spiritual-physical environment. As such, each treatment plan is uniquely matched with the defined needs and aspirations of the client. Furthermore, assessment and treatment are viewed as interconnected and a shared learning experience involving the expertise of both the worker and the client. In saying this, social workers can operate from the following clinical assumptions:

- Clients expect change and are motivated to modify their feelings, thoughts, and behaviors regardless of what reason brought them into therapy. They are there for a purpose, and the treatment must be purposeful and collaborative.
- Clients are resourceful in coping with adversity. Even though they may feel, think, or act like they are overwhelmed or inadequate, the fact is that they have dealt with and are dealing with their problems, albeit in ways that may not be as gratifying for them as they want or expect. Drawing upon and enriching this resilience to find more satisfying solutions is the therapeutic objective.
- Clients construct their bio-psycho-social-spiritual-physical worldview from their neuropsychological sensory experiences. Stored in the unconscious deep structure and emerging in the conscious surface structure, these experiences are the building blocks for change. The therapist's presentation-of-self models possibilities, guides decision-making, and provides learning opportunities for clients to locate and create resources needed for constructing new patterns or maps and making sought-after changes.

Treatment Concepts and Strategies

Primary and Preferred Representational Systems (PRS)

Given that NLP is a psycho-neurologically based treatment, clients and users of the approach predictably derive interpretative diagnostic data from the five senses. Referred to as the "representational system," they include the intersecting sensory systems of sight, or visual; sound, or auditory; touch, or kinesthetic; smell, or olfactory; and taste, or gustatory. These sensory systems automatically gather, sort, and store data in the deep structure according to the associated experience or experiences. As new data are received, they are used to create further categories or add to existing ones in ways that shape and reinforce surface structure patterns of thought, emotion, and behavior. The interconnectedness of the senses provides people with enough data to form patterns to use in dealing with a range of day-to-day events. How adaptive the sensory-based patterns are in dealing with adverse, traumatic, and threatening situations indicates the level of personal resilience that has been learned and nurtured by the individual to deal with cognitive, affective, behavioral, and/or environmentally induced stressors. Accepting that everyone is resilient to a greater or lesser extent, the impact that different stressors have on the individual will test the efficacy of their personal resilience to protect them when they are at risk. People using the range of representational systems are more

often than not the most resilient, and are able to construct more comprehensive patterns than those who draw data from fewer than the entire array of sensory data sources.

Considered from an NLP perspective, when people experience a high level of stress, they revert to a dominant representational system in terms of taking in, analyzing, and responding to environmental inducements. Originally, the PRS was determined through analysis of linguistic predicates used by people and via eye movement accessing cues (Bandler & Grinder, 1975; Grinder & Bandler, 1976). The assumption was that the connection between linguistic predicate use and eye movement would be one and the same. However, discussion and clinical observation suggests that there could in fact be dissimilarities between how people take in, categorize, and store data in the unconscious, or deep structure, and how they consciously relay information linguistically in the surface structure. Therefore, the "primary" way of receiving data may be different from someone's "preferred" way of relaying information through language. With this debate, the literature at times interchanges the words "primary" and "preferred" when discussing the same thing, while at other times considers them different aspects of the representational system (Einspruch & Forman, 1988; Jupp, 1989). For our purposes, we will accept that people might well have both a primary and a preferred representational system, and that they may be the same or different. To differentiate them in this chapter, conscious constructions will be referred to as "surface structure preferred representational systems" or SS-PRS, and unconscious constructions will be described as "deep structure preferred/primary representational systems" or DS-PRS. This calibration of NLP will hopefully allow the practitioners and clients alike to approach the treatment process with more flexibility in terms of establishing rapport and trust when conducting clinical assessments, and choosing and using communication-based techniques.

One way to determine an SS-PRS is for the social worker to concentrate on the client's use of predicates (adverbs, adjectives, and verbs) when they speak. A noticeable preference is likely to appear in the client's choice of words due to being under stress, which in turn will inform the practitioner on how best to establish a meaningful line of communication with the client using similar sensory-based predicates. Matching predicates, the social worker can relate directly to clients by starting where they are, using the SS-PRS that makes the most sense to them. It is worthwhile noting that clients can and do use the range of representational system predicates when speaking and will tend to do so during a session; however, the circumstances that led to their seeking help will very often give rise to their focusing on an SS-PRS that they prefer to use when distressed. Therefore, practitioners need to be aware of when clients move into issues of concern to them, as it is at these times that the potential for change can be most dramatic. It is worth mentioning that the predicates used by clients are related to their cultural customs and do vary. In North America, the tendency is to use predicates that are more visual, auditory, and kinesthetic to refer to thoughts, feelings, and behaviors. Olfactory and gustatory predicates do exist for sure, but they are much less prevalent when used in this way in the English language. Nevertheless, social workers need to be mindful that their clients may be using SS-PRS predicates, regardless of their cultural background, which fall outside the presumed norm. Let us take a look at some examples of SS-PRS predicate–rich client/worker scenarios and the use of matching by the therapist:

Visual SS-PRS predicate matching:

Client: My mind just went *blank* when I *pictured* myself there with my relatives again. I just couldn't *imagine* any way to get out. It was like one of those *movies* where the *scene* just keeps getting *shown* over and over again.

Worker: So if I understand what you've *illustrated*, it *appears* as if you can't *imagine* the situation being different. *Looking* at what you've *portrayed*, let's consider another way to *look* at it. Sometimes a different *perspective* can *show* us a way forward so that the movie has a different storyline and the ending *looks* different.

Auditory SS-PRS predicate matching:

Client: It is incredible to me that when you *say* what's on your mind to people you care about and they don't even *hear* you. Incredible. I just said what

was on my mind and I got *yelled* at for simply *telling* the truth. It seems like you can't even make a *sound* anymore without being criticized. I guess I'll just go back to *mumbling* what I think to myself.

Worker: I *hear* what you are *saying*. When you are *speaking* your mind it can be disappointing, to *say* the least, when someone you feel affection for doesn't seem to *hear* what you're *saying*, or *hears* it in a way different than you intended. It sounds to me that the message you are *expressing* is not *ringing* a bell with the people the way that you want it to be *heard*. It is important to be *listened* to by people who matter to you. How about we *talk* about other ways to get your message across so that you are better *received*?

Kinesthetic SS-PRS predicate matching:

Client: I have been *arm-wrestling* over what to do about this forever. Every time I get to the point of *jumping in* to buy a house, I *pull* back *feeling* that it would be just too much for me to *stomach*. It would be easier if I knew I had the *support* of my family and friends, but I am just not sure if I can *handle* it alone. I'd like to reach out to someone, but I am afraid of being pushed away. Even now as I think about it, I can *feel* the hairs on the back of my neck *stand* up and my blood pressure *going through* the roof. I *feel* so *stuck*.

Worker: Making a decision like the one you describe can be *upsetting*. This seems especially *hard* for you when you don't *feel* that you have anyone to *turn* to for *backing*. The fact that you keep *working* at finding a way *forward* tells me that you are determined to *reach* your destination of owning a home of your own. Let's *tackle* the issue of how to *rally* those you care about to *help* you in your *struggle* to *make* a choice.

Olfactory SS-PRS predicate matching:

Client: The whole situation *stinks*. Right from the start, I knew something was *fishy*. I should have guessed when they invited me to dinner at their place, with all the wonderful food *aromas,* that it was a setup. Now all I can *smell* is that person's cologne and it makes me want to *turn up my nose* to any other offers of friendship in the workplace.

Worker: It is always difficult to decide what is the right thing to do when you find that what you thought was going to be a good decision *reeks* of betrayal. The challenge for you now is to pick up the *scent* of what to do next and whom to trust. My hope is that you come out *smelling* like a rose.

Gustatory SS-PRS predicate matching:

Client: I don't know what to say. The affair left a *bad taste* in my mouth. My partner said that it was a one-time fling, but I don't believe them. All they wanted to do was *feed* their own ego.

Worker: Everyone is looking to be emotionally *fed* and the decisions they make often can seem *unsavory*. The task for you, it seems, is to figure out what *scraps* of this relationship, if any, are worth saving. Let's see what you can *cook* up.

By attending to the client through predicate matching, the social worker avoids the typical clinical stumble or roadblock that far too often results from therapeutically missing the mark in terms of the client's mode of communication. We have all either experienced or heard of practitioners saying things like "So, how did you *feel* about that?" using a kinesthetic rejoinder only to have the client respond using a dissimilar SS-PRS framework such as the auditory, "I don't understand what you are *asking* me," or visual, "I am not sure what you are *looking* for." Challenging as it may be, matching the SS-PRS of clients makes sense, but in cases where it is difficult to determine this, or when the client uses multiple sensory systems, an overlapping predicate approach may be clinically worthwhile to consider. Furthermore, by overlapping predicates, the social worker models for the client an optimal way to communicate to others what they are thinking and feeling (Ivey et al., 2009; Lankton, 1980). In the following client–worker interchange, the use of overlapping predicates is presented.

Overlapping SS-PRS predicate matching:

Client: *Picture* this: there I was *telling* my life story to someone who I *felt* would *listen* to me. You know, appreciate what I was trying to *show* them. Well, it didn't work at all. They just *looked* the other way, *shrugged* their shoulders, and *told* me it was my problem, not theirs, to deal with. It left a bad *taste* in my mouth, and I thought to myself, "This *stinks*."

Worker: It *sounds* to me like they didn't want to *see* it your way from the outset. It is always difficult when someone you want to *unburden* yourself to isn't there when you need them, or in a way that you want them to be. *Distasteful* as it may have appeared, there might be a *whiff* of hope in the *air*. If you *reflect* back, what did you *do* and *say* when you needed someone's help?

Eye Accessing Cues

As mentioned, there are different sites where sensory data are found. We have just looked at one located in the conscious surface structure, but as mentioned, PRS can also be found in the unconscious deep structure. Observing eye movement is an expedient way to access the deep structure primary representational system, or DS-PRS, of people. To do this, the practitioner observes the direction in which clients move their eyes when asked a question. It is important to be nonspecific in terms of sensory wording to ensure that the client uses their DS-PRS and not one suggested by the social worker. These "eye accessing cues" help the practitioner determine the primary representational system of the client used in the unconscious deep structure for categorizing and storing sensory data to be used in creating conscious surface structure patterns or maps (Bandler & Grinder, 1979; Buckner, Meara, Reese, & Reese, 1987; Dilts, Grinder, Bandler, & DeLozier, 1980).

In addition to the ease of using eye accessing cues to determine a person's DS-PRS, it does not require the client to verbalize a response to the social worker. On the contrary, the advantage of the technique is that clients do not have to take their DS-PRS and program or translate their unconscious data into consciously expressed language. Social workers choosing to use the eye accessing cues technique need to be intentional in their choice of words. The ensuing examples of sensory-neutral phrases may prove instructional:

> *Think* about how you could do it. *Deliberate* on what the steps would be. *Recall* what you have done previously to solve a problem. *Consider* what resources you would need to get the job done. *Deliberate* on how you might have done things differently. *Reflect* on when you were the most satisfied or pleased.

Once the direction of eye movement has been determined, the practitioner needs to assess their findings. A glance up and to the left or right indicates that the client is using a visual DS-PRS. Similarly, if the client looks straight ahead, they are visual. A look to the left or right, or down and to the left indicates that the client's DS-PRS is auditory. Peering down and to the right implies that the client is kinesthetic. Scanning back and forth suggests that the client is processing the question and trying to access the data from their unconscious deep structure. Much like doing an Internet search on a computer, some people will take longer than others in order to find the needed information. This then calls for the social worker to be patient while the client finds what they are looking for in terms of their DS-PRS. (Of note, the aforementioned information on eye accessing cues is for right-handed individuals. This diagnostic schemata is reversed for those who are left-handed; i.e., down and to the left for kinesthetic, and down and to the right for auditory.)

The Four-tuple

Realizing that people are constantly taking in a spectrum of sensory data, it is now understandable how these in turn influence the cognitive, affective, and behavioral aspects of our bio-psycho-social-spiritual-physical selves. Shaped internally as patterns or maps and conveyed externally via sensory-based linguistic communication, the array of representational systems will be used by people to construct and convey what they are thinking, how they are feeling, and why they are behaving the way they are. Obviously, the flow of information needs to be handled in a sense-making fashion so that the person can understand the information and messages they receive, and make the ones that they send coherent and meaningful to others. In order to do this, a selection is made at both the unconscious deep structure and conscious surface structure levels with respect to which representational system to use and when to use it. This cascading of PRS from best to least desirable choice is based on the situation and circumstances confronted by the person using existing patterns or maps drawn from *internal* memory or ones constructed from *external* experiences in the here and now.

Clinically speaking, clients use a "what works" selection process to make sense out of what they are experiencing and to determine how best to act or react to what they are confronted with. Referred to in NLP as the "four-tuple," a "set" terminology is used by practitioners to describe what they are witnessing from clients (Bandler & Grinder, 1975). The first step is to assign the senses set values. V is used for visual, A for auditory, K for kinesthetic, and O for both olfactory

and gustatory. When the social worker determines whether the PRS being used is internal or external, a qualifying value is assigned using $^{(i)}$ for internal and $^{(e)}$ for external.

The four-tuple is an excellent assessment and instructional tool to use with clients. It is helpful for both worker and client in determining how PRS are ordered and where the source of the information is. As clients make the gains they are hoping for in treatment, the four-tuple can be used to see where they are in terms of using internal and/or external resources to make choices and address challenges.

To illustrate this, let us consider a client with an internal four-tuple. The individual would be intent on reviewing patterns or maps used in the past to deal with a here-and-now issue. They might well be so consumed by their ruminating that they block out what is happening around them. Explaining this by way of a four-tuple interpretation, the client would be viewed as V^i, A^i, K^i, O^i. Let us reverse this scenario and consider a client who is entirely external in their approach to dealing with an issue and does not draw upon their past experiences to assess the situation and make decisions. This person's four-tuple would be construed as V^e, A^e, K^e, O^e. Clearly, clients do not fit nicely at one end or the other of the spectrum when it comes to having an internal or external locus, but rather are found to be somewhere in between. The mix of PRS used by a client would depend on what they can access and what is needed at the time to deal with the issues confronting them. Normally, a balance between constructed internal (remembered) and external (here-and-now) experiences should be expected and displayed in the PRS used to create a four-tuple. Achieving balance is important for clients, and being able to use the range of PRS is crucial from a clinical perspective as it shows evidence of the client's ability to effectively use resources in adapting to bio-psycho-social-spiritual-physical challenges.

Metaphors

Metaphors are therapeutically powerful ways to help deal with conflicting and often painful material rooted in the client's unconscious deep structure, which rises to the conscious surface structure as problematic patterns or maps of dysfunctional thought, feeling, and behavior. By circumventing the conscious surface structure, practitioners use stories, parables, and analogies to locate resources within clients that are vital to problem resolution. Considered healing narratives imbued with meta-messages, they contain underlying or implied meaning, which convey information about a person that has importance and shapes, not only their understanding, but their perception. At the same time, they convey and shape the understanding and perception that others have about the client. Metaphors join the social worker with the client by eliciting a mutual bond on collaborating to find solutions in a way that is nonthreatening and respectful. In so doing, a shift of perspective takes place, which moves the client from thinking, feeling, and behaving as if "things" are not working, to a position of seeing possibilities that "things" will work out.

The power of metaphors lies in their place in everyday speech. Just think about "a battle of wills," "a heart of stone," "a light at the end of the tunnel," "don't judge a book by its cover," or "shooting the messenger." These are a few of the many metaphors we commonly use to convey our thoughts, feelings, and behaviors, and to comment on those of others. Using metaphors therapeutically must be an intentional act directed towards calming, challenging fixed ideas, and bringing about change. As a suggestion, clients might be encouraged by way of a metaphor to face up to an oppressive aspect of their life by creating a linguistic symbol of strength, courage, and competence.

Here is a modest example wherein the italicized words in the client's statement reflect their thoughts and feelings of inadequacy. The italicization within the worker's response is the meta-message meant for the unconscious deep structure. The goal is to cause the client to construct a new or alternative pattern or map of adequacy:

Client: I feel *weak*. I am *afraid* of my own shadow sometimes. I am as *useless* as can be. I'll *never* be able to figure my way out of this rat maze.

Worker: Hmm. Life is a journey through time during which the *battles of the mind* are *fought and won* by the *fearless lionhearted* who *draw strength* from deep in the wells of their souls where the warrior within lies waiting for the chance to *rise up* out of the depths to *take control* and *overcome the oppressor*.

As such, metaphors are meta-message alternative narratives that clients adopt as therapeutic reminders of their resiliency, incorporating hope, confidence, and self-acceptance. Some also choose amulets, keepsakes, or tokens to carry with them as physical signs of what they have achieved. Social workers employing metaphors from an NLP perspective will find the technique a highly effective, intentional way to use narratives to address the complexities of problems presented by clients (Dilts & DeLozier, 2000). This is particularly true in cases where clients are operating from personal "storylines" that weaken or incapacitate them cognitively, emotionally, and/or behaviorally. Understanding that narratives can be reworked, or created anew, practitioners will find the use of metaphors incredibly powerful in helping clients confront what oppresses them. Thinking in a different way leads to feeling differently, and acting otherwise.

Anchoring

Our senses are constantly being flooded with information of various sorts and from multiple sources. We encounter it directly and contend with it vicariously. In each instance, we evaluate the information on a continuum ranging from positive to negative and imprint it with thoughts, feelings, and behaviors. This encoded information can be based on once-in-a-lifetime occurrences, or they may be repeatedly reinforced through analogous events. However they come about, they make a lasting impression on our psyche, or inner self, and through deletion, distortion, and generalization become enduring responses to likened experiences. In NLP, the term *anchor* is used to refer to persistent and predictable points of cognition, affect, and behavior response created from sensory experience. The resulting associations can vary, from being empowering for the individual to being detrimental to their well-being.

The narratives expressed by clients during treatment are chock-full of anchored experiences from their pasts, which tend to be negative and, as a result, adversely affect their handling of challenges in the here and now. This misalignment affects operative functioning and thus the person's ability to adaptively translate what they are receiving in the way of sensory data from others and the environment. Understandably, this can at times be overwhelming for clients and create mix-ups in terms of decoding received information and the encoding messages to be sent. This can then overload a person's facility to communicate effectively, and they begin to delete, distort, and generalize their available choices to the point where alternatives become fewer and fewer, or nonexistent. Clearly, this can have a devastating and demoralizing effect on one's ability to form and maintain meaningful relationships.

Fortunately, NLP is founded on a strengths perspective of being able to deconstruct a person's personal narrative to determine what is not working, and to reframe it into a narrative wherein the previously negatively anchored events are reattributed with neutral or positive significances (Krugman, Kirsch, Wichless, Milling, Golicz, & Toth, 1985). This results in beneficial consequences for both the unconscious deep structure formation of cognitive, affective, and behavioral patterns or maps and their conscious surface-structure exemplification. It also introduces a new-modeled response for the client on how to manage and manipulate data in a way that supports bio-psycho-social-spiritual-physical health and well-being.

Everyone commonly expresses anchors, often unknowingly. That is just how commonplace they are. A simple handshake or touch on the arm conveys meaning, which in turn is interpreted by the recipient as being okay or not okay. These are what NLP would refer to as kinesthetic anchors. Similarly, body language sends signals that anchor feelings. Visual anchors are plentiful as well. A certain look when someone conveys something or other can elicit a corresponding look, which in turn anchors the message. Auditory anchors abound. A certain tone of voice, or turn of phrase can emphasize and anchor the importance of what is being said. Olfactory smells, and gustatory tastes, too, can convey and be used to accentuate and anchor meaning.

Recognizing that anchors are common occurrences in everyday life, it is important for practitioners to intentionally affirm and use them as important "ah ha" moments for clients in terms of insight and/or intervention. Clinical work is an intentional process, as has

been repeatedly said. As such, it is imperative to use every opportunity and means to bring about wanted and needed change for the client. Kinesthetically, social workers can join the words they use with touch. Understanding that physical contact with a client can be controversial, caution and care must be exercised. Nominally, a handshake connected with words can convey and anchor an intended thought, feeling, and/or behavior. The commentary might run something like, "Now that you have *touched upon* an idea that *feels right, moving forward* I get the *impression* that you will *climb out of your troubles successfully*." This then couples a nonverbal and verbal intention geared towards increased choice and change. When this is combined with attending body language, physical proximity, and affirming motions, gestures, or appropriate touch, the anchor can be further reinforced. Of course, matching the client's representational system is vital to the success of the outcome. Let us turn our attention to how anchoring can be done in other than kinesthetic ways.

What we say, hear, and read are auditory functions. The framing of thoughts, emotions, and behaviors into the words we speak and write are the narratives by which we live. We add emphasis to what we have to say by using inflection and cadence. It can also be accentuated by whether we face someone when speaking, look away when speaking, or alternate looking at and away from the person to stress the significance of what is being communicated. Given that social workers, for the most part, are engaged in talk therapy, becoming well-versed in how to be as purposeful as possible when it comes to using auditory anchors makes sense. This is especially the case if the client's representational system we are trying to match is auditory. If so, the worker might relay to the client the following, "By *listening carefully*, you have succeeded in *writing a new chapter* in your life that *tells a tale* of how to *overcome adversity*. Those who matter to you will *hear* you *loud and clear*." Now think about how the words set out in italics form a meta-message and how you could increase the "volume" or meaningfulness of the anchor by using your voice and body language. Auditory anchors can also be paired with letter writing, poetry and prose, assigned readings, text messages, email, online chat, creating a "news flash" headline, and other written mediums.

Turning to visual anchors, the role of facial expressions according to Frith (2009) is often overlooked in terms of the significant part they play in the complexity of communication. They can take the shape of reflexive, implicit signals and responses, or they can be premeditated, explicit signs and replies. In addition to the face, what we wear, the gestures we make, and how we adorn ourselves and our surroundings can impart a message. Mirroring others in terms of visual anchors is quite common, as there is an unconscious tendency and a conscious belief that if one assumes the attributes of the other, one can become the other. Often referred to as *transference*, this is quite common. One only has to think of a fashion fad, or looks and gestures of a favorite celebrity to see how accoutrements and associations can impact one's thoughts, feelings, and behaviors. The same can be said of others who have an effect on the client, and this includes the social worker. Anchoring visually requires the practitioner to match the client's representation system. This can be done detached from, or in conjunction with, other PRS. As an example, the worker might say, "Your *choices appear* to be limited, but if you *imagine* that you have *alternatives*, what would they *look* like? Can you *see yourself doing things differently*?" The meta-message, emphasized by words and looks, would compel the client to be creative in finding new ways to deal with challenges. To make this even more noticeable, the social worker might use pictures, videos, and visual arts to heighten the client's experience of change and to establish the anchor.

Expectably, the potential uses of olfactory and gustatory anchors in the helping process are linguistically fewer than kinesthetic, visual, and auditory ones. This being said, scents and tastes can be soothing and therapeutic. The aroma and taste of teas and coffees can infuse the air with positive expectations. Also, food and snack items can provide people with anticipatory and nurturing experiences. The atmosphere in clinical settings can reinforce the power of olfactory and gustatory anchors, but care is needed, as smells and tastes that are considered positive by one client may be the exact opposite for another. As such, the determination of

the clients DS-PRS and/or SS-PRS is critically important and can reveal how best to proceed.

Using the right words can create an atmosphere that is nurturing and provides pathways to potential recovery, growth, and well-being. In this vein, Abramowitz and Lichtenberg (2009) refer to "olfactory-based hypnotherapy," which has assisted clients in dealing with issues related to post-traumatic stress disorder (PTSD), fear of hypodermic needles, and panic disorder. Anchoring using an olfactory representational system, the practitioner might say, "You certainly noticed that something didn't *smell right*, but you were able to move to a place where you now you can *breathe clearly* and *everything is fresh as a daisy*." From a gustatory perspective, the work may sound like this, "What they did seemed to be in bad *taste*. Fortunately, you have the resources to *cook up something new* that will provide you with a *recipe for success*."

It is undeniably true that anchors can and do communicate different messages and meanings, depending on the person. Even when the intention is clear, the environmental circumstances may have a mitigating effect on what is being attempted. A good example relates to a client dealing with a particularly challenging experience in the therapist's office. Books and magazines on clinical issues, pictures and posters of happy people doing fun things, clothing and jewelry, and other material items can all be considered extraneous anchors, which may be associated with or attached to the client's thoughts, emotions, and/or behaviors. When the client returns to the office, these associations or attachments might well reemerge and rekindle in the client negative or positive connotations or connections, which in turn can have an influence on the course of treatment. To avoid any potential for revictimization, the social worker needs to be on the lookout for this type of possibility and keep the client focused on the here-and-now, and set or reset anchors as necessary to overcome therapeutic regression or relapse. Here are two examples. The first looks at what not to do, and is followed by an illustration of best practice using NLP:

Negative anchor:

Worker: So, what has been happening since the last time we were together?

Client: It's been a really *hard week*. I don't know what *I did wrong*, or where to *turn for help*. It seemed like no one wanted to *give me any support*. I felt *so much pressure* it wasn't funny.

Worker: Life is (worker looks at client and emphasizes the word) *tough* sometimes. When you are (continuing to focus gaze on the client, the worker places their hand on the client's forearm) *carrying this kind of weight, it feels like life sucks, I bet. You're all alone and nobody cares* (worker loosens grip, removes hand, and then looks away while speaking in a soft monotone), but you have the resources to figure this out and get through this.

Client: (Teary-eyed, sniffling, placing head in hands, and in a quiet, faltering voice) I knew it was hopeless to expect that anyone, even you, could help someone like me.

Positive anchor:

Worker: So, what has been happening since the last time we were together?

Client: It's been a really *hard week*. I don't know what *I did wrong*, or where to *turn for help*. No one wanted to *give me support*. I felt *so much pressure* it wasn't funny.

Worker: Life is (worker looks at client and emphasizes the words with a smile) *tough*, but fortunately *only sometimes*. (Continuing to look at the client while speaking, the worker leans forward and touches the client's forearm) *I'm here to help you. You're not alone* and *you have the resources* to *figure this out* and *get through this*.

Client: (Sitting up straight, looking at the worker, grinning slightly) Knowing someone is here for me makes me feel like there's still hope still and that I can do it.

Change Personal History

Every last one of us has a personal narrative that relays our lived and learned experiences. They are constructed stories, usually pointedly focused on a theme, which signal to others and remind us of who we are and what is important. They are tales that guide our cognitive, affective, and behavioral readings and responses to our bio-psycho-social-spiritual and physical environment. Personal narratives hook us, and others, into what is significant to us and what is not. They are sensory expressions, supported by "evidence" derived from fact and fiction over time. They can be chronological accounts, or compositions of events and understandings. They are thick with plots and subplots,

overflowing with how to explain and attain what we have gained or desire, and/or how to avoid adversity. As such, they can be helpful if they are progressive narratives that are helping us get closer to our goals. Conversely, they may be unhelpful, or regressive, narratives that take us away from our aspirations. Others may be stability narratives, which do neither, but rather suggest to us that we are neither closer to nor further away from our objectives. We are simply stuck. However, by deconstructing the client's personal narratives into their constituent parts and patterns or maps, the social worker will come across the sensory building blocks that can be used to generate alternative possibilities. Called *change personal history*, the therapeutic process is highly effective in helping clients overcome constricting stability and regressive narratives (Bandler & Grinder, 1979; Grinder & Bandler, 1981, 1982).

Locating unpleasant, upsetting, and diagnostically disturbing thoughts, feelings, and behaviors is the first order of business in being able to begin the process leading to the generation of new personal narratives replete with health-giving patterns or maps that can be anchored in the here and now. Through the change personal history, re-scripting using existing client sensory-based "text" and new or amended imagery and metaphors, imagery becomes the formula for transformation. Interestingly, change personal history can use mental imagery to help clients produce new personal narratives without having to verbalize their thoughts and feelings. What follows are the steps taken in conducting a change personal history intervention:

1. The client is asked to remember a past event that is causing or contributing to their present despondent state of mind. This can be done by the client's sharing the narrative with the practitioner, or by simply picturing the event. Observing changes in the client's sensory presentation-of-self as they remember the experience, the social worker asks that they find again the sights, sounds, feelings, smells, and tastes that come to mind. When responses are noticed, they need to be anchored in the here-and-now by the practitioner.
2. The client is asked to then think of another time when a similarly concerning event took place, and the preceding procedure is followed in terms of fleshing out the sensory cues and anchoring the event. This is repeated until the social worker determines that the client has exhausted their inventory of problematic experiences. By this time, a number of related memories will probably have been recalled and anchored.
3. Next, the client is asked to remember a past event that was upsetting but somehow coped with or overcome. Once more, this may be done by verbally recounting the event or through nonverbal reflection. The social worker highlights and/or reframes the strengths and resiliency displayed by the client in contending with the challenging event and anchors these along the way. Ever mindful that the client may find it difficult to locate an event that was handled well and prevailed over, the practitioner can aid the client in constructing a "healing fiction" wherein they dealt with and/or defeated adversity. This also needs to be confirmed in terms of sensory cues that the client has accepted the change and then anchored it accordingly.
4. The social worker then merges the positive anchors from the client's narratives to create a powerful super-resource, which in turn is anchored. The practitioner then asks the client to sequentially go back over the already stated or reflected-upon undesirable and harmful past experiences that brought them into treatment and to consider how the new super-resource could be used to deal with the challenges they faced then and now. When confirming sensory signals are identified, the social worker anchors the positive super-resource on top of the negative anchor associated with the experience. To confirm success, the social worker asks the client if the super-anchor has been agreed to and is enough to make the change occur and remain.
5. As a check, the social worker asks the client to do a before-and-after inventory of anchors to see if the new super-anchor has been accepted and is in place. Surveying the client's sensory responses to the questions,

the practitioner looks for confirmation, and if it is not seen, then step 4 is repeated and additional resources located and anchors established.

6. As a final point, the client is asked to use *future pacing*, which allows the client to go over how they would handle a similar stressful situation in the future (Bandler, 2010; Grinder & Bandler, 1982, 1982). Much like a dramatic rehearsal, the new narrative, encoded with automatic sensory responses in the form of new patterns or maps, is used to deal with adverse conditions. If there is any indication that the new super-anchor is not achieving the intended results, then steps 4 and 5 are repeated, and the effectiveness of the change personal history is retested.

Swish Visualization

Metaphorical images are visually constructed snapshots, or clips, of events that have meaning to the individual. They can be negatively or positively premised and are continually emerging in the mind to make sense of what is being experienced, to remind us of how we responded in the past to similar experiences, and decide what to do right now. Understandably, these constructed visualizations can be either helpful or hindering in terms of goal attainment. A demonstrated way to address problematic visualizations is by way of the *swish visualization* (Masters, Rawlins, Rawlins, Weidner, 1991; Wake, Gray & Bourke, 2013). This NLP practice technique helps clients flush out negative thoughts, feelings, and behaviors by using positive metaphorical images. It is an approach that can be used effectively with individuals, couples, and families according to Juhnke, Coll, Sunich, and Kent (2008). In particular, the authors found utility in using the swish visualization with certain parents who had either lost a child due to suicide, or were trying to adjust following a child's attempted suicide. This being said, they caution that clinicians using the swish visualization with clients suffering from certain mental disorders such as panic attack, suicidal ideation, delusion, or hallucination should carefully monitor aftereffect of the intervention as it could contribute to capricious changes in client mood and behavior, which might result in unwanted retraumatization. What follows are the steps to use when conducting a swish visualization with an individual:

1. Ask the client to choose a past or present troubling symptom or event that is undesirable.
2. Invite the client to explain what sensory cues signal to them that the symptom or event is about to begin.
3. Have the client describe a thought, feeling, behavior, or event that gave them pleasure and might be used to replace the negative symptom or event in the future.
4. Query the client on whether or not there could be an unwanted aftereffect from exchanging the symptom or event.
5. Request the client to visualize him- or herself in a theater watching a movie or play about the troubling symptom or event through binoculars turned backwards so that the images look very far away. They can barely hear what is being said and feel very distant from the scene. Suggest to the client that they adjust the binoculars so that what they are seeing, hearing, and feeling is getting increasingly blurred and shrinking in size to the point where it is almost imperceptibly placed in the bottom right-hand corner of the binocular lens. They can now barely hear what is being said and feel totally unconnected to the production.
6. Once this is done, ask the client to imagine him- or herself reversing the binoculars so that they can focus in on what they are about to see. Ask them to cast their gaze to the top right-hand corner of the lens where the image of the pleasing thought, feeling, behavior, or event has come into view. Get the client to make the image bigger, the sound clearer, and their feeling of involvement greater until they feel that they are almost in the film or on the stage.
7. To conclude, guide the client to imagine that the troubling symptom or event has been edited out of the movie or play and replaced by the new footage or scene. Have the client look through the imagined binoculars again and relate what they are seeing, hearing, and feeling to make sure that the negative symptom or event has truly vanished from the screen or stage. If not, then repeat the steps to ensure that the swish visualization process was followed precisely.

Reframing

Cognitive, affective, and behavioral shaped patterns or maps communicate intention. In NLP, intention is always positive, in spite of the fact that the person may not be using positive means to reach their objective. Without a doubt, patterns or maps framed within personal narratives may contain dysfunction, but the constituent parts can be reconstructed, or reframed, into workable solutions to disturbing difficulties (Dilts & DeLozier, 2000; Sharpley, 1987). Moreover, if clients had at their disposal limitless choices, they would regularly choose what works best to get what they needed or wanted. The trouble with this, of course, is that both positive and negative choices can reap rewards, but not without consequences. Considering this, it is vital that congruity be achieved between the positive intention and the means to the end being also positive. In so doing, the potential for negative consequences for the client will be mitigated. Thus, framed personal narratives and their component patterns or maps may need to be reconstructed or reframed to accomplish goals that are satisfying and positively reinforcing. The *reframing* intervention in NLP is a useful way to alter compromising thoughts, feelings, and behaviors by way of metaphors, narratives, and imagery to bring about change.

Early on in NLP, Bandler and Grinder (1982) described how reframing of internal resources could transform sensory coded previous experiences held and used by clients to understand and make goal-related bio-psycho-social-spiritual-environmental choices. Reframing changes the structure of perception and meaning of events and the associated thoughts, feelings, and behaviors. Pesut (1991) also describes how reframing can alter and expand the worldview of clients conflicted by a wide array of mental health challenges. What follows is a step-by-step procedure to help clients using the reframing technique (Bandler & Grinder, 1982):

1. Ask the client to identify a disconcerting thought, emotional or behavioral pattern or map that they would like to change, or eliminate.
2. Have the client assign a number, letter, or color to it so that it is partitioned off from the rest of the client's personal narrative.
3. Allowing the client to close their eyes if they so wish, have them connect with the pattern or map and ask if it is okay to communicate with the now numbered, lettered, or colored part of the person in charge of the part. To know that this has been agreed upon, propose to the client that they intensify the clarity, level, or strength of the part. Once that is done, the practitioner needs to look for a sensory cue or cues to determine if agreement has been given. Affirmation is important, as it is a positive anchor, which is needed to proceed.
4. Receiving affirmation, then request the client to separate the part's positive intention from the negative thought, feeling, or behavior attached to it. The client can do this either verbally or nonverbally. Once that is done, pose the following question to the client, "If you had a way to reach your positive intention with a resource that was as good as, or better than, the one currently being used, would you be willing to try it out?" Wait for a verbal or nonverbal affirmation, as this is the anchor needed to cement the change.
5. Working in concert with the client, construct at least three positive new patterns or maps that could be used to bring about the goals of the positive intention. Anchor in turn each new pattern or map when the client provides either a verbal or a nonverbal cue.
6. Test the client's willingness to try out the new pattern or map by stating, "It's now time to replace the numbered, lettered, or colored part. Are you ready to do this and reach your positive intention in a new way?" Receiving a verbal or nonverbal affirmative response, you now know that the reframing has succeeded.
7. As a last step, request that the numbered, lettered, or colored part that was disconcerting be a blank screen, motionless, and peacefully silent and allow the new pattern or map to do its job. Look for verbal or nonverbal concurrence. Ask if other parts of the personal narrative are willing to do the same. Again, look for verbal or nonverbal agreement. If an affirmative response is received on both counts, then you are done. If the requests are rejected, then return to step 2 and repeat the procedure.

Implications and Applications for Social Work Practice

The attraction of any treatment theory is its applicability to practice. Implied in this is the understandability of the theory's concepts and how these in turn give rise to plausible and applicable intervention strategies. Social workers are confronted by a gamut of client system concerns and maladies, which require the practitioner to have at their disposal a treatment option that addresses the presenting problem. As outlined above, NLP provides ample options, which are highly effective in helping people find solutions and make desired changes. What is perhaps less known about the approach is that its scope includes an array of direct and indirect practice applications (Angell, 1996, 2002, 2011; Dilts, 1983; Wake, Gray, & Bourke, 2013). Additionally, NLP is easily joined with other practice perspectives as an interlocking theoretical approach to advance clinical understanding of the person and their constructed environment and help clients reach their potential.

Interventions with Dyads, Families, and Small Groups

The association between Bandler and Grinder, NLP's founders, and some of talk therapy's most celebrated practitioners is well documented, including the likes of experiential dyad/family therapist and social worker Virginia Satir and Gestalt therapy founder and psychiatrist Fritz Perls (Andreas, 1991; Bandler, Grinder, & Satir, 1976; Davis & Davis, 1983; Grinder & Bandler, 1976; Nichols, 2007). Bandler and Grinder were particularly interested in "what works" aspects of the master therapists they observed. What they learned confirmed their ideas about the tie between positive intention and neurolinguistic patterns or maps to achieve personal well-being. Finding this common key, the founders of NLP, as well as other aficionados of this theory of therapeutic change, were able to further our understanding of how people processed sensory information and used this cognitively, affectively, and behaviorally to make sense of and interact with the bio-psycho-social-spiritual-physical world.

As has been discussed, the assignment of significance to thoughts, feelings, and behaviors relays to the self and others constructions of the real world as a territory, which NLP calls a pattern or map. The complexities of these constructions lie both in the unconscious deep structure and in the conscious surface structure of every person. Therefore, any attempt to transform thoughts, feelings, and behaviors must, by design, be uniquely based on a theory that not only works, but also is believed to be effective. This expectation, embodied in the therapeutic relationship, is as pivotally important in NLP as the theory itself and the acceptance of its methods. This then ensures the likelihood that what happens in the clinical session does not just stay in the session, but is generalized to other environments of significance to the client or clients. The added complexity of dealing with more than one person in dyadic, family, and small-group therapy lies in the fact that everyone is different and the systems that affect them and with which they interact are constructed by them in unique ways. The social worker's effectiveness in building rapport between participants provides a platform for the exchange of ideas, modeling of behaviors, and achieving open-mindedness with respect to human diversity, which are crucial to interpersonal coping and change. Small-group work can be particularly challenging, as the members may at the outset of therapy have little in common apart from the issue that brought them into treatment. Of course, even how the issue is conceptualized and demonstrated can vary from person to person. The same can certainly be said for dyadic and family members as well. However, it has been found that NLP is an effective modality in bridging differences and achieving solidarity between clients and in helping one another out (Chiders & Saltmarsh, 1986; Shelden & Shelden, 1989). Guiding clients in how to access and use internal resources in ways that work is the crux of the change process.

Clients engaged in NLP-based treatment learn that how they remember or think through experiences to themselves internally and how they display this externally by way of their presentation-of-self can be problematic, depending on the patterns or maps accessible and how they are perceived by others.

Connecting clients with their PRS can help them gain essential insights into who they are and how they communicate with others. At the same time, clients discover that the PRS of others may well differ from their own and, as such, be at the root of why they are experiencing disappointment, resentment, nervousness, loneliness, and/or other bio-psycho-social symptoms.

PRS are displayed both verbally and nonverbally through sensory-based personal narratives composed of patterns or maps, which are in turn communicated to others as purposeful messages and meta-messages. Considering these as roles, Bandler, Grinder and Satir (1976) created a typology of four basic archetypal characters, which they suggest be used in family therapy but are just as applicable for work with dyads and small groups. Referred to as the *placater, blamer, computer*, and *distracter*, these roles are played out in dyadic, family, and group relations and provide an interesting way to describe individuals and their interactions with others. The *placater* represents someone intent on pleasing others at their own expense. The *blamer* has self-interest at heart and is consumed with controlling others. The *computer* is intent on everything being precise, logical, cerebral, and socially/politically correct at the expense of emotional connection with others. The *distracter* is a rebellious and impulsive individual whose uncaring attitude and actions are displayed with indifference.

In treatment, the social worker can sort out and use character types to help clients gain insight into their presentation-of-self and how this may limit their ability to form and/or maintain relationships with others. As helpful complements to other NLP diagnostic tools and intervention strategies, the *placater, blamer, computer*, and *distracter* concepts provide an added element to understanding the client's personal narrative and how their representational system, patterns, or maps get played out consciously in surface structure. Not to forget, the concepts of *generalization, distortion*, and *deletion* also come into play as contributing factors to clients' taking on all or some of the features of archetypal characters. How problematic assuming or approximating a role is for the individual becomes the focus. Are they purposefully working towards realizing their goals using positive means, or are they falling further away from their goals by the roles they are playing out? If nothing is happening, then they are stuck in a role that is neither rewarding nor unrewarding. Change requires action, which in this case requires a rewriting, re-scripting, or replaying of a scene or scenes from the client's personal narrative to look at old roles and to try out new ones. It is a thought-provoking, emotional, and active intentional experience that is played out publicly with partners, family, and group members. The anticipated outcome for individuals is to gain better insight into themselves and others in terms of how, presently and in the future, they can deal with and overcome hard times. Consider a family therapy session wherein the son is upset with his father for not allowing him to go with his friends on a camping trip. The father's not wanting his son to go on the outing lies in his rationale that his son will get into some sort of trouble, although he has no grounds to base this on outside of his own experience as a wayward youth.

Worker: (To the father) What particularly are you thinking would happen if you allowed your son to go on the camping trip with friends?

Father: (*Computer*) Well, when I was his age (worker redirects his gaze from the father to the son. The father in turn looks at his son), I went on a camping trip with my buddies and we got busted by the cops for drinking underage and drug possession—it was just marijuana. It looked a lot worse than it was, but nevertheless I had to get with the program so that my folks and the police knew I was not the person they were seeing.

Mother: (*Blamer.* To husband) You shouldn't be telling the boy that! Just because you're a delinquent doesn't mean that he is.

Son: (*Distracter.* Alternating glances between father and mother) You two are both jerks and should mind your own business! I can do what I want, when I want, and with anyone I want! If I want to party with my friends, why should you care? I'm not hurting anybody.

Worker: (Reframing roles and narrative) It appears that each of you must really love each other. The emotional level is so strong and rich in caring and concern. Dad, you want the best for your son. Mom, you want your son to be independent and successful. (To son) And your feedback to your parents is saying to them that they don't have to worry, you will do what is right and not get into trouble, or be trouble to them.

Son: (To worker, who redirects son to look at and speak to his parents) That's right. I am not going to risk getting into a mess with the law, or having my parents come to bail me out. That would be totally humiliating.

Worker: I hear you loud and clear. Dad, Mom, what do you hear your son saying?

Father: Well, that makes sense to me and I accept what he says. (Looking at son) I trust you and I'm okay with you going camping with your friends. Just be careful.

Mother: Hmm. I'm okay about what I am hearing, too. (To son) Have fun with your friends and like your dad says, be cautious. (To husband) I am sorry to have lashed out at you that way. I know you were just concerned about our boy.

Father: (To wife) I'm sorry, too. Sometimes I worry so much about doing the right thing that I forget about who I am doing it for (looking back and forth at wife and son) and it is the both of you. Well, it is for all of us, really.

Son: (To mother and father) I hear you both. I get the picture and I won't be an embarrassment to you or myself. I promise.

Reframing the family's script by having clients break away from the typecast roles allows less rigid roles to be played out, which in turn leads to desired change and closeness.

Additional Applications in Social Work Practice

Co-occurring conditions or disorders are frequently seen in practice. These can create challenges for social workers when the practice theory they are using is not flexible enough to help them understand and intervene appropriately to provide treatment. NLP, however, provides an adaptable model and methodology for practitioners to use. In the field of addictions, a number of authors have described how NLP-based interventions have been effective in treating clients and client systems in terms of understanding the complexity of the problem and how to achieve and maintain recovery founded on improved communication (Davis, 1990; Doorn, 1990; Hennman & Hennman, 1990; Isaacson, 1990; Sterman, 1990a, 1990b, 1990c, 1990d, 1990e; Tierney, 1990).

Another area of concern for many people where NLP has been found to be extremely helpful is in dealing with a number of somatic and psychosomatic conditions (Bandler, 1984; Einspruch & Forman, 1988; Hossach & Standidge 1983; Juhnke et al., 2008; Krugman et al., 1985; Wake et al., 2013). For instance, the symptoms of PTSD can be not only troubling but also debilitating, as we know. Gregory (1984) and Hossach and Standidge (1983) described how NLP interventions can provide clients with relief from symptoms, particularly those associated with anxiety. Shelden and Shelden (1989) also indicated that NLP is effective in helping adult survivors dealing with issues associated with being sexually abused as children. In all of these cases, NLP's here-and-now strengths and capacity-building focus reduces the potential of clients' being retraumatized. In terms of assessment, Helm (2000) discussed how a standardized questionnaire can be used to determine the PRS of blind and visually impaired clients. As well, the author cited how NLP is also being used in forensic interviewing (Helm, 2003).

For those interested in how NLP can be used in organizational leadership and other macro-applications, there is an abundance of sources to choose from. For example, Lavan (2002) discussed how NLP can be used in management, and Dowlen (1996) examined the approach's utility in management learning. In terms of marketing, Nancarrow and Penn (1998) and Skinner and Stephens (2003) examined the uses of NLP in promotion. From a social work perspective, the writings of these authors and those derived from other sources may have some utility.

Empirical Base

Central to NLP is the art and science of understanding and helping people. The approach is founded on an appreciation of human diversity, with an understanding that within these differences lie similarities. Interpreting this requires an "artist-scientist" who can be creative yet precise. In social work, our practice wisdom is values-based and emerged from our systemic approach to helping people. We started with our art as intuitive caregivers, advocates, and problem solvers, and borrowed and created knowledge and methods to improve and perfect the science of our craft. Not surprisingly, then, NLP has an appeal for social workers engaged in the

helping process. We are better artists as practitioners because of the "brushes, paints, and mediums" at our disposal to work with. Our acquired knowledge allows us to perform masterful work in helping others. The descriptions of how things work and prescriptions for how to make things work better, derived from NLP, fit us professionally. As you would expect, it is difficult to reduce art and an artist into generalizable scientific variables or concepts, due to the fact that each practitioner as an artist will be somewhat different in how they practice their art, even when using the same understandings and interventions. Of course, this has not prevented applied social scientists and others from wanting to verify unequivocally that NLP is all that it claims to be. Not surprisingly, some results on NLP's effectiveness are mixed (Gumm, Walker, & Day, 1982; Elich, Thompson, & Miller, 1985; Fromme & Daniell, 1984; Krugman et al., 1985; Roderique-Davies, 2009; Sharpley, 1984; Sharpley, 1987). Other research shows support for NLP's conceptual framework and methods (Dilts, 1983; Davis, 1990; Einspurch & Forman, 1985, 1988; Gregory, 1984; Graunke & Roberts, 1985; Hossach & Standidge, 1983; Shelden & Shelden, 1989). Even with the divergence in scientific support for NLP, this theory of practice continues to gain attention and receive accolades from professional and consumer adherents.

The guiding aphorism of the social work profession is to "start where the client is." Some debate the importance of this, indicating that too much weight is placed upon developing and preserving the therapeutic relationship rather than focusing on the problem (Zastrow, 2009). Others would counter by saying, "The client is not the problem, the problem is the problem," and that the alliance between the worker and the client is an important and pivotal part of the helping process (Goldstein, 1990; Duncan, Miller, Wampold, & Hubble, 2010; Meredith, 1986; Turner, 1986). Without relationship, a practice theory and the expectation that it can and will work mean nothing. As is stated repeatedly in NLP, clients have the resources necessary to make the changes they need to make, and with the help of the social worker, they will discover the keys to succeeding in their quest.

As with any approach, there are parameters. NLP requires clients to be cognitively able to participate in the treatment. Limiting factors can include the use of certain medications, street drugs, or other substances that affect the person's ability to fully engage in this sensory-based approach. Adding to this, clients suffering from serious mental illnesses would find NLP unbeneficial. Furthermore, NLP being a here-and-now theory of practice, clients intent on exploring the past may find that present orientation and future pacing methodology unsatisfying.

Prospectus

NLP originated as a way to bring about change by uncovering the "structure of magic" inherent in most approaches to understanding the mind and helping people who were struggling with the challenges of day-to-day life. Much before and since then has been added to the literature of practice, including NLP, to "re-mystify" what works in therapy, and this is unfortunate. Hopefully, in this chapter, the reader has been able to discover or rediscover the essence of NLP and how it can be used in social work treatment. It provides a therapeutic language that intersects with our allied disciplines, which are similarly committed to helping people in need, and the theory and concepts of the approach continue to gain popularity with other fields of professional preparation and practice. Social workers seeking promising practices to help clients find solutions will learn answers in NLP.

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23

Oppression Theory and Social Work Treatment

Susan P. Robbins

Oppression

This approach views social work as a social institution with the potential to transform oppressive social relations that govern the lives of many people by supporting transformational potential.

Oppression theory is derived from several different disciplines and theoretical traditions and encompasses a broad array of concerns related to power, privilege, domination, stratification, structural inequality, and discrimination. However, due to oppression theory's varied foundations, it is probably more accurate to speak about oppression *theories,* because the primary concern of each theory generally focuses on different aspects of oppression or specific oppressed groups, often to the exclusion of others. To a large degree, oppression theory shares similar conceptual frameworks with sociological conflict theory, critical social theory, feminist theory, and the empowerment approach to social work practice, based on their overlapping interests in power and inequality. Drawing on these theories, anti-oppressive social work practice is primarily concerned with the social, political, and economic *structures* as well as social and psychological *processes* that initiate, maintain, and enforce oppression.

Historical Context

The current use of oppression theory and the newly emerging field of anti-oppressive social work practice are based on the profession's longstanding commitment to social justice. According to Heinonen and Spearman (2001), *social justice* is "an abstract and strongly held social work ideal that all people should have equal rights to the resources of a society and

should expect and receive fair and equal treatment" (p. 352). Although the development and articulation of anti-oppressive practice is relatively new, concern for social justice has been prominent in both earlier and contemporary radical, progressive, structural, feminist, and liberatory frameworks (Campbell, 2003).

The ideal of social justice can be traced to the work of the settlement house movement and its corresponding advocacy for progressive social reforms at the beginning of the 20th century. Social workers during this era were actively involved in social policy initiatives to improve the conditions of the immigrant poor, women, and children. Spurred by collapse of the economy and the ensuing Great Depression, the Rank and File Movement of the 1930s brought with it an awakening of political activism that had all but vanished in the 1920s. This movement's affiliated journal, *Social Work Today,* advocated progressive legislation, labor organizing, and other measures that would be seen today as radical or anti-oppressive practice (Gil, 1998; Reisch & Andrews, 2001; Wenocur & Reisch, 2001). Progressive social work did not reemerge for several decades, despite the fact that professional social work organizations continued to espouse official rhetoric that reflected anti-oppressive sentiments. However, Reisch and Andrews note that while advocating social justice ideals, they also promoted practices that reinforced the status quo. This is not surprising, because the ideals of progressive social work have never been held by the majority of those in the profession (Mullaly, 2006). Thus, conventional social work, which seeks to preserve the prevailing social order, has been the mainstay of social work practice through much of the profession's history.

The social movements of the 1960s brought about a renewed awareness of and interest in structural factors that influenced people's lives, and the radical social work movement of the 1970s embraced a neo-Marxist class analysis with a focus on reducing poverty and inequality, affecting structural change, and influencing social policy. Specific concern about social class and economic forces can be seen in the materialist approach to social work practice (Burghardt, 1996). Embracing the radical social work heritage, but critical of its narrow focus on class analysis, structural social work theory proposed a broader framework that examined all forms of oppression, including inequality based on race, class, gender, sexual orientation, ability, and age (Campbell, 2003; Mullaly, 2006; Rose 1990). Campbell credits structural social work as a key development in articulating an anti-oppression stance. However, subsequent feminist, anti-racist, cross-cultural, and postmodern theorists voiced concerns that anti-oppressive theory failed to adequately address issues related to their specific interests. In response to this critique, oppression theory today more clearly incorporates the multiple dimensions and expressions of oppression.

Basic Assumptions and Concepts

Although theorists have proposed varying definitions of oppression and its dimensions, Marsiglia and Kulis (2009) have noted that two basic ingredients are necessary for oppression to exist: "a group that is being oppressed and an oppressor who benefits from such oppression" (p. 33). In order for one group to oppress another, there must also be differential power between the two that results in inequality and injustice. There are many ways to define and conceptualize power, and there is variation and disagreement within and among oppression theorists. Some portray power as relational, as something that people "use and create" (Fook, 2012), while others define it as the ability to control collective actions and decisions (Robbins, Chatterjee, & Canda, 2012). The element of control does not necessarily depend on physical coercion, but may be accomplished through unjust policies and practices that lead to and enforce discrimination, exploitation, and marginalization of devalued groups of people. These variations of definition will be discussed in more detail later in relation to specific theories.

Privilege, domination, and exploitation are central features of oppression, and theorists have started to examine multiple levels of oppression and, in particular, the ways in which oppression is linked to interlocking systems of privilege or domination. Privilege can be understood as the flip side of oppression and is an unearned structural advantage that allows those with power to dominate and exploit the powerless. In essence,

oppression cannot exist in the absence of privilege, as they are interdependent. Furthermore, domination is not necessarily a conscious act, and those with privilege need not be aware of their relative privilege in order to be part of an oppressive system. Importantly, oppression takes place within specific historical contexts, and oppression theorists typically include this in their analysis.

Social stratification plays an important role in oppression as well, because it places entire groups of people into categories and, based on these categories, systematically allows or denies them access to social and economic rewards. Oppression theory proposes that the way in which these categories are created and maintained is based on power, privilege, and domination. Those in power not only have the ability to define these categories, but also to control which groups have access to the rewards. Due to this, inequality is seen as a structural feature of society because those in power arrange economic and social relations and rewards to benefit themselves. Thus, power and privilege are structurally rooted in the economic and political system.

An important mechanism by which structural inequality is maintained is discrimination. Discrimination involves actions on the part of dominant groups that have a differential and negative effect on people who are devalued and marginalized due to their group membership. Like domination, discrimination may not always be intentional or overt, but it is a necessary prerequisite for exploitation. Concomitant with discrimination are the processes of stereotyping and prejudice, which are used to justify the exploitation of others.

Oppression, domination, and exploitation exist on multiple levels of social interaction, and contemporary oppression theory examines the ways in which social and cultural categories of differentiation interact or intersect to create a system of oppression. The term *intersectionality* is used in oppression theory to address the experiences of people who are subjected to multiple forms of oppression and domination.

Oppression Theory

As noted, authors in diverse academic fields have written about oppression, and there is an extensive literature on various aspects of power, privilege, domination, discrimination, and inequality. Oppression can be based on a variety of factors, including social class, race, gender, ethnicity, sexual orientation, disability, or other categories by which people are defined as "lesser than." This, in turn, provides justification to treat them as objects of discrimination, exclusion, and domination. Oppression occurs not only at the institutional level, but at the intergroup and individual levels as well. This chapter reviews some of the theories that have been most prominently used in anti-oppressive social work practice.

Theories of Class Oppression

Theories of class oppression examine the ways in which social class is used to oppress and marginalize people based on their class status. These theories most typically emphasize the institutional nature of oppression and see power as the ability to dominate other groups or individuals, often referred to as having "power over."

All contemporary versions of oppression theory have their roots in the work of Karl Marx, a 19th-century German philosopher, revolutionary, and theorist who integrated works from a variety of disciplines including economics, political science, history, and sociology. Although best known for *The Communist Manifesto* (Marx & Engels, 1848/1955), he was a prolific writer who was profoundly concerned about the transition of Europe to an industrial, manufacturing economy. This transformation irrevocably changed the nature of labor, products, consumption, as well as the economic and social structure of society. Such changes, according to Marx, created a polarization between two dominant classes—*workers* (the proletariat) and *capitalists* (the bourgeoisie)—and led to exploitation, inevitable class conflict and struggle, and alienation.

Although class antagonism and struggle over resources had existed in previous eras, industrialization created a new class system as well as new forms of oppression. Because the machinery necessary for mass production was now concentrated in the hands of a very few, workers were forced to sell their labor for wages that were set by the owners whose primary

interest was in maximizing their own profits. According to Marx, this created an inherent form of exploitation because the wages paid to the laborers did not reflect the true value of the wealth created by their labor. This was further compounded when items they produced were later sold back to them at inflated prices (Perdue, 1986). Capitalist exploitation also led to the pauperization of the working class and created hostility between owners and laborers, who struggled against their exploitation. In turn, owners further consolidated their interests and developed an awareness of their class position, which Marx termed *class consciousness*.

The exploitation of workers also created alienation in three interrelated spheres of social life: political, religious, and economic. According to Marx, when people become alienated, they become estranged, demeaned, depersonalized, and powerless. The economic monopoly of the bourgeoisie was evident in the political arena, and, by consolidating their interests, they transformed their economic power into political power and dominated the political institutions as well (Abraham, 1983).

The bourgeoisie also controlled the dominant ideologies and, in this manner, controlled the ideas by which workers came to understand themselves and the world around them. According to Marx, the religious, political, and economic ideologies of the wealthy legitimized and reinforced the status quo, which favored their interests. Furthermore, ideology was used as a form of social control to disguise and subdue class conflict. He believed that exploitation, alienation, and ideological domination were intricately interwoven. Ideological domination by the ruling class could be seen in common and pervasive aspects of people's lives such as religion and nationalism.

Calling religion the "*opium* of the people" Marx argued that the emphasis on rewards in the afterlife focused people's attention away from the inequality and oppression they experienced in their lives. When people believe that their lot in life is preordained, religion becomes a form of social control that thwarts attempts at rebellion. This, according to Marx, was a central feature of *religious alienation*. Political ideology and *political alienation* function in a similar manner because the ideology of "nationalism" disguises the inequalities inherent in a capitalist system.

Marx believed that the struggle for both the proletariat and bourgeoisie was to free themselves from *false consciousness,* an unquestioning acceptance of a prevailing social order that supported an inherently oppressive system. In Marx's utopian vision, he believed that workers worldwide would eventually unite, become politicized, and organize to overthrow capitalistic exploitation by means of a violent revolution. The political and economic order that he predicted would emerge would be socialism, followed by communism, the hallmark of which was the end of private property and social classes. Although Marx's prediction of worldwide revolution did not come to fruition, his theory represents an important sociological and economic analysis of society that provided the conceptual basis for subsequent theories of oppression. Importantly, Marx laid the groundwork for an examination of both the structural features of oppression as well as the social and psychological processes by which people come to accept their own domination and subjugation.

Drawing on Marxist theory and Catholic *liberation theology*, Paulo Freire, a Brazilian educator and theorist, sought to liberate people from the domination of the ruling class through a *critical pedagogy* that would prepare students to challenge and break the prevailing cycles of injustice, exploitation, and oppression. Freire, like Marx, believed that the ruling class imposed its values and culture on others and that knowledge was used by dominant groups to oppress and subjugate the masses. He proposed that oppressed people experience life as "objects" being acted upon, rather than as "subjects" who are in control of their own lives. Due to this, they lack skills that are essential for influencing the institutions that have control over their lives. Freire proposed that one of the primary institutions used as a tool of subjugation is standardized education. Best known for his criticism of "banking education," Freire held that through repetition and memorization, teachers deposit knowledge into students who are treated as empty accounts, or receptacles. According to Freire (1993), banking education indoctrinates students to adapt to

oppression, subverts their creative abilities, and reduces them to manageable beings who adopt the oppressive view of reality deposited in them. The more the oppressed adapt to their situation, the more easily they can be dominated. In addition, banking education fosters ideological control that serves the interests of the oppressors by diverting the attention of the oppressed away from the situation that oppresses them. In essence, the insidious nature of oppression prevents the oppressed from recognizing the reality of their circumstance. According to Freire, their perception of themselves is impaired by their submersion in the reality of oppression (p. 45). Many of Marx's themes are apparent in Freire's work, and, like Marx, Freire also believed that the problem is not only with the oppressed, but the oppressors as well, who subvert their own humanity by turning everything around them into objects to be dominated.

Another characteristic of the oppressed is self-depreciation which results from internalizing the opinion the oppressors hold of them. Through this process, the oppressed become convinced of their own unfitness and suffer from a duality that becomes established in their innermost selves: "They are at one and the same time themselves and the oppressor whose consciousness they have internalized" (Freire, 1993, p. 49). This consciousness becomes so ingrained that people come to identify with and imitate their oppressors. Freire believed that in order to free themselves from oppression, people must first recognize that they have been destroyed, reject negative images of themselves, replace such images with those of autonomy and responsibility, and begin to transform themselves from objects to subjects.

In order to combat the fatalism experienced by the oppressed and to actively involve them in their own liberation from object to subject, Freire proposed a dialogical method that consisted of identifying problems, analyzing the root causes, and initiating action plans. This represented a significant change from traditional "banking education," and required that educators and learners be equal participants in order to engage in continuous dialogue. Through mutual dialogue, the oppressed become better able to analyze their conditions, develop a critical consciousness or *conscientizacao*, and subsequently engage in action to become liberated from their external and internal oppression. According to Freire, this requires collective strategies that include the liberation of the oppressors as well as the oppressed. Goldenberg (1978) aptly sums up the condition of the oppressed: "Oppression, in short, is a condition of being in which one's past and future meet in the present—and go no further" (p. 3).

Theories of Racial Oppression

In contrast to class oppression theories, theories that examine racial oppression emphasize both the institutional nature of oppression as well as the intergroup dynamics that sustain it. Thus, the focus is on both the oppressive structures as well as the intergroup processes of prejudice and discrimination. Much of the literature on racial oppression in the United States emerged in response to the history of black slavery and, due to this, examines the history and contemporary experiences of black Americans, the system of racial oppression in America, and the oppressive dynamic of white privilege (Blauner, 2001).

Blauner suggests that Marxist theory and the dominance of European social thought that guided many successive generations of American theorists diverted attention from race and race relations. This was due to the incorrect assumption that race and ethnicity would become irrelevant as societies matured. Contrary to this stance, Blauner believes that race, racism, and racial oppression occupy a central and independent role in American economics, politics and culture, and white privilege and domination are critical components of the dynamics that give rise to pervasive inequality. Relying on the framework of colonialism, as seen in the broad context of the expansion of white European control, he proposes that racial oppression and conflict today are based on white Western dominance over non-Western people of color (2001, p. 22). Thus, contemporary ethnic and racial divisions are, in part, products of our colonial past. This alone, however, is insufficient to understand the complexity of racial oppression, and he proposes that racial oppression theory must include the "combined existence" and "mutual interpenetration of both colonial-racial and capitalist class realities"

(p. 23). Even though white privilege is pervasive in all social institutions, he sees its expression in the labor market as the primary factor that determines peoples' lifestyle and social status.

In their examination of the history of the oppression of black Americans, Jonathan H. Turner, Royce Singleton, Jr., and David Musick (1986) propose that oppression can be defined as "a situation in which one, or more, identifiable segments of the population in a social system systematically and successfully act over a prolonged period of time to prevent another identifiable segment, or segments, of the population from attaining access to the scarce and valued resources of that system" (pp. 1–2). This definition underscores several important dimensions of oppression, and proposes that it requires more than one group simply exerting "power over" another group. In their formulation, oppression must not only prevent access to resources, it must also be *systematic, prolonged,* target an *identifiable* group, and be *successful.* According to Turner et al., oppression is "both a process and a structure" (p. 2). As a process, it involves attitudes and acts, such as prejudice, stereotyping, and discrimination, that place and keep others in the lower ranks of the social structure. At the structural level, a hierarchical system is created by this process, and identifiable groups are placed at the bottom of this structure. These groups then organize their lives and identities around their place in the social structure.

Importantly, Turner et al. point out that oppression varies by degree and does not always lead to people being placed in the lowest ranks. Drawing on Max Weber's three dimensions of stratification, *power, property,* and *prestige*, the authors stress that some groups may be allowed access to material well-being (property) but denied access to power and prestige. Thus, oppression can be selective and differentially applied. However, when groups such as black Americans are systematically and successfully denied access to all three resources, they become trapped in a castelike structure and experience greater oppression than those who are allowed to occupy the middle ranks.

Other racial oppression theorists and authors have examined the structural and behavioral manifestations of racism and internalized oppression, and their work adds to an important body of literature that informs anti-racist and diversity practice in social work (Batts, 1998; Dominelli, 2008, 2010; Williams, 1999).

Theories of Gender Inequality and Oppression

The fields of women's studies and feminist theory have provided an extensive literature related to women's inequality and oppression, and the theories briefly summarized here examine the social and psychological processes that lead to the power disparities that undergird oppression. The primary focus of feminist theories is on the subordination of women and, due to this, it draws less from Marxism than do other oppression theories. However, feminist theory has made a significant contribution to oppression theory by expanding the scope of analysis to include an examination of the intersectionality of sexism with other forms of subordination, such as racism, heterosexism, and class oppression.

Feminist theory has also expanded the definition of power to include four forms of power that many contemporary feminist authors use in their understanding and analysis of oppression: *power over, power from within, power with,* and *power to do* (see Townsend, Zapata, Rowlands, Alberti, & Mercado, 1999). As discussed above, *power over* refers to institutionalized power that allows people to dominate others. *Power within* is a form of personal power that develops when oppressed people join together to share their struggles. *Power with* emerges in work with others, as people collectively and cooperatively organize to change their conditions, and *power to do* (also called *power to*) refers to the capacity to act and the concrete actions that people take to effect change (Finn & Jacobson, 2008). Many see this as a more nuanced approach to power, but the shift to seeing power as a relational rather than a structural feature of society has significant implications. Lukes (2005) has suggested that the way in which power is conceptualized is, itself, shaped by power relations, "how we think about power may serve to reproduce and reinforce power structures and relations, or alternatively it may challenge and subvert them"

(p. 63). In fact, some feminist scholars contend that the concept of *power over* is a product of a male worldview of domination. Many believe that redefining power from a relational perspective provides a sounder theoretical base for practice with transformational possibilities.

Writing from a feminist perspective and influenced by Foucault's (1980) concept of power, Iris Marion Young (1990) rejected the static concept of *power over* as being the primary force in oppression and proposed five forms, or "faces," of oppression that she believed better explained the interactional nature of oppression: *exploitation, marginalization, powerlessness, cultural imperialism,* and *violence.* She also held that racism, sexism, ageism, and homophobia can operate separately from the dynamics of class and, therefore, are distinct forms of oppression.

Exploitation is "a steady process of the transfer of results of the labor of one social group to benefit another" (Young, 1990, p. 49). Accordingly, the two aspects of gender exploitation include the transfer of the fruits of labor to men as well as the transfer of sexual satisfaction and emotional nurturing (p. 50). Although this is exploitive, it is not necessarily coercive because it arises from, and is supported by, ongoing social relations and processes. Marginalization, which Young saw as the most dangerous form of oppression, is the process by which categories of people are excluded from participation in social life and may also be severely materially deprived or exterminated (p. 53). Powerlessness, according to Young, is a relative phenomenon for most people, in that they may have some degree of power in relation to others, even if they do not have the power to decide policies that affect their lives. People who are truly powerless have no power at all. Cultural imperialism establishes the dominant group's experience and culture as universal norms, and those who do not conform to these norms are labeled as the "other." Violence, the fifth face of oppression, includes not only unprovoked physical attacks, but also harassment, intimidation, and ridicule, when used intentionally to stigmatize others. Young sees violence as a social process that is systematic.

When viewed on a continuum, these more subtle forms of violence, often referred to as *microagressions*, can have a profound effect on socially marginalized groups, even if they are not intentional. Psychologist Derald Wing Sue (2010) defines microaggressions as the "everyday verbal, nonverbal, and environmental slights, snubs, or insults . . . that communicate hostile, derogatory, or negative messages to target persons based solely on their marginalized group membership" (p. 3). Whether they are purposeful or unintentional, microaggressions can elicit negative emotions such as anger, frustration, hopelessness, and invalidation (Nadal, Davidoff, Davis, & Wong, 2014), and their cumulative effect can have a dramatic and negative impact on both psychological and physical well-being.

Although these five types of oppression, or combinations of these, may be experienced by a specific oppressed group, Young does not believe that any of these is a necessary condition of oppression for any specific group. Nonetheless, the presence of any one of these is sufficient to determine that a group has been oppressed. She believes that by examining these systems of oppression separately, it is possible to compare the specific types of oppression that are experienced by each oppressed group.

In a feminist, phenomenological examination of the psychological dimensions of oppression, Sandra Lee Bartky (1990) incorporates insights from Freire, Young, and, more directly, from Frantz Fanon's (1967) study of the psychic alienation of black men. While recognizing the fact that economic and political oppression can be psychologically oppressive, she proposes that psychological oppression has its own distinct modes that operate to produce internalized messages of inferiority. She examines three social processes, as set forth by Fanon, which are used to deliver messages of inferiority to women: *stereotyping, cultural domination,* and *sexual objectification*. In describing these processes, she is particularly concerned about the ways in which *fragmentation* and *mystification* are present in all three. Fragmentation is the splitting of the person into parts, while mystification obscures the reality of psychological oppression and produces a depreciated self and corresponding guilt or neuroses.

Stereotypes are used to sustain both racism and sexism and prevent people from achieving

an authentic choice of self. Female stereotypes also limit women's independence and autonomy by portraying them as beings who cannot and should not be as autonomous as men. Cultural domination and depreciation also rob women of an authentic sense of self because male characteristics are portrayed as the norm for personhood. Finally, sexual objectification reduces women to their sexual parts and also distorts their ability to see themselves as whole persons. As these negative messages become internalized, women are placed in a double bind, in that it is "psychologically oppressive both to believe and at the same time not to believe that one is inferior" (p. 30). Bartky sees a strong similarity between psychic alienation and Marx's alienation of labor. In both, human functions are split from the person and prevent people from engaging in activities that are essential to leading a full human existence.

As noted above, extensive feminist literature has addressed many of the concepts that are central to oppression theory. Given the differences in the way that power is conceptualized, one of the challenges for future research and scholarship in this area will be achieving a better theoretical integration regarding the nature of power.

Social Work Contributions to Theories of Oppression

Over the last several decades, there has been an emerging literature in social work on anti-oppressive practice (see, e.g., Appleby, Colon, & Hamilton, 2010; Baines, 2008; Clifford & Burke, 2009; Chatterjee, 2015; Dominelli, 1996, 1998, 2002; Fook, 2012; Gil, 1998; Hines, 2012; Marsiglia & Kulis, 2009; McLaughlin, 2005; Morgaine & Capous-Desyllas, 2014; Mullaly, 2002, 2006; Sinclair & Albert, 2008; Strier & Binyamin, 2014; van Wormer, 2004). However, no social work authors have developed unique theories of oppression, and most have relied on frameworks related to feminist, anti-racist, critical, conflict, empowerment, or social justice theories.

David Gil (1998), for example, provides an in-depth analysis of the evolution of thought related to exploitation and oppression, strategies to overcome injustice, the importance of radical policy analysis, strategies for social change practice, and the dilemmas faced by the social work profession in fully embracing a social justice stance toward practice. Katherine van Wormer (2004) reviewed a range of social, political, and psychological theories and concepts that undergird anti-oppressive practice and proposes an excellent model for anti-oppressive policy analysis. She also delineates various methods for achieving restorative justice. Bob Mullaly (2006) offers a conceptual framework for structural social work that incorporates many of the elements of theories discussed in this chapter, and his work is often cited as a useful theoretical base for anti-oppressive practice.

One of the leading proponents and authors advocating anti-oppressive social work practice is Lena Dominelli (1996, 1998, 2002, 2008, 2010). Her classic book on theory and practice for anti-oppressive social work draws heavily on feminist and anti-racist theory and provides a contextual framework for affecting change at the intergroup and structural levels. Her work in this area reflects theoretical sources that also can be seen in her earlier writing on feminist and anti-racist practice.

Anti-Oppressive Social Work Practice

Anti-oppressive social work practice includes a variety of approaches and theories related to social work's commitment to social justice. The tenet that social workers engage in anti-oppressive practice can be found in the codes of ethics of both the National Association of Social Workers (NASW) and the International Federation of Social Workers (IFSW). Concomitant with professional values and principles related to the concepts of social justice and political action, social workers are expected to address social injustice by pursuing "social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people," as well as prevent and eliminate domination, exploitation, and discrimination (NASW, 2008). Similarly, a basic principle of the IFSW (2004) is that social workers challenge unjust practices and policies that are "oppressive, unfair or harmful."

Due to the fact that "anti-oppressive practice" is an "umbrella term" for diverse approaches, it is best seen as a stance, or perspective, toward

practice rather than a particular method (Campbell, 2003). Despite variations, Campbell lists core values and principles embodied in anti-oppressive practice to include:

- Shared values of equity, inclusion, empowerment, and community
- An understanding that the thoughts, feelings, and behaviors of individuals are linked to material, social, and political conditions
- Recognition of the link between personal troubles and public issues
- Recognition that an unequal distribution of power and resources leads to personal and institutional relationships of oppression and domination
- The necessity of promoting critical analysis
- The importance of encouraging, supporting, and "centering" the knowledge and perspectives of those who have been marginalized and incorporating these perspectives into policy and practice.
- The importance of articulating the multiple and intersecting bases of oppression and domination while not denying the unique impact of various oppressive constructs
- Conceiving of social work as a social institution with the potential to either contribute to, or to transform, the oppressive social relations that govern the lives of many people
- Supporting the transformative potential of social work through work with diverse individuals, groups, and communities
- Having a vision of an egalitarian future

These values and principles can be seen in a variety of practice approaches, all of which seek to challenge oppressive conditions and redress social injustice. Approaches that are most commonly associated with anti-oppressive practice include structural social work, critical social work, feminist practice, anti-racist practice, Afri-centric practice, practice with Aboriginal and indigenous peoples, and disability practice. Campbell has noted the one factor preventing the adoption of a generic, anti-oppressive model of practice is concern that unique and specific expressions of oppression will be minimized or lost in such an approach. Thus, some have deliberately retained, for example, a feminist or anti-racist approach to practice to ensure that their specific concerns are fully addressed.

This trend can also be seen in the abundant literature on feminist, anti-racist, diversity, and radical social work practice in the United States. Although this is true in other countries as well, much of the emerging scholarship on anti-oppressive practice has come from Canada, UK, and Australia (Dominelli, 1996, 1998, 2002; Fook, 2012; McLaughlin, 2005; Mullaly, 2002, 2006; Sinclair & Albert, 2008).

Anti-oppressive practice addresses the eradication of oppression at the multiple levels in which it occurs: the personal, interpersonal, structural, and cultural. Because oppression involves attitudes, behaviors, inter-group relations, as well as institutional and cultural norms and policies, associated practice techniques and methods are similar to activist approaches used in the structural and empowerment approaches. These include, but are not limited to, education, participation, community and neighborhood organizing, consciousness raising, advocacy, policy practice, and practice aimed at eradicating structural inequities. At its core, anti-oppressive social work is social justice–oriented practice (Finn & Jacobson, 2008).

Research Challenges

Due to the fact that oppression theory is based on a series of assumptions and premises that do not lend themselves to empirical verification, quantitative research on oppression theory is difficult, if not impossible, to conduct. One can readily examine, for example, the degree of inequality by examining a variety of concrete conditions such as income, health, or educational attainment through census data and studies on mobility. The sheer existence of inequality, however, cannot explain why or how it occurs, and it is this very explanation that is at the heart of all theories of oppression. Not surprisingly, oppression theories most typically rely on qualitative methods, due to their ability to provide a rich description of the lives and realities of the oppressed. Qualitative methods can also be used to examine the way in which policies can create unequal or unjust situations or examine the ways in which policies are differentially applied to create injustice. Katherine van

Wormer (2004), for example, contends that policy analysis is inherently political and discusses the necessity for conducting historical, international, economic, and political analysis of policies that affect people's lives. She also outlines a specific process for examining policies that is consistent with anti-oppressive practice and discusses how emphasis on structural barriers differentiates it from traditional policy analysis.

A central tenet of oppression theory is that there are multiple truths about society, social relationships, and the nature of reality and, thus, it is important to embrace research methods that accurately describe these multiple truths. Although this stance is philosophically consistent with the theory itself, it presents challenges in a profession that increasingly calls for evidence based on quantitative methods and, due to this, it is unlikely that this tension will be resolved. This is unfortunate, because qualitative methods may ultimately provide the most appropriate form of research for these theories.

Conclusions and Future Prospects

As discussed above, anti-oppressive practice encompasses a variety of practice approaches that are concerned with social justice. The unique and particular interests of those who embrace a model of practice based on a social justice perspective have prevented the broad adoption of a more general anti-oppressive framework. This is likely to continue due to the specialized interests that people bring to the practice of social work. Finally, as Gil (1998) has so aptly pointed out, despite the profession's commitment to social justice, most social workers see their practice as apolitical and rarely challenge systemic sources of oppression. Not surprisingly, those invested in the system are the least likely to engage in its liberation.

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24

Problem-Solving and Social Work

Micheal L. Shier

Problem-Solving

The problem-solving theory, developed by H. Perlman, builds on and seeks to enhance clients' abilities to face psychosocial problems within the potential of a supportive and focused relationship that combines reality and challenge.

Perlman's (1957) problem-solving method was a critical and timely alternative for understanding the help-seeking process. Her foundational points—person, problem, place, and process—together provide a holistic model or framework for understanding social work practice in general. While this seminal work on problem-solving within social work practice is instrumental for understanding present methods of client–worker interaction, it does not say enough about treatment beyond a general application of psychosocial methods of intervention with a moderate focus on educating and improving the coping capabilities of clients to the problems that develop within life. In recent years, problem-solving has been little explored in relation to therapeutic intervention and prevention within the social work profession or other, more general approaches to practice, such as community-based work or practice in organizations. The alternative has been increasing focus on the strengths and solution-focused approaches; fundamental to both, though, is *problem-solving*.

Interdisciplinary social science has contributed a growing body of literature recently on the therapeutic aspects of problem-solving (for a review of relevant research, see Nezu, Nezu, & D'Zurilla, 2013). Foundational points similar to Perlman's person and process appear in many of these discussions. Such work might have a significant impact on social work practice with clients who need therapeutic intervention and could help clarify generalist practice for new social workers.

Here the premises of problem-solving within the counseling psychology literature are discussed, particularly the points related to problem orientation, as they apply to social work practice and education, to examine how these two streams of literature intersect.

Problem-Solving

Within counselling psychology, solving problems that occur in day-to-day living has been referred to as "social problem solving" (D'Zurilla & Nezu, 1982; Nezu, Nezu, & D'Zurilla, 2013). The concept of social problem-solving, like the problem-solving process in social work, was a critical development in the literature. Until the 1960s, problem-solving was investigated only in relation to the physical and physiological aspects of the problem-solving act, and, as a result, was an area of investigation primarily for the discipline of neuropsychology. Some writers began to ask: What purpose does problem-solving have for human functioning? From that question developed a trajectory of research that has investigated the implications of problem-solving for psychological and social functioning (Nezu, Nezu, & D'Zurilla, 2013).

The term "social problem-solving" highlights the social context of problem-solving. Many writers of problem-solving methods of interaction and intervention have stressed the importance of the social environment on human problems (D'Zurilla & Goldfried, 1971; Haley, 1987; Perlman, 1957). The "social context" refers to the place where the real-life problems take place and considers the impact of factors within the social realm (i.e., beyond the individual) on these problems. Nezu, Nezu, and Perri (1989) have defined social problem-solving as "the process by which people both understand and react to problems in living" (p. 27).

The process of problem-solving involves both cognitive and behavioral aspects. D'Zurilla and Nezu (2007) suggest three aspects in particular. The first is the metacognitive level, where a particular orientation to problems exists (the cognitive-emotional responses a person has when faced with a particular problem or problems in general), which they refer to as the motivating function. The second level is the performance level, where there is a set of problem-solving skills. Underlying this performance level is the third level, which comprises the cognitive abilities that determine an individual's ability to solve any given problem.

In this framework, a *solution* to a problem is any coping response a person has to alter the problematic experience (D'Zurilla, 1986; Nezu, 1987). Such a response may be positive or negative; that is, it may or may not create the desired change or outcome. Thus, as noted in earlier work of D'Zurilla and Goldfried (1971), an effective problem-solving intervention must consider the adequacy and effectiveness of people in resolving problems. Problem-solving is considered an important aspect of social competence (D'Zurilla, 1986), and it calls for the establishment of specific problem-solving skills. A process for effective problem-solving, known as *problem-solving therapy*, has been developed by clinical psychologists over the past several decades (Nezu, Nezu, & D'Zurilla, 2013). Problem-solving therapy includes: (1) problem orientation (how people perceive problems); (2) problem definition and formulation (clarifying and understanding the specific nature of the problem); (3) generation of alternatives (identifying as many solutions as possible); (4) decision making (evaluating the available solutions); and (5) solution implementation and verification (self-monitoring and evaluation of outcome), along with specific abilities required of a person to solve problems (D'Zurilla, 1986; D'Zurilla & Goldfried, 1971; D'Zurilla & Nezu, 1982, 1999, 2007). *Problem orientation* is the motivational component, which refers directly to people's perception of problems in general and their own ability to find an effective solution to a specific problem, while points 2 through 5 refer to the specific skills that a person needs to be taught to solve a problem effectively (Nezu, Nezu, & Perri, 1989).

When taken together, the skills necessary to help solve problems resemble the process of problem-solving identified by Perlman (1957) and others for social work practice. For example, Compton and Galaway (1994) suggest that "problem-solving is a rational process including actions to define the problem, actions to collect information on which to base decisions, actions to engage the client in goal setting and decision making, actions to produce change, and actions to produce progress" (p. 10). A difference between the two streams of literature, however, is the emphasis placed on the *problem orientation* of the client and its subsequent implications for the process of problem-solving.

Problem-Solving Theory in Social Work

The problem-solving process in social work was founded on principles associated with *functionalist* theory. According to Perlman (1986), the process assumes, as the functionalist theorists argue, that:

1. clients seek help at a point when they are in crisis (or facing a particular problem that they are unable to resolve on their own with their present abilities),
2. the agency in which a client seeks services can affect both the help-seeking process and the client's problem itself,
3. the impact of the relationship between the social worker and client needs to be considered in order to help with the problems being presented,
4. the length of time of the therapeutic process impacts outcomes with clients (i.e., the therapeutic process must have a beginning, middle, and end), and
5. it is often possible to break down a problem into manageable parts (partialization).

Together with Perlman's years of experience in social casework, these principles formed the basis of her theory of the problem-solving process.

As a caseworker, Perlman began to recognize that the process itself was primarily about the social caseworker helping individual clients cope more effectively with their problems. This realization contrasted with the primary focus of social work education at the time, which was on diagnosis and treatment. In her initial work on the subject, Perlman (1957) described *social casework* as follows: "A person with a problem comes to a place where a professional representative helps him [or her] by a given process" (p. 4). In other words, a person who experiences some challenges or barriers in personal functioning (whether individually or socially based) seeks help from a professional who works in an agency that specializes in a particular type of help. While at this place, the person forms a helping relationship with the professional, who then helps the person develop coping responses to the problems he or she is facing. Compton and Galaway (1994) describe this problem-solving process as the underlying framework for generalist social work practice. They also argue that the problem-solving process itself is not a method of treatment; instead, the method of treatment is to be determined on the basis of client goals and presenting problems while engaged in this process. As a result of this distinction, emphasis within the social work literature has been placed primarily on highlighting the *process* of problem-solving, rather than the psychosocial intervention of social problem-solving therapy.

Following Perlman (1957), others have attempted to define the stages or steps of problem-solving in social work (Compton & Galaway, 1994; Sheafor, Horejsi, & Horejsi, 1988). Perlman (1957) initially postulated three primary components of the problem-solving process: collecting information about the problem, explaining the problem and setting a particular goal, and implementing a plan of action to resolve the problem. The relationship between the therapist and the client was the defining feature that made this process significantly different from the process of diagnosis (Woehle, 1994). Compton and Galaway (1994) similarly describe a contact phase, a contract phase, and an action phase. Likewise, Turner and Jaco (1996) in the fourth edition of this chapter provided a succinct overview of these phases. For each phase, Compton and Galaway (1994) suggest how social workers can proceed with clients and monitor their own reflection and desires in the helping process. This process includes an assessment of the client's motivation, capacities, and opportunities to work through the problem (Compton & Galaway, 1994; Perlman, 1986). Compton and Galaway (1994) describe *motivation* as the level of hope for or discomfort with achieving the desired goal (i.e., the solution to the problem); *capacity* as the skills and knowledge needed to work on the problem; and *opportunity* as the resources and supports required to engage in the problem-solving process.

These steps and stages are important and have already been largely incorporated into generalist social work practice and the values and ethics of the profession (Heinonen & Spearman, 2006; Turner & Jaco, 1996). However, this framework does not provide enough empirical evidence on why solving problems is important, how some

people can solve problems effectively and others cannot, what the long-term psychosocial implications are for people to be able to effectively solve problems, and how coping abilities differ for each person or based on the nature of the problem. Also, this literature focuses primarily on the *process* of problem-solving and the stages to move through to resolve a particular problem (or set of problems). Instead, if one were using problem-solving as an intervention in practice (as is the case with problem-solving therapy), greater emphasis would likely be placed on the motivational aspects that both Perlman (1957) and Compton and Galaway (1994) describe as instrumental in the assessment phase. While these authors view motivation in terms of hope or discomfort about solving the problem, in most cases motivation is more complicated. It might include the social environment or cultural, psychological, and emotional factors, as shown in the counseling psychology literature on problem-solving therapy. In particular, the description of problem orientation in problem-solving therapy suggests an alternative understanding of motivation, and one that can lead to more structured interventions of problem-solving in social work.

Problem-Solving Therapy

Various forms of problem-solving therapy have emerged over the years, but D'Zurilla and Goldfried (1971) are generally credited with creating this method of therapeutic intervention. Problem-solving therapy was developed from the modern tradition within psychosocial intervention scholarship that focuses on teaching clients a particular skill set (D'Zurilla & Goldfried, 1971)—specifically, teaching clients a process for solving the problems that they experience. Within this therapeutic orientation are assumptions about problems themselves and the implications of solving problems for psychological, emotional, and physical well-being (Nezu, 2004). The primary focus of this approach is to improve individual-specific "coping" with problematic life situations. Like most psychosocial interventions, it attempts to achieve outcomes by teaching individuals different ways of responding to their problems that will improve their psychological and social functioning and overall well-being (D'Zurilla & Nezu, 2007; Nezu, Nezu, & D'Zurilla, 2013).

Recent research has evaluated this approach and applied it in multiple settings with a variety of demographic subpopulations (Arean et al., 2008; Barrett et al., 1999; Bender, Springer, & Kim, 2006; Catalan et al., 1991; Chen, Jordan, & Thompson, 2006; Gellis et al., 2008; Hegel, Barrett, & Oxman, 2000; Hegel, Dietrich, Seville, & Jordan, 2004; Rath et al., 2003; Slonim-Nevo & Vosler, 1991; Sternberg & Bry, 1994). Most of this literature finds problem-solving therapy to be an effective method of clinical intervention. Some examples of service-user groups, disorders, or experiences include: Traumatic brain injury, depression, self-harming youth and young adults, depression symptomology, people with personality disorders, experiences of pain, reintegration of formerly incarcerated adults, among many others (for a full list, see Nezu, Nezu, & D'Zurilla, 2013).

Recent meta-analyses support the results from these individual studies. For instance, Malouff, Thorsteinsson, and Schutte (2007) find that problem-solving therapy is significantly more effective than no treatment, treatment as usual, or placebo groups for reducing mental health symptomology. Similarly, Bell and D'Zurilla (2009) find that problem-solving therapy is as effective as other psychosocial therapies and medication treatment for people with symptoms associated with depression. They also find that the effects of the intervention are improved through the inclusion of combined training in positive problem orientation and problem-solving skills (Bell & D'Zurilla (2009). It is likely that the same factors that affect psychotherapies in general—voluntariness of the client, the issues or problems being presented, the individual or group therapeutic context, the duration of treatment, and the assignment of homework—also affect the outcome of problem-solving therapy (Malouff et al., 2007). It is important to recognize also that I used the word "intervention" because problem-solving therapy in theory could also help prevent problems or side effects of poor coping skills. However, further research is needed to explore the preventive potential of this method. A fundamental distinction between problem-solving therapy and a process of problem-solving needs

to be recognized. While many treatment methods might focus on solving a particular problem, problem-solving therapy attempts to teach people how to solve problems in general, and it follows a structured process (see Nezu, Nezu, & D'Zurilla, 2013, for a treatment manual). Compared to other treatment methods, it may be less concerned with solving a specific presenting problem (D'Zurilla & Nezu, 2007). Scholars of problem-solving therapy have not yet determined which elements of the intervention are shared with other therapeutic types and which aspects are unique. The absence of these comparisons limits our ability to determine whether problem-solving therapy leads to solving more real-life problems over time, which is one of the primary intentions of the intervention (Mynors-Wallis, 2002). However, some studies have begun to emerge that indicate that the outcomes of problem-solving therapy can have longer-term effects for specific subpopulations (such as elderly people) and conditions (such as depression symptomology) when compared to other interventions (Arean et al., 2010; Gellis et al., 2007).

Problem-Solving Therapy and Social Work

Within social work education, problem-solving is taught in relation to generalist social work more as a theoretical framework of practice and less as the foundation of a specific therapeutic intervention. While problem-solving has historical roots in social work, this intervention style has not been explored enough within clinical social work settings. In fact, applying problem-solving therapy to the practice of social work may seem problematic—especially in relation to other theoretical paradigms of social work, such as structural social work theory or even person-in-environment theory. Social workers who work from other theoretical models might not support the wholehearted focus of problem-solving therapy on an individual's present coping abilities, given the types of problems that develop in their clients' lives.

However, the focus on problem orientation within problem-solving therapy has useful implications for social work practice and our present discipline-specific understanding of problem-solving theory. "Problem orientation" describes how people perceive or evaluate social problems and their own ability to cope with the problems that develop (Nezu, 2004). The other aspect of problem-solving therapy, "problem-solving style," refers to the cognitive-behavioral activities that people engage in to solve their problems. Thus Perlman's (1957) approach, an example of problem-solving style, does not fully take into account the fact that problem orientation will have a direct impact on problem-solving. Problem orientation is about changing one's perception of the problem, while problem-solving style is about solving the problem (with or without the intended outcome). This latter aspect has been more closely aligned with social work practice. Incorporating the problem orientation principles from counseling psychology might usefully expand our understanding of problem-solving in social work to include its role as a specific intervention within practice, rather than a structured process that defines practice in general.

Indeed, social work practitioners are engaged with clients in a way that seeks to link clients' personal experiences with their social environment. How we interact, as individuals, with our social environment, or how our lives are shaped by the social milieu that surrounds us, is of great importance for social work. As we all know, social problems such as poverty or oppression have a negative impact on people and their overall functioning. Incorporating a problem-solving intervention approach might help people realize the implications of their social environment for their present situation and individual problems, such as homelessness or substance abuse. People who realize that certain interactions with the social realm have resulted in or maintained their present problems might be able to challenge future negative interactions and resolve an issue before it creates further problems. Recent research on labor market attachment supports this point. While people may recognize that barriers within their social environment are affecting their employment status, they associate these issues with their own unemployment experiences only minimally, in many cases identifying things that they need to change within themselves to solve their problems (Graham, Jones, & Shier,

2010; Shier, Graham, & Jones, 2009; Shier, Graham, & Eisenstat, 2015). It would seem that these people have negative problem orientations that have probably contributed to maintaining a cyclical pattern of under-employment or unemployment.

At present, problem-solving therapy focuses primarily on the individual and his or her capabilities to cope with life problems. Social work could add a further layer—a stage where people recognize that some of their problems are socially rooted or have a social environment component. This recognition might also contribute to the preventive component of the problem-solving therapy intervention.

By recognizing, as we interact with clients, that their problem orientation affects their present situation, we can expand our understanding of the problem-solving process. Building on the contributions of Perlman and cognitive behavioral psychologists, we can use the idea of problem orientation to provide a more structured approach within teaching generalist social work practice. How people respond to problems would seem to be a useful place to start, rather than just going ahead with the process of solving the problem through a mix of intervention techniques. What is missing in the formulations about problem-solving is an understanding of how clients perceive problems and how social workers perceive them, both in practice and in social work education and training programs. Including problem orientation changes the problem-solving approach from a simple procedure for working with clients to a determined and defined method of intervention.

In no way is it being suggested here that practitioners should wholeheartedly take this problem-solving therapy model and apply it to generalist social work practice, but it would be useful to begin to take pieces of it to understand better how people respond to problems, and the reasons for seeking help that underlie any specific presenting problem of a client. What this clinical psychology research has shown is that just helping people develop skills to solve a particular problem is not effective for producing long-term competency in problem-solving (Nezu, 2004). When working with people in community-based practice, we offer immediate, short-term relief. This is a problem-solving process, although it is just immediate and reactive to a presenting problem. Addressing the problem orientation of the person first and then working through the process of problem-solving (using whichever therapeutic method of intervention is necessary) redirects the thinking of practitioners from the here and now to the long term. It means using a method of interaction that could be preventive and offering a structured process that new graduates of Bachelor of Social Work programs can implement when working with clients, especially in settings that are not traditional clinical settings offering counseling therapies. Problem-solving as a process of practice has not been redefined in recent years to reflect the changing nature of social work within the many diverse areas and settings of practice that are now available.

Problem Orientation and Social Work Practice

By assessing the later models of the problem-solving process in social work, we find that many people have moved away from understanding the sociological aspects of problem-solving, which Perlman was seemingly describing by emphasizing the person, the place, and later the provisions (resources) and the profession (Perlman, 1986). There is too much emphasis on the process and too little training of new practitioners in how to engage effectively with clients through problem-solving. For example, the motivational aspects of problem assessment are missing from these models of the problem-solving process. It is within this motivation that we begin to understand how a particular person is adapting to the external environment and how the individual's internal processes are influenced (positively or negatively) by the problems he or she is facing. I have discussed the possible link of problem orientation to a direct clinical setting of practice, but what about other areas of social work practice? Two examples here are provided that have relevance beyond the clinical setting and suggest alternative methods of interaction within social work practice when problem orientation is considered within the assessment. Considering problem orientation within the problem-solving process might have

an impact on the overall process that is undertaken by the practitioner. The first example is a case of culturally sensitive practice, and the second relates to "mezzo social work practice"—specifically, that of third-sector (nonprofit) organizations—and the related structures and service delivery models.

Applications to Practice

Recent studies (Al-Krenawi & Graham, 2001, 2009; Graham, Brownlee, Shier, & Doucette, 2008) have found that the social work knowledge base needs adaptation to ensure effective practice with groups of differing cultures or in particular geographic or local contexts. Recognizing the problem orientation of the client helps define intervention that is appropriate for differing cultural groups. It would be reasonable to suppose that a mix of factors (e.g., cultural, social, psychological) must be considered to understand the particular problem orientation of a client, and the client's perception of the helping relationship as it relates to this specific problem orientation.

Studies by Graham, Bradshaw, and Trew (2008, 2009) of one distinct cultural group, Muslims living in North America, found that some Muslim-Canadians have different expectations from the helping relationship for resolving their problems—that is, their view differs from what students in general social work education programs are taught to expect. Graham, Bradshaw, and Trew (2009) also found discrepancies between formal social work education and training and the methods of practice adapted for assessment and clinical intervention with some Muslim-Canadian clients, as well as challenges to professional boundaries and termination of treatment.

An expanded understanding of the problem-solving process that includes problem orientation could offer a solution to these discrepancies in practice. The way these particular clients perceive the helping relationship and their expectations of specific solutions to issues and more direct approaches to intervention when receiving services are a direct result of their problem orientation. Culture clearly plays a role in developing problem orientation, not only in this group but in any distinct group.

Failure to recognize a client's problem orientation affects the practitioner's responses to that person, and in the case of diverse social groups, has direct implications for effective, culturally appropriate social work practice. In other cases, not recognizing the particular problem orientation of clients might act to maintain cyclical patterns of help-seeking. For example, if clients have a negative perception of problems and their own ability to solve them, they may be able to resolve the current presenting problem but will not develop the necessary perspective to solve future problems.

Until now, I have discussed the implications of including problem orientation at the micro-level of practice. The next example considers how problem orientation affects practice at the mezzo-level, specifically in nonprofit organizations. In the present political and economic climate, a process of social welfare retrenchment and decreasing resources for social service provision at the macro-level is affecting such organizations (Chappell, 2006), limiting their overall ability to function and meet their service mandate. The solution (or specific coping response) to this problematic situation has been identified as seeking philanthropic donations for services and volunteers to run programs—as is characteristic in a neoliberal ideology of social welfare development (Anheier, 2005; Hasenfeld, 2000; Powell, 2007).

If they followed the traditional problem-solving process, these organizations would be likely to focus primarily on the problem (the lack of resources) and seek to develop the skills needed to relieve the problem (although these actions do not necessarily make things better). For example, some organizations may choose to undertake social action campaigns, seek opposition political-party support, contact private foundations for monetary support, or quietly make cuts to their present programming structure. The alternative approach of focusing first on problem orientation helps these organizations recognize that they have a negative problem orientation, which is probably a direct result of their interactions with the social environment or a byproduct of their educational training and background. At the root of this negative problem orientation is the

fact that some organizational leaders of direct social service nonprofits see themselves in a "vendor" type of relationship with government funders, rather than in a partnership capacity in social welfare development (Shier & Handy, 2015a). This perception changes their view of the problem of social welfare cutbacks, their role within the system of social welfare provision, and, more importantly, possible solutions. In this instance, focusing first on problem orientation would allow the organization to consider its positive role in the present situation of social welfare provision, as well as alternative ways to relieve the immediate problems. These solutions might be more aligned with forming collaborative relationships with similar organizations and with government sectors, or they might include activities such as research, practice evaluations, and local community forums to discuss service delivery (Shier & Handy, 2015b). In fact, contemporary discussions of social innovation and social entrepreneurship among direct social service nonprofits demonstrate the role of a positive problem orientation in resolving emerging and persistent issues for groups of service users (Shier & Handy, 2015a).

Problem Orientation and Social Work Education

Incorporating the concept of problem orientation into the problem-solving theory of Perlman (1957) and later writers has direct implications for social work education, and in particular for training generalist social work practitioners in undergraduate programs. Recognizing the problem orientation of the client could allow us to create a revised model of problem-solving within social work that practitioners could apply in their direct work with clients. Further investigation of how practitioners could assess a client's problem orientation would be needed.

Problem orientation can also usefully inform discussions about social action and social justice. How people make the link (as suggested in structural social work theory) between their personal problems and the inequalities that exist within the wider social realm has not been explored within the literature. Practitioners could help clients make these links by incorporating problem orientation into the intervention process, first by illustrating how the social environment affects their present situation, and then by helping clients achieve the change that is desired.

Teaching people how to take part in social action could also be considered an exercise in teaching problem orientation. The way people respond to a particular social issue that affects their lives (whether directly or indirectly) and the way they view their ability to solve structurally based problems or participate in social action are direct considerations of problem orientation. As a result, teaching social work students about social action and social justice, focusing specifically on how they can create change or contribute to rectifying the many structural inequalities within society, might be useful in developing positive problem orientations.

Problem orientation can also help improve practitioners' understanding of the effectiveness of problem-solving skills within their practice. The process outlined by Perlman and others taught clients to identify a problem, articulate their goals, create a plan of action, and follow through on that plan in order to develop their problem-solving skills. Perlman (1986) highlighted the assumption that if people are taught how to solve one problem, they will apply the skills to other settings as well. However, the research on this subject is inconsistent and inconclusive. Some people may not be able to maintain their problem-solving skills for more than a limited time after treatment. If the practitioner does not recognize the problem orientation of the client, developing and applying these skills may not help the client achieve the desired outcome, especially if the client's problem orientation is negative.

Conclusion

Problem-solving is an underlying aspect of social work practice, but it has received less attention in recent years as a foundational concept—or even assumption—of contemporary social work practice. Why do social workers spend so much time solving problems? While Perlman explained why a problem-solving

process might be useful in social casework, her reasoning was largely premised on her own experiences in working effectively with clients through direct practice. While this form of knowledge transfer (from the practice realm to the academic community) is commendable, the problem-solving process has not been the subject of extensive empirical inquiry and analysis in recent years. Here we have examined problem-solving in two contemporary social work contexts—communities that include diverse cultural groups, and nonprofit organizations challenged to adapt and innovate in the face of emerging and persistent social issues impacting service user groups. The interdisciplinary nature of human problem-solving allows us to learn from another helping profession—clinical psychology—to reevaluate our own practice in problem-solving. The essential difference is to include problem orientation in our assessment.

Unfortunately, the literature remains at a bit of a crossroads with regard to problem-solving theory, and there is less certainty about the future of this method of intervention in social work practice. Problem-solving, though, acts as a theoretical foundation to the social work profession, and therefore this crossroads gives opportunity for practitioners, educators, and students to think about how problem-solving intersects with their work and to explore this concept of problem orientation within the multiple domains and mix of methods of intervention of our practice.

This leads to a final point. A topic missing from this discussion that warrants future investigation is how to work with clients who have negative problem orientations. For example, we might ask: What practices were useful in helping clients establish more positive problem orientations? Is problem orientation improved with increases in self-esteem or recognition of personal experiences in solving problems, or are there other factors to consider? The focus on problem orientation is important to producing longer-term solutions for clients, groups, or communities, but we are left with limited answers about how to engage with them in a way that helps develop our capabilities as practitioners faced with challenging negative problem orientations.

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The Psychoanalytic System of Ideas

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Telling the story of psychoanalysis and Sigmund Freud is sure to trigger the same controversy among social workers as it does among all critical thinkers. Yet this particular model of the mind that processes all of human experience from pleasure to trauma has earned a historical place that cannot be ignored. Freud was a gifted writer—relaxed, often funny, sometimes self-deprecating—and he began his career in neurology without the benefit of technology that, 100 years later, largely confirms his discoveries. Perhaps because of its resonance in Western culture, Freud's work exerts as great an influence today as in the early part of the 20th century. Psychoanalysis comes into perspective when set against a backdrop that includes the Enlightenment philosophies of Europe, the French surrealists, antisemitism, monarchy, modernism, fascism, and ultimately democracy. Richard Sterba (1898–1989), who wrote lyrically about life in the Vienna Psychoanalytic Society and was just a medical student at the time, evoked the sheer power of these ideas. "The closeness to Freud's work *in statu nascendi*," he said, "gave us the feeling of participating in a major, future-shaping scientific and cultural process."[1] Virtually all the "talk" therapies we use today derive from that same process, whether the client is a whole organization or an individual adult, a child, a family, a group, or a community.

When Sigmund Freud decided to unite the psychoanalysts in 1918, he settled on two principles that have largely disappeared from the story and that are critical to social workers. The first was to standardize all psychoanalytic training programs scattered throughout Europe (though still lacking in America): he would convince

the psychoanalysts of the need for a systematic method by appealing to their Enlightenment sensibility and beliefs in social progress. This was the original generation of psychoanalysts—the pioneers of the early 20th century's radically new kind of mental health treatment. The setting was Vienna (Austria), where Freud's colleague Dr. Julius Tandler (1869–1936) launched a post–World War I massive social welfare system, including vast community-housing developments, public health and mental health agencies, early childhood education programs, clean streets, and local gardens.[2] Postwar "Red Vienna," as it has come to be known, produced the social justice core of psychoanalysis.

The second principle was more significant. Freud was puzzled by physicians' class-based approach to psychiatry. In truth, he believed, "the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery."[3] Freud grew up in a liberal family, and, although a Jew, had received a humanist education at the University of Vienna. World War I had sparked his sense of social justice when he saw that many of the soldiers accused of "malingering" were actually suffering from "war neurosis" (or "shell-shock," a cluster of psychiatric symptoms resembling what we call post-traumatic stress disorder [PTSD] today). Indeed, Freud publicly argued against their treatment by electrotherapy because, as his colleague Ernst Simmel (1882–1947) said, society could not afford to ignore "whatever in a person's experience is too powerful or horrible for his conscious mind to grasp and work through."[4] He felt that this social ignorance had the effect of widening the gap between poor soldiers and those from affluent families. Freud's second principle, then, was that the psychoanalysts should start free community-based clinics, first for the soldiers, then for anyone who was unable—for any reason—to pay for their treatment. Regardless of the level of intervention, the client's unconscious does not have a social class; class is a social arrangement that may resonate with a client's subjectivity, but is no more innate than the clothes we wear. This subjectivity or class consciousness, along with social justice, would become pervasive if unacknowledged themes in psychoanalysis.

By the time Freud had crystallized these ideas, two major changes were underway in American psychology and social work. The psychologists had adopted behaviorism and adhered to John B. Watson's definition of their field as "a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behavior."[5] Dispensing with the introspective methods that James Jackson Putnam and Morton Prince were introducing to psychology, the behaviorists applied animal research to study the human mind. Meanwhile, professional social work was gaining strength and founding schools in New York, Chicago, and Boston.[6] If 1909 was a watershed year for psychoanalysis, social work saw President Theodore Roosevelt initiate the legislation establishing a Federal Children's Bureau, the first White House Conference on the Care of Dependent Children, and Sigmund Freud lecture on assessment and treatment of childhood trauma at Clark University.

In this series of landmark lectures, Freud repudiated the Victorian era's attempts to disdain psychopathology, refute the effects of trauma on children, repress desire, and ignore sexuality—all in the name of "civilization."[7] The Clark lectures, later published as a series of modernist essays, outlined the fundamental elements of psychoanalytic theory and technique and became the foundation of a system for developing psychotherapies that respected human experience and individual character. Thus, beyond the theory, came Freud's attempt to describe how psychoanalysis would resolve psychological problems that proved well beyond the technical and theoretical capabilities of his predecessors.

Like the professor he was, Freud divided the essence of his findings into five distinct categories. The first, and the least controversial, explained the often-unacknowledged distress of people whose depression or anxiety interfered with everyday functioning, and who could be treated unambiguously in the analyst's office or at the clinic. Too few clinicians were able to handle recurring psycho-physiological symptoms (manifestations of conflict between the conscious and the unconscious) without medication or hypnosis, a technique Freud disliked. (Later, Freud and his colleagues would devise

a formula for expanding these outpatient services.) For the second lecture, Freud focused on obstructions in child development—the unnerving traumatic effects of family or institutional abuse (often sexual) that had been noted by many others but described in a way that placed the blame on children themselves. This account led to a third category, in which Freud urged his audience to lend meaning to those cryptic wishes (for the return of the dead, for sex with a parent) so distressing to society that we disguise them even in dreams. And with this, he moved toward the fourth pillar of psychoanalytic theory, the delicate subject of infantile sexuality. He even broached the idea that we are all born bisexual, and that this undercurrent not only stays with us all our lives regardless of eventual orientation, but also should not be subjected to any moral charge. "One may attribute to every child," Freud said, "without wronging him, a bit of the homosexual disposition." Perhaps because he refused to idealize culture or human nature, Freud knew that the fear of liberating sexual repression was deeply threatening.

So, in the last lecture, Freud took up the question of people who truly need help yet who reject it because of their fear of cultural stigma. Why is mental illness experienced as such a profound disgrace? Even surgeons are allowed to excise a tumor without dishonor to themselves or their patients. In contrast, a therapist might be "afraid of doing harm by psychoanalysis; anxious about calling up into consciousness the repressed sexual impulses of the patient, as though there were danger that they could overpower the higher ethical strivings and rob him of his cultural acquisitions." This was a sobering venture into cultural criticism: that Freud could consider the long-term consequences—not of psychic pain, but of the harm done by culture that prevents people from getting the help they need to ameliorate the pain. Even today, it remains to be seen how much evidence is required to justify a truly comprehensive public mental health system of the kind the psychoanalysts were proposing in the 1920s.

Freud's lectures gave social workers a way of understanding the troubled children with whom they (but few others) worked daily. Disturbances of childhood were neither personality defects nor biological inheritances, Freud said, but rather the result of brutal environmental forces such as rape and poverty. He showed that "civilization" demands repression and imposes a particularly stringent moral code on the "cultured classes." America's ethic of puritan morality exemplified, for Freud, the repression inherent in these moral codes. The influential anthropologist Franz Boaz attended Freud's 1909 lectures. And years later, members of that audience, from Emma Goldman to the American psychiatrist Adolf Meyer (who joined the rotating faculty of the Smith School for Social Work), still talked about psychoanalysis with enthusiasm: not of a professor or a critic, but the enthusiasm of a humanist. "For the first time I grasped the full significance of sex repression and its effect on human thought and action," Emma Goldman recalled. "[Freud] helped me to understand myself, my own needs; and I also realized that only people of depraved minds could impugn [his] motives."[8] Bringing all of this together was formidable, and involved sophisticated and intelligent leadership—the kind of intellectual leadership for which social work is rarely given credit, and that the Nobel prize–winner Jane Addams, among others, proved it possessed.

"I discovered some new and important facts about the unconscious in psychic life," Freud said simply at the end of his life, in 1938. "Out of these findings grew a new science, Psycho-Analysis."[9] As a theoretical model, psychoanalysis would both revolutionize our understanding of the human mind and also result in a large-scale regrouping of modern life. Eventually, Freud thought, "the conscience of society [would] awake,"[10] and the psychoanalysts' urban activism would encourage governments to deliberately engineer new forms of social welfare planning. From 1920 to 1933, arguably the most generative period in the history of psychoanalysis, members of the International Psychoanalytic Association formally refuted Europe's monarchist traditions, not only with their belief in the dynamics of the individual unconscious, but also by pooling their creativity toward the greater good: they joined municipal governments, mounted lecture programs in the public schools, advocated for reforms in health and mental health, and planned free outpatient

clinics (some brought about and some not) for indigent citizens of Vienna, Berlin, London, Budapest, Zagreb, Moscow, Frankfurt, Trieste, and Paris. "Whatever fosters the growth of culture," Freud wrote to Albert Einstein in 1932, "works at the same time against war."[11]

While the theories and therapies have been amended and transformed by psychoanalysts over the last 100 years, Freud's own impact on Western culture and society has been virtually incalculable. His name has become synonymous with the practice. But almost since its inception, and certainly since its arrival in America, anti-clinical clichés have surrounded psychoanalysis from across the political spectrum.[12] Psychoanalysts themselves have, at times, alleged that clinical objectivity requires distance from politics, social policy, and social thought. As Wilhelm Reich, one of the field's most biting theoreticians, observed as early as 1936, "the conflict within psychoanalysis in regard to its social function was immense long before anyone involved noticed it."[13] Almost every new interpretation of the history of psychoanalysis claims from the outset that none of its predecessors placed the subject within its accurate social, political, and cultural context. Yet each one of these histories, from Freud's own[14] through Carl Schorske[15] to Elisabeth Roudinesco,[16] has crafted a distinct narrative including the seemingly irreconcilable contradictions between individual human behavior and the larger social environment. According to Eli Zaretsky, no one has been able to grasp psychoanalysis in its entirety, because we lack an explicit sociocultural framework in which to understand its opposite; that is, ourselves as individuals distinct from family and society. To fill this gap, Zaretsky proposes, we should see that psychoanalysis was "the first great theory and practice of 'personal life'."[17] This definition reframes psychoanalysis and offers us a post-industrial, dawning of modernism (1880s–1920s), deep sense of identity so distinct from the family and so totally individual that each person carries their own unconscious system of symbols and narratives "apparently devoid of socially shared meaning." Social work is no exception, and social work critics have long suggested that individual psychological investigation precludes anti-oppression advocacy, and that psychoanalytic studies place the individual person at a remove from culture.

Like Freud, many clinicians have found that what may seem paradoxical—a deliberate use of two implicitly contradictory words, "unconscious" and "science," within one thought—accurately represents the challenge of understanding the human mind. To others, psychoanalysis is simply another dimension of Western hegemony wrought of capitalism and undifferentiated reverence for the individual. But to most, psychoanalysis has survived as a system of thought, and is richer today in its variety of applications than ever before. In 1918, when Freud took up the task of rebuilding the psychoanalytic movement eroded by World War I, he did so within the "social democratic" framework that would soon remake post-monarchy Vienna. Psychoanalysis expanded in the context of *début de siècle* Vienna's humanist and vigorous social welfare ideologies, and repositioned the analysts from their social margins (as intellectuals and Jews) to a newfound political nucleus predicated on "otherness."

The history of psychoanalysis is also, in many ways, the history of social work. With the advent of modernism at the turn of the 20th century in both Europe and America, the psychoanalysts were joined by conscientious social service agencies that sent, at different times and places, a vast range of patients into their offices: children, adolescents, alcoholics and substance over-users, men suffering with sexual dysfunction and women who were accused of same, people of all ages with diseases aggravated by depression. Runaway and misbehaving children were sent to analytic group homes in Vienna long before 1938, and in Detroit after the war. Adults with schizophrenia or psychoses were treated in psychoanalytic sanatoria outside of Berlin until 1933, and later in their American equivalents in Massachusetts, Maryland, and Kansas. Psychiatry brought in new diagnoses every decade. Neurosis was the original mode, then borderline personality disorder, and today "bipolar" is in fashion. In the narrative of culture wars closely fought since the early 1940s, two rival concepts of psychoanalysis—as nefariously liberal to conservatives, as élite to class-conscious liberals—have played out in politics, in the arts, and in society at large. American

psychoanalysts themselves (social workers included) have struggled with choices between orthodoxy and revisionism, between individual treatment and public advocacy, and between two models of service delivery, the medical and the social. And not all social workers chose to affiliate with Sigmund Freud. "We read all about [Alfred] Adler. We formed two gangs, one pro-Freud and one pro-Adler," said Gisela Konopka in 1984 during the taping of an oral history session with NASW's Vida Grayson (p. 35).

> I chose Adler because [of his] concept of the fight against authoritarianism. . . . Adler was part of the Socialist movement in Vienna, and I felt identified with that. I thought he knew more about the environment. When social work said "inner" versus "outer" I can't see any of those things in terms of "versus." It's not the way I grew up.[18]

In fact, Freud and Adler were quite compatible politically; they differed on the impact of sexuality in human development.

Selected Psychoanalytic Treatment Modalities

One of Freud's first modernist interventions was the radical reshaping of clinical environments. The setting was the therapist's private office, replete with personal icons—books, antiques, paintings—and the patient used a couch instead of a chair.[19] This new design, with the therapist's own seat placed outside the patient's sightline, precluded superficial exchanges between patient and analyst. Instead, the patients, perhaps just short of dozing off, could let their memories float into present consciousness, and the analyst could organize these thoughts into more or less logical insights concerning the painful consequences of repressing horrible childhood experiences. In Vienna, where this reconfiguration was introduced in 1896, the medical and academic communities first ignored the new method, then rejected it, and finally embraced it as their native contribution to world science and culture.

As we have seen in this brief historical overview, most of the psychoanalytic treatment techniques used by today's social workers, and effectively so, originated in the early 20th century. Clinical methodologies still applied today—and still debated—were pioneered in the psychoanalysts' first free outpatient clinic, the Berlin Poliklinik. Anna Freud, Melanie Klein, and Hermione Hug-Hellmuth forged child analysis there. Karen Horney introduced the female perspective and cultural relativity in psychoanalysis. Sándor Ferenczi's fractionary (or time-limited) analysis was put into practice there, as was Wilhelm Reich's in-depth case conference, and a range of protocols such as free-treatment eligibility and length-of-treatment guidelines. The underlying theories—the childhood roots of psychological disorders in adulthood, the dreamlike logic of the most rigid yet unexplainable symptoms, the powerful pressures of ambivalence toward family, and the deeply subversive acknowledgment of human sexuality—worked well.

When turning our attention to early 20th century psychoanalysis, we can see the extent to which the era's health and mental health endeavors enriched each other and were animated by common ideals. We begin with Sigmund Freud, the paradoxically bourgeois yet revolutionary neurologist whose unrelenting clinical investigations and lyrical case studies of mental disorders made him, then as now, a scientific celebrity. Freud championed, among others, Sándor Ferenczi, a modernist Hungarian intellectual who alternated lengths of treatment and varied the psychotherapist's level of activity; Ernst Simmel, a German doctor who brought about inpatient psychoanalytic treatment; and Wilhelm Reich, whose journey through Marxism and psychoanalysis remains a controversial narrative of possibility. The impact of their discoveries, added to those of Melanie Klein, Anna Freud, Karen Horney, and subsequently Donald Winnicott and Jacques Lacan, helped create a mythology of discovery that is still with us today. What follows is a selective overview of psychoanalytic theory and technique that continue to thrive in today's social work milieu.

Child Psychoanalysis

In the spring of 1928, Margaret Powers, a State Charities Aid Association child welfare worker who would later set "the highest standards of casework"[20] at Cornell University Hospital's

department of psychiatry, set out to find a new treatment method suited to the mental health needs of urban adolescents. Powers interviewed Mary Jarrett, associate director of the Smith College School for Psychiatric Social Work, before turning her search to Berlin and its extraordinarily dynamic Psychoanalytic Poliklinik. As Powers spoke with the Institute's resident psychoanalysts—child analysts, educators, political activists, specialists in psychiatric disorders—she learned that many had been pursuing highly innovative clinical paths. The most important advances in the understanding of infant and child development have emerged primarily from these psychoanalytic studies of children and adolescents. As Erika Schmidt (2009, p. 56) writes in her integrative paper, "both clinical social work and child psychoanalysis borrow from psychoanalytic theory for explanations of motivation, development, and technique."[21] But exactly who "discovered" child analysis is a matter of debate.

Variously attributed to Anna Freud, Melanie Klein, or Hermine Hug-Helmuth, the practice of child analysis really took root in Vienna and Berlin of the mid-1920s. Freud had derived his own theory of infantile and childhood sexuality from the retrospective analysis of adult patients, and ambiguously corroborated his conceptual framework with observations of his own children, grandchildren, and patients like "Little Hans."[22] Later, while all three analysts (Klein, Hug-Hellmuth, and Miss Freud each claimed the truest adherence to Freud) sought to understand the psychic life and mental development of children, the women took significantly different positions on technique. In Vienna, Hermine von Hug-Hellmuth played with the children in their home environments but stayed away from interpretation.[23] In contrast, Berlin's Melanie Klein, who used little wooden toys for play therapy, valued in-depth interpretation that emphasized her belief in the child's capacity for transference similar to adults'.[24] "She absolutely insists on keeping parental and educative influences apart from analysis," Alix Strachey reported to her husband and co-translator, James.[25] Klein's was a highly individualized approach to working with traumatized children for whom protective fantasy may override painful reality. Meanwhile, Anna Freud, also in Berlin at the time, disavowed transference in children and took up the ego-psychological supportive stance to which social workers largely still adhere.[26] Avoiding suggestion, she sought to accurately understand and then clarify the meaning of the child's self-directed play.

Anna Freud's position and her emphasis on ego-supportive treatment is echoed today in numerous American child therapy centers. Among Miss Freud's most influential adherents were Erna Furman, Rudolf Ekstein, Anny Katan, Thesi Bergman, and countless more child analysts who spread out across the United States after fleeing Nazism in Austria and Germany.[27] Erik Erikson worked with Anna Freud, Dorothy Burlingham, and Eva Rosenfeld at their innovative Hietzing School in Vienna. Others, like Esther Menaker, George Mohr, Helen Ross, and Margaret Gerard, were among the Americans who had traveled to Europe before 1933 (or the United Kingdom after 1938) and who brought home a new understanding of child development, along with a unique set of therapeutic skills. These analysts articulated the method of child psychoanalysis but also, in a sense, a license to listen to children's' speech, to value and respect it with a mind newly alive to the pain implicit in their narratives of trauma. The model found its way into residential treatment facilities, outpatient clinics, private offices, and group homes for adolescents like Fritz Redl's Pioneer House in Detroit. In their unconstrained play, children can (consciously or not) express the underlying meaning of feelings and problems unacceptable to parents and teachers. The fundamental premises of social work theory such as the psychosocial perspective, when combined with the centrality of relationship as a medium of change and a commitment to social justice, inform the work of today's child therapist. Dr. Furman, who, when interviewed by Theresa Aiello in the 1980s, told her that they "analyze the very rich and the very poor and we all agree that they are very much alike in the tragedy of their early childhood. It's the in-betweens who do a bit better."[28]

Brief Psychoanalytic Treatment

"Is there such a thing as a natural end to an analysis?" Freud asked in *Analysis Terminable*

and Interminable.[29] Written in 1937, with the Nazis at Vienna's doorstep and World War II starting to take shape, Freud's short book took on one the great puzzles of psychotherapy. Two streams of thought—not in themselves inherently incompatible—converge in the debate on length of treatment. If the goal of psychoanalysis is to know oneself by making what is unconscious conscious, the answer is "no," because the human mind evolves incessantly in response to psychological impulses and environmental pressures. If, however, the goal is the relief of symptoms, then the answer is "yes," as in, for example, the treatment ends once the anxiety is reduced. The answers are as variable as the therapies themselves. But the real challenge in the book's title, as Gilda de Simone points out, is not to select which analyses can be terminated and which not; instead, one looks for which *elements* of an analysis can be concluded and which others should be continued.[30] "Terminability" and "interminability" are not fixed points but coexist on a dialectical continuum. And most important, this dialectic exists for both therapist and patient. Given the forces of transference and counter-transference, the therapist is as liable to wrap up a therapy prematurely as the client.

Common American wisdom would have it that psychoanalysis is endless. In a society predicated on individual independence, the ongoing need for psychological or social support implies a kind of vulnerability that violates our Calvinist cultural values. Largely because of this, as Robert Emde says, the question of termination is really "a fundamental challenge concerning our thinking about developmental continuity and change."[31] The first and second generations of analysts, however, seemed to have fewer qualms. Psychoanalytic practice unfolded in plain offices, case by case, on couches where theory hovered invisibly over clinical encounters. At least between 1918 and 1938, psychoanalysis was neither impractical for working people, nor rigidly structured, nor luxurious in length. And by 1937, Freud had concluded that "whatever our theoretical view may be, I believe that in practice analyses do come to an end."[32]

The early psychoanalysts exercised nearly all variations of clinical flexibility. They adapted alternative solutions to bewildering dilemmas: appropriate duration of treatment, for example, was subjected to as much debate, or perhaps more, in the 1920s as today. Influenced by Ferenczi, the Berlin version of brief therapy became an official curative technique called "fractionary" analysis. In Vienna, the clinicians asked whether they "should endeavor to achieve quick successes in order to shorten the duration of the treatment?" Paul Federn questioned the wisdom of discharging patients at their own request. Then again, lengthy treatment was just as debatable as the interrupted analysis because, after all, nobody is ever truly symptom-free. Who (therapist or patient) is served best by what (long or short treatment)? These were the kinds of problems thrashed out in the basement conference room of the Ambulatorium, the psychoanalysts' free clinic in Vienna where Erik Erikson worked in the 1920s; the case conference was initiated by Wilhelm Reich and remains today the standard format for discussing clinical practice (including the therapist's own errors) in mental health settings.

Treatment plans had to be carefully worded (for example, designating an analysand "symptom free" instead of "cured"), especially given the imperative for confidentiality and the psychoanalysts' relationship to public social services. Prospective patients must feel welcomed, and former patients who had interrupted or ended analysis prematurely (or who had been intended for fractionary analysis) should feel comfortable enough to resume treatment.

How many days each week are necessary for effective analysis? Just how many months should an analysis last to be complete? Are such decisions best made by the patient or by the clinician?

Most analysts refused to implement *a priori* time limits on treatment, regardless of diagnosis. Daily sessions were ideal, but since so many of the patients were employed, analysis three times a week was more widespread. By 1926, the three-hours-weekly treatment schedule was found generally adequate and retained as standard practice in Berlin. Just as Freud had compared therapy for neuroses to the treatment of other chronic illnesses like tuberculosis: "the fuller and the deeper the success, the longer does the treatment take."[33] Shorter-term treatment was one of those "hyper-ingenious,

forcible interventions" whose outcomes vary according to pathology; nevertheless, analysts were urged to investigate fractionary, that is time-limited or intermittent, regimens.[34] They "liked to experiment with interruptions," Franz Alexander recalled, "and the expression 'fractioned analysis' was frequently used."[35] Eitingon viewed length of treatment as patient-driven, or failing that, as a mutual decision between therapist and patient. He enjoyed developing advantageous "*fraktionäre*" schedules devised for patients like schoolteachers who needed "a month at Xmas, 3 weeks at Easter, etc., beginning in December."[36] Activity in treatment was an innovation, an extension of psychoanalysis perhaps, but not a replacement.

The question of length of treatment has confounded psychoanalysts ever since Ferenczi came up with the idea of flexibility. Can individual treatment be shortened or speeded up? Is the analytic hour 60 minutes or 45, or can it vary? In the history of clinical practice, psychoanalysts have alternately embraced and repudiated short-term treatment. But they never sought to deny anyone the basic right to treatment based on the mere ability to pay. In doing so, they gave today's therapists a road map of sorts. Jeremy Safran (2002), for one, brilliantly followed this map into relational treatment, pointing out the influence of the brief time frame on the uses of counter-transference, disclosure, and the ongoing process of therapeutic enactment.[37] But the basic idea is perhaps best summarized by Charles Socarides (1954). "By using the insights gained through a thorough knowledge of psychodynamics and the rapid application of these concepts . . . an important tool is added to the armamentarium of the therapist."[38]

Psychoanalytic Treatment of Severe Disorders

"Psychoanalytic Therapy Wins Backing" proclaimed the *New York Times* in 2008, as though fish could speak or corn grew on Mars. "Intensive psychoanalytic therapy, the 'talking cure' rooted in the ideas of Freud, has all but disappeared in the age of drug treatments and managed care," the reporter alleged. "But now researchers are reporting that the therapy can be effective against some chronic mental problems, including anxiety and borderline personality disorder."[39] The core of this statement is an attempt to describe how psychoanalysis can, even in today's apparently rapid-fire world, gain on mental health problems that seem beyond the capabilities—moral as well as physiological—of medication. Paradoxically, the tempting myth that analysis is intended only for the "worried well" persists (in social work as elsewhere), though the subject always been more of a clinical challenge than a mystery to psychoanalysts themselves. As Otto Kernberg, arguably the dean of psychodynamic treatment today, said in 2004, psychoanalysts are well-equipped because they have both the theoretical and clinical tools to diagnose and treat severe cases of personality disorder, including borderline and narcissistic structures.[40] And in the summer of 2008, Glenn Gabbard, Peter Fonagy, and Stephen Sonnenberg joined Kernberg in Belfast to present the contemporary psychoanalytic conceptualization of severe disorders, including the treatment of psychotic states, trauma, addictions, violence, and the nature and function of suicidal ideation. Known for his empirically grounded frameworks, Gabbard consistently refutes the cynics. "Psychoanalytic treatments," he says, "may be necessary when other treatments are ineffective."[41]

The *New York Times* notwithstanding, the effectiveness of psychoanalytic treatment for severe disorders is neither new nor unknown. In the mid-1920s, Ernst Simmel, a colleague of Freud's and co-director of the Berlin Poliklinik, created the Schloss Tegel sanitarium, just outside Berlin, for indigent people with severe psychiatric disorders to be treated psychoanalytically. Simmel believed that impinging social and economic forces are as great a challenge to patients' recovery as their internal disorders are. "This was a pioneering enterprise," said his colleague David Brunswick (1947), "in which [Simmel] not only introduced psychoanalytic treatment of somatic illness, addictions, sexual offenders, schizophrenic borderline cases and other psychoses, but also saw to it that nursing and occupation therapy were carried out with psychoanalytic insight and aims."[42] Harry Stack Sullivan, Adolf Meyer, William Alanson White, Abram Kardiner, Karl Menninger, and

Edward Kempf applied psychoanalysis to their work with psychotic patients in American state hospitals.[43] They thought of psychoanalysis as a way of enhancing what the psychiatrists had started: by developing a therapeutic relationship based on transference and countertransference, or using the structural model of the mind to restore the functioning of a weakened ego, or tolerating a schizophrenic person's compromised representation of reality. The "basic concept," emphasized Sullivan, "is neither *mind* nor *society* but *person* [italics in the original]."[44] The analyst's own sensibility was, for Sullivan, what had to be studied, and the questions he posed on anxiety, schizophrenia, and human loneliness had to be pondered before they could work with patients.

Neuroscience and Empirical Studies of Psychoanalysis

The systematic exploration of irrational behavior, the domain of the unconscious, is the predominant theme in psychoanalytic theory and therapy. Despite a century of exploring the nature of unconscious processes, however, empirical investigations have lagged behind clinical inquiry. Fortunately, today's exciting research in neuroscience and brain physiology is confirming the biological basis for virtually all unconscious emotional processing and also providing major insight into the link between behavior and biology. Certain social workers may be concerned that biological investigations—and even biologically based interventions like psychotropic medications—may compromise psychoanalytic sensibility, blame the victim, or unduly stigmatize mental illness. In contrast, neuroscience actually completes the "bio" component in the bio-psycho-social model. "Underenthusiasm for the neuroscientific revolution," summarizes the social worker Rosemary Farmer (p. 40) "is as unwarranted and as harmful as overenthusiasm."[45] And basic knowledge of neuroscience is indispensable when working psychoanalytically with people with severe "biologically based" disorders, emphasizes Glen Gabbard (1992), who studied the intimate and reciprocal connection between psychosocial and neurophysiological factors.[46]

American culture's present-oriented appetite for tangible results seems to feed everything from risky mortgages to managed care. While psychoanalysis is hardly immune to this imperative, the demand for confirmation of treatment efficacy and effectiveness may not be misplaced. Of course the question "Does it work?" needs to be contextualized with responses such as "For whom?" and "What is the definition of 'successful treatment'?" In view of these large questions, the research has been divided into several categories: studies of the psychoanalytic process itself, and empirical studies of psychoanalytic concepts.

Launched in the 1970s, psychoanalytic process studies sought to measure, in a very precise way, the relationship between therapeutic technique and the outcome of treatment by quantifying selected micro-interventions or, occasionally, whole sessions. The studies first caught on among clinicians eager to acquire the cachet promised by empirical validation, the "gold standard" of the randomized controlled trial, making psychoanalysis as valuable as competing treatments. The politics of the medical market loom as large in psychoanalysis as elsewhere. Nevertheless, the studies move in surprising directions, and for those who still hold to the traditional case report for evaluation, the ambiguity of clinical practice is well reflected in their often-incomplete conclusions. One of the most comprehensive comparisons of treatment outcomes and related factors (Blomberg et al., 2000) studied more than 400 subjects before, during, and up to three years after subsidized psychoanalysis or long-term psychodynamic psychotherapy. The longer patients were in treatment, the study showed, the more they improved—impressively so among patients in psychoanalysis—on self-rating measures of symptom distress and morale. In contrast, improvement was weak in both groups on a self-rating measure of social relations.[47] As to brief treatment (defined as under 20 sessions), Peter Fonagy and his colleagues (2005) updated their exhaustive survey of the therapy outcomes literature to answer key questions frequently asked by their colleagues, namely:

1. Are there any disorders for which short-term psychodynamic psychotherapy (STPP) can be considered evidence–based?

2. Is STPP uniquely effective for certain disorders, as either the only evidence-based treatment or as a treatment that is more effective than the alternatives?
3. Is there any evidence base for long-term psychodynamic psychotherapy (LTPP) either in terms of achieving effects not normally associated with short-term treatment or in addressing problems that have not been addressed by STPP?[48]

In an interesting critique of quantification, Drew Westen and Joel Weinberger (2004) reconsider a contemporary "chicken-and-egg" phenomenon; namely, the predictive (or not) correlation between expert clinical assessment and statistical prediction. In fact, they conclude, standard psychometric procedures can be so utilized that quantified clinical description becomes statistical prediction.[49]

Freud called off his "project for a scientific psychology" because he was hampered by the limited technology available in 1895, not because he thought that biology was irrelevant. Given today's vast improvements in medicine and specifically neuroscience, biological theories of mental health have entered public awareness in the way psychoanalysis did 100 years ago. The latest technology in neuroscience, combined with today's more stringent research methods in psychotherapy, is allowing us to understand more clearly how the brain and the (unconscious) mind intersect (Gabbard, 2000).[50] Capturing the tremendous progress made in the 21st century in the field of interpersonal neurobiology, Dan Siegel (2012) has meaningfully expanded on the tripartite bio-psycho-social model of the mind. From neuron and neuronal networks to language, relationships, community, and culture, Siegel's work in child development maps out a future shared by neuroscience and psychodynamic theory.[51] In a whole new field of investigation called "neuropsychoanalysis," Mark Solms, Jaak Panksepp, and Oliver Sachs have gone a long way in demonstrating the biological basis for unconscious emotional processing within the human brain, perhaps the same process Wilhelm Reich attempted to isolate over 40 years ago. With the advent of functional brain-imaging technology and the emergence of a molecular neurobiology, Solms has tried to connect the psychoanalytic study of the mind (thoughts, dreams, emotions, associations) with the anatomical structure of the brain. His method enables us to identify the neurological organization of almost any mental function without contradicting essential psychoanalytic hypotheses.[52] Interestingly, this laboratory-based neuroscientific work confirms many of Freud's original observations, not least the pervasive influence of non-conscious processes and the organizing function of emotions. And finally, the neuropsychological structures and processes associated with the human unconscious are beginning to be understood.

Macro Psychoanalysis

Just as psychoanalysis has never been limited to clinical work with adults, so, too, the method goes beyond the scope of individual treatment. "The replacement of the power of the individual by the power of a community," Freud wrote, "constitutes the decisive step of civilization."[53] On this macro level, psychoanalysts believe that social systems (from work organizations to local and national communities) are amenable to self-reflection, and that psychodynamically oriented social workers who are organizational consultants can help them become more democratic and tolerant of internal conflict. The treatment relationship is itself a social process. The pioneers of contemporary sociology—Talcott Parsons, Clyde Kluckholn, Marie Jahoda, Paul Lazarsfeld—knew this well, and their work was informed by psychoanalytic theory and method. Parsons joined the Boston analysts Grete and Edward Bibring to study the ambiguous development of self-control in response to collapsing external authority. The social psychologist Erich Fromm incorporated psychoanalysis into his writings on critical theory developed at the famously Marxist Frankfurt Institute for Social Research. Like Wilhelm Reich and Ernst Simmel, Fromm tried to account for the paradoxical tolerance for fascism he saw in Germany of the early 1930s. Similarly, Wilfred Bion, a founding member of London's Tavistock Clinic, pioneered the study of leadership and group and organizational dynamics. Indeed, for most of its life since 1947, the Tavistock Institute of Human Relations

has been as much an interdisciplinary meeting place for researchers looking to apply psychoanalytic and open systems concepts to group and organizational life, as a place to study human relations within organizations, communities, and the broader society. Similar to an individual who unconsciously internalizes oppression, subjugated social groups seem to conform subjectively to situations that are objectively against their best interests. And like individuals, social groups can best resist by pursuing insight or critical consciousness. This, too, was Freud's premise in *Civilization and Its Discontents* of 1930, his habitually misinterpreted call for collective resistance to oppression.

The key factor in macro psychoanalysis, as Ernst Simmel and Otto Fenichel's work suggests, is to think of treatment as a unified clinical and political discourse, a praxis based, not on the strictures of establishment standards, but on an ideology of dialectical materialism. Simmel had served as an army doctor and director of a hospital for shell-shocked soldiers during World War I, and because he had witnessed "the waste of human life during the war years," Simmel urged his colleagues to participate in "the human economy . . . for the preservation of all nations."[54] Simmel was, in the 1930s, director of both the Schloss Tegel inpatient psychoanalytic facility and the Socialist Physicians Union where he was joined by Albert Einstein in Berlin. The Union's study groups explored legalizing the eight-hour work day (along with its health implications and cultural meaning), occupational health and safety, maternity leave for pregnant and nursing mothers, child labor laws, and socialized medicine. They fought for birth control and against the criminalization of abortion. Simmel's colleague Otto Fenichel, author of the classical textbook of psychoanalytic orthodoxy while, at the same time, heading a left-wing opposition group in Europe and later—in hiding—in America, argued that the importance of psychoanalysis lay precisely in its social, even Marxist, dimension. "We are all convinced," Fenichel wrote from Oslo in March of 1934, "that we recognize in Freud's Psychoanalysis the germ of the dialectical-materialist psychology of the future, and therefore we desperately need to protect and extend this knowledge."[55]

If we think of psychoanalysis as a comprehensive theory of mind, and of the mind as a system, then we can expand the scope of clinical investigations to look at the nature of unconscious processes in macro systems such as work organizations. Work organizations can benefit particularly from drive and object-relations theory to explain, for example, employees' reluctance to form attachments to a corporation that fails to provide a holding environment; drive theory explores patterns of aggression and gratification.[56] Social work consultants, who are highly attuned to the psychodynamics of the consultation process itself, can develop strategic interventions for agencies questioning their mission as well as the effects (positive or negative) of unconscious motives on groups and organizations. One of these unconscious motives is described in Freud's original concept of "signal anxiety." This self-protective ("defensive" is the more classical word) function of the ego is used to anticipate dangers, both real and imagined. While the neurophysiological structures and processes related to unconscious anticipation in humans is just beginning to be understood,[57] work organizations have named this same function "strategic planning" or "forecasting."

Psychoanalysis brings tensions to light and locates them within historical, political, economic, scientific, and international systems at play within the organization's unconscious processes. For example, white-on-black racism can be explained psychoanalytically as a defense (fear of the unknown) or a projection (their fault, not our guilt). Of course, no explanation excuses misbehavior, and it does not in itself relieve the organization of its responsibility to handle the conflict democratically. As with other systems, however, coupling insight with appropriate organizational or social policy can reduce inter-group (in this case, interracial) tension. And release of tension is, after all, a key purpose of psychoanalytic treatment.

Conclusions

The acclaimed Viennese writer Sigmund Freud presented, over 100 years ago, a way of imparting logic to our tempestuous minds and societies. When we first read Freud's essays on

psychoanalytic theory and practice, they seem more a collection of scabrous anecdotes than a rigorous consideration of clinical technique. They involve attacks of frantic crying, overwhelming parents, violent traditions, nasty jokes, spurned lovers, and the intransigent push of sexual desire from infancy onward. Psychoanalysis would help us, if not make sense of all this, at least gain a measure of stability and learn to live with it.

Psychoanalysis blends a theory and a practice that, taken together, straddles human physiology, social justice, and psychology to resolve an interminable succession of possible conflicts: between mind and body, person and culture, imposed norms and instinctual desire, the unconscious and consciousness. How important is it today? Because psychoanalytic terms are now so entrenched in Western language, arguments "for" and "against" have become fairly trite. True, psychoanalysis can serve as a reminder that mental anguish makes for social discomfort—and vice versa. Nevertheless, as we have seen in this chapter, the overall discourse remains breathtaking in its scope and possibilities.

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26

The Psychosocial Framework of Social Work Practice

Emilia E. Martinez-Brawley and Paz M.-B. Zorita

Although social workers often make theory in practice, the relationship between formal theory and practice in social work is a vexed one. Social workers often express an ambivalent, if not hostile attitude toward theory.

(Howe, 1997, p. 15)

Many would think that writing a chapter in a book on social work theory would be an unrewarding experience, except that writing about psychosocial theory in social work practice is like writing about social work itself. Psychosocial theory constitutes the very marrow of social work practice. Particularly in casework or clinical practice, the worker engages intimately with the client and is able to assess the inner and outer dimensions that have historically differentiated social work from psychology, psychiatry, or other psychotherapeutic approaches. In this sense, it might be viewed as reminiscent of "the narrative" as it is often defined in cultural studies, where *the text* is located in a historical moment, within a particular gender, class, race, and ideology (Denzin & Lincoln, 1994). In the client's story, which is a fundamental tool of the psychosocial approach, the observer would identify the physical, social, and cultural location of the teller (Kelley, 2011; Neimeyer, 1993; White & Epston, 1990). In other words, the story reveals the client's bio-psychosocial dimensions.

A Historical Sketch of the Movement

The embryonic stages of the psychosocial approach can be traced to the early the years of the Charity Organization Society, when the

pioneers realized that the paternalistic "Lady Bountiful" 19th-century approach to social problems was not enough. The serious challenges that the members of the Charity Organization or the settlement houses, for that matter, encountered, were far too complex to be approached from a purely individual perspective. The ministry and the medical profession had responded to the needs of the poor by focusing on what was wrong with them personally, but the social workers knew that there were traumatic environmental forces that added to their dilemmas. An awareness of the environment became as essential as an awareness of the new "sciences" that could provide further explanations and even ways of intervening. The biopsychosocial elements of persons were clearly intertwined. The emphasis on science, from Charles Darwin and *On the Origin of Species* (1859), to Herbert Spencer's "social Darwinism" (circa 1900), to Abraham Flexner and his serious critique of the social work profession in 1915, all contributed to social workers' focusing on a broad approach that could accommodate new scientific and other coherent information that social workers always collected through common sense. The time was ripe for the emergence of the biopsychosocial theory, framework, or perspective.

Although social work harks back to the efforts of British pioneers, as Robinson and Kaplan (2011) stated in the previous edition of this work, it was the American Mary Richmond (1917) "who actually set the stage for the development of modern casework theory and practice" (p. 388). Josephine Shaw Lowell, another American, was also instrumental in developing the movement of scientific charity. As a commissioner of the Board of State Charities in New York for over 13 years (1872–1885), her influence was felt primarily among the agencies, where she emphasized efficiency and cooperation (Trattner, 1986).

The American efforts of the psychosocial movement sprang from social work at the grass roots. The theoretical framework was inductive. Basic information—what today would be called data, was collected systematically by the trainees of the Charity Organization Society (COS), who were encouraged to continue developing their skills when they entered agencies in the field.

> For more than a quarter-century, from 1899 to 1930, she [Richmond] and her associates formulated and evaluated practice concepts and techniques constantly examining, modifying, and elaborating their ideas as new evidence appeared, always trying to respond to concerns and questions raised by the growing number of social workers. (Robinson & Kaplan, 2011, p. 388)

Although the nature of the information collected would probably not come up to the standards of hard data today, it must be understood that the foundations of social work practice developed, not from an experimental model, but from practical work. The COS trainees were responsible for insuring that all observations were accurate, contrasted with reality, and nonjudgmental, in the sense that helping the poor had been judgmental before. The social sciences of that time differed fundamentally from today's, inasmuch as the prevailing cultural paradigm then tended to be concerned with getting away from "religious mysticism." There emerged an "unbounded faith in the application of rational intelligence—and its keenest instrument, the 'scientific method'" (Germain, 1973). Speaking of Mary Richmond over three decades later, Germain states:

> We see in *Social Diagnosis*, for example, the demand for an exhaustive collection and weighing of facts from the premise that uncovering the cause will reveal the cure, a premise that reflected nineteenth-century science and scientism. (Germain, 1973, p. 10)

But, in spite of her emphasis on science, Richmond still emphasized the environmental forces that were the most prominent in the milieu. Her time was one of great social and economic upheaval (immigration, health conditions, disability). The solutions of the sciences of the day were heavily influenced by economics.

At the start of the 1920s, a change occurred. Social work turned to the "psy-" complex with the arrival of Freudian or psychodynamic theories. The scientific method as perceived in the 19th century had failed to deliver on the hopes of practitioners (Zimbalist, 1977), but social workers' fixation with science continued to pester the profession. In the 1920s, social workers turned to psychology and psychiatry as the new sciences of the period.

> Rhetorical Freudian psychology was a welcomed substitute for the sterile laboratory psychology that emphasized intelligence tests, diagnosis and classification. The richness and coherence of Freudian thought replaced rational and intellectual orientations with a need-basis of behavior founded on longitudinal derivations. (Goldstein, 1976, p. 31)

Leading social work schools in the United States turned to the "psy-" disciplines, especially the work of Freud, to develop intervention approaches for social casework. (The works of Otto Rank were also important in a tug-of-war of various psychological theories, but that would require a separate discussion.) Here, suffice it to say that the Freudian school was to have considerable influence on the developing social work profession and the schools of social work for the next three decades. Psychodynamic principles and personality theory (*id, ego*, and *superego*) became a dominant framework in social casework and in understanding practice.

Psychiatric specialties developed in the United States and United Kingdom, and social work followed suit. Other leaders like John Bowlby, a British psychologist working with children during the war, took on the topic of childhood emotional deprivation and separation anxiety. Unlike the Freudians, he based his explanations on the actual observation of children in the famous Tavistock Clinic in London and at the East London Child Guidance Clinic in Islington. By the 1950s, his theoretical work indicated the fundamental importance of maternal care in human development (Bowlby, 1951). Bowlby was received with great suspicion by the more Freudian-leaning community but with enthusiasm by others, among them the social workers of the day schools of social work, who often incorporated the seminal works of Bowlby in their clinical curricula (Bowlby, 1951, 1958). Child welfare and family practice were strengthened by Bowlby's contributions to the complexities of early attachments to the personality.

The influential Gordon Hamilton furthered the legitimacy and validity of the psychodynamic theory in social work (Hamilton, 1951). There were also parallel forces emphasizing relationships; work with groups was reinforced and bound to social work during this period.

In the decade of the 1950s, Perlman (1957) developed the problem-solving approach, which, as Turner and Rowe (2013) suggested, became for many practitioners the very essence of social work intervention. Generalist approaches, solution-based work, and others movements of the 1960s are also based on problem-solving principles.

The beauty of the psychosocial approach as it continued to develop is that it combined many theories with practice wisdom. In terms of psychological theories and psychiatric knowledge, the psychosocial approach did not isolate any contribution. It did not reject the environmental forces in understanding behavior. The approach was and has remained flexible. In the same way that inductive thinking captures and weaves in new ideas without discarding the useful "old," the psychosocial approach has the capacity to incorporate the contributions of new thinking and discoveries about the human condition with careful attention paid to what came before. In "Searching Again and Again," Martinez-Brawley (2001) notes the need "to address some of the exclusionary assumptions of recent paradigms in social work" (p. 271), paradigms that blatantly discard what came before. The psychosocial approach does not do that in general terms, thus offering opportunities "to legitimize the possibility of many alternatives for understanding the complex phenomena that surrounds the practice of social work in a very heterogeneous world" (p. 271). This means that it allows social workers in the 21st century to traverse various cultural contexts, racial realities, religious beliefs, and traditions. As Martinez-Brawley (2001) suggested when she quoted John Updike (1997), "one of the best ways to include those who are 'not like us'—whoever the 'us' may be, is to travel the roads of many 'parallel universes'" (Martinez-Brawley, p. 271).

Principles of the Psychosocial Approach

The Centrality of Person-in-Situation

The basic premise of the psychosocial approach is that of person-in-situation. In this sense, the method relies on a full awareness of the environment as well as on full knowledge

of the intrapsychic dimensions. This is what Robinson and Kaplan (2011) suggested when they said that "psychosocial understanding is ecosystemic" (p. 389). Hollis, in her original work *Casework: A Psychosocial Therapy* (1966), suggests:

> The term "situation" implies most often a human situation—family, friends, employer, teacher and so on—the situation is as complicated as the person who confronts it. When the person reacts to the external press, this reaction in turn becomes a press upon some other human being, who then responds with his own set of perceptions and needs. Hence understanding of the person in-his-situation requires varying degrees of understanding of the psychology of all the people involved in the Gestalt. For the situation is never just one person but rather a multiplicity of persons (to the sociologist a "role network") having varying degrees of importance in the life of the client (Hollis, 1966, p. 10).

In the reality of the late 20th century, when social workers finally understood that individuals are the result of many formative factors (race, culture, religious beliefs, place in the family order, etc.), the situation and the stressors took on different values in the Gestalt. First Nations, for example, have always seen the natural world as an extension of human beings. As Mawhiney and Nabigon (2011) stated in discussing the Cree medicine wheel:

> The natural world was not something separate from our emotional and mental life, and so could not be dominated or mastered. . . . Nature was part of us and we were a part of the natural world. Unlike Westerners, who see themselves as dominating other parts of nature, First Nations people viewed our relationship with Nature as an equal. (Mawhiney & Nabigon, 2011, p. 16)

The same can be said for the relationship many cultures have with the situational forces that surround them, whether they be nature, the spiritual world, the ancestors, monarchs, and so on.

Relationships Are Essential to the Method

Since Perlman (1957), the idea that social workers needed to focus as much on the relationship of the worker to the client as on the client's intrapsychic mechanism remained fairly well established. When Hollis came along, she further underlined the importance of relationships not only in diagnosis but also in treatment. Relationships serve as a mirror of our perceptions of self. They are the way in which we measure the effect we have in others and take the measure of our surrounding support system. When relationships break, we suffer not only environmentally but also psychologically, often requiring redefinition of self and correction via treatment.

> Inaccurate perception can extend toward the self as well as toward others. An important component in the way we regard ourselves is the way in which other people regard us. . . . This particular mechanism has a circular effect. When an individual feels himself an outcast for any reason, he begins to distort his perception of how other people react to him. Even when the behavior toward him does not fit his stereotype of rejection, he reacts as if it did and uses this belief to reinforce his picture of himself—a vicious circle indeed. (Hollis, 1966, p. 20)

A Broad Range of Techniques Is Used for Eliciting Information

There are many techniques that the psychosocial worker can use for clarifying the situation and understanding the milieu of the client. For example, a strictly Freudian social worker might frown upon the use of directive techniques, preferring the client to come up with his/her own narrative about the situation that affects him/her. A psychosocial worker can follow other helpful paths in eliciting explanations and descriptions from the client, even including directive techniques to help the client reflect and ponder. The way of conducting the social work interview is freer or less constricted by the fear of influencing the responses. The social worker is aware of the outcome—to resolve the problem of the client—and is able to make a judgment about the best techniques to apply. For example, a worker might say, " 'Please tell me a little more about the problem at work' or 'Just what is it that happens when you and your family get together?' When the feelings are ventilated, clients often experience immediate emotional relief" (Robinson & Kaplan, 2011, p. 395). Furthermore, when the client's narrative becomes more complex, the social worker can recognize and point out persistent patterns

of behavior that might be aggravating the situation. The traditional tension between eliciting or not eliciting hidden thoughts and feelings in the client is not the crux of what the method is. The social worker assumes that the client has hidden feelings or thoughts and that he or she might access them during the sessions with the social worker. So it becomes the work of the social worker to help unearth them. This is a stage of reflexivity for both the client and the worker.

> We have noted that clients can become aware of defenses of which they were not previously conscious and that they can recall childhood experiences which they seemed to have forgotten. Certainly, they often become aware of feelings and thoughts, especially ego-dystonic [ones . . .], which they not only had never before put into words but had never allowed themselves consciously to experience. (Hollis, 1966, p. 134)

The aim of all treatment is, in a way, the gaining of insight. For the psychosocial caseworker, insight is gained through reflection, but it is a guided reflection in which the worker plays a role that is more active than in the traditional psychodynamic interview. This is why it can be said that the psychosocial approach's distinguishing trademark has been flexibility and adaptation. It is not an esoteric approach or one that would be outside the reach of most well-trained caseworkers. All the tools are within the normal armamentarium of the clinician.

What the Psychosocial Approach Absorbed from Other Theories

From Behaviorism and Its Derivatives

Behaviorism took hold on psychological theory when B. F. Skinner disseminated his laboratory experiments on operant conditioning and extended them to explain how humans learn behavior (Skinner, 1938). Skinner's theories, which are seldom used today in their pure form, solidified two principles: that learned behavior that is reinforced repeats itself, while learned behavior that is not reinforced tends to disappear. His principles were first used in education (in the late 1950s and the 1960s), when a number of teaching methods emphasized "rewarding" positive behavior while withholding rewards from the negative ones. Teachers in schools—and to some extent social workers in corrections and mental institutions, resorted to the ever-present "tokens" to entice clients to practice positive behaviors that, in reality, often led to a sense of self-efficacy. But, as Polgar (2013) suggested, identifying what is rewarding or not rewarding to a particular client is always a clinical challenge. It can be said with some confidence that social workers were not heavily influenced by behaviorism, but the theories of reward and punishment the latter espoused were taken up by other social theory psychologists who brought them out of the laboratory environment, and they did influence social work (e.g., the theories of Bandura, 1986; Ellis, 1962; Beck, 1976). Furthermore, the social work "empiricists" (however loosely defined) utilized behavioristic principles because behavior and its manifestations can be measured in what were perceived as "scientific terms" (Fischer, 1973; Hudson, 1982; Van Wormer & Thyer, 2009).

The psychosocial method absorbed some behavioral techniques based on the principle that "functionality and dysfunctionality are environmentally induced [and] as such, behavioral techniques are optimally compatible with how social work views the human condition" (Polgar, 2013, p. 485). All behavior can be viewed environmentally and in historical and cultural terms, thus leading to a fuller view of the person-in-situation, which, as mentioned above, is a basic tenet in the psychosocial approach.

From Systems Theory

The psychosocial approach was never contrary to the principles that later became the crux of the systems approach. The unit of analysis for the psychosocial approach has always been the individual in a situation, and the "situation" is, in many ways, an element of the ecosystem. But let us look a bit more historically to systems theory as it was developed by the "clinical sociologists" of the 1960s (Berne, 1964; Bertalanffy, 1968; Buckley, 1967). According to Buckley, a system is "a complex of elements or components directly or indirectly related in a causal network" (1967, p. 41). Expanding on this, Goldstein (1976) comments,

The components may be relatively simple and stable or complex and changing. The relations between them may be mutual or unidirectional and may vary in degree of causal efficacy or priority. The particular configuration at any time constitutes the structure of the system at that time, thus achieving a "whole" with some degree of continuity and boundary. Concomitantly, some process of interchange is going on with other systems. (Goldstein, 1976, p. 110)

This general understanding of systems was applied to the way in which humans behaved and related to one another. The human system was very complex and amenable to change; as a step forward from the highly individualistic approaches, it was understood that various pieces were not isolated but related to one another in very fundamental ways. Opportunities opened up to apply modalities or techniques in the change process, following the dictum that "the whole is greater than the sum of its parts." The many therapeutic interventions that developed addressed the changes that could occur within human systems by merely adjusting one component. Therapists of all varieties emphasized different ways of moving the pieces of systems, from mild adjustments to chaos. Authors in social work discussed systems theory (Germain, 1973; Pincus & Minahan, 1973; Siporin, 1975; Bowen, 1978; and many others). Systems theory contributions were not particularly attuned to the thinking of minority cultures and women until Virginia Satir entered the family social work scene in the 1960s with her book *Conjoint Family Therapy* (1964) and Devore and Schlesinger produced *Ethnic Sensitive Social Work Practice* (1996) from a systems perspective. Salvador Minuchin (1974) and Harry Aponte, of the Philadelphia Child Guidance Clinic (circa 1994), fundamentally revolutionized the scene. Aponte's book *Bread and Spirit Therapy with the New Poor: Diversity of Race, Culture and Values* (1994) highlighted the practical ways in which ethnicity and culture had to be considered in systems before any intervention could take place. A review in the *Journal of Contemporary Psychology* stated: "This is not another how-to book, although it is practical and applied. Instead, it is a book that addresses the tough situations and quandaries facing therapists working with clients who differ from them in culture, ethnicity, lifestyle, or beliefs" (*Journal of Contemporary Psychology,* 1994).

While the application of systems to social work with families and couples went through a phase of near-fanaticism, it has now been transcended by a more realistic consideration of individuals and groups within larger systems. Social workers always understood that the basic principle of homeostasis or balance-maintenance required for the successful functioning of individuals was a time-tested affirmation that had to be respected. Nevertheless, the important principles of systems as a way of looking at the world were incorporated into other basic practices. The psychosocial approach was enriched with many of its insights.

Regardless of the particular methodology or combination of approaches employed, social workers possess an in-depth understanding of the relationship of the individual to various environments and the synergistic relationship that each entity has to the other. . . . Social workers are taught to recognize that all parts of any system are interrelated, interconnected, and interdependent and therefore it is imperative to take into account the influence of various systems and subsystems on client functioning. (Andreae, 2011, p. 243)

From the Strengths Perspective

The strength perspective is a derivative and humanistic development of the concept of self-efficacy. The strengths perspective capitalizes on very empowering notions that social work had in its more philosophical epoch and was further undertaken during the 1960s, as a result, in part, of minority movements in the United States and Canada. However, the strengths perspective was popularized as a new way of practicing social work by Saleebey (1997), who emphasized that practicing from a strengths perspective meant refocusing all that social workers do to help clients "shed the irons of their own inhibitions and misgivings" (p. 3). But the strengths perspective can also be viewed as a corollary of the humanism that had always been "bred in the bone" of social work. Saleebey himself suggests in the opening of his seminal book, that "the idea of building on clients' strength has achieved the status of adage in the lore of professional social work" (p. 3).

The strengths perspective was a reaction to the medical model that the strengths practitioners viewed as applying negative rather than positive thinking to people. This model had over-emphasized deficit and popularized labels that allowed social workers to hide behind detrimental views of clients. Saleebey, like Szasz (1978), felt that labels such as "chronically problematic" or "schizophrenic" behavior served no purpose other than to debase clients. Most psychosocial practitioners would have probably stayed away from such labels, but the realities of agencies' diagnostic requirements might have led them down that path. Goldstein (1997) captured this situation as follows:

> I suggest that political and proprietary reasons coupled with the noble status of a medical science have some say in sustaining the stature of the psycho-pathological or medical model; it is not uncommon for social work educators to insist on courses in psychopathology "because social workers need to understand how this orientation applies in psychiatry." And so, when students who are eager to gather in the contrivances of respectable professionalism are exposed to the doctrines of the pathological model as they are inscribed in the *Diagnostic and Statistical Manual*, can they argue against or have any reason to resist the finely wrought and morbid taxonomies of human defects and flaws? (p. 25)

The strengths perspective caught fire as a theory in the 1980s, particularly in the schools of social work of the Midwest and Western U.S. The strengths perspective as defined by Saleebey (1997) was based on two constructs, that of strength of the human being and that of the resilience of persons. While the two constructs are often used synonymously, they are closely related but not exactly the same. However, for this discussion, suffice it to say that the principle of resilience as defined by Vaillant (1993) is "the self-righting [capacity], both to be bent without breaking and the capacity, once bent, to spring back" (p. 248). The strengths and resilience perspective uses this principle in relation to human beings, thus creating a very empowering and positive ambiance where pathology is seldom present. Most social work problems, for strengths social workers, are within the domain of the person to solve. The social worker needs only to guide, help reflect, and occasionally point to resources. The client has the innate ability to do the rest. This perspective is very congenial to the psychosocial approach, although the latter might see more limitations or be less optimistic about the capacity of individuals who have already come to the social worker after attempting to do many things for themselves.

From the Narrative Approach

The narrative approach is a very complex derivative of many philosophies and theories of intervention. The antecedents of this approach can be found in literature, where the text of stories was analyzed in the discovery of further meanings. Antecedents can also be found in philosophy, where the existentialists searched for meaning, or the constructionists, particularly of a social-psychological bent, who viewed reality as a co-construction of meanings between the person and her or his experiences. All these elements came together with the postmodernists who doubted the validity of "single truths" and validated through Foucault's (1980) work the interpretation and construction of "personal realities."

Moreno's (1937) psychodrama had endorsed the story as a form of psychotherapeutic intervention. White and Epston (1990), from Australia and New Zealand, had brought the principles of the narrative into social work and psychology as a way of family intervention. The basic premise of the approach is that people construct a dominant line in the story of their lives and that they fit subsequent actions into that story, often overlooking other lines that might be healthier and equally important. As White and Epston would say, people often "subjugate" other lines to the dominant one, forgetting alternative explanations. The same principles applied to families were applied to individuals.

A goal of narrative therapy is to encourage individuals to see more realities, more alternative explanations. As Neimeyer (1993) has suggested, therapy is not so much aimed at correcting behavior as at instructing the individual on alternatives.

> The role of the social worker is collegial. As narrative therapy helps clients re-author their lives through seeing other truths and other possible interpretation of events, the role of the therapist is to listen, wonder and ask reflective questions. Clients are invited

to assess other realities that are not necessarily more true [sic] but are also true. (Kelley, 2011, p. 317)

The psychosocial approach has flexibly accommodated narratives that have always been essential to social work interventions. The postmodernists added dimensions to how narratives can be interpreted, reinterpreted, and "deconstructed" for meaning. If a particular line of a life story is harmful to the client, the therapist can encourage "editing." The clinician becomes co-editor, if not co-author, of a new story, a role that is not antithetical to the psychosocial approach.

Conclusions

Of the various approaches social workers have used through the decades, it is the psychosocial the one that was probably the least "faddist." More unusual or extreme forms of intervention have come and gone, leaving little trace on the social work horizon (e.g., some radical approaches, a few encounter themes of fairly risky principles, approaches based on primal scream therapy, etc.). The psychosocial approach has remained grounded on common sense, not denying that there is a reality to which most people adhere, but also accepting, as most constructivists do, that such a reality is molded and modified by individuals in search for answers. Carpenter (2011) offered an interesting description of the kind of common sense that would be germane to the psychosocial method:

Commonsense would have us believe with Gertrude Stein, for instance, that "a rose is a rose is a rose" because all competent observers agree that a certain kind of flower *is* a rose and not an elephant. . . . Each individual will experience "a rose" in some different way and derive a somewhat different meaning from the experience than all other individuals, but each will still call it a rose. (Carpenter 2011, p. 120)

A reality of sorts exists, but it is fluid and subject to interpretation. Even in the sciences, reality has become malleable and scientific "truths" have become more questionable. Very recently, the critical psychiatrists have discussed the scientific validity of placing the burden of mental illness on purely biological forces such as chemical imbalances or brain functioning. *The Diagnostic and Statistical Manual of Mental Disorders III* (DSM-III), DSM-IV, and the most current, DSM-5, have attempted to further analyze the etiology of mental illness and produced a very complex classification with little consensus forthcoming from the psychiatric community. The avalanche observed in the use of prescription psychiatric drugs to address dysfunction and the epidemic of depressive conditions has worried critical psychiatry, and many articles have been produced on the subject. Joanne Moncrieff, an eminent figure in the movement, has been praised for her book *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* (2009), which questions the science and merits of the whole psychiatric drugs enterprise, viewing it as influenced by vested commercial, medical, and political interests. Moncrieff's book has been suggested as essential reading for counselors and psychotherapists and has been highlighted as questioning the notion of biological mental illness, something that Thomas Szasz had done decades back in *The Myth of Mental Illness* (1961). The commonsensical approach of the psychosocial perspective continues to be validated through the decades, if not on statistical, definitely on clinical evidence.

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27

Relational Social Work: A Contemporary Psychosocial Perspective on Practice

Carol Tosone and Caroline Rosenthal Gelman

If one word is needed to begin to sum up what fifty years of living has taught me, that word is relatedness.

(Bertha Capen Reynolds, 1963)

The relationship between the social worker and client has been consistently central to, if not the hallmark of, social work practice, from its earliest inception to the contemporary variants described in this volume. Whether it was "friendly visitors" providing "scientific charity" or settlement workers advocating community activism (Hollis, 1964), these pioneer social workers cultivated relationships with clients in order to attain identified goals. Several authors (*inter alia*, Horowitz, 1998; Shephard, 2001) have noted similarities between the relational aspects of psychoanalysis and early casework theory as articulated by Mary Richmond (1917, 1922), Charlotte Towle (1945), Bertha Capen Reynolds (1934), and others. Relatedly, others (e.g., Borden, 2000; Ornstein & Ganzer, 2005; Goldstein, Miehls, & Ringel, 2009) have applied relational psychoanalytic principles to social work supervision (Ganzer & Ornstein, 1999, 2004) and treatment, including substance abusers (Ganzer & Ornstein, 2008) and cross-cultural therapeutic dyads (Tosone, 2005).

By contrast and extension, this chapter will examine an aspect of clinical social work that we term *relational social work*, an approach born of the vision of these social work pioneers and one that continues to evolve to meet the demands of present-day context-bound practice. From its inception, social work developed its own unique understanding of what constitutes "relational." We will define *relational social work,* tracing its historical roots and describing it as a contemporary psychosocial approach that takes into

account the intersubjective and interpersonal aspects of the client and clinician in a specific interactional context of practice. We will also describe the core aspects of relational social work, demonstrating its similarities to and differences from relational psychoanalytic concepts through the use of a case illustration.

Defining Relational Social Work

Relational social work is not a social work appropriation of the psychoanalytic term "relational," since the focus of attention needs to be internalized and actualized object relations, and the early contributions of Mary Richmond and other social workers pre-date the inception of the object relations tradition, from which relational psychoanalysis derives (Mitchell, personal communication, cited in Sheppard, 2001). "Relational" in a social work context is broadened beyond the intrapsychic and interpersonal realms, and extends to the intra- and inter-systemic dimensions in operation in both the clinician's and client's lives. That is, relational social work involves the individual's internalization of, and interface with, the macro-systems of the larger society, including the cultural, economic, political, and other institutions and structures. Succinctly defined, "relational social work is the practice of using the therapeutic relationship as the principal vehicle to effect change in the client's systemic functioning, referring to the inherent interconnection of the intrapsychic, interpersonal, and larger community systems" (Tosone, 2004, p. 481).

Although the point of intervention is with the individual, and not with the larger systems the person interacts with, the relational social work approach emphasizes the meanings that the client assigns to these interactions based on personal, familial, cultural, religious, and other factors. It rests on the premise that a person's internalized and interpersonal object relations mutually influence each other, but also act on and are affected by macro-environmental structures. Importantly, these macro-structures need to be considered in a dynamic context, taking into account the conscious and unconscious meanings that the client ascribes to these institutions and their representatives.

As the term suggests, relational social work views the client and clinician as individuals in interaction with each other, and as a dyadic unit of attention. The conventional social work emphasis on the "person-in-situation" (Hamilton, 1940) is replaced with the "client and clinician–in-situation" (Tosone, 2004, p. 483) as a focus of attention. As individuals in interaction with each other in a particular context of practice, the client and clinician are influenced by complex internal and external forces, including their reactions to each other based on perceptions, biases, familial history, and other experiences. Together, they form a unique dyad contextualized by these forces as well as the setting of practice and identified goals of intervention.

Relational Social Work: A History

Relational concepts that now resonate so strongly with clinicians across fields such as psychology and psychiatry and that have found increasing empirical support from neurobiological research can be found at the very origins of the social work profession, constitute a consistent presence throughout its history, and pre-date relational psychoanalytic and psychodynamic conceptualizations, as we delineate in the following brief history.

Bertha Pappenheim: "Anna O."

One can trace the relational roots spreading through social work theory and practice across its 100–plus year history even to its "prehistory" as a profession. Bertha Pappenheim, the famous "Anna O.," was a young woman treated by Breuer and discussed by him with his colleague Sigmund Freud (1895/1953–1974). Anna O. was instrumental in developing the technique of "the talking cure": as she recounted for and with Breuer memories of the difficulties she experienced caring for her ill father under the restrictive conditions for women in 1880s Viennese society, the array of symptoms she had developed—neuralgia, depression, hallucinations—lifted. This mutual construction of her narrative is a key aspect of relational work.

While Anna O.'s treatment with Breuer ended abruptly and she was not completely well

for several years afterward, by the late 1880s, Bertha Pappenheim emerged as a forceful social welfare activist, with a particular concern for oppressed and marginalized women (Swenson, 1994). Because of her role as a social work pioneer and her co-creation of the talking cure, Tosone (this chapter's co-author) has suggested that Pappenheim be considered "the first relational social worker" (2004, p. 480). In particular, Tosone notes that, given Pappenheim's seminal role in the development of a key feature of psychoanalysis, the "talking cure," that relational social work began at psychoanalysis's very inception. While the talking cure emphasized inner psychic life at the expense of the prevalent sociocultural and political environments, Pappenheim supplemented her treatment with Breuer by attending to sick and poor people, which "helped her greatly" (Breuer, p. 31, cited in Swenson, 1994). In this way, she developed a broader conceptual basis for what constitutes the therapeutic process; attention to the curative potential of the environment played a significant role in her recovery. Consistent with a relational understanding of treatment, not only was there a mutual construction of her narrative, but both she and Breuer were transformed in the process. Her narrative is ultimately one of self-discovery and self-healing through the process of helping others.

Mary Ellen Richmond

Key aspects of relational social work as defined in this chapter are clearly evident in the thinking and writing of Mary Ellen Richmond, often credited with developing social work as a profession in the United States (Agnew, 2004). Richmond systematically developed theoretical and practical aspects of casework and diagnosis in a series of seminal works, including *Friendly Visiting Among the Poor: A Handbook for Charity Workers* (1899), *Social Diagnosis* (1917), and *What Is Social Casework? An Introductory Description* (1922).

An understanding of the relationship between the client and worker as critical to effecting change is central across all of Richmond's work, and her conceptualization of its importance only deepened as her thinking developed. For example, in *Friendly Visiting Among the Poor*, Richmond writes: "Friendly visiting means intimate and continuous knowledge of and sympathy with a poor family's joys, sorrows, opinions, feelings, and entire outlook upon life" (1899, p. 180). Thus, even at this early stage of her thinking about what casework is and how it works, Richmond stressed the development of a relationship between worker and client, and one that seeks to understand the client's experience.

In an effort to professionalize the work of friendly visitors Richmond moved towards a "scientific" approach to casework, which focused on the person-in-situation and systematized the gathering of data to arrive at a "social diagnosis" (Freedberg, 2015, p. 3). Relationships are inherent in Richmond's very definition of social diagnosis, and encompass both micro- and macro-levels, still a key paradigm of social work:

> . . . the attempt to make as exact a definition as possible of the situation and personality of a human being in some social need—of his situation and personality, that is, in relation to the other human beings upon whom he in any ways depends or who depended upon him, and in relation to the social institutions of his community. (Richmond, 1917, p. 357)

Richmond returns to this essential role of relationships in her later works:

> The field of social casework is the development of personality through the conscious and comprehensive adjustment of social relationships, and within that field the worker is no more occupied with abnormalities in the individual than in the environment, is no more able to neglect the one than the other. The distinctive approach of the caseworker, in fact, is back to the individual by way of his social environment. . . . When we put "social" in front of the word environment, the environment ceases to be environment in space merely—it widens to the horizon of man's thought, to the boundaries of his capacity for maintaining relationships, and it narrows to the exclusion of all things which have no real influence upon his emotional, mental, and spiritual life . . . the art of social casework is the art of discovering and assuring to the individual the best possible social relatedness. (1922, pp. 98–99)

Richmond's deepening understanding of the relationship's role in social casework was articulated in a speech entitled "The Social Case Worker's Tasks" given at the National

Conference of Social Work in 1917. In this speech, Richmond highlighted the skills that exemplify a social caseworker:

> Distinguishing marks of [social caseworkers] were, first, skill in discovering the social relationships by which a given personality had been shaped; second, ability to get at the center core of difficulty in these relationships; and third, power to utilize the direct action of mind upon mind in their adjustment. (1971, p. 399)

Thus, in Richmond's view, the crucial component of direct treatment was the development of a strong relationship between worker and client based on trust so that the worker could use her influence, with the client's participation, to effect change (Woods & Hollis, 2000).

In her subsequent writing, Richmond further elaborated on the importance of the relationship between worker and client to facilitate change at both the individual and environmental levels:

> Success in social casework demands a high degree of sensitiveness to the unique quality of each human being. An instinctive reverence for personality, more especially for the personality least like his own, must be part of the caseworker's own endowment. . . . It is the caseworker's privilege to discover and release the unduplicated excellence in each individual—to care profoundly for the infinitely varied pattern of humanity and to strive, with an artist' striving, to develop the depth and richness of its color tones. (Richmond, 1922, p. 158)

In this way, Richmond encouraged the development of a respectful, engaged connection between worker and client, while anticipating key aspects of relational practice. Such key concepts include self-awareness (particularly when working with clients whose experiences most differ from yours), mutuality, and the reciprocal impact of the relationship on both participants: "Success demanded growth in personality of the caseworker herself; the service is reciprocal" (Richmond, 1922, p. 260).

Social Work's Diagnostic School

In the 1920s and 1930s, Freud's theories of personality and treatment made inroads at schools of social work. Among core concepts that permeated social work from Freud's thinking were the complexity of the mind and the existence of aspects that were unavailable to our conscious self, the importance of early experiences in shaping our understanding of ourselves and others, the idea that symptoms have meaning, and that, in the context of a therapeutic relationship, insight and self-knowledge can be curative. While the diagnostic school was criticized for neglecting the social aspects of people's complex problems, social workers such as Gordon Hamilton and Bertha Capen Reynolds, luminaries associated with the diagnostic school (Dorfman, 1996), retained and promoted Richmond's understanding of two major modes of treatment—direct work with the client and indirect work in the broader environment—and maintained the focus on the client–worker relationship as the vehicle for change (Woods & Robinson, 1996).

For example, Gordon Hamilton's *Theory and Practice of Social Case Work* (1940), used as the primary textbook in schools of social work for decades, emphasized the importance of the relationship in promoting change, but rather than the worker influencing the client to act in what the worker considered to be in the client's best interests, there was a new focus on client self-determination, which has remained a core value of the profession. Furthermore, as Gordon Hamilton added, "it is not only clients who must be active in solving their own problems if they are to grow; social workers must develop a democratic method which releases activity in themselves and their fellows" (p. 33). Such an understanding of casework speaks to the mutuality and reciprocity of the client–worker relationship that is central in relational social work.

The relationship as the catalyst for change was a core and consistent part of Bertha Capen Reynolds's thinking throughout her long career, from her training in psychoanalytic theory as a psychiatric social worker at Smith College, through her social activism and Marxist ideology which sought to combine care for the individual with structural approaches for lasting change (Reynolds, 1963). In this way, her work encapsulated relational social work as using the therapeutic relationship to effect change in the client's systemic functioning, inclusive of intrapsychic, interpersonal, and larger community systems. In one of her most important works,

Learning and Teaching in the Practice of Social Work, Reynolds (1965) writes:

> Helping implies a helper and a helped. If we constantly see ourselves as on the giving end of the relationship between helper and helped, we provide a safe harbor in ourselves for all the unconscious desires to be superior, desires to which science teaches us that we are subject no less than other people. . . . We need to take exercises in being helped, as well as in helping. We must learn in order to give. Indeed, we must receive from those to whom we give, in order to give to them—receive of their understanding, their energies for action, their feelings in the situation which guide our way in it. . . . A scientifically oriented profession demands also professional workers who are committed to an unrelenting search for truth, even when it concerns their own behavior, and to an unwavering desire to see people able to give as well as to receive, to help as well as to be helped. The details of how to practice such a profession remain to be worked out by many thousands of workers over many years, but the line of direction is clear enough to follow. (1965, pp. 29–30)

Social Work's Contemporary Psychosocial Approaches

In fact, the "details as to how to practice" with such a keen focus on the relationship as curative, and the imperative of self-awareness, mutuality, and reciprocity in this relationship have continued to mark the direction of social work thinking since, particularly in what has come to be known as the psychosocial approach, the successor of the diagnostic school.

The term *psychosocial* was coined in 1930 by a sociologist teaching at the Smith College School for Social Work, and had been used by Hamilton to emphasize that all problems have both emotional and social components and as such must be addressed from these multiple levels (Woods & Robinson, 1996). Florence Hollis, who studied casework under Bertha Capen Reynolds, wrote the definitive psychosocial textbook (with subsequent editions coauthored with Mary Woods), underscoring the inextricable interconnection between individuals and their environment, and the centrality of the client–worker relationship to effect change:

> . . . relational social work exemplifies a contemporary psychosocial approach to social work practice. Furthermore, the core principle that "when people are engaged in empathic human relationships—with their loved ones and with social workers—untapped wellsprings of strength, creativity, and resilience are often released" (Woods & Robinson, 1996, p. 563) are finding empirical support through leading-edge neurobiological research. Two decades of work has shown that physical, psychological, and emotional connection to others, particularly primary objects, facilitates the maturation of brain systems involved in processing of emotion, modulation of stress, and self-regulation (Schore & Schore, 2008). Thus, an empathic, attuned relationship literally serves to regulate the client's arousal through changes in their brain structure and function. This understanding of what happens at a biological level both explains and justifies the relational social work approach that has permeated our field for most of its history (Schore & Schore, 2008, pp. 9–20)

Distinguishing Features of Relational Social Work: A Comparison to Relational Psychoanalysis

Relational social work shares important characteristics with relational psychoanalysis, notably the use of the treatment relationship as the catalyst for client change. Mitchell (1988), founder of the relational school of psychoanalysis, notes that its basic tenets grew out of the British object relations and American interpersonal traditions, both of which emphasized the intersubjective nature of practice and the therapeutic relationship as the primary medium of therapeutic action. As a school of thought, relational psychoanalysis has continued to evolve and is steeped in additional theoretical perspectives of the postmodern persuasion, including feminist theories, philosophical epistemology, and the narrative construction of subjective truth. As noted by Tosone (2004) and Ornstein and Ganzer (2005), relational psychoanalysis and relational social work share several key features:

Two-person psychology—The clinician is an active participant in the treatment process and contributes to the creation of the client's narrative, such that the unfolding of the client's narrative is an iterative coconstruction. The focus is not on the one-person model of the clinician offering insight

and interpretation of the client's psychopathology, but rather on the mutative potential for both the client and clinician as a result of their therapeutic interaction.

Mutuality—Embedded in the two-person perspective is the reciprocity and mutual influence that occurs between the client and clinician; it is not only the client that is changed by the therapeutic process, but the clinician also engages in self-reflection to better understand him-/herself, as well as the client. The personal attributes of the clinician enter into the treatment relationship, both shaping and refining the process, and being influenced as a result of the interaction. There is ongoing mutuality in that both the client and clinician shape each other's affect, thoughts and actions based on the interaction of their unique configurations of their respective subjectivities and interpersonal experiences.

Subjective nature of truth—Truth is viewed from a postmodern perspective and is subjective in nature. Truth is contextualized by the historical, ethnic, gender, religious, sociopolitical and other matrices that shape one's intrapsychic make-up, belief system and interactions with others, including the clinician. Objective or historical truth is a modern, abstract construct not possible because the perceiver of the truth has a unique perspective on the other. From a relational postmodern perspective, truth is decentralized and subjective, and the client's truth is perceived and filtered by the clinician through his or her own subjective perspective.

Enactment—While the clinician strives to provide a corrective emotional experience for the client through the therapeutic relationship, the clinician and client may invariably find themselves engaged in an enactment of their old ways of being. Each may unconsciously provoke the other to respond in a particular way. That is, through the transference, the client may perceive the clinician to be like a person from his or her past and the client's behavior may elicit a specific reaction from the clinician. The clinician, in turn, responds through his or her own subjective lens and past experiences, and may also evoke a particular response from the client. The enactment itself provides therapeutic value; the discussion and working through the experience potentially leads to mutual growth and reparation.

Countertransference as a therapeutic tool—The enactment described above may lead to the clinician's self-disclosure of countertransference reactions. From a relational perspective, countertransference is a core therapeutic tool in the clinician's armamentarium to better understand the client, not a hindrance to be overcome as seen from a one-person psychology. Countertransference, like transference, is inevitable and reflects both the clinician's subjective experience of the client based on his or her past experience and an externally based response to the client's actions and provocations. Selective disclosure of countertransference reactions may be used to facilitate the treatment. (Tosone, 2013, pp. 252–253)

Relational Social Work in Practice: A Case Illustration

Although relational social work and its kindred approach, relational psychoanalysis, have much in common, core to the social work approach is attention to the individual's internalization of and interface with the macro-systems of the larger society. These macro-systems are dynamic and laden with conscious and unconscious meanings for the client and clinician as individuals and as a dyad. For example, it is not uncommon for clinicians to refer clients for needed services, only to learn that the clients did not avail themselves of those services. Their previous experiences, as well as those of significant others, and members of their community influence the extent to which they are receptive to services and the representatives who offer them.

Case Example

Consider the example of a single, 35-year-old Latina mother, Milagros, who reports having anger management issues with her adolescent daughter. Milagros is employed full-time for a cleaning service; she often works into the night, and her 14-year-old daughter,

Alicia, is home alone without supervision on those evenings. Although Milagros has been in recovery for one year, she briefly lost custody of her daughter due to her drug and alcohol abuse. Her daughter was placed in kinship foster care at the time. Currently, Milagros has limited family support because of the shame she brought to the family through her substance abuse. Milagros was referred to a community mental health clinic by her Child Protective Services (CPS) worker and has been seeing a clinical social worker for one month. Milagros is reluctant to accept the clinician's referral to an anger management group because she is fearful of being judged and possibly having her daughter placed in foster care again if it were revealed that she has hit her daughter on occasion. The 30-year-old married white clinician, Marsha, is from an upper-middle-class background and has no children. Marsha finds herself judgmental about Milagros's situation and has difficulty relating to her since she is not a Latina mother, nor has she struggled financially or with an addiction.

In this example, the relational social worker's interventions need to take into account the meaning of seeking and receiving services in the context of the: (1) client's specific culture and subculture; (2) perception of the clinician based on the client's history and experiences with previous clinicians; (2) nature of the client's membership in community organizations and peer groups; (3) family dynamics; and (4) intrapsychic functioning. Marsha needs to consider how she is being perceived by Milagros, who has had negative experiences with CPS and who feels ashamed that she has alienated her otherwise close-knit family. Milagros feels overwhelmed by the experience of being a single parent and senses that Marsha, based on her style of dress and the questions she asks, cannot possibly understand what it is like to be a single Latina mom without family support. She feels judged by Marsha and hesitates to reveal that she has hit Alicia on occasion because she doesn't want her to follow the same self-destructive path; Milagros fears that Marsha may report her to CPS if that information is revealed in the group. Marsha senses that Milagros feels that rich white women are not to be trusted, and is frustrated that Milagros is refusing the service when she feels that group work will complement their work.

In this example, the relational social worker needs to engage in candid self-examination while also being open to discussing the client's perceptions of her, how these perceptions may affect the therapeutic process, and the client's fears about attending the group. In contrast to relational psychoanalysis where the focus of attention would probably be on the meaning of the client's anger and the intersubjective matrix co-created by the dyad, in relational social work, the clinician is bound by his or her context of practice and the asymmetrical nature of that practice. That is, as Hoffman (1999) observes, there are hierarchical elements in the therapeutic relationship by virtue of the therapist's social sanctioning, theoretical knowledge, and clinical training. But in relational social work, the power difference is concrete. In this case, Marsha has periodic contact with Milagros's CPS worker, and any report of violence or neglect puts Milagros in jeopardy of losing her daughter.

Conclusion

There is significant interest in and use of relational approaches in contemporary practice in many helping professions, in part because of the support for this approach has been derived from current neurobiological research that finds that attuned relationships can have an impact on brain function and development, resulting in improved capacity for self-regulation and modulation of stress. However, much of the social work literature discussing relational approaches has tended to borrow from relational psychoanalysis and made much of its affinity to core values of the social work profession.

In this chapter, we have drawn attention to social work's own relational approach, one that pre-dates relational psychoanalytic ideas and has been present in social work thinking and practice from its inception. Given its centrality in the profession's theoretical development, in addition to focusing on the importance of the relationship as the vehicle for change, a relational social work approach has also expanded social work's core person-in-environment understanding of a client's experience to include the clinician's experience in relation to the client and the environmental context in which the practice occurs. While from a relational social work approach the point of intervention is with the individual and not the larger systems, the emphasis is on the meanings that the client assigns to these interactions and institutions. The relational social work clinician serves as a systems expert in understanding the interactional nature of the intrapsychic, interpersonal, and macro-systems of the community

and larger society, bringing this understanding to bear to the helping relationship. Such a comprehensive approach is particularly relevant in our contemporary, complex world.

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28

Relational Theory and Social Work Treatment

Dennis Miehls

Relational Theory

This theory emphasizes the restorative elements of the therapeutic relationship as a major contributor to change by stressing relatedness, which views the self as being shaped in interaction, more fluid than finished.

In this chapter, relational theory is considered a framework of ideas that have grown out of a number of clinical and psychodynamic theories of the past 50 years. Psychoanalytic thinkers who moved away from a classical Freudian theory began to offer alternative ways of understanding the relationship between clinicians and their clients. There are two distinct phases in the development of relational theory. This progression moved from what were termed theories that are one-person psychologies to two-person psychologies (Goldstein, Miehls, & Ringel, 2009). Broadly speaking, relational theory has evolved into a way of understanding client–worker interactions that emphasizes the mutuality of the interaction. Relational theorists recognize that clients and social workers co-create the clinical relationship in such a way that it empowers clients to maximize their strengths and potential. Clinicians who utilize relational principles in their professional relationships emphasize the restorative elements of the therapeutic relationship as a major contributor to change processes. Furthermore, relational theory "focuses on studying relatedness in context and makes this integral to a theory of practice. It views the self as more fluid than fixed, and as shaped in interaction relative to social or interpersonal settings and backgrounds" (Hadley, 2008, pp. 205–206). Relational theory is particularly suited to working with oppressed populations, as the social identities of clients are honored and understood to be a major contributor to one's identity. Feminist scholars who wrote about the social construction of gender (Benjamin, 1988, 1998; Dimen, 2003) and authors who theorize about race and class (Altman, 1995, 2000; Leary, 1997) have made major contributions to relational theory.

Recognizing the influence of culture on one's development furthers the fundamental social work construct of working with "person-in-environment." Social workers have a long history of applying relational theory principles in their work with clients. The social work profession, with its historical emphasis on the benefits of the therapeutic relationship (Richmond, 1917, 1922; Hamilton, 1940), foreshadowed the relational theory movement in the psychotherapy literature (Sheppard, 2001). Ironically, other mental health disciplines have not traditionally credited social workers for their contributions. Horowitz (1998) commented, "Like Moliere's Bourgeois Gentlemen who didn't realize that he'd been speaking prose for more than forty years without knowing it, perhaps social workers should consider that we've been relational, postmodern, and cutting-edge for eighty years without knowing it" (p. 378).

Historical Origins of the Theory

As noted, there are two distinct periods of relational theory development. Though moving away from some of Freud's classical "drive-structural model" of understanding human behavior, the formulations of early relational theorists

> still referred to what has been termed a "one-person" psychology that views development as an "individual" activity that is aided by the presence of a caregiving other. A second group of more contemporary theorists have put forth concepts that are broadly referred to as "two-person" psychologies that emphasize mutuality and interaction. (Goldstein, Miehls, & Ringel, 2009, p. 18)

As noted, there were numerous contributors to the shift in psychoanalytic thinking who began to emphasize the idea that relationships with other people shape the structure of the mind (internal world) of individuals and that these important attachment relationships shape the personality of individuals. Again, this is in contrast to the Freudian understanding of what shapes the nature of the mind and personality structure.

Contributors to the one-person psychology of relational thinking originated from both the United States and England. Much of the earlier thinking about relational theory was formulated by authors who have been grouped together as a result of the similarities of their theories. These are:

- British object relations (Bowlby, 1958, 1988; Klein, 1932, 1952; Fairbairn, 1940, 1952; Winnicott, 1965, 1975)
- The American interpersonal school (Harry Stack Sullivan, 1953, 1954)
- American object relations (Jacobson, 1964; Kernberg, 1975, 1976, 1980; Mahler, Pine, & Bergman, 1975)
- Self psychology (Kohut, 1971, 1977, 1984)
- Self-in-relation theory (Jordan, 1995, 1997; Miller, 1973)

Common tenets of this range of theorists include the fundamental notion that humans are relational by intent and that attachment to caregivers is necessary for species survival. In other words, one's libidinal energy is object-seeking, not pleasure-seeking (as suggested by Freud). An important concept of all of these theories is that infants/children develop an internal world of object relations that has been shaped by the interpersonal interactions with significant others, such as parents or grandparents. The internal world of object relations shapes the individual's interpersonal interactions with others. Many of these interactions are unconscious, and thus individuals who have unsatisfying or troubled relationships as adults are often not aware of their interpersonal style. Often, one-person relational therapy would assist clients to become aware of their relationship patterns and to also use the clinical/therapy relationship as a holding environment that helped reshape the client's earlier object-relations impairments.

The more contemporary two-person intersubjective and relational theorists emphasize the mutual and interactional process that occurs between infants and significant objects. These theorists support and elaborate on the findings of infant researchers and developmental psychologists who have been studying the attachment and interactive styles of infants and their parents (Beebe & Lachmann, 1988; Stern, 1985). Following this research, relational theorists understand that the clinical relationship is shaped by the mutual interaction of client and clinician. Both shape the interaction

in a recursive and reciprocal manner. In two-person relational theory, the clinician interacts with clients with authenticity and transparency. As such, relational theorists are mindful of their subjective reactions to clients and use these reactions, when appropriate, with self-disclosure of feelings and genuine responses to clients.

Goldstein, Miehls, and Ringel (2009) note that three different streams of thought contributed to the development of two-person psychology:

- New York University postdoctoral program in psychoanalysis (Mitchell, 1998, 2000; Mitchell & Aron, 1999; Mitchell & Black, 1995)
- Intersubjective theorists (Atwood & Stolorow, 1984; Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1994)
- Infant researchers (Beebe & Lachmann, 1988; Stern, 1985)

Relevance for the Social Work Profession

Contemporary relational theory is particularly relevant to the social work profession, considering its mandate to work with and provide services to oppressed populations. As noted, social work is relational at its core, and the added dimensions of empowerment, mutuality, and authenticity of the clinical relationship underscore and emphasize the National Association of Social Workers Code of Ethics (2008). For example, three values and their corollary principles are directly relevant to relational social work: the principles of respecting the inherent dignity and worth of the person, the importance of human relationships, and social workers behaving in a trustworthy manner, with integrity (NASW Code of Ethics, 2008, p. 5–6). Beyond these clear links to the Code of Ethics, Goldstein, Miehls, and Ringel (2009) note that "The relational model's emphasis on the client's and clinician's subjectivities and the co-construction of new relational patterns based on a mutually created therapeutic space add new dimensions to clinical social work practice with vulnerable and oppressed populations" (p. 148).

The compatibility of feminist thought to relational theory further complements the underlying tenets of the social work profession. Relational theory continuously contextualizes one's identity, and thus the interface of clinical work with social advocacy work is another important link for social work practitioners. In other words, relational theory offers an opportunity to critique social practices that marginalize vulnerable populations and to assist clients to reconsider their own internalized oppression, if it is present. For example, many gay or lesbian clients have internalized a negative sense of themselves based upon the social construction of queer identity in society. A relational theorist assists the client to update his or her own sense of self by critiquing the social construction of the dominant culture's view of homosexuality. Other social identity factors are deconstructed in similar ways by the social work relational practitioner. Furthermore, relational social workers encourage discussion between themselves and their clients in terms of their differences in social identity. Again, the recognition that the client and clinician are equal participants in the clinical process, with equal authority and agency, is often a very liberating and empowering experience for the generally marginalized client. Goldstein, Miehls, and Ringel (2009) suggest that relational theories initiate new questions in the process: "These questions concern the therapist's, as well as the client's subjectivities, their mutual perceptions of one another, and the ways in which both influence each other through the racial, social, economic, and cultural contexts they are embedded in" (p. 149).

The Conceptual Frame of Relational Theory

Basic tenets of the conceptual frame of relational theory have been introduced in the previous sections of the chapter. One of the most important concepts in relational theory underscores that the subjectivities of both client and social worker shape the helping relationship in a complex and dynamic manner. The social worker certainly has a level of experience, expertise, and a knowledge base. However, the social worker does not necessarily act as an

"expert" in the interaction; the clinician is not a neutral observer in the process of the client. Relational theory suggests that both "construct this dynamic together, influenced by what each brings to the dyad, including the influences of their experiences in the contexts in which each has lived" (Hadley, 2008, p. 211). So, the traditional views of transference and countertransference are significantly extended in a relational model. Following the lead of intersubjective theorists (Atwood & Stolorow, 1984; Mitchell, 2000; Natterson & Friedman, 1995), relational theorists suggest that every feeling response of the client is explicitly related to the real interpersonal interaction with the clinician. Traditional views of transference would suggest that the client is attributing characteristics to the clinician in a way that is a repetition of relationship patterns that were established in one's past interactions. In this model, transference is thought of as being something that the clinician understands as a conflict within the client alone. Not so in relational theory; rather, relational theory suggests that any reaction of the client is embedded in a real experience with the clinician. Relational theory recognizes that transference does exist, but it also suggests that both conscious and unconscious reactions of the client and social worker are stimulated as a result of the interpersonal exchange between the two. Similarly, countertransference responses are not considered idiosyncratic responses of the clinician towards the client (which traditionally would have been thought to originate from some conflict within the clinician or would have been understood as a response to some dynamic within the client). Rather, relational theory suggests that the countertransference response has been co-created in the unique interactions of the dyad and that an understanding of this response is firmly rooted in the subjectivities of both participants.

The conceptual frame of the mutuality and co-creation of the relationship then leads to a more nuanced and complex view of the treatment relationship. Certainly, the goals of the clinical process are formulated around the client's particular needs and circumstances. However, the social worker does not only offer "technical" observations, but offers an authentic relationship with the client. At times, this may involve social workers' disclosing aspects of their own feelings and/or uncertainties to the client. This does not imply that an "anything goes" approach is endorsed by relational theory; self-disclosure is used to understand the rich dynamic between the two so that clients can better understand the complexity of their inner world, and/or to facilitate change. At times, the clinical relationship becomes the focus of the work in a direct and continuous manner. This process leads to the possibility that some relationship rupture between the two, and the successful repair of the rupture can yield significant growth for the client in terms of relationship patterns and offers an opportunity to update their sense of self. Relational theory terms this sort of relationship rupture an "enactment," and this concept will be elaborated on later in the chapter.

De Young (2003) suggests that relational therapy is essentially performative. She suggests that insight (alone) about one's family history or relationship patterns does not contribute to a change process for the client. She says, "particular insights . . . have no power to change anything for a client unless they are performative insights, or insights that are intimately connected to interactive, emotional experience" (p. 4). Again, read the importance of the treatment relationship. She elaborates, saying, "The essence of therapy . . . is in everything that you and your client do together—how you interact to construct ideas, how those meanings move both of you, and how your interactions change over time, especially when you reflect on what goes on between you" (p. 4). Rather than trying to avoid conflict between the client and the clinician, the relational social worker fully anticipates that he or she will become fully immersed in the client's life narrative in an intimate way, and that if the treatment is to be effective, then there inevitably will be relational issues and enactments between the client and the social worker. As noted before, the relational worker does not see the site of the "problem" as within the client but with the client's interactions within the social context of their life and within the social context of the clinician's life. The motivations of the actions of the clinician should always be transparent to the client; De Young (2003) comments on Owen Renik's metaphor

about the therapist process, citing that he suggested that the therapist's engagement is *playing with your cards face-up.* According to De Young, Renik (1966) suggests that the patient can engage with the clinician's transparent feelings and intentions as fallible opinions, not as scientific or moral pronouncements.

One further conceptual framework is important to note in relational theory. It is clear that relational theory discusses the interactions of the self (client) and other (clinician and/or context) as being fundamental in shaping the client's view of self. Relational theorists suggest, though, that there is a third construct to consider in understanding relationships. This is referred to as "the third space." Mitchell (1988) comments:

> Relational theory focuses on three aspects: the self, the other, and the space between the two. There is no "object" in a psychologically meaningful sense without some particular sense of oneself in relation to it. There is no "self," in a psychologically meaningful sense, in isolation, outside a matrix of relations with others. Neither the self nor the object (other) are meaningful dynamic concepts without presupposing some sense of psychic space in which they interact, in which they do things with or to each other. (p. 33)

This concept underscores the essence of relational theory—that is, that there is no such thing as a linear interaction in which a message or communication is a one-way street. Rather, relational theory suggests that communication of any sort happens in this third space that is neither wholly self nor wholly other. This concept is very similar to contemporary neurobiological theory as well. There, theorists are suggesting that there is no such thing as a single brain. For example, Cozolino (2006) suggests that all brain development happens only in interaction with another person. Of relevance for this chapter, Cozolino (2006) suggests that there is a space between two people called a "social synapse." It is in this intermediary space that brain development happens in a recursive fashion.

The concept of the third space in relational theory is "utilized to understand how culture, race, and ethnicity that both client and therapist bring with them influence the treatment, and how the interaction between client and therapist is transformed into a new, third dimension" (Goldstein, Miehls, & Ringel, 2009, p. 157). Mattei (2008) refers to this as the "ethnic third"; she emphasizes that this is a crucial (although often unverbalized) dimension of any treatment process. With these core conceptual frameworks in mind, the chapter now turns to the practice implications of relational theory.

Implications for Assessment and Treatment

Assessment

As the reader might expect, the treatment relationship is a key component to understanding the client's concerns and presenting issues. Regardless of the presenting concerns, relational theory suggests that aspects of relationship history and the social context in which one grew up and the client's understanding of his or her relationship narratives will be intrinsically involved in the assessment and treatment process. Keeping a focus on the context of the individual's history is crucial in completing an assessment based on relational theory. De Young (2003) comments,

> What's wrong is neither entirely inside the client, in his psychological makeup or dysfunction patterns, nor entirely outside in the world, in forces that impinge upon him. Instead, according to a relational model of psychotherapy, the problem exists in those spaces or activities where outside influences and inside responses interact to create the shape and feel of a "self." (p. x)

Here, too, relational theory is compatible with the social work profession's view of assessment, which is biopsychosocial and thus more holistic than that of some other professions.

A key aspect of assessment is to determine the immediacy or "crisis" elements of the client's presentation. Clearly, relational practitioners assist in initial problem-solving around the crisis components of the client's presenting concerns. An active, collaborative approach is essential, and the clinician recognizes that a premature focus on "relationship" issues might be detrimental to a client who is experiencing an acute situational crisis. That said, the relational clinician does listen attentively for relationship and contextual themes in the assessment of any

crisis situation. The relational clinician understands that most presenting concerns will have some connection to attachment relationships; however, the timing of when this concept is introduced is important.

Clients in crisis often require some ego-supportive work in order to restore some equilibrium to their world. And, as appropriate, the relational clinician begins to educate clients about the interface of current feelings with one's past relationships with others, while considering the social context and identities of the client. Goldstein, Miehls, and Ringel (2009) suggest, "It is useful for the clinician to explore the meaningful relationships in a client's current life situation and whether there are any changes, stresses, disruptions, disappointments, rejections, conflicts, or losses that are affecting the client" (p. 94).

The relational clinician certainly engages in empathic listening during the assessment phase of the work. And the clinician will gently guide the process so as to help the client fill in missing pieces of information. The clinician will assist clients to expand their understanding of their life narratives. Relational theory understands the benefit of "making meaning" out of the complexity of one's history as a key aspect of feeling more cohesive in terms of one's sense of self. It is important that the clinician fully understand that his or her own attitudes, belief systems, and actions will be continuously be scrutinized by the client, even during the assessment phase of the work. Thus, it is important for the worker to be self-monitoring and to be in tune with any subtle shift that the client demonstrates. The beginning interactions of the dyad are particularly telling in terms of the client's internal world, and how the client positions himself or herself with the clinician is a very important source of assessment data.

During the assessment, the clinician gleans some understanding of what motivates the client generally, and the client's typical way of engaging and interacting with the world. It is useful to consider how adaptive or maladaptive these patterns have become for the client. Much of the client's usual way of presenting in the world will be somewhat unknown to him or her, and thus the assessment process begins to ascertain what the client is consciously aware of, in terms of his or her interpersonal patterns. Here, too, it is important to have some assessment of how the client understands the influence of the social construction of his or her identity. Most clients do not appreciate how powerful societal messages are and how these messages shape their sense of self; the clinician begins to introduce these ideas to the client during the assessment process. As noted previously, messages about gender, race, ethnicity, sexual orientation, as examples, profoundly shape the client's view of herself or himself.

The relational clinician will appraise the degree of traumatic events in the client's earlier life. It is an unfortunate reality that many of our clients who seek social work services have experienced some sort form of trauma during their childhood. Understandably, this reality will complicate the assessment and the treatment process. Commenting specifically on the process with traumatized individuals, De Young (2003) suggests,

> As clients share themselves with you more deeply, they hope that you will understand them ever more deeply, they hope that you will understand them ever more deeply and completely. But at the same time, their painful relational history leads them to expect that you will fail them, judge them, and abandon them. And inevitably, in small ways at least, you do fail them. (p. xi)

In some instances, clinicians fail their clients in large ways as well, and enactments happen in the treatment process. The chapter now turns to the treatment process and will elaborate on the concepts of enactments and self-disclosure in relationally based practice.

Treatment

Treatment principles of relational theory draw from both the earlier relational theorists (one-person psychologies) and more contemporary relational theorists (two-person psychologies). Earlier relational theorists emphasized the holding functions of the treatment process, which include empathic attunement to the client and the minimization of any countertransference responses that might interfere with the development of empathy with the client. Early relational theorists focused on understanding the client's

past, including developmental arrests and relational patterns, and this focus led to treatment interventions that aimed to strengthen the sense of self, which would lead to the development of more satisfying relationships with others. The clinical relationship offered an opportunity for some corrective experiences for the client. In earlier models, client transference was thought of as a combination of what the client brought to the treatment and what might be triggered within the client as a reaction to the clinician's personality and actions. Earlier theorists tended to think that clients could induce certain countertransference responses within the clinician, and these could be used to understand the client's internal world.

Contemporary relational theorists stress the interaction between the therapeutic dyad rather than seeing the main function of the clinician as providing a holding environment. More space is given to the expression of the clinician's responses, including countertransference responses. Contemporary relational theorists promote a more spontaneous and authentic stance for the clinician. The deconstruction of the therapeutic relationship is emphasized, and these theorists see transference and countertransference as co-created by the dyad; understanding and working through conflict (enactments) between the two offers a great opportunity for change when managed correctly by the clinician. In reality, most clinicians who consider themselves relational probably practice with components of each of these models influencing the treatment. The following treatment principles may be used somewhat differentially by different workers, but these comprise the essential relational treatment principles.

The treatment is framed as a highly collaborative process, and relational clinicians educate their clients that both members of the therapeutic dyad will be intricately involved in the treatment process. This is often relieving to clients, who may have a stereotypical view that the clinician will be the prototype of a worker who is neutral, objective, and expert. Some clients will have had previous therapeutic experience in which perhaps the therapist listened attentively but reflected their questions back to them in a routine and nonspecific manner. A relational clinician is more apt to offer genuine responses, at times, when clients ask questions about the clinician's identity and/or treatment approach. Goldstein, Miehls, and Ringel suggest, "A collaborative approach communicates respect and validates clients' own experience and goes a long way in preventing a nontherapeutic interaction in which clients are placed in a diminished position in relationship to clinician's authority" (p. 107). As clients tell their life narrative, relational clinicians actively ask questions so as to fill in missing pieces of crucial information. Relational clinicians might share their own feelings of confusion and/or uncertainty about parts of the client's presenting concerns. This open, not-knowing stance is a key component to the treatment process, as it empowers the client, often resulting in enhanced self-esteem and a sense of efficacy within the client.

As noted, a treatment goal is the establishment of a therapeutic holding environment. However, relational clinicians take a more nuanced view of this and do not relate to every client with a cookie-cutter approach. Rather, the therapist's stance is determined by the particular and specific needs of each client. Some clients may require a great deal of reassurance; some may require contact in between sessions, and some may like more autonomy, for example. Likewise, it may be very important for certain clients to have some information about the background of the clinician, and at times the clinician may need to self-disclose certain aspects of himself or herself to firmly establish a strong holding environment. Likewise, a clinician needs to take a very active protective stance towards clients who are somewhat impulsive and/or self-destructive. At times, the relational clinician will perform a number of case-management functions for particularly vulnerable and/or distressed clients. Ensuring that the client has a strong network of health and mental health providers is crucial to doing the clinical work, and the relational clinician actively helps the client become as grounded as possible by supporting the client's ego functions and helping the client build a broad network of support. Farrell (2014) notes that utilizing a relational approach with the homeless population "requires a more nuanced and textured

approach toward building engagement and sustaining the treatment process" (p. 274). The author notes that the client's "suspicion, manipulation, denial, and the like are to be viewed through the relational lens as learned coping strategies rather than as classic resistance" (p. 274).

Similar to the nuances of the holding environment, another treatment principle of relational theory is to recognize the complexity of empathic attunement with a range of clients. Some clients need more distance in order to feel safe, while others need a great deal of confirmation that their feelings and life situations are exquisitely understood by the clinician. Beyond empathy, the relational clinician may need to set limits on problematic behavior. Again, it is best to work collaboratively with clients to assist them to manage anxiety, to deal with any addictive behavior, and/or to prevent any form of self-harm, including suicidal behaviors. Goldstein, Miehls, and Ringel (2009) note: "The unilateral establishment of strict rules should be avoided. For example, some clients who abuse drugs, alcohol, or food or who engage in self-mutilation and other forms of destructive behavior may not be able to maintain total abstinence or refrain from their usual behavior as a prerequisite to treatment" (p. 117). A relational clinician will certainly address self-destructive behaviors, but the timing of such interventions is important, and working with clients to set reasonable goals about the change process of self-destructive behavior often yields more treatment compliance and changed behavior over the long term. At times, the relational clinician needs to recognize that her social location might cause a vulnerable client to position her as a social control agent. Kenemore (2014) outlines key constructs in working with individuals who are reentering society following incarceration. The author notes that "the relational clinician must actively demonstrate an understanding, however limited, of the reentry individual's sociocultural experience and must also actively and effectively attend to concrete needs of the person" (p. 249). In addition to applying relational principles to the homeless population, relational clinicians are successfully extending their reach to a wide variety of clinical populations, Evangelical Christians (Cecil and Stoltzfus, 2014), Muslim clients (El-Amin and Nadir, 2014), and combat veterans (Tyson, 2014), to name a few.

As noted before, the relational clinician exercises spontaneity and genuineness while interacting with clients. The treatment approach in relational theory implies a more frequent use of self-disclosure by the clinician. Self-disclosures generally take one of three forms during the treatment. First, clinicians may disclose some aspects of their own feelings, attitudes, values, life experiences, and factual information about themselves or others in their life. Second, clinicians may disclose their feelings about what is going on in the treatment. They may share their rationale for certain interventions or comments. Berzoff (2015) expands on this idea when she talks about a relational concept that has to do with the process of the therapist sharing some of her reveries. She comments that it is often therapeutic for a clinician to share her process of coming to an interpretation, rather than seeing the interpretation itself as the curative factor. She says, "It is not the therapist's interpretations, per se, that are so mutative to a client, but the sharing and cocreation of feeling and reveries with the client that help the client become knowable to herself. . . . The therapist's mind becomes open to the client's scrutiny, and to contradiction, paradox, and surprise" (p. 68). Or, they may share some dilemmas that they are experiencing in the work with the client. For example, a clinician may suggest to a client that he is confused about how to raise a sensitive issue with the client. The clinician may suggest that he wants to ask the client about her sexual acting-out behavior but doesn't want the client to perceive the him as judgmental. Pointing out the dilemma to the client often encourages the client to be more forthcoming about the details of the dynamic issue, and it certainly offers opportunities to deepen the treatment relationship. The third type of self-disclosure involves the clinician's sharing some countertransference reactions. This is particularly important in dealing with ruptures in the treatment relationship (which will be discussed further shortly).

Therapist self-disclosure often leads to many positive outcomes. A client who often feels a sense of shame about his own feelings and actions may feel a great deal of relief when he hears that the clinician had struggled with a

similar feeling or circumstance in the past. Usually a client does not want to hear explicit detail of a clinician's experience but does feel some sense of mutual connection when the clinician is honest in response to a difficult question or questions that are present within the client. As the reader might anticipate, however, some self-disclosure by the clinician may lead to unexpected and problematic results.

This author was working with a woman who was a parentified this is defined in the following statement child and who often had to take care of her mother's emotional world. Her mother was often depressed, and the client often had to prop her mother up emotionally. In order to attend the funeral services of his brother, who had died precipitously, the author canceled two sessions with the client on short notice. This was at a particularly difficult time for the client. Probably because of feeling guilt, the author disclosed the reason for the cancellations. The author assumed that this explanation would offer some rationale for the client, but while it certainly explained the cancellation, the client seemed to become more distracted and sullen during the session. The author listened for some minutes and then commented, "It seems to me that your demeanor shifted when I told you of my brother's death." The client replied, "What do you expect? I guess I will have to take care of you, too." The author quickly said that she didn't need to do that and that he had his own support system. This further statement only aggravated the hurt feelings of the client and she seemed to feel chastised. The author went on to say, "I am sorry, I should have realized that my saying what I did might have felt like a burden." The client replied, "Maybe I'm being a selfish bitch. Of course I'm sorry about your brother, but I just want my therapy to be for me. I don't want to have to worry about you." Further dialogue revealed the extent of the client's caretaking activities with a range of others. This led to a deeper understanding of this dynamic within her, which had been activated by the clinician's self-disclosure (also reported in Goldstein, Miehls, & Ringel, 2009, pp. 121–122).

One final treatment principle is how the relational clinician manages disruptions and/or enactments in the treatment relationship. As noted, relational theorists understand that the here-and-now interpersonal interaction between the therapeutic dyad leads to transference responses of the client that are co-created between the two. The relational clinician expects that there will be disruptions in almost all treatment relationships. These are viewed as opportunities to facilitate change for the client (and perhaps the clinician). The clinician may become aware of disruptions in the treatment relationship when the client begins to show a subtle or more apparent shift in his or her behavior in sessions. The client may become more quiet in sessions; he or she may become detached or aloof, or perhaps angry as well. The repair of disruptions offers a potentially powerful therapeutic moment.

Dealing with disruptions is a multistep process. First, the clinician needs to directly acknowledge that there has been some sort of impasse between the two. It is important that both client and clinician explore the clinician's role in causing the disruption. The clinician needs to encourage the client to verbalize feelings of anger and/or disappointment and to certainly empathize with and legitimize these feelings. Often the clinician needs to give the client "permission" to express these feelings of anger, sadness, or rejection. It is also important for the clinician to acknowledge that he or she has played a role in the disruption. Furthermore, the dyad needs to fully unearth the client's meaning and perceptions of the rupture. The clinician may or may not offer some explanation for the empathic failure. In addition, the clinician needs to ask the client how this rupture can be repaired. If appropriate, the clinician eventually may link the feelings generated by the rupture to the client's past experiences with significant others. Clearly, this needs to be conveyed in a nonjudgmental manner, and the timing of this is crucial. It is very important that the clinician does acknowledge his or her real part of the interaction that contributed to the impasse, and it is often useful if the clinician apologizes to the client. Making the link to the client's earlier relationship experiences offers a powerful opportunity that leads to change and enhanced self-esteem within the client. Last, the clinician may make observations that their interaction is prototypical of conflict that the client might

be experiencing in current relationships. Self-reflection for clinicians is important, and they may discuss the impasse with their supervisor or their own therapist.

Relational theorists also understand that a more troubling sort of treatment rupture happens when there is an enactment between the client and clinician. "Enactments" are actual exchanges between the dyad that are often potentially destructive and have been experienced previously by the client in harmful and/or traumatic relationships. Individuals who are survivors of childhood trauma often do stimulate strong feelings within clinicians, and work with trauma survivors can be particularly prone to enactments. Trauma theory suggests that there is a "triadic self" that is internalized by survivors of childhood trauma. Basham and Miehls (2004) discuss this triadic self and understand that trauma survivors all internalize some aspect of identity that is described as victim-victimizer-bystander (rescuer). In other words, survivors of trauma often play out the role of the victim in the treatment relationship. At times, the clinician plays the corollary role to this and actually becomes somewhat victimizing in the relationship. At other times, the client victimizes the clinician, or the clinician might either arduously adopt a rescuer stance with the client or may ignore the real pain of the client, which is an enactment of the bystander role (many survivors of trauma describe that others in their family stood by and did not intervene in the abusive dynamics between them and the perpetrator).

While it is true that clients who are not survivors of trauma may also experience enactments in the treatment, this dynamic happens with some regularity with trauma survivors. The client and clinician unconsciously create a dynamic that actually replays the original relationship that was destructive. Trauma theory suggests that these enactments are an inevitable part of the treatment process. The clinician often is caught unaware of the enactment until the exchange has happened. Clinicians need to be particularly self-scrutinizing of their responses to clients and must be particularly alert to the possibility of enactments when they are behaving in ways that seem to contribute to affect escalation or dysregulation within the client. The steps outlined previously in terms of dealing with ruptures and impasses have relevance here as well when the clinician recognizes that an enactment has occurred.

The preceding are the key components to assessment and treatment from a relational model. Of importance, and as mentioned, relational clinicians will modify their stance on a case-by-case basis, but it is certainly true that a relational clinician will definitely be actively involved in co-creating the treatment relationship. Effective relational clinicians need to have a very well-examined sense of self, and often their own therapy furthers this process.

Limitations and Cautionary Notes

An oversimplification of relational theory may lead to some misuses of the concepts that have been put forward in this chapter. Practicing from a relational perspective certainly requires a great deal of experience and supervision. While the tenets of mutuality and equality in a clinical relationship have appeal to many practitioners and student practitioners, these concepts are complex and require a great deal of thoughtfulness in their application to social work treatment. Rather than suggesting an "anything goes" approach to treatment, relational practitioners use self-disclosure in a judicious and planned manner. It takes a highly skilled assessment to know when and how to use self-disclosure effectively in treatment. In addition, while relational theory suggests that practicing from a relational perspective can lead to growth for both the client and the clinician, relational theorists also emphasize that the focus of the growth process needs to be centered on the client's needs and goals. Relational therapists are sometimes criticized as being "self-indulgent," but of course the opposite is true; effective relational clinicians are anything but self-indulgent, and they do recognize that the work is not for the faint-hearted. Practicing relationally demands a particular type of self-awareness and self-monitoring. For this reason, it is this author's belief that social work students should be exposed to principles of relational treatment only after they have learned how to practice social work with more traditional boundaries and parameters.

Segal (2013) raises an important issue in terms of how relational theory is compatible with evidence-based practice. She wonders how relational practice will develop evidence of the efficacy of techniques that are "carefully selected in collaboration with the client" (p. 383). She encourages the social work profession to "explore the efficacy of placing relational theory—constructivist epistemology and all—at the center of generalist practice functions such as case management, program administration, discharge planning, and home visiting" (p. 384).

Implications of Relational Theory for the Future

Relational theory has captured the attention of many psychodynamic thinkers and academics. The author imagines that relational theory will continue to be influential in the development of treatment models in social work and beyond. As noted, this theory is a natural fit with social work, as it is particularly suited to working with oppressed populations. The theory contextualizes identity and deconstructs the social construction of identity. This is an encouraging shift in our understanding of the human condition and grows increasingly relevant as our North American society grows more and more diverse in terms of cultures and ethnicity.

This chapter has focused on the application of relational theory to clinical work with individuals. Goldstein, Miehls, and Ringel (2009) demonstrate the application of relational theory to couples, families, groups, and oppressed populations in their text, and readers are encouraged to look there for further application of the theory. In addition, relational theory is starting to be integrated into classroom teaching in schools of social work and other mental health professionals. Many are now integrating relational principles into their supervisory relationships (Miehls, 2010).

Finally, the author also recognizes the links between relational theory and contemporary attachment theory and also the burgeoning field of neurobiology. All three of these theory bases are converging in a manner that emphasizes the crucial importance of sound relationships that aid healthy psychological and brain development. As we embark on the second decade of the "new millennium," it is an exciting time to be practicing social work, and relational theory adds to the ever-changing and increasingly sophisticated theory bases that contribute to our effectiveness as practitioners.

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29

Resilience Theory and Social Work Practice

Robbie Gilligan

What Is "Resilience"?

Resilience is a concept that has gradually become more familiar in social work and human services, but it also has currency in many other fields of human endeavor: in engineering, provision of physical infrastructure, earthquake safety planning, crisis management in the face of natural disasters, etc. (Hayward, 2013; Chang, 2014, Bruneau et al., 2003). It also has relevance in disciplines such as sociology (Lockie, 2016), psychology (Masten, 2001), political science (Zebrowski, 2013), gerontology (Windle, 2011), and in a variety of fields of human service practice such as palliative care (Vanistendael, 2007), community development (Chaskin, 2008), and the care of young homeless people (Kidd and Davidson, 2007).

Resilience as it relates to social work may broadly be understood as "doing better than expected in the face of adversity." Like many meaningful concepts, resilience is not easily defined precisely. Another concept that presents such challenges is that of "beauty." No one would deny the value or relevance of the word "beauty." But there may be many opinions and cultural variations as to what is considered beauty. The word speaks to and enriches human experience. Arguably, the word "resilience" has a similar capacity to convey something powerful that can be recognized in many cultures, even if understood or expressed in a range of ways. While the term "resilience" grows in popularity and usage in the human services, there is still no widely shared and precise understanding. The phrase in the opening sentence of this

paragraph conveys something of its sense, yet it also betrays a certain vagueness. This gives rise to certain questions: What is meant by "adversity?" Does the intensity or duration of adversity matter? What is meant by "doing better?" What is the comparator—doing better compared to what or whom? Is it that the person is doing better now than before, or is it that the person is managing to get back on track more or less as they were before the adversity? Or is it that the person is doing better than their peers who are broadly in the same boat, or are they doing better than those peers generally? Whose view is reflected in the notion of "expected?" The term "resilience" may quite literally raise many questions. But this chapter will seek to show the reader that it is a rewarding term that more than repays efforts to better understand how it plays out in real life. The concept sheds important new light on the nature of helping and social work practice.

There seems to be increasing consensus on a number of points relating to resilience in the research literature (Vanderbilt-Adriance & Shaw, 2008), for example:

Resilience is not a trait.
Resilience is not static. It fluctuates according to shifting circumstances.
It is more helpful to think of resilience as relating to specific domain (e.g., educational outcomes) rather than as relating to global (overall) outcomes for a person.
It does not follow that resilience in one domain will carry over to other domains.

What Is "Adversity?"

"Adversity" is a core concept in thinking about resilience, since the notion of resilience requires its companion of adversity: someone displays resilience in the face of a given adversity, or set of adversities.

As it relates to social work or human service practice, adversity rarely takes a single form, or occurs in isolation. Typically, it may interact with certain surrounding circumstances, and these may sometimes serve to aggravate (or at other times to mitigate) the effects of the source of adversity. Adversity may arise from a single (one-off) event. This may have the effect of an unexpected *shock*: a natural disaster such as a tsunami; an unexpected death of a loved one. Adversity may also arise from *chronic conditions*: chronic hardship arising from poverty or other major stressors or an interaction between many such stressors over time. It is also the case, of course, that the line may become blurred between these two categories. The unexpected death of a lone parent may lead to chronic adversity where sources of support or income are scarce. The shock of losing a job may lead to the chronic problem of unemployment where the local labor market is weak, or where there is low demand for the skills the person has. Resilient adaptation in the face of the immediate shock of job loss may well be different from adaptation in response to the ongoing and possibly permanent state of chronic unemployment and associated loss of income. Chronic adversity may, of course, also leave one more exposed to shocks. For example poor people may be forced to live in places with a higher chronic risk of severe flooding, or live in relatively fragile structures in trailer parks where severe weather may have very destructive effects. Alternatively, where living conditions are good and support is high before and after a shock, its impact may gradually be contained over time, and "normal" life may be more easily restored—to some extent at least.

In considering all these issues, let us take the concrete example of a young person's progress in school. A child's progress in school goes into decline in the face of an episode of extended sexual abuse by a household member, leading eventually to placement in foster care. The placement means that the child has to change schools, and gradually shows recovery in terms of attainment in school. Since abuse and placement are known to be associated frequently with poorer school performance, the child's recovery may be said to reflect (educational) resilience in the face of the adversity of sexual abuse—and the surrounding circumstances of the case. This last phrase is noteworthy. As social workers know well, problems rarely occur in isolation. There is a context—surrounding circumstances—to a problem, which may aggravate or mitigate the impact of a problem such as sexual abuse. The impact of abuse may be influenced by the nature

and intensity of abuse, the pre-abuse levels of support and difficulties in the child's life, and the level of support on adjusting to life after the extended episode of abuse has finally ended.

Just as the potential impact of abuse relates to the wider context in the scenario, so, too, do the prospects for resilience. But determining the presence or absence of resilience is not a simple matter. Is the "test" of resilience in this example to be recovery to the extent that the child is back on track with pre-abuse levels of performance, or that s/he is doing better than that, or the s/he is achieving better than the average performance for children in care? These difficulties in definition do not make the concept of resilience meaningless or irrelevant for social work practice—certainly not—but they do remind us of the need for some cautious reflection on how we interpret the term as social workers.

Another example from the field of disaster recovery may help to shine light on some of these issues. Researchers in the field of engineering have suggested that resilience implies both " the ability to adjust to 'normal' or anticipated levels of stress and to adapt to sudden shocks and extraordinary demands" (Bruneau et al., 2003). While allowing for the differences between the fields of engineering and the social or human sciences, the proposed definition from our engineering colleagues seems to have at least some relevance for social work. Yet implied notions of "recovery" may be more slippery than they first appear. Positive adaptation in the early days after the disaster may be gradually replaced by decline in the longer term as the full implications of the loss are grasped, and as immediate support that has rallied begins to wane. This example highlights the relevance of the passage of time in assessing response to stress or resilience. And in extreme conditions, the very act of survival may be a sign of resilience. To preserve the human spirit, to find fragments of hope, may be an act of defiance in the face of adversity. Survival may rightly be seen as a sign of resilience in the immediate aftermath of disaster or violent conflict, but living in ruins, forgotten and without the means to build a new future or eke out a daily livelihood, is likely to drain any sense of resilience from the morale and capacity of the people affected

For a time in my teaching, I used a UNICEF (United Nations Children's Fund) photo from the Philippines of a nine-year-old girl from an impoverished family who lived on a huge, smoldering, toxic dump in Manila searching for items of value. What clearer example of absolute poverty could there be? Here was unambiguous adversity. Yet the photographer caught the child jumping up and down playfully on the broken sofa and smiling broadly. The image was in marked contrast to her surrounding reality. And for some time, I liked to use this image in presentations to help illustrate human capacity to transcend adversity, how the human spirit could shine through even in the most unlikely circumstances. But gradually, it became clear to me through discussion and reading that the passage of time was a crucial dimension in any consideration of the concept of resilience. The child was jumping with joy in the image of the photograph. It was good that she had this moment of joy, but the fragmentary moment captured in the photograph did not necessarily represent proof of resilience. She could be truly said to show resilience if she managed to transcend aspects of adversity linked to life on the dump in an *enduring* rather than fleeting way. She would show resilience if, *over time*, she showed better health outcomes, or more educational progress than might have been expected.

This example raises another issue—how to assess or measure any display of resilience. For many users of the term, resilience is not a subjective experience proven by claim; it is not enough for the person to lay claim to positive responses to an adverse set of circumstances. A subjective sense of positive adaptation in the actor or observer is not necessarily sufficient to justify the claim of "resilience." Many adherents would also expect some additional "independent," measurable evidence or data beyond the self-report of the person involved or observing. From their perspective, seeing the joy in the moment of the girl on the sofa, or hearing her positive outlook or account close to that moment, falls short in two ways. It falls short on the "passage of time" test, and on the "presence of corroborating independent evidence" test. And yet, is there also not something important to acknowledge in her moment of enjoyment? Perhaps the memory or expectation of such

moments helps sustain her and helps disrupt a narrative of complete decline and defeat. In a study of children living as domestic laborers in Nepal, a number of them reported finding support and hope in the occasional experience of religious festivals (Veitch, Dharel, & Ojha, 2014). These occasional positive "escapes" from day-to-day challenges helped them survive daily life. The memory and prospect of participation in the community event of the religious festival helped sustain their positive sense of self through the often-challenging times in between.

While objective indicators of resilient adaptation are clearly very relevant, it is also important (for social workers, especially) to appreciate the significance of subjective experiences that may provide sustenance in the face of extreme adversity. Head of medicine for the International Committee of the Red Cross, Paul Bouvier (2012) gives powerful examples of how seemingly inconsequential items or experiences could help prisoners held under extreme conditions to continue to find positive meaning (and dignity) in the face of deep adversity. (Such examples include well-thumbed pictures of beloved people or places, cards, perfumes, etc.). This is a reminder that support may take many forms—the physical daily presence of a helpful person, but alternatively, a memory or some other image or symbol of inspiration. In the case of physical items, they seem to be important in evoking memories of connections to valued people or contexts. They may also serve to reassure the person of their worth, dignity, and essential humanity. Again, the notion of disrupting a narrative comes to mind as an essential idea in relation to resilience. The power of these disruptions lies in how they reassure the person that there are exceptions, that the negative narrative is not all-consuming; that, at the least, there are little symbolic and practical glimpses of an alternative to the oppressive reality of their daily routine. Those glimpses can help sustain the resistance (and resilience) of the person in the face of the adversity reflected in the dominant narrative. Anyone or anything that serves to disrupt negative "master narratives" may become a source of resilience, however simple or "peripheral" that source may seem to the onlooker.

Each discipline may relate to resilience in its own way. Perhaps part of the social work connection to resilience is to value the moments of disruptive resilience as well as the more transformative and enduring changes that may sometimes flow from supportive relationships.

A social work student of mine had a field placement in a general hospital. On his own initiative, he brought some music tapes to an elderly patient with whom he was working. In this thoughtful and generous gesture, the student was showing his own very personal concern for the patient, but in acknowledging their shared love of music, the student was also helping to disrupt the master narrative of sick patient that may threaten to envelop an older person in hospital. The opportunity to listen to music helped disrupt that narrative and restored to the person the social role of music *aficionado*, a role also much valued throughout the wider community. This is not to mention the immediate pleasure and uplift from the direct experience of listening to the music. The music may have helped the person have an even brief experience of resilience in which he was better placed to face illness. For a social worker, the value of resilience lies, arguably, in its subjective experience in the moment, as much as in its objective, measurable endurance over time. Even a terminally ill patient may display and experience resilience.

People who hold significance in terms of promoting resilience in others may exert influence through "real-time" interactions. But there are various examples to show that *memories* of the remembered person's qualities and values may also be a positive influence despite later physical distance between the "influencer" and the "influenced." The power of memories does not contradict the general point of the influence of *present* experience. It is those memories that are *alive* and especially meaningful in the present that exert influence. Memories may reside in the individual or be shared within a family or community. They may often exert resilience related influence.

There is striking research evidence on how aboriginal communities in Canada with stronger active connections to cultural traditions (shared cultural memories) showed more resilience in the face of the threat of youth

suicide. Cultural continuity seemed somehow to contribute to the young person finding a self-continuity at a personal level (Lalonde, 2006). The rate of youth suicide was virtually zero in tribes that had retained a command of their traditional language (Hallett, Chandler, & Lalonde, 2007). Such studies illustrate how too narrow a focus on the individual may obscure the importance of powerful cultural and social forces at play in the scenario.

Young people may be influenced in their behavior by commitments made to parents before their death, or a sense of duty to the parent they have lost. One young woman who had gone on to grow up in care recalled at a training conference how her mother had asked her to study hard because of her natural ability, and how this advice had elicited a commitment that decisively shaped her later educational progress – a truly turning point experience in her life. The young woman had gone on to exercise her own agency in grasping the opportunity presented by her mother's advice and encouragement (Gilligan, 2009). Another young woman with drug problems and other difficulties reported that she had found motivation to change her life when a friend reminded her that her late father would not have approved of her problem behaviors. Her sense of duty, no doubt partly instilled by her late father, served as a source of resilience (and resistance) in the face of a narrative with otherwise negative prospects (Markova, Tomov, Alexandrov, Katzarova, Marinova, & Mateeva, 2014).

In considering the relevance of support for resilience, it is important to appreciate that support may take many forms and come from many sources. A person may find support in the actual or expected actions of others, family, friends, neighbors, etc.; they may offer help and encouragement. But people may also draw support from the meanings they give to, or find in, experience, or in patterns of behavior, of traditions, of beliefs of their own, or of their community.

Belief in God proved powerfully sustaining, according to the accounts of a sample of unaccompanied minors far from their home culture. Typically living with many challenges of uncertainty about their future legal status, isolation from family networks, and so on, they clearly experienced belief in God as giving continuity and meaning and some form of certainty (Ni Raghallaigh & Gilligan, 2010).

There may be other experiences which help to cultivate potential resilience, for example, positive experiences in recreation, education or work. One example is the benefits flowing to vulnerable children through participation in therapeutic horse riding (Burgon, 2011) or other youth development activities (Sanders, Munford, Thimasarn-Anwar, Liebenberg & Ungar, 2015). There is evidence across different cultural contexts that positive experiences in school may provide valuable resilience enhancing opportunities (Liebenberg, Theron, Sanders, Munford, van Rensburg, Rothmann, & Ungar, 2016). A further example is how opportunities to acquire work skills and experience may prove transformative for young people in care (Berridge, 2014; Arnau-Sabates and Gilligan, 2015). The thread connecting these positive experiences is often a positive relationship they offer the young person with influential others – carers, volunteers, professionals or other positive actors. There is strong evidence that relationships *and* positive activities are linked to resilience (Center on the Developing Child at Harvard University, 2015).

Reflecting on Adversity

Social workers need to be sensitive to the nature of adversity involved, to the different implications of chronic adversity and traumatic events (Bonanno & Diminich, 2013). A key issue is also the level or intensity of adversity. Adversity may generate different levels of risk with different implications for the degree, if any, of potential resilience. High and especially extreme levels of risk may make resilience less likely. So, too, may the presence of cumulative (multiple) risk factors (Vanderbilt-Adriance & Shaw, 2008). The degree of adversity may affect the potential for resilience. For one person, it may become possible to transcend the adversity, but not for another. The difference may be due to the level of meaningful support they can access as they negotiate their way through adversity. The nature of such support may vary, and in some cases may seem very modest. In other circumstances, finding fragments of experience

and support that sustain hope and positive meaning in oppressive circumstances may be a source of survival, of resistance, and of resilience (Bouvier, 2012). In considering why some people display "more" resilience in certain circumstances, one must remember that it does not necessarily mean they are "stronger" in terms of a trait of resilience. Adherents of a less global and static view of resilience would hold that differences in levels of displayed resilience may be more a reflection of differences in the "fit" between the person, the circumstances, and the nature of support flowing to them in that context. The person displaying resilience may happen to have a good fit between their circumstances and available support; the person without a display of resilience may lack such a fit.

Rutter (2012) reminds us of a critical point: research has established beyond doubt that there is huge variation in how individuals respond to adversity. This insight challenges deterministic assumptions that certain types of adversity necessarily produce automatic, predictable, or negative effects on those exposed. Instead, each individual responds in their own unique way to a given adversity. The die is not cast in the face of adversity. Indeed, Rutter suggests that adversity may sometimes produce a 'steeling' effect, thus making the person affected stronger. There is no certainty as to how each person will respond. This is actually a very powerful message and central to the importance and relevance of resilience. That notion of variable responses to adversity opens the door to uncertainty. That uncertainty becomes a potential seedbed for resilience; it becomes a basis for "reasonable hope"—an important companion in thinking about or "doing" resilience. Weingarten (2010) has argued the case for the value of embracing "reasonable hope" as a relational practice between helper and client, because "the future is not determined but can be influenced." Adversity leads to uncertain outcomes. The future is not determined in some predictable way by a given adversity in a given scenario. This uncertainty leaves open the possibility that what happens next (after adversity) can be influenced. This implies, in turn, the potential for better outcomes than might be expected. Such "reasonable hope" opens the mind to the possibility of resilience and to practice that searches for and supports its possible emergence.

How Does Resilience Relate to Other Theories Relevant to Social Work?

Several key concepts familiar from psychology and social sciences are relevant to our understanding of resilience. Resilience is widely understood as arising from support found in *relationships*. Based on their study of the lifetime implications of childhood maltreatment, Collishaw et al. (2007) observe that "'it was those individuals with good relationship experiences across different domains and across childhood, adolescence and adulthood who were particularly likely to demonstrate resilience" (p. 226).

The field of social work is familiar with the concept of *attachment theory*, which posits the value of dyadic attachment *relationships*—typically manifesting powerful bonds of commitment; as in the example, for attachment theory, of the prototypical relationship between a parental caregiver and child. While not discounting the value of these relationships, resilience thinking reminds us of the value of wider and less powerful relationships that may exist in a person's *social network*, the net of relationship connections that most people may have in their lives.

Social capital is an important but "slippery" set of theories about the qualities of relationships between people in a network. Social capital is broadly about the reciprocal obligations and commitments that may be felt to exist towards sharing forms of information and support with others. Social capital theory suggests that in certain types of relations the actors feel duty-bound to offer help or to respond positively to such requests. To not offer such help would be to step outside the bounds of acceptable behavior in the community. There is a further incentive to offer help. The "deal" in such relationships is that, if I help you today, you owe me similar help tomorrow; not literally, but the "debt" incurred reinforces the sense of mutual obligation into the future. Social capital may be said to flow, under the right conditions, through certain connections and to lie waiting to be tapped. Social capital offers a useful counterbalance to attachment theory, suggesting that even "weak" relationships may have considerable value under certain conditions or in a given

context. Social capital theorists have shown how "weak ties" may be influential in helping people find employment (Granovetter, 1973) or in coping in the aftermath of a disaster such as Hurricane Katrina in New Orleans (Hawkins & Maurer, 2010).

The relevance of concepts such as social network and social capital to understanding resilience reminds us how "social" or "relational" the concept of resilience actually is. Rather than being a personal trait, resilience flows from a person's relationship with one or more people, and it may be a quality also observable in wider groupings such as families or communities. Family structure manifested in processes and rituals such as regular shared mealtimes have been shown to be associated with resilience or better outcomes for children growing up in families affected by parental alcoholism (Velleman & Orford, 1999).

Resilience thinking has value for social work practice in a number of ways. It is a reminder of the potential for change in a given practice scenario. It remains open to the possibility that a person may prove able to break free of a "gloomy script." It highlights the power of "small things," how even seemingly "small" fragments of experience or elements in an overall profile may prove to exert considerable influence on subsequent progress in a person's life. It is too easy sometimes to overlook how seemingly marginal or small things may have an impact. One such example of the huge power of small things comes from aviation, where accident investigations often uncover some very subtle error or incident that has had huge consequences. The withdrawal of the supersonic plane Concorde from commercial service globally was linked to a fatal crash in Paris. The cause of the crash was linked in turn to traces of broken parts on the runway that had fallen unnoticed from an earlier departing plane, which the ill-fated Concorde aircraft had somehow "ingested" into its engines. The story underlines the message that small things may sometimes have big consequences. Resilience thinking emphasizes the same point, but with a more positive twist. Unlike the Concorde story, resilience thinking encourages the idea that small things may sometimes have positive and substantial consequences for an individual or more widely.

A case example from a remarkable social science research study illustrates powerfully the how change may come unexpectedly and from apparently "small things." Laub and Sampson (2003) reported on the latest and probably final wave of long-term research on the adult lives of a cohort of young delinquents in the United States. The study has now tracked the young men into old age. It is a longitudinal study involving many authors over a number of generations in its nearly 50-year span. The study sought to investigate whether young men who had been delinquent in their teens remained in crime or desisted in later life. In reality, the study revealed both tendencies, and also a group who moved back and forth. Those who desisted often physically broke ties with negative influences (by moving) and often found an influential positive relationship through marriage or other means. One of the cases is a powerful illustration of how resilience may play out over one lifetime. The participant, "Gilbert," was now aged 70 and had been sent to a reform school as a teenager and had been assigned to the electrical workshop where he met "Jack," who was in charge. Recalling Jack all these years later, Gilbert remembered that

> . . . he loved amateur radio. And he got me interested in radio and electrical stuff and things of that nature. . . . He saw the potentials in me. He saw I enjoyed electricity. I enjoyed radio and stuff like that. He took me under his wing. And I thought an awful lot of this guy in a short ten months I worked with him. He was a prince. . . . I prepared my whole life in ten months to do something. . . . Think about it. Those ten months were crucial in my life. Because they turned me around. [Name of prison] turned me around. Jack turned me around. Jack was a humanitarian and cared for me as an individual. Let's get down to brass tacks. What if Jack wasn't there? What if I wasn't offered the opportunity? . . . He treated me right. As a matter of fact, after I left [name of prison] year after year on a yearly basis I would take my wife and kids, we'd drive all the way to [name of prison] to see Jack. ("Gilbert" in Laub & Sampson, 2003, p. 141)

Serendipity was in play in matching Jack and Gilbert in the radio workshop. Gilbert's then getting on so well with Jack was also a key ingredient. Jack clearly had a strong, intuitive feel for the personal approach that *mentoring* work with troubled young people requires. Gilbert in

turn took up the opportunity, so that the experience became a turning point, quite literally, in his life. The relationship and Gilbert's exercise of his personal *agency* (through embracing the opportunity) were both critical to the process.

Resilience thinking also reminds the field of how important professional expectations and assumptions are. In many instances, arguably, social workers may be too deficit-led in their thinking. Prior knowledge and relevant experience may often lead them to "foreclose" prematurely on the possibility of change in a given scenario. Allowing our professional practice to be influenced by resilience ideas does not guarantee the prospect of positive change in all circumstances, but it may be said to "keep the door open." It is not so much that such a "resilience–open" practice approach causes the change, but it contributes to conditions favorable to such change, which remain open to the possibility of such change. Resilience thinking challenges notions of fatalism—that problems are so ingrained and entrenched that nothing can be done; that there is no possibility of change. Social processes such as diagnoses are ultimately social constructions, labels that are applied as a shorthand to describe a certain profile. Each person labelled an alcoholic may respond in different ways over time; some may manage to break free of a fatalistic view of the slim prospects for recovery. Resilience thinking encourages an openness to the possibility of change and the sometimes unexpected influences that may unlock that change.

Once sensitized to the relevance and potential of the concept, it is no longer easy for any professional, within social work or more widely, to discount the possibility of change. It may be said that the notion of resilience provides underpinning for *hope* in frontline practice. Ideas of resilience help engender a certain philosophical mindset in practitioners. They challenge default assumptions of gloom and doom in the face of adversity. Resilience is not just about what practitioners do, but about how they *think* about what they may do, how they appraise the scenario in which they must act. In working for change, it is important that social workers retain faith in the possibility of change, that they hold an expectation that change is imaginable.

Resilience thinking involves two key points: that change is possible, and that change may come in many different and often unexpected ways. There is no strict formula to follow or apply. The knowledge base on resilience highlights the relevance of support. But support may take different forms and be experienced differently. This variation in what gives rise to potential resilience is its strength, but for some also its weakness. The lack of a neat linear formula may frustrate some. But that is life!

What Are the Strengths and Limitations of "Resilience?"

No single theory can match all circumstances, or be relevant to all the facets of the complexity of human experience. And so it is for resilience. As in many parts of life, a strength can also be a weakness. The appeal and apparent accessibility of resilience as a concept may mean that it is adopted or promoted in ways that sometimes lead to over-reach. The following quote underlines the need for caution in our expectations of the concept

> Resilience can help to re-imagine possibilities or alternatives in people's lives; it can help to influence aspirations and perceptions that people may hold about their potential or their circumstances. But typically, resilience cannot alter those circumstances. It cannot, by itself, make a homeless family not homeless; it cannot make a violence-ridden neighbourhood not violent; it cannot make a hostile school environment not hostile. Resilience may, however, be able to influence sometimes how a person copes with or perceives their circumstances. It may be able to help stimulate the confidence to ask questions and imagine new possibilities. (Gilligan, De Castro, Vanistendael and Warburton, 2014)

Some of its proponents may claim too much for the concept because they are swept along by the enthusiasm it can engender. The social sciences that underpin social work should remind us to retain a healthy questioning attitude. The question is not so much whether resilience can be meaningful or relevant, but *under what conditions* it may be so?

To put it another way, some of the limitations linked to resilience have not so much to do with the concept, but with how it is used. Many commentators are too easily tempted to

make excessive claims, to claim universal properties for what is more realistically a conditional concept—resilience is not a global construct or property that resides in some people across all circumstances, or in some family or community groupings across all circumstances. Rather it is a process that recurs in unexpected ways and with sufficient frequency and impact to be given serious attention.

One important criticism of resilience—or of how it gets used—is the tendency for some to see resilience as something within the power and control of the individual. The victim of difficult circumstances is then seen as a culprit, because, according to this mistaken view, they have chosen not to exercise sufficient resilience. Such a view may sometimes gain traction since it may appeal to certain political viewpoints less favorable to funding support programs.

Issues for the Future

Writing as engineers, Bruneau et al. (2003) make a call that has resonance for social work research. They seek a move from "qualitative conceptualizations" of resilience to "more quantitative measures." While this view may not win full consensus in social work, it is hard to see how greater attention to measurement will not become part of the research landscape in resilience as it relates to social work. We still need to deepen our understanding by exploring and debating understandings of resilience, ideas about resilience. But we also need to add a new dimension, finding and applying appropriate forms of measurement relevant to social work practice. Canadian social work scholar Michael Ungar has been helping to pioneer such approaches. It is not that social work research on resilience should exclude the qualitative aspect. As in so many areas of social work practice and research, qualitative perspectives remain important in deepening our knowledge, but our understanding of the value and impact of resilience can undoubtedly be enhanced by the addition of insights from quantitative research.

Research on resilience is challenging for a number of reasons: the conceptual complexity of resilience, its frequently contested nature reflected in quite different "schools of thought" about resilience, and the necessarily multidisciplinary perspectives that resilience research generally requires. It is also important that resilience research rise to the challenge of "drilling down" into multiple specific issues and "cases" so as to generate more fine-grained and relevant insights, as is happening in the engineering field (Mebarki, Willot, Jerez, Reimeringer, & Prod'homme, 2014). An increasingly important issue in research relevant to practice is the translation of findings remote from practice to implications that are clear, accessible, and "practice-near." Social workers want resilience researchers to answer certain questions about whether and how resilience is relevant to social work practice. What are the key messages for practice that may flow from resilience research? What does it suggest that social workers should *do* in given sets of circumstances? The ideas relating to resilience yield insights relevant for practice, but more in the form of guiding principles to be tested for relevance in a given context than an off-the shelf universal formula.

What Can Social Workers Do to Cultivate Resilience?

Resilience thinking represents an invitation to social workers to remain open to change, to appreciate the power of "life's ordinary plenty" in the words of the Irish poet Patrick Kavanagh (1972), or "ordinary magic" in the words of psychologist Ann Masten (2001). It is an encouragement to be aware in every scenario and decision of the importance of social support, and especially of the sources of support that may actually or potentially be at play in a given scenario. It is a call for an openness to a fresh narrative, to the power of serendipity, to chance opportunities that may prove influential, *if* they are grasped and that effort of grasping is supported. Since adversity is often multi-faceted it follows that efforts to cultivate resilience must embrace all relevant possibilities – the obvious and the less obvious. The *combination* of influences may make the difference (Schoon and Bartley, 2008).

Social work can operate at two levels. It can seek to recognize, promote, and support processes that are observed as enhancing resilience, or that are judged as likely to do so. These processes may occur in response to the intentional

efforts of others, or as a positive side effect of actions by someone close to the scenario, including the focal actor. The social worker seeks to identify and "cheer on" positive processes that they observe in a scenario. The social worker can also seek to stimulate, from scratch, activities that are known to show promise, that may lead to the cultivation of valued social roles, to the uncovering of special talents or interests. The social worker should seek out and support the "small things" that may serve to disrupt narratives of deficit and despair. Thus, the social worker will recognize how acquiring new interests or hobbies, or expressing of talents or realizing educational potential are all ways in which a person's identity may be transformed in potentially life changing ways. The social worker sensitized to the relevance of resilience will remember that 'small is not trivial'—apparently modest gains – as in the acquisition of a hobby or a step forward in education may produce disproportionately positive side effects. While the value of informal support is rightly highlighted in much of the practice-relevant resilience literature, it is also important to acknowledge the work that has highlighted how professionals may directly help cultivate or support resilience (Sanders, Munford, Thimasarn-Anwar, Liebenberg, & Ungar, 2015; Ungar, 2013).

Social work and resilience are well matched, but as in any relationship, there is a danger of becoming either over-invested or too detached. Sceptics and enthusiasts both need to become more discerning. Resilience has great potential value, but it is neither the answer to everything, nor another passing fad that can safely be dismissed.

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30

Role Theory and Concepts Applied to Personal and Social Change in Social Work Treatment

Dennis Kimberley and Louise Osmond

All the world's a stage,
And all the men and women merely players:
They have their exits and their entrances;
And one man in his time plays many parts,
His acts begin seven ages. At first the infant [.]..
Last scene of all, That ends this strange eventful history,
Is second childishness and mere oblivion.

—William Shakespeare

Contextual History of Role Theory and Concepts in Social Work

Social work has attended to persons who come for service in terms of biological factors, psychological factors, social factors, and their interactions, which support or impede personal and social development and functioning (Kimberley & Bohm, 1999; Kimberley & Osmond, 2009; Shulman, 2012). Many theories and paradigms that social workers have contributed to (*Diagnostic and Statistical Manual of Mental Disorders* [DSM-III to DSM-5], American Psychiatric Association, 2013, pp. 20, 488; Petrovich & Garcia, 2015), as well as therapies informed by social learning theories that are applied by social workers (such as self-determination and social support–social care theories), assume role theory and associated concepts, often without role theory being applied consciously as a dominant model (e.g., trauma-compromised functioning, Shulman, 2012, pp. 738–752). Common-factors theories that emphasize the social structure and relational processes that contribute to influencing personal and social change, through counseling-therapy or other

social care interventions, suggest that roles and relational processes that account for transtheoretically based therapeutic changes reflect relatively common patterns of therapeutic activity, even though semantically similar conceptual labels applied by each theory may vary in terms of preferred language (such as *problems* or *strengths* in personal and social functioning; see Sprenkle, Davis, & Lebow, 2009; Bertolino, 2010). Social group work, family therapy, partner counselling, supportive foster care, addictions interventions, corrections expectations, compromised mental health, health challenges, and anticipated life-cycle transitions, among other professional helping themes, all address one or more of these issues: role functioning, role expectations, role strain, role conflict, role ambiguity, role overload, role transitions, as well as role evolution and devolution (Williams, 2011). These role sub-themes are often associated with patterns of differential rights, privileges, and social position(s), as well as influences on identity formation, ("residential school survivor"; "professional"). Social justice concerns, as they appear in society and within professional practices, imply rights and responsibilities associated with social roles and social position (such as protection of women and children; empowering mutual aid in social group work). Related oppression concerns imply barriers, inequity, and unfair opportunities: to enable social role functioning and meeting associated needs (such as persons with disabilities); to support personal and social development (e.g., compromised personal and social functioning for maltreated and exploited children); to build capacity and resilience, to enable optimization of social functioning (such as survivors of "Indian" residential schools). Diverse vulnerability concerns within the context of social work practices imply problems, risks, harm, and unmet needs that influence personal and social functioning (e.g., victims and survivors of complex trauma; see Briere & Scott, 2015, pp. 197–2014; Shulman, 2012). As well, diverse human potential foci celebrate and support strengths, resilience, capacity, potential, and self-actualization—all implying strengthening and changing role functioning (such as the strengths of the human spirit to rise above adversity; see Ungar, 2012).

Role theories and related concepts, largely adopted from social psychology, as developed or interpreted by sociologists (e.g., Goffman, 1963; Mead, 1934), psychologists (Moreno & Zeleny, 1958), anthropologists (Mead, 1949), social workers (Grinker, MacGregor, Selan, Klein, & Kohrman, 1961), and psychiatrists (Ackerman, 1958), have provided sensitizing concepts, theories, paths for analysis, and dynamic understandings about how persons and collectives view and express themselves, as well as meet social expectations, especially in social interaction, including in interpersonal relational contexts. Some social workers have applied role concepts, theories, and presumptions about roles as acted out, explicitly to address problems, risks, needs, harm, strengths, resilience, and human potential that persons and collectives experience or exhibit within the context of personal and social functioning, with a special interest in assessing and supporting changes in role functioning (Appleby, Colon, & Hamilton, 2011; Karls & O'Keefe, 2008; Karls & Wandrei, 1994; Kestenbaum & Wahl, 1994). Many social work concepts, theories, and practices (such as feminist social work; child welfare practice), and those from cognate disciplines applied by social workers (such as deviance theory, Scheff, 1975); social identity theory (Cass, 1979); and stigma theory (Goffman, 1963), make implicit assumptions about role expectations and related social positions—the latter referred to in some postmodern thought as "social location." For example, social justice and oppression theories describe how some persons take on and integrate identities (e.g., "survivor" role relative to an experience of "rape" or child abuse) and related life scripts (such as role scripts, such as volunteers in rape crisis counselling; or children's protection worker) which may be associated with identification of persons and collectives as marginalized, stigmatized, over-responsible, victimized, traumatized, exploited, oppressed, and disadvantaged and/or privileged, all while being resilient, evidencing strengths, and demonstrating abilities. Fundamentally, role theory and related concepts help social workers analyze client systems in dynamic interaction with their physical (such as an "Indian" residential school) and social (such as a women's addiction treatment group) environments based, in part,

on role expectations, social role functioning, and associated interpersonal responsibilities—often contextualized within social care and social reform intents. The empirical indicators of social role functioning are typically observed in actions, beliefs, attitudes, values, expectations, and motivations as expressed or as signaled nonverbally, as well as relatively repeated and often predictable patterns of interaction that persons exhibit in their social-relational and physical environments (e.g., group citizenship in a trauma survivors group for exploited youth).

Social role theory may sensitize social workers who provide social work treatment to attend to personal capacities, potential and actual problems, risks, harm, needs, and injustices associated with role functioning and role expectations, as part of a social work assessment and social diagnosis. For example, workers may challenge how some roles in society may be stereotypically ghettoized or associated with one group (e.g., women more often provide personal care to infirm parents of both sexes). Other roles may be inherently unjust (such as the scapegoated child; Pillari, 1991) and may be expressed in unjust family dynamics (such as a parentified child; DeYoung, 2003). As well, role adaptations to cope with life situations may appear functional at one level but may also contribute to problematic and unjust relational dynamics at another (such as over-responsible partners of alcoholics; Bepko, 1985). In addition, social workers are aware about how both anticipated and unanticipated life transitions may be associated with personal and collective distress; role theory points to assessment opportunities within the context of role-related distress associated with complexities of role functioning as well as transitions in role expectations (Appleby, Colon, & Hamilton, 2011; Karls & Wandrei, 1994). Just as persons may experience intrapsychic conflicts (such as to follow basic instincts or to self-regulate) they also may experience social role conflicts (such as a parental caregiver and disciplinarian, or female parent and male parent roles). "Sick role" dynamics may be normative (such as a reduction of social expectations after heart surgery) or be judged as representing clinically significant "pathological" role dynamics (such as in Munchausen's-by-proxy syndrome [MBPS]; personality disorder). Other roles may be defined as primarily deviant (such as a pedophile who distributes child porn), or as being reflective of a self-fulfilling prophecy based on the unjust application of a deviance label (such as mentally disordered; Denzin, 1968). Notions of role ambiguity, confusion, complexity, conflict, rigidity, incongruence, strain, ambivalence, progression, and regression, role modelling, and overwhelming social role expectations may also inform social work assessments.[1] Questions for social workers and client systems include: What are the problems, risks, needs, resiliences, strengths, capacities, ambivalences, and potentials in terms of role functioning within a set of associated social roles (such as a child, sibling, student)? To what extent are role expectations of a person or collective contextually—functionally adaptive or maladaptive; justified or not justified; subjected to negative social support (such as continued harmful drug use by peers) or positive social support (such as harm reduction and recovery supported by peers)? What are the implications of role expectations and privileges, as ascribed or internalized, within the contexts of imperatives associated with culture, color, race, ethnicity, religion, sex, and gender, sexual orientation, ability status, or age?

Social work, being a change- and action-oriented vocation and profession (Goldstein, 1984; Kimberley & Osmond, 2009), enables personal and social change, including increasing strengths and reducing injustice, by helping persons and collectives understand the roles they and others play, in one or more social contexts, and related psychosocial dynamics (such as a victim of bullying in interaction with a bully in a junior high context). As well, patients/clients/consumers may wish explore how they might wish, need, or be required to change their role performances in a social context (such as parenting capacity within the context of justified children's protection); social workers may then apply various intervention theories (such as empowerment theory), concepts (such as self-actualization), and practices (such as reframing), all to enable needed, desired, or required personal and/or collective change and associated motivation—words that signal social and internalized role expectations.

Such applications may help the person or collective sustain the change in role identity (such as from victim, to survivor, to social-emotional leader), social role functioning (such as presenting self as confident and assertive, and acting congruently), as well as in acting on role responsibilities as well as rights (such as safe and protective child care and parenting). In this analysis, the authors focus on role theory, concepts, and related practice wisdom, as may be applied, directly and indirectly, in assessment and treatment in diverse social work contexts in the interest of enabling optimization of desired, needed, and/or required, or otherwise justified personal and social change—in individuals or collectives such as partners, families, or treatment groups.[2]

Roles: Concepts and Theories for Social Work Practice

Roles as Determined and as Socially Constructed

"The larger number of participants in the group interview, permitting the advantage of diversification of roles, has one of its consequences the appearance of problematic roles." [contextualized quote];

Alfred Kadushin, 1972

The concept of *role* (sometimes referred to as *social role*) implies a societally or smaller social group, constructed and culturally determined, set of social expectations, associated with the boundaries of status and identity (such as a foster child) and patterns of conduct internalized and expressed in social interaction, and undertaken, or placed on, the person by himself-herself ("unlovable-undesirable child"), by significant others ("rejecting parents"), by a membership group (such as a teen gang), and/or by the community and/or by society (such as police as representatives of society and social order), which that person typically internalizes and assumes or takes on (Dandaneau, 2007), such as becoming tentatively bonded with a surrogate parent. Social *role* also implies sets of interactive, interdependent, and interrelated responsibilities, rights, privileges, and opportunities for individual and collective agency. The latter is evident in terms of relatively conscious and willful acts to both construct their realities (such as identifying as a member of the foster family and assuming their surname), and to more consciously and mindfully process biopsychosocial determinates of role performance (such as justified, desired, and needed change in foster child–foster family bond). While roles may be socially and culturally determined, in part, people and collectives also have opportunities for a degree of agency in how they manage, modify, interpret, and act-out a role relative to their social position, social situation, and social context (such as a participant in a group of male "batterers"). Another implication is that roles act as determining some boundaries of self-identities, but people and collectives also actively construct, reconstruct, and socially present their identities within role boundaries (Cass, 1979). One paradox of self-agency is that role performances may come to be expressed in habitual and relatively unconscious patterns.[3] Important questions for the social workers include: To what degree is the client's best interest served by meeting social role expectations (such as a parent, student, employee)? To what degree is their best interest served by empowering client systems to be agents in changing expectations, related role responsibilities, related unjustified oppressions, and related social identities? Individual and collective commitments to needed, desired, or required changes in role expectations, role functioning, and/or role responsibilities are implied in much of social work intervention. To what degree are rights, privileges, and social positions coherent and justified?

Social Position and Social Role

If a role set is assigned to an elevated social position and the related status assigned to it (such as a professional social worker), within a given social context (such as protection of children and youth), then associated rights (privileges and powers) and responsibilities may have significant social value and high performance expectations associated with that role (such as to assess a child as in need of protection and to be sanctioned to apprehend and place a child exploited for child pornography). Others may have deviant, marginalized, or otherwise contextually "lower" social positions in terms of value, voice, and range of power

(such as a sex trade worker; exploited youth). Important questions for the social workers and clients are: "To what extent are role expectations and associated social responsibilities clear, confusing, ambiguous, double-binding, overwhelming, or contributing to internal or interpersonal conflict, ambivalence, and 'role strain'—when role expectations and identity demands, are not sufficiently congruent, supported, or justified? To what extent are the social requirements of a role inconsistent with the respect given to the person or collective in the related social positions?[4] To what extent is there a paradox of significant power associated with a devalued social position but one of high value in specific social contexts?" (such as a drug pusher).

Roles Sanctioned and Required

The term "role" may be used to give direction to the analysis of personal and collective responsibilities that a person or persons undertook in acts of commission or omission, which might be interpreted as warranted, or not, in a given social situation, in a broader social context (such as not disciplining a recently arrived, frightened foster child for a minor infraction). Such roles may be sanctioned before or after the fact (such as expecting that an abusive male leave the home), or may be challenged after the fact (such as failure to take seriously a male's complaint about partner abuse). Or, the social worker may ask: "What responsibility did this parent have in protecting, or failing to protect, the child?" There is an implication in applying role theory and associated concepts that persons in a given culture or society are reasonably familiar with the boundaries of role expectations (such as a child caregiver), social role functioning (such as caring for a child), as well as how related responsibilities are typically expressed in actions required of individuals (such as a parent) or collectives (such as school personnel)—conscious and unconscious, intentional and habitual. A person, or people, within a role set may be judged to be: over- or under-responsible within the context of age, stage, and a social situation, or as an adequate or less-than-adequate role model, expressing an adaptive or maladaptive,[5] or congruent or incongruent, set of responsibilities relative to common expectations for a given role and context—including cultural context.

Individual or collective commitment to needed, desired, or required changes in role expectations, and/or social role functioning, and/or role responsibilities are implied in much of social work intervention. Role definers, rights, and expectations may be both socially constructed and socially determined, but persons and collectives also have opportunities for a degree of agency in how they manage, modify, and act out in a role, relative to social position (such as a recovering charged and convicted addict), social situation (such as being in the presence of active drug users who support his "sobriety," and using their positive support) and social context (such as living under a parole order to not use and not be in the presence of users). Another implication is roles as defined and as acted out influence self-identities but that persons and collectives also actively and unconsciously construct their identities (such as self-regulating and in control; see Hood, 2012). Important questions for social workers and clients include: "To what degree is clients' best interest served by meeting social role expectations as defined-directed by others (such as a parent, student, employee)? To what degree is their best interest served by empowering client systems to act more as relatively self-regulating agents in changing: self and social expectations; related social responsibilities; patterns of acting in role performance; patterns that are experienced as role conflict, role strain and associated dissonance; and the boundaries of self and social identities? To what degree are role requirements contextually justified?"

Roles in Interaction and Social Organization

A major assumption in role theory is that social organization and social order, of a society, community, social institution, social group, partnership, or a family, are, *in part*, created by the individual as well as the collective: socialization, internalization, acceptance, or compliance, and congruent actions, converging and integrating in a relatively coherent whole (Mead, 1934). In the majority of social contexts, to not have an

internalized working understanding of interdependent and interacting sets of social role expectations and related responsibilities would be likely to result in relational disharmony, family chaos, or social disorder.[6] The expectations for the conduct of one set of social actors (such as a social worker) typically implies *reciprocal expectations* for an associated social actor (such as a client/consumer and therapist-helper), or some *mutual patterns of conduct* expected of persons within a group of social actors with a common identity or purpose (such as alliances in support group for aboriginal persons who had been in residential schools), or *complementary patterns of conduct* (e.g., one foster parent may very able as a caregiver and the other as a mentor and disciplinarian)—often with prosocial presumptions of parental cooperation. From an interactional perspective, the social group affects the person, and the person influences social group dynamics—including in terms of role functioning and role modification (Shulman, 2012). General questions for the social worker and her/his client system are: "In whose best interests are the expectations and related responsibilities of social roles sets, challenged and changed? In whose interests are role expectations met or not? Who is empowered to define and apply the criteria associated with role performance that are judged to be personally, collectively, and/or socially functional or not—with due consideration to social context, situation, culture, and power differentials? To what extent are role scripts acted out, in a more or less unconscious fashion, or more or less habitual patterns, without much conscious thought? To what extent do relational roles evidence relative mutuality, reciprocity, cooperation, coherence, and complementarity?"

A Paradox of Flexible Fixed Roles

Notwithstanding that common expectations of a role within a social context may be relatively fixed in definition and recognizable patterns, role expectations, role function, associated responsibilities, and related identities are not as likely to be fixed or immutable. The boundaries of role functioning may include a wide array of related expectations, not all of which need to be performed in any given situation in order to sustain a role position, or to act out the role with efficacy. Boundaries of role expectations and function may change over time with the social development of the collective (such as women's roles and men's roles, Tranter, 2004; the roles of members of a therapy group may change as the social group coheres, Shulman, 2012). A person may change role performance or roles based on multiple reasons (such as role transitions during developmental and life transition changes, Hick, 2010). Also, role performance or role function may change through conscious, willful, relatively rational and planned effort (such as personal agency, advocacy, counselling, therapy, or policy) or through relatively unconscious processes (such as assuming traditional aspects of role by an aging Aboriginal who is gradually treated more and more as a community "elder"). Some roles may have relative stability and continuity for a period of time (such as a parent, or child protection social worker), and may be associated with resiliency (Bowen & Martin, 2011), or may be temporary and transitory (such as a person undertaking unexpected crisis intervention, or a "bingeing party animal"). Assessment of a person's life experiences and presenting concerns may explore relatively stable roles, changing roles, temporary roles, potential roles, desired roles, required roles, and the ability to modify roles and self-identities while still being in a role—implying some agency. Increased awareness may help the clients/consumer(s) to set goals for role function changes, to modify role expectations, to negotiate changes in related responsibilities and expectations, to assume new roles, or to follow paths of discovery or developmental unfolding, given new opportunities (such as exploring Aboriginal foster parent roles).[7]

Assessment of Role, Function, Responsibilities, and Expectations

Biopsychosocial Assessment of Personal and Social Functioning: PIE

Based on biopsychosocial and person-in-environment (PIE) and current ecosystems assumptions (Appleby, Colon, & Hamilton, 2011), the PIE system for classifying social function within the context of typical ranges

of social roles, with due respect to culture and contexts of the expression of those roles, was designed by social workers who wished to moderate the "medicalized model" of assessment and diagnosis. They wished to integrate valid concerns with personal and social functioning problems and strengths, as well as social environmental, mental health, and physical health considerations, which might act as associated risks or supportive factors for individuals (Appleby, Colon, & Hamilton, 2011; Karls & O'Keefe, 2008; Karls & Wandrei, 1994). The PIE classification system enables the social worker to make quantified estimates of problem levels,[8] and to integrate social functioning assessment with mental health assessments while applying DSM or ICD criteria (*Diagnostic and Statistical Manual of Mental Disorders; International Statistical Classification of Diseases and Related Health Concerns*). The model supports the social worker and client, within themes of ecological understanding of persons in their environments as well as biopsychosocial assessment and interventions, in assessing *problems with social role functioning* (Factor I)[9] and related difficulties along a number of dimensions, any of which may change or be changed over time.[10] Considerations in assessment include, but are not limited to:

- Identifying the range and scope of the roles that are problematic (such as a parent role: child care, parenting, provision for the children's basic needs)
- Evaluating problems directly associated with role functioning (such as responsibility: current parental capacity is not congruent with the parents' adequate knowledge and skills)
- Judging the severity of the role performance concerns (i.e., there is a high risk of justified child-removal)
- Describing the duration of clinically significant problems (over 12 months)
- Evaluating the range and scope of client coping—as evidence by contextually justified indicators of social role functioning ("The parents have taken a prescribed parenting course and have done well in learning parenting knowledge and skills, but have yet to implement their learning in the interests of the children, even with supplementary *in vivo* parent coaching")
- Challenging situations where societal or systemic role expectations are overwhelming or otherwise oppressive, especially when not fully justified

The process is one of assessment with the client, at times conferring with collaterals, as well as formulation and articulation of issues, indicating needs for change in terms that the client is able to comprehend. The questions for the social workers and the primary clients are: "How do apparent capacities, strengths, and deficits in role functioning converge, within a given context, with due respect to age, stage, and culture, to justify expectations for needed, required, or desired changes in social role functioning? To what extent are expectations for change in personal and social functioning based on internal desires and needs? External "pressures? Internal and external motivators?" (See, for example, the analysis of the interaction among culture, context, gender, and marital-parental role expectations by Archuleta, 2015.)

Integrating Systemic and Situational Factors in Assessment of Role Function

One of the hallmarks of social work theory has been situating persons, as individuals or collectives, in transaction with, and being influenced by (social determinism), or influencing (agency; social construction) their social and physical environments. The PIE assessment model supports the social worker and the client in considering *environmental problems* (Factor II), with special reference to those that typically may be associated with creating, aggravating, sustaining, or blocking resolution of concerns in role functioning—often reflecting diverse scholarships, among which are included the contextual-historical, situational, systemic, structural, and cultural factors. For example, parents may have added distress because their child may have a problem with bullying at school, which affects his academic and social role at school as well as his functioning within his family; as well, parental complaints to school authorities have resulted in no effective or socially supportive

action. The dimensions of social factors that are included in the PIE system are sufficiently broad to enable relatively unlimited options regarding social situations, social structures, and cultural factors, which may compromise desired, needed, or required, social role functioning or related changes.[11] Among the questions for the social worker and clients are: "What are the social factors, social structural factors, social situational factors, contextual-historical influences, or cultural realities in the clients' environment (Appleby, Colon, & Hamilton, 2011, pp. 16–77) that may support desired or needed role functioning, impair role functioning, or impose unjust or otherwise oppressive role expectations on a person or collective?" A layer of analytical complexity may be added to the assessment and service plan if the client desires to assume, or retain, a social role (such as sex trade worker), especially a role set that conflicts with community-cultural norms for another role (such as being an active caregiver and parent, as well as acting as a socially acceptable "role model"). Role theory predicts that there are likely to be conflicts, ambiguities, ambivalences, and "strain" within a role set (such as caregiver and disciplinarian) and between or among roles (such as sex trade worker and parent to a child), and that resolution of conflicts between the desired and the required may be imperfect—thus contributing to role strain (Tranter, 2004).[12] Superficial ideologically based role-strain resolutions such as client empowerment, client strengths, and client self-determination may not be highly achievable; in some social work interventions, or in client-consumer-patient actions, or through expressed social expectations; one "best interest" may be purchased at the expense of another. Accepting the social work tradition of supporting the most vulnerable and those needing the most imminent social care, among the questions for the social worker and the clients include: "Who gains by changes, or lack thereof, in social role functioning? Who "loses" by changes, or lack thereof, in social role functioning? Are there optimal changes and justified expectations that could support a gain–gain outcome (such as reduction of over-responsibility for a parentified child; an associated increase in parental capacity and timely responsibility-taking)? What are the dynamics of power differentials in defining desired and required personal and social changes?" (If a parent is given too much unjustified power, then the progress that her/his children make in care may be judged to be sufficient to give the parent another chance, when the parent(s) have not made child-centered improvements in parenting motivation and performance.)

Integrating Health and Mental Health Factors in Assessment of Role Function

The PIE assessment model supports the social worker and the client in considering *mental health problems* (Factor III) that may interact with the clients problems in meeting desired and/or required role expectations. For example, if a parent's capacity is compromised by mental health and addiction problems, then problems in personal and social functioning may pose risks and harm for the children and the family (Kimberley, 2010). Mental health considerations may intersect with environmental considerations (for example, persons challenged by concurrent disorders are more likely, within a group of persons needing mental health services, not to be provided with, or to not use, needed services). General questions for the social workers and clients include: "What range of social role functioning is efficacious, even under conditions of being compromised or at risk due to mental health and/or addiction problems? What are the likely impacts, or interactions, of mental health problems with compromised, desired, and expected role functioning? How do improvements in mental health impact the prognosis for verifiable, sustained, context-relevant, or otherwise clinically and socially meaningful gains in role functioning? At what point do systemic demands for personal and social change exacerbate concerns with role functioning and mental health or addiction risks?"

The PIE classification system similarly supports the social worker and the client in considering physical *health problems* (Factor IV) that may interact with social role functioning and related personal, social, and environmental problems.[13] For example, if capacities of a person

who is accustomed to being effective in multiple social roles are seriously impaired by a stroke, then what implications might that have for role expectations, responsibilities, needs with respect to support roles, and self-identity related to employee roles, spouse/partner roles, parent roles, community roles, and instrumental roles such as driving a vehicle? In some situations, return to some desired social role functioning such as driving may not be likely or permitted. Return to required expectations of employment such as operating a vehicle may never be met again. The client's social environment (say, an employer) may, or may not, be willing to make supportive accommodations. The progress of the client in resuming desired and expected role functioning and related self-identity, with due respect to age and stage, even with needed treatment, may be slow, with regressions often being anticipated; improvements are likely to be imperfect though often demonstrating genuine strengths compromised by medical realities. Similar to mental health, general questions for the social workers and clients are: "What range of social role functioning is efficacious even under conditions of being at risk, compromised, or otherwise constrained, due to health issues or related social responses? What are the likely impacts, or interactions, of health problems with compromised, desired, and expected role functioning? How do improvements in health status, or relapses, and associated well-being influence the likelihood of improvements in role functioning? At what point do systemic expectations for personal and social change exacerbate concerns with role functioning as well as health challenges?"

In general, the application of role concepts may help the social worker and the client-consumer-patient formulate a social work assessment, ally to modify an assessment, as well as plan for personal and social change directions and supports. The change process may include systemic change and monitoring progress, which includes changes in role functioning and social expectations or responsibilities associated with ascribed and assumed social positions, related roles, cooperative relationships, and self-identities. At times new roles may be needed, and the client/consumer/patient may have to adapt and cope with a transition to modified responsibilities and changes in social position and identity.

Role Theory and Concepts in Social Work Treatment: A Synthesis for Informed Action[14]

A Biopsychosocial Interactional Perspective

In reflecting on treatment options and social work service planning that promote and enable needed, desired, or required personal and social change, including systemic-structural changes, with the general goals of optimizing the best interests of the clients, the authors propose a *biopsychosocial interactional* model (BPSI). This model is personal and social change–oriented and supports an integrative and trans-theoretical approach to treatment.[15] What follows is an integration of some role theory, role concepts, and selected practices, as well as overlaying role theory concepts within existing practices from other models. The orientation is towards changing role expectations by self and others, and changing role functioning in the interests of modifying problems, risks, needs, and harm, including actualizing strengths, resiliences, capacities, and potential, as well as changing self-identities associated with roles. Paradoxically, some change-oriented interventions may be in the interest of supporting clients' self-determination, where changes might be in the direction of reducing internal and external pressures for changes in role expectations, role functioning, or related responsibilities, which may be unjust and/or unwarranted. While many role dynamics may interact with relatively predictable patterns of thought, affect, expression, and relational dynamics, the client-consumer-patient is defined as having agency in changing role functioning, including in terms of becoming more mindful and aware of unconscious action patterns and relational dynamics (such as coordinated and cooperative mutual and reciprocal efforts), associated with changeable biopsychosocial dimensions. Taking on roles and constructing parts of roles or new roles fits with an interactional model (Shulman, 2012), without adopting non sequiturs that all of a person's or collective's

psychosocial realities are socially constructed or that all changes must be evidence-based and replicable.

Social workers may apply one or more interventions, with diverse practices, applying varied concepts, and with logically intersecting theories, converging to support a coherent and integrative approach to personal and social change, desired by (such as improved parenting) or required of (such as no longer acting with the rights and powers of a custodial parent) the clients. In applying integrated interventions from a BPSI perspective, social workers may apply role theory (such as role expectations desired or required), concepts (such as inter-role and intra-role conflicts and/or cooperation), explicit role-application practices (such as psychodrama, Emunah, 1994; Landy, 1993; play therapy, Webb, 2015; family therapy, Waters & Lawrence, 1993; Hanna & Brown, 1999), and practices that implicitly apply social role-like notions (such as strengths-based practices, Berg & Reuss, 1998; social justice practices, Csiernik & Rowe, 2010; oppression theory, Appleby, Colon, & Hamilton, 2011).

In promoting a change orientation, the social worker may explore a set of personal and social change opportunities, embedded with role-oriented analysis, with herself/himself, the clients, significant others in the social environment, and within social systems-structures. The following analytical and change dimensions may be applied to guide interventions to enable contextually and situationally relevant, verifiable, and sustained change, with due respect to social role expectations and functioning, including cooperation and mutuality. These dimensions of change respect specific social situations within a broader social and cultural context, where role responsibilities are acted upon, and where they are compromised by personal, relational, or systemic-structural dynamics.

Case Example 30.1: A Biological Self, in Psychosocial Context

What changes in biophysical, biochemical, biomedical, neuropsychological-neurosocial realities would support improved social role functioning by the person (such as parenting attachment) or collective (such as being a supportive group citizen in a therapy group)? Are there role expectations and functioning that might be changed, and by whom, to give just recognition to biological realities of the person or collective (such as persons living with AIDS)?

For example, social workers with family-support and child-protection roles were faced with parents who expected too much in terms of family, school, and community role functioning of their 12-year-old, who had to manage severe symptoms related to attention-deficit hyperactivity disorder (ADHD), cognitive functioning limitations associated with Klinefelter's Syndrome, and social marginalization, in part due to physical features and his problems with self-regulation, even under conditions of medical treatment with multiple medications. The boy's school was less than supportive and exacerbated his marginalization. School personnel defined the child not meeting role expectations as being "willful and resistant." Interventions included: working with the school system to acknowledge, as well as coaching selected school personnel to support, strengths and potential, and to apply situationally justified expectations for academic and social role functioning. Working with the parents and child in *in vivo* family therapy included modifying parental expectations (such as eliminating unnecessary negative consequences, such as blaming the child for his mother's depression), including their expectations for the child (such as accepting that they could not expect him to follow a parental agenda and complete a college degree). His social environment was further modified for him in what the therapists called a mutually supportive "two-family system," where the child went into a foster home that was integrated therapeutically with the parent's home to create a relatively seamless therapeutic effect in the interests of the child gradually assuming more age-stage, and situationally fair, social role functioning. The therapists advocated for improved medical treatment of his confounding biomedical conditions. With the support of *in vivo* individual and dual-family therapy, simulating therapeutic foster care, and a long-term case plan, the youth completed high school, when he was expected to leave school prematurely, and he obtained gainful employment, when he was at high risk for being unemployed. He successfully maintained relationships with his social supports, who, in turn, learned to not be unjustly demanding in terms of role expectations and responsibility-taking. This case also benefitted from an integration of neurosocial

understandings such as exemplified by Matto, Strolin-Goltzman & Ballan (2013) and Lefmann & Combs-Orme (2013).

Case Example 30.2: Self in Social-Historical and Developmental Context

What changes in personal and social developmental needs and experiences would support improved social role functioning by the person or collective? Are there role expectations that might be changed, and by whom, to give justified recognition to both common and unique developmental needs and experiences? What role patterns may be changed with respect to attachment and social bond dynamics influencing developmental needs? What developmental sequelae have most likely interacted with identity development, social location, and role performance?

For example, a social worker with a women's services role was faced with a young professional woman who was very apprehensive about losing her professional license because she had "slept with 150 different men a year," and abused drugs and alcohol, and was observed by others in many "compromising situations." Her developmental history was one of severe sexual abuse, including exploitation for the production of child pornography. She had clinically significant problems with attachment and bonding and "would not sleep with the same man twice." She wished to be able to be a partner in a committed heterosexual relationship, to reinforce her professional identity, and to "leave" her role as a "one night stand bar fly," "behind" her.

In-depth dynamic therapy, applying some developmental and trauma theory, included work on complex trauma and attachment disorder, but a rational-emotive behavioral therapy model was also applied to reduce her fears of healthy social bonds, increase her ability to enter into social roles that could develop over time into mutual intimate social bonds, without rushing to sexualize emotional, intellectual, and social intimacy. The therapist also enabled her to break patterns of accepting advances from men who were probably a risk, and increase her understanding of healthier expectations in female–male relations. When she did give up her "street life" and connected with a male who was able to bond at a healthier level, he took part in some of her therapy sessions. There he could learn to moderate his expectations of her as a woman with unique developmental damage in a committed relationship, and new roles for her linked with "self-reformation." A subtext of her progress was controlling substance use, a harm-reduction model, so it did not compromise her progress in personal and social functioning, including professional role functioning. Success of harm-reduction and self-regulation was evidenced in her showing up at her professional office without symptoms of withdrawal accompanied by improved professional performance. The social worker saw the fundamental strategy as overcoming developmental damage that compromised present personal and social functioning, while being supported by transformed role functioning.

Case Example 30.3: An Emotive Self, in Interaction

What changes in affect and the experience of related sensations, or expression of feelings and emotions, would support improved social role functioning? Are there role expectations that might be changed, and by whom, that respect the person's or collective's preferences for experiencing and expressing sensations, feelings, and emotions, versus suppression and repression of affect?

For example, a social worker faced with a family, a battered woman, and a support role, was helping a young lone mother with a five-year-old child who felt ambivalent about returning to her seriously abusive and dangerous husband. She loved her son and typically was very good as a caretaker and parent. On the other hand, she felt lonely, sad, and grieved for the multiple losses in her life. She and the protection worker were both uncertain about her resolve to protect herself and her son.

The social worker explored how the mother's social supports from family could be activated and how neighborhood supports might be built and sustained. The young mother was supported to the role transition of single mother, through counselling, including plans for increasing self-confidence and self-esteem, in part through a gradual program for academic progress, correlated with expected increases in positive affect. The social worker saw herself as respecting the client's vulnerabilities and risks by applying trauma theory, respecting the client's potential by applying strengths- and resilience-based theories, and respecting the client's need, desire, and requirements for adaptive change by applying social role theory to enable improved personal and social

functioning and thus, among other intentions, sustained changes in stability, self-esteem, affect, and its expression.

Case Example 30.4: An Aware Self and Cognition in Interaction

What changes in cognitive functioning, cognitive content, and cognitive-neurological factors would support improved social role functioning? Are there role expectations and associated beliefs, attitudes, and values, which might be changed, and by whom, that respect the person's or collective's cognitive change ability?

For example, a social worker with addictions assessment, counselling, and case-management roles was faced with a boy aged 19, with an IQ of 140, who was near death due to use of multiple mind-altering chemicals. The client had used methamphetamine, which is associated with changes in neurological structures that decrease memory. He had also used "crack" cocaine, which can speed up mental processes (such as a flight of ideas), and at the same time impair one's ability to sustain focus and attention. The drugs he used were associated with paranoid thinking that compromised much reasoning and decision-making. The other drugs he used, such as XTC ("Ecstasy") and alcohol, impaired his judgement and disinhibited his sexual expression, contributing to increased risk of sexually transmitted infections (STIs). He expressed pro-drug and pro-street lifestyle beliefs, attitudes, and values, which increased his imminent risks. The client expected the street drugs to make him feel better, without considering the negative consequences.

The social worker suggested beginning with a harm-reduction program to enable more clear self-directed thinking about desired changes to reduce the likelihood of a preventable death, as well as to increase his motivation to commit to an inpatient program. The social worker challenged the client's plan for a premature return to his role in learning at a community college because his performance would probably be compromised by his cognitive abilities at the time. The social worker saw his own role as balancing the need for safety with timely problem-solving, and the client's need for insight (such as making the unconscious more "conscious" as associated with personal and social functioning). Strategies included empowerment while challenging premature solutions, with harm-reduction commitments expected to enable improved cognitive functioning to support deeper and lasting gains.

As the young man's cognitive functioning improved, he was able to assume and sustain more pro-social roles, was able to use more pro-harm-reduction social supports, and was able to integrate optimized self-regulation into reality-based plans to return to school.

Case Example 30.5: Behaviors Determined and Actions Willed, in Interaction

What changes in patterns of behavior, willful action, and self-regulation in social interaction would support improved social role functioning, based on intrinsic and extrinsic motivations? Are there role expectations that might be changed, and by whom, that respect the person's or collective's preferences for behavior, consciously willful actions, and self-control?

For example, a social worker with a family services role was faced with patterns of habitual behavior by a father of not assuming care, parenting, and bonding responsibilities for his eight-year-old stepdaughter. The stepfather claimed that he had made conscious attempts to undertake a parental role earlier, when he moved in with the girl's mother, but that this "did not work" for him and the girl. The stepfather reported that he avoided discussing parenting issues because there was a risk of conflict he did not know how to resolve, so "doing nothing was better than doing something . . . that would go wrong."

The social worker recommended that she interview each family member in terms of their needs and wishes and then hold joint sessions between the mother and child, followed by a family session. She noted that at some point there would probably be, among other plans, work on role-complementarity, co-parenting and childcare roles, avoiding some conflicts and role strain, stepfather role boundaries, and reality constraints, which could work for all three family members. She also recommended knowledge and skills-development particular to a step-parenting role with a daughter.

The social worker saw her role as supporting verifiable and sustained change through the coherent application of cognitive behavioral theory, social learning theory, and family dynamics theories, with primary changes being improvements in parenting, co-parenting, and familial relational roles.

Case Example 30.6: Self, Social Bonds, and Intimate Relationships

What changes in intimacy, attachments, and sexual expression would support improved social role functioning? Are there role expectations that might be changed, and by whom, that respect the person's or collective's needs and preferences for attachments, intimacy, and sexual expression that might be expected in marriages, families, and other close or lifelong partnerships?

For example, a social worker with health counselling, psychosocial assessment, and case-management roles, was faced with a woman who had had a mastectomy and who, as part of coping, had distanced herself from her husband. He believed that his partner of 15 years had detached, had become more superficial in terms of emotional and verbal intimacy, and that she expressed a wish to "avoid anything sexual at all costs," even though he was sensitive and expressed no such expectations.

The social worker focused on a message of normalization ("to be expected") in terms of short-term critical responses by the woman, hope for the future based on other couples who had been through similar crises, support for needed patience, and reaching for past strengths and solutions that might provide the basis for a return to, or for building anew, relationship- and marriage-sustaining joint expectations.

The social worker saw her role as helping with crisis management, relationship solutions, couple strengths-building, individual and couple's counselling, and sexuality counselling, in the interest of transforming relational role expectations and functioning.

Case Example 30.7: Self, Social Bonds, and Social Relationships

What changes in relationship needs, social bonds, and interpersonal relationship patterns would support improved social role functioning? Are there role expectations that might be changed, and by whom, that respect the person's or collective's needs and preferences for relationship, social bonds, and efficacious interpersonal relationship patterns?

For example, two social workers co-led a group for advanced treatment of sex offenders. The social workers interpreted their roles as helping the group and each member to progress towards reducing and consciously controlling re-offense risks, as well as increasing pro-social functioning.

As part of two group sessions, the social workers used psychodrama techniques, which included one half of the group assuming victim roles (based on their real-life experiences as victims or perpetrators), with the other half "getting in touch with their perpetrator roles and identities." These psychodrama experiences were followed by group debriefing about what each drama experience meant emotionally and cognitively, especially in relation to feeling and building accurate victim-centered empathy.

The social workers saw themselves as applying integrated group dynamics theories, psychodynamic theories associated with accurate empathy, building, and social bonding, dramaturgy, as well as capacity-building with respect to increasing mutual aid capacities, social responsibility, and replacing perpetrator roles with genuine protective roles.

Case Example 30.8: Role Performance in Social Situational Context

What changes in structural, systemic, contextual, and situational determinants could support improved social role functioning? Are there role expectations that might be changed, and by whom, that respect the person's or collective's needs and preferences for social systemic changes? Are there cultural factors that may be supported as strengths, or be challenged as being unjust (such as female genital mutilation as part of coming of age).

For example, a social worker working with victim assessment, support, case-management, and referral roles was faced with a female client who was a victim of partner violence where the partner was charged and convicted. When the young woman returned to live with her former partner, her children were removed as children exposed to violence; the authorities were contemplating long-term placements. The woman was battered again and made a complaint; this time she was "determined" to not live with the male batterer "ever again."

The Victim Services worker advocated to Children's Protection and the court for her to have "another chance," as the mother was effective in terms of independent childcare and parenting, and had agreed to stronger supervision and safety measures than in the past.

The victim's services worker saw her roles as supporting strengths-building and systems-change, within the context of feminist-based advocacy, with due respect for contextually relevant child safety

needs. She supported the mother's role transition to more confidence and in sustaining self-protection as well as verifiable child-centered parenting, care, and safety, through counselling and psychosocial education (such as impacts on children from exposure to violence).

Case Example 30.9: Motivation for Role Compliance or Role Change

What changes in personal and collective motivation, including intrinsic and extrinsic factors and self-direction, would support improved social role functioning? Are there role expectations that might be changed, and by whom, that respect the person's or collective's needs for self-direction and preferences for motivation? What extrinsic sources of motivation may be justified within the client's social contexts? What efforts are needed to get beyond contemplation to sustained changes in role functioning?

For example, a Children's Protection social worker was faced with a family with four children, one a newborn, in which both parents had adequate knowledge and skills for childcare and parenting but did not demonstrate an ability to sustain competent and safe parenting, even under conditions of supervised access, where the motivation to demonstrate effort and change might be expected to be the highest. The children had to be removed for their safety, as the parents spent most of the family resources on alcohol, drugs, and themselves, and devoted little of the family resources or quality time to the needs of the children. The children evidenced many and significant indicators of physical and emotional neglect, even though family resources were adequate. The parents expressed a high wish for self-directed parenting, without intrusion, as they defined their knowledge and skills as being "above average." Neither parent had insight into intrinsic factors that might compromise sustained motivation for child-centered best interest. Both had insight into extrinsic factors that they summarized as: "If we don't get our act together, then we are going to lose our kids for good."

The protection worker commissioned an independent assessment of their parenting capacity that included an evaluation of the dynamics compromising intrinsic child-centered motivation and related personal and social functioning—especially as related to parental capacity. The independent assessor uncovered multiple developmental dynamics, maternal mental health problems and addictions, and paternal developmental dynamics and substance-use concerns, which had to be addressed before sustained gains in child-centered parenting, based on intrinsic motivation, could be expected. In short, protection services could not expect timely gains in sustained parental role functioning until the parents resolved and stabilized some of their developmental, mental health, and addictions issues. In-patient addiction counselling had the added benefit for the mother of offering a model for role and identity transition such as being "a person in recovery." A goal was to make sufficient substantive and sustained parent-centered changes to enable movement towards genuine, sustained, and verifiable child-centered motivation. In terms of social role functioning, among the short-term plans were included supervised access with active parent-coaching, enabling the children's mother to not become overwhelmed with childcare and parenting duties during the early stages of trauma therapy and addictions recovery, as well as enabling the children's father to focus on protecting the children and providing care and active parenting, in alliance with home care supports.[16]

Case Example 30.10: Identity Formation as Biopsychosocial Interaction and Convergence

What changes in interaction of biopsychosocial factors and convergence of personal and social factors, in identity formation and identity transitions, as well as self-concept, self-esteem, and self-worth, would support improved social role functioning? Are there role expectations that might be changed, and by whom, that respect the person's or collective's needs and preferences for experiencing and expressing themselves in social contexts? What conflicts and strains in role functioning are interactive with identity and potential transformation?

For example, a social worker with responsibility for children's mental health, especially children who had been maltreated, had been involved with the child of the family in the previous case, where the eldest female child, aged six, was chronically rejected by her stepfather, even though she had been formally adopted by him. The girl was then systematically and relentlessly (daily) scapegoated and took on the role of scapegoat, in that she began to "look for" and expect negative attention and blame. As well, she was "parentified" (had assumed a parental role), and in acting out this over-responsible

role, such as monitoring the needs of her newborn brother, she was further scapegoated for being "too big for her britches" and, alternatively, for "not helping her mother" (a double-bind communication that contributes to role strain and identity confusion). Her stepfather blamed the child for supervised visits not working and for "not letting her mother show what she could do." He gave the child the clear responsibility for making supervised visits work; the child would even cue the social worker that her mother would "not last much longer"—a metaphor for the beginning deterioration of a supervised visit. The child would ask to leave early, to return to her foster placement, as if to protect herself from being blamed for parental "failures." The child could not count on her mother to protect her or care for her; the stepfather provided more adequate care but often supported the mother in parentification and scapegoating family dramas.

The social worker examined how biopsychosocial factors in the child's development, her family life, and her community life supported negative identity and related role function, as well as positive identity (such as a teacher seeing her as a sweet and helpful child). The social worker put integrated therapeutic foster-care plans and supports in place to enable the child to assume the role of a dependent child, and to enable her build self-esteem based on child role expectations and responsibilities, and to not feel the need to reinforce her self-esteem and identity as a "little adult" who takes age-stage-inappropriate protection, care, and parent-coaching initiatives, is very wise, very able, and is very helpful to adults.[17] Part of the goal was to reduce role conflicts and role strain, and to differentiate and substitute age-stage-appropriate roles for the child, without pathologizing the child's over-responsible role performances.

An Existential Self

What changes in existential meaning, existential realities, and spiritual paths would support improved social role functioning? Are there role expectations that might be changed, and by whom, that respect the person's or collective's needs and preferences for meaning, spiritual paths, and processing existential life shifts?

Social workers often work with persons so oppressed and marginalized that they define themselves as being "unimportant" and perceive their lives as having little meaning at best, and "no meaning" at worst; are there roles and role function changes and other existential transformations that could enable a client to take a life path that would improve meaning narratives, meaningful identities, outcomes, and meaningful role transitions?[18]

Social workers who have a role in helping with grief, loss, mourning, and complex grief, or other sources of loss of meaning in life, are faced with many complexities and uncertainties. Among the existential challenges are supporting a return to role functioning (such as a woman who is widowed, but still a mother and employee) or significant existential shifts based on life's new realities (such as a change in meaning, social position, role expectations, and identity after having a stroke and related job loss). Social workers also help people process existential shifts based on insight into new meaning in life (such as happiness associated with having a child and being a father, rather than accumulating material goods), or fundamental spiritual-existential shifts, sometimes associated with having cancer (such as through new mindfulness).[19] Some social workers may also approach change from a human-potential movement perspective that is not so much based on problems, risks, harm, pathology, oppression, solutions, or "dysfunction," but rather on a path to future-oriented self-actualization, self-discovery, and coherent role transformations, versus primarily socially predetermined objectives.[20]

Integration

This BPSI model recommends the integration of the above dimensions with due respect to all relevant biospsychosocial dimensions in interaction, each with the others. The net result respects the complexity and uncertainties in the phenomena and situations where social workers undertake assessment and treatment responsibilities. The shift in the biopsychosocial realities may appear as if they fit chaos theory more than any planned treatment intervention with presumed predictive validity, but if the outcomes are framed, at least in part, in terms of desired, required, expected, and needed changes in role functioning, as well as related responsibilities or rights, then there will be empirical referents to

verify change, and sustained change, which is relevant to personal and social functioning in given social situations in given contexts. The paradox is that, while social roles are socially constructed and assigned culturally contextualized meanings, they also have empirical referents that provide clear, relatively repeated, and partially integrated indicators that the socially constructed role is being expressed in more or less predictable patterns of personal and social functioning, with relatively anticipated outcomes and social order.

An advantage of the BPSI paradigm, applied with due respect to personal and social functioning of individuals and collectives, is that it does not expect the social worker to become fixated on any ideology or theory, or to become obsessed with any narrow and rigid concept, in providing service. Fixation on narrow boundaries of practice are seldom in the best interests of the client-consumer-patient, but it may well be in the interests of proselytizing an ideology and theory. As well, common factors and integrated treatment models, where informed transtheoretical understandings intersect in the interest of serving the client, rather than the client serving a theory, hold more promise both empirically and heuristically.

The BPSI model, integrated with role functioning theory, may be applied across traditional services methods such as individual, family, couple, group, organization, community, policy, society, or the "global village," or in nontraditional service contexts such as a virtual community, with virtual roles (such as exhibitionism online, or counselling online). Role theory enables informed assessment and intervention throughout the life-cycle, including with newly constructed roles (such as e-therapy),[21] which reflect the ongoing transitions and evolution of social systems. (Role concepts may be applied in traditional service contexts such as child, youth, and family services, or in nontraditional services, such as secret services where counselling service records may not be kept.)

In short, role theory may help guide treatment under conditions where complex role functioning interacts with complex social situations, and where social integration of roles is expected, or needed, often in the interests of self-satisfaction, social order, cultural fit, or the sense of a relatively integrated and stable but adaptable self, while factoring in both relatively stable as well as evolving cultural imperatives.[22]

Notes

1. A common example from social work is where the professional has a helping role and a social control role; these roles often conflict and contribute to role strain or incongruence between one set of social-relational expectations and another. While such role conflicts may be reduced and brought to some working agreements, they are part of the reality of social work practice.
2. Each exemplar used in this analysis is based on a merging of case situations from multiple cases representing the realities of social work practice, especially in the Western world, and are in no way intended to further marginalize, disadvantage, or oppress any social group. The cases are not intended to deny or minimize the value of, and the need for, structural-systemic change.
3. For a discussion of unconscious influences on social behavior, see Bargh and Morsella, 2008.
4. For example, in the role of parentified child, it is not unusual that the child is given a metaphorical double message such as: "Take responsibility; back off, who elected you boss?"
5. The use of the terms "adaptive" and "maladaptive" are based on the authors' acceptance of the functional school theory that maladaptive self-expression may be functional; what may be judged by some to be dysfunctional still serves a function for that social actor.
6. Depending on the depth of theorizing and conceptualizing: there are *cognitive theory* and social learning theory assumptions that persons internalize sets of beliefs, attitudes, values, and expectations that guide their actions relative to a role and associated position (such as cognitive scripts and rational decision assumptions); there are dynamic theory assumptions that some aspects of role are expressed with little conscious awareness (unconscious motivation to create family stability by the over-responsible parentified child); there are behavioral theory assumptions that some sets of role behaviors become habitual and that a social stimulus triggers relatively predictable patterns of role performance (disinhibited actions of the impaired "alcoholic"); there are *interactional or transactional assumptions* that persons assume, change, and govern their roles based in part on how the "other" is playing, or not, his/her role (the over-responsible partner).

7. Besides the references noted in our analysis of the concept of "role" and related concepts, the authors benefitted from a review of the sections on role, in the *Blackwell International Encyclopedia of Sociology* (Ritzer, 2007; Franks, 2007; Hindin, 2007).
8. Quantification is based on a severity range from "No problem" to a five-point scale from "low" to "severe"; a duration index ranging from "more than five years" to "two years or less" on a six-point scale; a coping index on a six-point scale ranging from "Outstanding" to "No coping skills" (1994, pp. 35–37).
9. Factor I: Social role functioning and problems are conceptualized and articulated under broad headings such as family roles, occupational roles (which included a student role), and "life situation roles" (client roles). Each broad category has multiple subcategories, and included a subcategory of "other." The categories schema also includes a set of role problem types, each extensively developed, which are reflective of common social work treatment dynamics: power, ambivalence, responsibility, dependency, loss, isolation, victimization, and mixed (1994, p. 18).
10. While medical and psychiatric diagnoses may change over time, they are often presented as more substantially stable than are changes in problematic social role functioning and related social factors.
11. Consistent with the attention to relational and systemic supports and social care in social work, the environmental systems classifications schema articulates broad categories, each more fully developed, among which are included: economic/basic needs, education and training, justice and legal, health, safety, and social services, voluntary supports, and affectional support systems. The schema considers issues of injustice, discrimination, lack of support, unjust expectations, and unexpected crises (Kestenbaum & Wahl, 1994, pp. 23–34).
12. The PIE classification system would explore the environmental factors as potentially being unjustly discriminating (lifestyle discrimination, Kestenbaum & Wahl, 1994, pp. 34) against a sex trade worker-parent unless there were other social role-functioning issues associated with the sex trade occupational role that compromised the parenting role and/or child care (e.g., addictions and mental health–compromised parenting). Related issues of oppression and discrimination are analyzed by Appleby, Colon, and Hamilton (2011, pp. 16–77).
13. To be clear, the notions are that addictions, mental health, or health problems may exacerbate problems in role functioning but mental health, addictions, or health services may also ameliorate some problems and support the person or significant others in enabling more efficacious and satisfying role performance. There is a significant literature on sick roles and mental illness roles, with due respect to cultural contexts.
14. The BPSI model is derived from the theoretical and conceptual analysis and synthesis by Kimberley and Bohm, 1998, and Kimberley and Osmond, 2009, which help the client and the practitioner partialize their efforts in the interest of needed, desired, or required changes in personal and social functioning, including systemic changes in supports and expectations. Spiritual-existential concerns are integrated within the BPSI change dimensions as needed.
15. An integrative approach differs from an eclectic approach in that the purpose is to enable informed situation-relevant logical consistency and coherence in the application of concepts and practices that are derived from multiple, but contextually and culturally relevant, theoretical-conceptual-application schemas—a trans-theoretical paradigm for influencing change.
16. For discussions of motivational theory and its relationship with personal and social change within social work contexts, see Holman, 2011.
17. The paradox with roles such as the parentified child and the scapegoated child is that they may be very functional in terms of some family dynamics and family homeostasis, and may even serve a family-preservation agenda, sometimes with language such as "over-responsible child," though such roles are also most likely developmentally damaging at best, and pathological at worst.
18. The authors take the position that, while meanings are socially constructed, and as they are given and taken in social interaction, the social actions acting in reference to such meanings also have empirically verifiable and often predictable empirical sequelae.
19. The reader is referred to the application of mindfulness therapy in social work such as Hick and Bien, 2008, and to transformative interventions, Satir, 1988.
20. See, for example, human potential notions in Satir, Banmen, Gerber, and Gomori, 1991.
21. Goffman (1963) anticipated and analyzed virtual identities.
22. It was not the primary purpose of this analysis to focus on social worker roles in treatment. For a more in-depth analysis of social work roles, the

reader is referred to Dorfman, 1996; Kimberley and Osmond, 2009; and Shulman, 2012.

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31

Social Learning Theory and Social Work Treatment

Bruce A. Thyer

Social Learning

Based on the premise that much of our behavior is learned and changeable, knowledge of operant, respondent, and observational learning is used to beneficially modify client behavior through the use of tested, ethical procedures.

The purpose of the practice of social work is to change behavior. Whether one engages in clinical work with individuals, couples, families, small groups, or organizations, or provides supervision, administration, community organization, or policy practice, the eventual bottom line is to effectively change the behavior of people. Towards this end, our discipline has adopted or developed a plethora of approaches, some of which are firmly grounded in a well-crafted theoretical orientation, others less so. A very widely used approach to practice is known as *behavioral social work*, which has been defined as:

> the informed use by professional social workers of assessments and interventions based on empirically derived learning theories. These theories include, but are not limited to, respondent learning, operant learning, and observational learning. Behavioral social workers may or may not subscribe to the philosophy of science known as behaviorism. (Thyer & Hudson, 1987, p. 1)

These learning theories were developed largely outside of social work but have been incorporated into our field almost from its inception. Box 31.1 includes some selected quotations dating back to the 1920s reflecting the positive contributions that the behavioral orientation was

Box 31.1 Early Statements on the Importance of Behaviorism to Social Work

"Sooner or later, too, I believe, every conscientious physician, as every earnest educator, *social worker*, economist, sociologist, every attorney and judge, every artist and craftsman, every laborer for human welfare, every man or woman hurt or seeking to avoid being hurt, striving to understand intelligently themselves and their fellow creatures, must come to grips and to terms with its [behaviorism's] strange doctrines that possess a power and a fascination."

(Berman, 1927, pp. 26–27, emphasis added)

"Two dominant schools of thought may be recognized as differentiating case work approach and treatment at the present time; behaviorist psychology and psychiatric interpretation. The former emphasizes habit training, conditioning and reconditioning in treatment. . . . Illustrations of a partial use of this psychology in treatment are abundant in any case work area."

(Robinson, 1930, pp. 83–84)

"Behaviorism may be described as the theory that learning is the association of a new impression with the circumstances present at the time of receiving it. It has several obvious merits. It integrates emotion and intellect in a manner which realistically reproduces actual experience. It is socially acceptable, in the main, as it places such large faith upon capacity to learn, given the right conditions for association . . . behaviorism affords a first-class technic, without specializing in the abnormal. . . . It is invaluable for the social worker in his efforts to understand the conduct of his clients, because it refers him back to the past experiences in which are to be found the particular circumstances which have determined the attitude or the habitual responses for each individual. Thus behaviorism opens up endless possibilities for social work. . . . It is also of value in treatment, for some of the most interesting work of the behaviorists has been in the field of what is called reconditioning."

(Bruno, 1934, pp. 197–198)

"The time has now come to make a transition to a full scientific methodology in personality analysis and therapy. Behaviorism has attempted to understand the intricacies of personality and to work out a treatment technique based on this understanding. From the viewpoint of behaviorism, personality is the conditioned result of the infinite number of experiences that come with living in environments which become more complex as man makes them so. Both individual and environment are studied, because a realistic view of behavior makes this inevitable. Social workers should examine and understand this point of view, which offers a more comprehensive explanation of human motivation and its meaning than the mysticism of psychoanalysis."

(Houwink, 1937, p. 202)

". . . the socio-behavioral approach provides a viable and potentially durable framework within which to practice. Contained within it are important empirical bases lacking in many more traditional approaches."

(Thomas, 1967, p. 15)

". . . social learning theory holds a rather optimistic view of man's ability to change his behavior. Since all behavior is malleable, and if the conditions maintaining behavior can be controlled, and the proper reinforcers found, then change is possible . . . the promise of social learning theory for the treatment field appears to be great."

(Whittaker, 1974, pp. 86–87)

seen to have for social work practice. Discipline-specific reviews—those addressing a social work audience—of operant (Reid, 2004; Schwartz & Golddiamond, 1975; Wong, 2012), respondent (Thyer, 2012), and observational learning theories (Fischer & Gochros, 1975; Wodarski & Bagarozzi, 1979) help translate these principles into the unique aspects of what social workers do. As noted in the definition provided above, behavioral social work is a strongly theoretically based orientation, and any social worker proposing to make use of behavioral methods should have a thorough grounding in the scientific theories underlying its approaches to assessment, intervention, and the evaluation of practice. Sundel and Sundel (2005) is one excellent general introduction to social learning theory focusing on a social work audience.

Behavioral social work can be seen as three related but distinguishable components: a

wide-ranging theory, numerous specific practice methods, and a comprehensive philosophy of science. It is important to keep these three elements distinct, because the merits and limitations of each should not be confused with the approach as a whole. For example, the philosophy of science called *behaviorism* is a well-developed approach to addressing the major elements that are the focus of philosophy, issues such as epistemology, ontology, language, free will versus determinism, values and ethics, etc. (see Thyer, 1999). However, one need not subscribe to the philosophy of behaviorism to make use of the interventive methods based upon social learning theory, and objections to the philosophy may have little bearing on the validity of the approach's underlying theory or practice utility. Similarly, one can subscribe to the principles of social learning theory yet not be a philosophical behaviorist. Or one can use behavior practice techniques even if one believes the underlying theory is incorrect. Individuals whose conceptual framework embraces all three elements—the theory, the practice methods, and the philosophy—generally call themselves "behavior analysts" or "radical behaviorists," with "radical" meaning "complete" (not referring to political extremism).

However, most social workers who make use of behavioral methods do so as a part of a more eclectic approach to practice. A large-scale survey of clinical social workers conducted by Timberlake, Sabatino, and Martin (1997) found that 43% reported using behavioral methods "frequently." A more recent survey (Pignotti & Thyer, 2009) of about 400 licensed clinical social workers (LCSWs) found that the most common theoretical *orientation* they reported using was cognitive-behavioral (42%), with psychodynamic theory the next most common (21%). Pignotti and Thyer (2009) previously found that, in terms of the most frequent *interventions* used during the past year, cognitive behavioral methods topped the list, being used by 73% of the LCSWs they surveyed. Conveniently, behavioral social work enjoys the strongest level of empirical support, in terms of outcome studies with positive results, of any approach to practice (Gorey, Thyer, & Pawluck, 1998; MacDonald, Sheldon, & Gillespie, 1992; Reid & Fortune, 2003; Reid & Hanrahan, 1982; Rubin, 1985).

What Is Behavior?

In behavioral social work, as is true for behaviorism in general, "behavior" refers to what the person does. It makes no difference whether or not an outside observer can view what is occurring; if it is something a person is doing, it is behavior. I stress this point because behaviorism is commonly construed as focusing only on the overt actions of people and not on their inner, lived experiences. Given the importance of these latter elements in our lives (e.g., the love I feel for my family), if it is seen (erroneously) that behavioral methods ignore these issues, then the approach may be discarded as somehow incomplete or limited. Although it was the psychologist John B. Watson in the early part of the last century who claimed that the sole legitimate subject matter of psychology was overt behavior, this limitation was never really adhered to, and several decades later, B. F. Skinner asserted that the proper subject matter of behaviorism was both public behavior and our inner lives. It is in this sense that behavioral social work is currently interpreted, and this is reflected in the definition of behavior contained in *The Social Work Dictionary*: "Any action or response by an individual, including observable activity, measurable physiological changes, cognitive images, fantasies, and emotions" (Barker, 2014, p. 38).

Thus, the focus of behavioral social work is not only on changing overt behavior, but also on any private events experienced by clients as problematic. This would include attitudes (e.g., racism, see Arhin & Thyer, 2004; Lillis & Hayes, 2007; Hayes, Niccolls, Masuda, & Rye, 2002), fear, opinions, dreams, obsessions, anxiety, hallucinations, depression, delusions, etc., as well as an interest in enhancing positive inner qualities, such as self-esteem, optimism, and hope. Some of the earliest behavior therapies were focused on helping clients with affective problems such as severe anxiety, and they were found to be very helpful in this regard.

What Is the Relationship Between Inner and Outer Behavior?

In much of lay and professional psychology, it is contended that our inner lives drive our outer

actions. For example, to eliminate racist actions, the first step often is said to be to change an individual's attitudes, since one's attitudes are said to cause one's actions. Or to alleviate the lethargic behavior, weeping, and expression of hopelessness associated with depression, it is claimed to be crucial to alleviate the inner state of depression (the feeling), and then the overt symptoms will improve. Behaviorism does not subscribe to the theory that attitudes (or other inner mental events) *cause* overt actions. Rather, the behaviorist puts forth the more credible hypothesis that both overt actions and attitudes (or feelings, opinions, etc.) are similarly brought about largely by one's learning history. How one has experienced reinforcement and punishment for past actions helps shape both future overt activity and our inner lives related to those activities. Therefore, to change attitudes and behavior, one will probably need to experience changes in the reinforcers and punishers one is exposed to.

Social worker Harris Chaiklin (2011) has prepared an overview on research on the relationships between attitudes and behavior, and contends that our disciplinary preoccupation with changing attitudes in order to bring about changes in comportment is unsupported by the available scientific research. Chaiklin concludes, "It is not necessary to change attitudes to change behavior" (p. 31). Are attitudes and feelings important in a behavioral analysis? Very much so. However, they are not seen as causal; they are more behaviors to be explained.

Basic Propositions of Behavioral Social Work

Behavioral social work is based on a limited number of deceptively simple but fundamental propositions (Fischer & Gochros, 1975). These include the following:

1. Human behavior consists of what we do—both observable behavior and unobservable behavior: overt acts, covert speech, thoughts and cognition, feelings, and dreams. All those phenomena that people engage in are considered behavior.
2. To a large extent, much (but not all) of human behavior is learned through life experiences. This learning occurs throughout the lifespan.
3. It seems very likely that similar fundamental learning processes give rise to individual human behavior across cultures and life circumstances and account for both normative and many so-called dysfunctional actions, feelings, and thoughts.
4. Interpersonal behavior is also a function (to some extent) of these learning processes, giving rise to dyadic, group, organizational, community, and societal phenomena. These larger-scale activities are, to a great extent, a more complex operation of fundamental learning mechanisms.
5. There are at least three major empirically supported learning processes that collectively make up social learning theory: respondent learning, operant learning, and observational learning.
6. To the degree that the learning processes responsible for developing and maintaining behavior can be identified and altered, it may be possible to effectively change behavior toward desired ends.

Each of the above propositions is well supported and difficult to argue against, particularly given the qualifiers used (e.g., "to some extent," "but not all"). This is not persiflage. Behaviorists recognize the importance of other factors giving rise to human activity, factors such as one's genetic endowment, life *in utero,* and other biological factors such as health, disease states, exposure to toxins, radiation, pollution, etc. Our lived environments are both physical and behavioral, and consist in part of the extent to which our actions result in various consequences. Behaviorists make no claim that their orientation provides a sufficient accounting to explain *all* human activity. Theirs is the more modest claim that the factors they focus on are very likely to be salient in most situations and deserve careful consideration as to their potential role in a given circumstance.

Learning Theory

The three major learning processes that behavioral social work is based upon are called operant learning, respondent learning, and

observational learning. Each of these will be briefly reviewed.

Operant Learning

This type of learning is simplistically defined as "A type of learning defined by B. F. Skinner (1904–1990) in which behaviors are strengthened or weakened by altering the consequences that following them" (Barker, 2003, p. 306). It is called *operant learning* because it refers to the extent to which the behavior "operates" on the environment, which in turn produces consequences for the behaving person. Consequences that strengthen subsequent behavior are called *reinforcers*. If a stimulus is presented, and behavior is later strengthened, this stimulus (colloquially, something good) is called a *positive reinforcer*. If a stimulus is removed, and behavior is later strengthened, this stimulus is called a *negative reinforcer* (think of the term *relief*). The corresponding processes are called positive and negative reinforcement, respectively. Consequences that have the effect of weakening behavior are called *punishers*. If a stimulus follows a behavior and that behavior later is subsequently weakened, this type of consequence is called *punishment*. If the consequence involves the presentation of a stimulus (something bad), the stimulus is called a *positive punisher*, and a stimulus that, if removed (something good), subsequently weakens behavior is called a *negative punisher* (think of being fined). The corresponding operations are called positive and negative punishment. Any behavior that produces consequences is liable to be affected, either strengthened or weakened, by those consequences.

Other operant processes include that of *extinction*, which occurs when the consequences that are maintaining a given behavior are discontinued, and the behavior subsequently weakens. *Shaping* occurs when "new patterns of behavior are fashioned by reinforcing progressively closer approximations of the desired behaviors and not reinforcing others" (Barker, 2003, p. 395). In this way, simple actions (hitting a piano key) can be systematically refined to yield more complex activities (e.g., playing a sonata). Operant processes are crucially involved in much of human learning, in both normal development across the lifespan (Bijou, 1993; Schlinger, 1995), as well as in the etiology of so-called abnormal behavior and psychosocial problems. Contingencies of reinforcement affect, not only individuals, but also the functioning of larger groups of people, including organizations, communities, and society as a whole. The entire field of social welfare policy can be construed as the governmental imposition of artificial contingencies of punishment (usually) and reinforcement (less often) related to behaviors that politicians deem important to change (Thyer, 1996).

Here are some everyday examples to make these processes a bit clearer. You insert coins in a soda machine and a few moments later receive a can of cold soda. The act of putting the coins in the machine was positively reinforced: positively (because something was presented), and reinforced because you are more likely to do the same actions in a similar situation. Drinking the soda refreshes your thirst. The act of drinking is negatively reinforcing: negatively because something aversive was taken away (thirst), reinforced because you are more likely to drink that beverage in the future (as opposed to chugging down highly salted water). During dinner, you reach across your mother to grab the salt. Your elderly mother slaps your hand, saying "Mind your manners." In the future, you are less likely to reach across your mother. This is positive punishment: positive because something unpleasant was presented contingent on your behavior, and punishment because this behavior is weakened (at least around Mom). You are speeding home from class. You are stopped by the police for speeding and have to pay a substantial fine. In the future, you speed less (for a while, at least). Speeding has been negatively punished: negatively because something pleasant or desirable was taken away, and punished because the behavior in question is weakened. Keep in mind that negative reinforcement and punishment are not synonymous. The former always strengthens behavior and the latter weakens it. We usually like to be negatively reinforced (think of relief), and we dislike being punished.

Respondent Learning

Another fundamental way in which people learn is via respondent conditioning, also

known as *Pavlovian conditioning*. Respondent learning is quite distinct from operant learning, although it is common (and a mistake) for the two approaches not to be separated. Most social workers will have learned something of the fundamentals of respondent learning, which occurs when a neutral stimulus is paired with a unconditioned stimulus (UCS), something that automatically elicits a simple, reflexive form of behavior. Some example of UCSs in everyday life include sharp pain and loud noises, each of which usually causes the listener to flinch or withdraw quickly. If some neutral stimulus occurs just before a UCS, after one such (or several) pairing(s), the previously neutral stimulus can come to evoke a similar reaction. Many readers will have fearful reactions to the sound of the dentist's drill, a reaction that is a conditioned response to the sound of the previously neutral noise of the drill, because in the reader's past, the drill sounds immediately preceded a sharp pain. After only a few such experiences, the sound of the drill alone may be sufficient to make one flinch, to feel fearful, or to have an elevated heart rate. A more complex example occurs when cancer patients initially receive chemotherapy, medications with toxic effects often administered in clinic settings via an intravenous drip. The clinic surroundings and the IV apparatus are initially neutral stimuli. After one or more episodes when the medication is administered (neutral stimuli), the person may experience nausea and vomiting as a side effect of the medication. Soon, many chemotherapy patients come to experience nausea and even vomiting upon entering the clinic environs. The medication is a UCS; the naturally occurring nauseating side effects are unconditioned responses. The neutral clinic setting becomes a conditioned stimulus (CS) resulting in anticipatory nausea (a conditioned response) even before the medication is administered.

There are many subtle variations of natural and contrived respondent learning processes, including *respondent extinction*, wherein a conditioned stimulus is repeatedly presented, absent the UCS, so that the conditioned response is gradually weakened. One need not personally experience respondent learning processes in order to be affected by it; observing others is another way, known as *vicarious conditioning*. Few of us have personally been attacked by a vampire, but if we saw a fanged Bela Lugosi outside our window, most of us would be seriously frightened. Why? None of us have been injured by a vampire, but we have certainly seen plenty of movie depictions of people being killed by them. This is vicarious respondent learning. *Higher-order respondent conditioning* occurs when a neutral stimulus immediately precedes an established CS (or CS_1). In this way, the neutral stimulus can come to evoke reactions similar to those elicited by the original CS, leading to the development of a CS_2, then perhaps a CS_3, and so forth. By the time one has developed a CS_n^{th}, the links may be so subtle as to elude discovery, leading to conditioned reactions that seem inexplicable or nonsensical.

Respondent learning is responsible for many of our emotional reactions and is implicated in the establishment of emotions and attitudes. It is intimately involved in much of normal human development as well as in the emergence of problematic behavior such as anxiety disorders. Many therapeutic approaches make use of respondent learning principles, and one of the earliest books on this topic appeared in 1949, a text called *Conditioned Reflex Therapy* (Salter, 1949). Thyer (2012) provides a good overview of the application of respondent learning principles to social work theory and practice.

Observational Learning

Observational learning is also known as *modeling*, defined as "a form of learning in which an individual acquires behaviors by imitating the actions of one or more other people" (Barker, 2003, p. 276). Much behavior acquired by operant learning can also be acquired by observation. Observing others can help one develop an entirely new behavior, may inhibit certain activities, or may have the effect of reducing any reluctance to try something. For example, at an amusement park, I was recently confronted with a terrifying roller coaster my kids wanted me to ride with them. I was able to calm myself to the point of getting on and riding the thing by observing the reactions of the prior riders as they coasted to a halt at the end of their ride. Most were laughing and happy. This relieved my anxiousness (somewhat!).

Although one need not receive immediate reinforcement for imitating the successful behavior of others, this does not mean that observational learning is unrelated to reinforcement. In fact, modeled behavior that is never subsequently reinforced will probably undergo operant extinction. It is more likely that the capacity to acquire new behavior by observing others is another form of learning present from infancy throughout one's life, but that to the extent that modeled behavior is followed by reinforcement, even sporatically, we develop a strengthened repertoire for imitating others. Simply put, if you do as Mommy demonstrates and the new behavior is immediately reinforced by naturally occurring consequences, two things in reality get strengthened: the first is the modeled behavior directly, and the second is the likelihood of imitating Mommy (and then, of course, others). With many repetitions of this process, first perhaps with parents, then siblings, others family members or caregivers, and ultimately strangers, the human being develops a strong generalized capacity for imitation. This is a highly efficient form of learning that shortcuts the need to directly and immediately experience the effects of contingency shaping. Baer and Deguchi (1985) provide a very good exposition of how modeling may well be a highly developed form of operant learning. Fischer and Gochros (1975, pp. 101–102) provide a list of conditions that appear to facilitate learning via modeling, including, among others:

- Use models who are important to the observer.
- Show the model being reinforced.
- Reinforce the observer for imitating the model's behavior.
- Use multiple models.
- Use repeated modeling experiences.
- Graduate practice exercises (from less to more difficult).
- Arrange for reinforcement from the natural environment as soon as possible, etc.

These three learning theories have been combined to develop a viable alternative to the traditional stage-based theories of human development across the lifespan (see Bijou, 1993; Schlinger, 1995), a perspective that remains oddly excluded from most social work textbooks on human development in the social environment. Similarly ignored are behavioral perspectives on what has been labeled "personality theory" (Lundin, 1974; Staats, 2003). This is difficult to fathom, since social work theorists of every persuasion are in accord that these principles are to some degree valid and important. The processes of operant, respondent, and observational learning are well supported in terms of empirical research as to their legitimacy, and they have led to the development of some very effective methods of interpersonal helping.

Learning Theory and the Person-in-Environment Perspective of Social Work

If social work has anything akin to a unique perspective that distinguishes it from related human service disciplines, it is said to be the person-in-environment (PIE) point of view. Here are some representative quotes illustrating the perceived centrality of this perspective:

- "Behavior is the result of the effort of the person to establish himself in his environment in such a way as to give satisfaction to himself." (Bruno, 1934, p. 45)
- "Flexibility, change, and movement are of the very nature of social interaction. It is no wonder that social workers give close attention to behavior, which is the pulse of the human organism's attempts at adaptation." (Hamilton, 1940, p. 305)
- "A basic assumption . . . is that human behavior is the product of the interactions between the individual and his environment." (Northen, 1982, p. 63)
- "The human being and the environment reciprocally shape each other. People mold their environments in many ways and, in turn, they must then adapt to the changes they created." (Germain, in Bloom, 1992, p. 407)
- "The ecosystems perspective is about building more supportive, helpful and nurturing environments for clients through environmental helping, and increasing their competence in dealing with the environment by teaching

basic life skills." (Whittaker & Garbarino, 1983, p. 34)
- "The ecological perspective makes clear the need to view people and environments as a unitary system within a particular cultural and historic context. Both person and environment can be fully understood in terms of their relationship, in which each continually influences the other within a particular context. . . . Ecological thinking examines exchanges between A and B, for example, that shape, influence, or change both over time. A acts, which leads to a change in B, whereupon the change in B elicits a change in A that in turn changes B, which then changes or otherwise influences A, and so on." (Germain & Gitterman, 1995, p. 816)
- "Person-in-environment perspective . . . [is] an orientation that views the client as part of an environmental system. This perspective encompasses the reciprocal relationships and other influences between an individual, the *relevant other* or others, and the physical and social environment." (Barker, 2003, p. 323, emphasis in original)

Here are some selected quotes illustrating how this same perspective is central to social learning theory and behavioral analysis and therapy:

- "Men act upon the world and change it, and are changed in turn by the consequences of their action. Certain processes which the human organism shares with other species, alter behavior so that it achieves a safer and more useful interchange with a particular environment. When appropriate behavior has been established, its consequences work through similar processes to keep it in force. If by chance the environment changes, new forms of behavior disappear, while new consequences build new forms." (Skinner, 1957, p. 1)
- "Most behavioral science emphasizes the power of the environment; it sees environment as constantly controlling behavior, and it sees behavior as constantly affecting the environment. Indeed, the point of most behavior is to affect the environment." (Baer & Pinkston, 1997, p. 1)
- "Behaviorism's environmentalism does not imply that the organism passively reacts to the environment. The relationship between the organism and the environment is interdependent and reciprocal. . . . That is, although the organism interacts with its environment, its reaction also changes the environment. The organism is then influenced by an environment changed by its own behavior, behaves again, changes the environment again, and so on. Thus the organism's relationship to its environment is one of mutual influence." (O'Donohue & Ferguson, 2001, p. 57)
- "Behavior analysis is essentially the study, definition, and characterization of effective environments as arrayed over time, with 'effective' defined by the dynamics of behavior. . . . Psychological process is construed as behavior–environment interaction. It does not consist in phenomena that underlie that interaction." (Hineline, 1990, p. 305)

The apparent congruence between social work's PIE and behavior is both obvious and compelling. Behavioral approaches are a largely environmentally based perspective on understanding, predicting, and controlling human behavior, as opposed to the mentally oriented theories common to most other approaches to social work. An example of this behavioral perspective on PIE is called *functional analysis*, and an illustration of this process was narratively described by one social worker over 40 years ago:

> During the initial phases of a project integrating orthopedically handicapped children into groups of nonhandicapped children, no specific instructions were given to the group leaders regarding the degree of "special attention" they were to provide the handicapped children. After a few sessions, it was noticed that one leader appeared especially overprotective: Every time the handicapped child approached this leader, he was treated with excessive warmth and openness. At the direction of his supervisor, the leader observed the results of this interaction carefully. It became apparent that the leader was, in effect, rewarding passive, dependent behavior and that this was detrimental to the integrative attempts. On the basis of this observation, the leader predicted that if he were to respond more critically to this behavior, that is, to redirect the handicapped child whenever feasible and realistic, the child would become less

passive and more independent and would interact more with his peers (at this point, a hypothesis has been developed and a "prediction" made wherewith to test the hypothesis). The leader adopted this approach, and his prediction was borne out, namely, that a more objective response did affect the specific elements of behavior under consideration in a desirable fashion. (Holmes, 1967, pp. 95–96)

In effect, when a target behavior is identified, the social worker observes the client in his or her natural environment to ascertain the antecedent circumstances and consequences surrounding this behavior. From these qualitative observations, specific hypotheses are generated regarding potential etiological and maintaining contingencies. These hypotheses are then tested by deliberately changing the presumptive causal consequences via environmental manipulation. If the behavior reliably changes as the consequences are changed, then one has, in effect, isolated at least some of the variables causally responsible for the behavior in question. One is thus examining the functions that the behavior has for the individual concerned—hence the term "functional analysis."

Ethical Issues

Behavioral approaches represent perhaps one of the most ethical approaches to the delivery of the human services compared to other theoretical orientations. This is because they enjoy a generally sound empirical foundation and are thus consistent with our ethical standards that mandate social workers base their practice, in part, on empirical research. Indeed, it can be reasonably contended that clients have a right to be offered effective interventions—that is, those supported by sound outcome studies yielding positive results with individuals who are similar to one's client, and who experienced similar problems (Myers & Thyer, 1997). Like all approaches to social work intervention, behavioral methods are governed by our professional codes of ethics and legal regulations. Clients can be abused by all forms of therapy, and no approach is exempt from this potential for misuse. Social workers attempting to make use of behavioral methods should do so with a sound understanding of social learning theory so that these approaches are applied in an informed and professional manner, and not as a rote technical skill. Social workers choosing to focus their professional life through providing behavior analysis and therapy may wish to join any of a number of behaviorally oriented professional organizations, such as the Association for Behavior Analysis (http://www.abainternational. org/), for professional development, training, and continuing education. Many states offer an advanced practice credential called "Board Certified Behavior Analyst" (see http:// www.bacb.com/) that clinical social workers may qualify for. This is a credential that can be earned in addition to, or in lieu of, licensure as a clinical social worker.

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32

Social Networks and Social Work Practice

Elizabeth M. Tracy and Suzanne Brown

Practitioners recognize that clients are rarely isolated, but tend to be surrounded by social networks that may support, weaken, substitute for, or supplement the efforts of professional helping. This chapter will trace the significance of social networks, and the related concept of social support, to the social work profession and the corresponding development of social network assessment and intervention within contemporary social work practice. We believe that knowledge and skills in assessing and mobilizing social networks are important for every social work practitioner, micro- and macro-practice alike. We begin by defining basic terms and concepts. We next examine how the concept of social networks is closely linked to the origins and mission of social work practice. The development of social network analysis and the entrance of social network assessment and intervention into the profession of social work are described, followed by a presentation of program examples illustrating the range and types of applications of social networks. The chapter ends with a discussion of current issues and challenges for the future.

Central Terms and Definitions

The term *social network* refers to a set of individuals and the ties among them (Wasserman & Faust, 1994). There are two broad sub-fields within social networks (Scott, 2000). One is the study of *whole networks*, examining the pattern of relations within a group bounded by geography or some characteristic, such as all the clients in a treatment program. The second approach, the focus of this chapter, studies *personal social networks*, examining the relations

surrounding a focal person, such as a client in a treatment program. A personal network approach considers the behavior of individuals in the context of the people with whom they directly interact. Personal network variables can be conceptualized as either *compositional* or *structura*l. Compositional network qualities include, among others: (a) size—the total number of people in the network; (b) relationships of network members—friends, family, professionals, etc.; (c) frequency of contact—how often people in the network interact with one another; (d) duration—how long people in the network have known one another; and (e) reciprocity—the amount of give and take between network members. Examples of structural network qualities include: (a) density—the percent of ties that exist out of all possible ties; (b) components—network members who are connected to one another directly or indirectly; (c) multiplexity—network relationships that serve more than one function; and (d) centrality measures—measures of network activity and information flow. Sometimes composition and structure can be combined, such as identifying who is the most structurally central person who provides support.

It is important to distinguish the structural links of the social network from the resources or "supports" exchanged within the network. *Social support* refers to the many different ways in which people render assistance to one another. According to Gottlieb's (1983) empirically derived definition, "social support consists of verbal and/or nonverbal information or advice, tangible aid or action that is proffered by social intimates or inferred by their presence and has beneficial emotional or behavioral effects on the recipient" (pp. 28–29). Social support then consists of a variety of helping behaviors, including advice and guidance, companionship, emotional support and encouragement, and concrete assistance (Barrera & Ainley, 1983; House & Kahn, 1985; Wood, 1984). Social support can be provided spontaneously through natural helping networks of family and friends or can be mobilized through professional intervention.

A *social support network* refers to a set of relationships that provide nurturance and reinforcement for efforts to cope with life on a day to day basis (Whittaker & Garbarino, 1983). Not all social networks are social support networks, nor do all social networks reinforce pro-social behaviors. For example, Freisthler, Holmes, and Wolf (2014), in what they refer to as the "dark side" of social support, demonstrate how parental social companionship networks may serve to increase the risk of child maltreatment. Likewise, larger social networks do not necessarily provide more social support. It is also important to note that supportive ties exist within networks that also contain non-supportive ties (Wellman, 1981). In addition to the actual support received, the *perception* that others would be available to help is a factor in the experience of supportive relationships (see Hobfall, 2009, for a discussion of received versus perceived support). Due to such complexities, social support provided through personal social networks is viewed as a multidimensional construct consisting of social network resources, types of supportive exchanges, perceptions of support availability, attitudes toward help-seeking, and skills in accessing and maintaining supportive relationships (Heller & Swindle, 1983; Marsella & Snyder, 1981). Pierce, Sarason, and Sarason (1996) posit three overlapping and mutually influencing components of social support: support schemata, supportive relationships, and supportive transactions. Sarason and Sarason (2009) point out the bidirectional nature of social support in that support occurs in the context of a relationship between receiver and provider of support.

Historical Significance to Social Work

Almost by definition, social work has recognized the importance of social networks in clients' lives. Social work's traditional focus on the person-in-the-situation and concern with both the individual and the environment have repeatedly brought the profession back to examining natural helping networks. It is helpful to look back at how earlier social workers envisioned and intervened with naturally occurring social resources (Becker, 1963). In essence, the friendly visiting of the Charitable Organization Society workers *was* a social network intervention, in that the social network

of the client was expanded with the addition of a formal helping resource. The friendly visitor was a personal link to the world of resources, and used influence to arrange services through unique personal and professional social network contacts. For example, friendly visitors inquired about job openings among friends and acquaintances and arranged summer holidays for children in the country homes of their personal friends. Friendly visitors were advised to (a) establish "friendly relations," (b) offer practical advice and training, and (c) arrange or procure concrete services (Richmond, 1918). Try as they might, though, friendly visiting could never fully overcome the social class and ethnic differences between the visitor and the family. While the key relationship was neighborly, friendly visiting never approached the mutuality generally associated with informal helping.

One of the basic tenets of friendly visiting was to seek the most natural and least official sources of relief, bearing in mind the ties of kinship, friendship, and neighborliness (Richmond, 1918). Investigation and mobilization of natural sources of help were considered important aspects of coordinated, organized welfare services. The overall purpose of charity work was to develop resources within the family, rendering material relief from the outside unnecessary. Each resource was to be contacted regarding "some definite promise as to what they themselves will do" (Richmond, 1918, p. 188). The movement felt that indiscriminate charity would destroy these natural social network resources.

The social work described by Mary Richmond radiated outward along the lines of the client's social network. Richmond aptly recognized what social workers today have rediscovered—that prior to "social work," there were natural systems of helping. She stated in *What Is Social Casework?* (1922, p. 5):

> Almost as soon as human beings discovered that their relations to one another had ceased to be primitive and simple, they must have found among their fellows a few who had a special gift for smoothing out tangles in such relations; they must have sought, however informally, the aid of these "straighteners."

Richmond (1917) outlined 20 most commonly used resources and the best methods of exploring them, such as practical strategies to enlist cooperation and support, and principles to guide the choice and use of social resources. This approach structured the linking and mobilizing of resources in a manner vastly different from the personal influence of the friendly visitor. Rather than viewing the social network as the *medium* of help, the social network was beginning to be viewed as an *adjunct* to treatment. The worker's task was to identify and mobilize, to act as go-between, to organize resources where none existed, and to re-knit ties long broken. Relatives, for example, were consulted because of the family history they could supply and for their backing and cooperation in the treatment plan.

Origins of Social Network Analysis

The development of social network theory and analysis drew from a variety of disciplines and theoretical perspectives within sociology, anthropology, and psychology. Scott (2000) describes the study of social networks as stemming from three main traditions. One tradition from which contemporary social networks theory draws is the sociometric analysts who, informed by Gestalt theory, sought to depict group dynamics, structure, and the flow of information among group members. For example, Moreno (1934) examined friendship patterns and how psychological well-being was related to what he termed "social configurations." His innovative use of the *sociogram* was a way to depict the properties of these social configurations; by using points to represent people and lines to represent social relationships, the sociogram could visually display how one person influences another, who had multiple connections, and who was isolated within a group.

Another theoretical foundation of social network theory derived from the work of anthropologists and sociologists in the 1930s and 1940s who investigated informal relations and structures within larger systems. For example, Hawthorne's classic study of the Western Electric Company used anthropological fieldwork techniques to construct sociograms to depict the informal organization as distinct from the formal organization of the company (Scott, 2009). Anthropologists began to apply

field work methods to study urban communities, subgroups, and cliques.

The third tradition undergirding social network analysis is seen in the work of British anthropologists. Barnes's (1954) analysis of relationships in a Norwegian fishing village and Bott's (1957) study of marital patterns among London families are generally thought to be the beginning of what is now referred to as *social network analysis*. Mitchell (1969) laid out a set of sociological concepts to explain the structural properties of ego-centered networks—the direct and indirect links to an individual. Mitchell presented concepts such as reciprocity, density, and reachability, among others, as ways to describe relationships within social networks. Granovetter's work (1973) on the strength of weak ties extended these concepts as he studied how people acquire information about jobs and the kinds of links that provide the best sources of information.

Theoretical and Conceptual Background and Frameworks

Numerous different theoretical frameworks inform the study and application of social networks within social work practice. *Stress and coping theory* posits that the ability to cope with stress depends on one's personal and social resources (Lazarus & Folkman, 1984). Social support is often conceptualized as *a coping resource* or social "fund" (Thoits, 1995, p. 64) to draw upon in responding to stressful life events. Social network resources may enable people to change the situation, change the meaning attributed to the situation, and/or change their emotional reaction to the situation—all functions of coping responses. Two models have been proposed to explain the process through which being embedded in a social network has a beneficial effect on well-being—the *main* or *direct effects* and the *buffering hypothesis*. The direct effects model argues that social support has a beneficial effect, irrespective of stress level. Direct effects of large social networks are viewed as providing socially rewarding roles, predictability, and sense of self-worth (e.g., Berkman & Syme, 1979). Belonging to a social network may also help people avoid experiences that would otherwise result in physical or psychological distress. The buffering model states that individuals experiencing significant life stress, but with strong social support, they will be protected from symptoms associated with stress. In this model, social networks are important in the stress appraisal process, emotional reactions, and coping behaviors (Cassel, 1974; Cobb, 1976). For example, as applied to the field of substance abuse, research by Longabaugh, Wirtz, Zweben, and Stout (1998) supports both direct positive effects of investing in networks supportive of abstinence, as well as buffering effects of abstinent supporters within substance-using networks.

Additional alternative models have been proposed, including the *stress deterioration* model in which stressful life events are thought to impair social support resources, in turn resulting in more stress (Dean & Ensel, 1982). For example, divorce may result in substantial changes in social network composition that may in turn impact the availability of social support (Wilcox, 1981). Particular life events, such as cancer, may lead to stigma, with resulting loss of social network contact and social support. Another alterative model is the *stress prevention model* (Gottlieb, 1983; Gore, 1981), in which the availability of social networks is thought either to prevent the occurrence of stressful life events in the first place, or the labeling of events as stressful when they do occur.

Social network analysis at this point in time consists of an approach and set of methods, rather than a full body of social theory per se (Scott, 2000). There continue to be discipline-specific diverse approaches to social network analysis—the distinction between whole and ego-centered networks being the most obvious division. In addition to the stress and coping theoretical approach outlined previously and the ecological perspective detailed later, which have received the most attention within social work, social networks have been viewed within the context of exchange theory (Wellman, 1981), rational choice theory (Lin, 1982), and attachment theory (Mikulincer & Shaver, 2009). More recently, the importance of social networks as a form of social capital has been explored (Bottrell, 2009). The perspective of dynamic network theory has also been proposed to

explain how social networks influence goal achievement; this approach posits eight social network role behaviors that explain how social networks assist in goal pursuit (Westaby, Pfaff, & Redding, 2014).

Social Networks' Entry into Social Work

Ecological Perspective

Social work's interest in social networks is firmly rooted in the ecological perspective (Bronfenbrenner, 1979), which focuses on the interface between people and their environments. This approach recognizes that social ecologies—the people, places, times, and contexts in which social interaction occurs—offer both the cause of and solution to problems (Barth, 1986). The implications of the ecological approach have been conceptualized as (1) building more supportive nurturing environments through various forms of environmental helping, and (2) improving client's competencies through the teaching of specific life skills (Whittaker, Schinke, & Gilchrist, 1986). Social network assessment and interventions are compatible with the ecological perspective, given that understanding the potential for growth and stress within the client's social network, the functions of network resources, and obstacles to using network resources are essential parts of an environmental assessment (Gitterman & Germain, 1981).

Drawing from the ecological perspective and following the social network tradition of visual displays of social relationships, Hartman's "ecomap" (Hartman, 1994; see also Mattaini, 1993) is perhaps the most widely used means to visually document the social context of a client's life. First, names of people, groups, and organizations are identified and encircled. The distance between circles indicates closeness of relationships, while lines drawn between the circles represent the quality of the relationship (e.g., stressful, tenuous, or positive). The ecomap has been adapted to a variety of social service settings and helps the worker and client jointly determine available resources, gaps in resources, and direction for intervention.

Linking Formal and Informal Helping

The ecological perspective also drew attention to the fundamental importance of neighborhood and extended family resources. Consequently, the linking of formal and informal helping networks was seen as an important function of social work practice and supported the entrance of social networks into social work. The incorporation of social networks into practice and policy was prominent from the 1980s on. This was evident in Great Britain. The Barclay Report (see Olsen, 1983, for a discussion of social support networks from a British perspective) on the roles and tasks of social workers stressed utilizing and developing close working relationships with informal caregivers and community networks. The term "community social work," as defined in the Report, referred to enhancing informal support networks as well as coordinating the interface between formal and informal care. Within the United States, there was interest in informal helping resources in a variety of social work practice fields. The 1981 White House Conference on Families took up the issue of informal support networks, and how support systems could be strengthened by government policies (Wingspread Report, 1979). Enhancement of social support networks—strengthening existing ties, enhancing family ties, and building new ties—became an important thrust of case-management services for persons with severe mental illness (National Institute of Mental Health [NIMH], 1987). Child welfare policies following the passage of PL 96-272, The Adoption Assistance and Child Welfare Act of 1980, required that supportive services be provided to families as a means to prevent family disruption, to reunite families where separation had been necessary, and to place children in alternative permanent settings.

During this period, there were several key social work educators and researchers who were largely responsible for introducing and articulating the role of informal community helpers in relation to more formal service delivery systems. Maguire (1983) published a concise guide, *Understanding Social Networks,* which presented networking approaches as a

means to "maximize the use of natural helping networks and use professionals more efficiently" (p. 7). Whittaker and Garbarino (1983) published *Social Support Networks: Informal Helping in the Human Services,* a compilation of informal helping strategies across a wide range of client populations and service delivery systems; the preface to this volume stated that the book addressed a "quiet revolution" taking place in human services and declared that the purpose of the volume was to suggest ways in which "formal and informal caregivers can join together in new and creative alliances to offer a more effective and compassionate response to people in need of help" (p. xi). Their volume was the first work to compile the growing research evidence of the role of social networks across many fields of practice within social work, and to draw upon the ecological perspective to present social workers with compelling ways to complement rather than compete with informal social support networks.

In a similar vein, Naparstek, Biegel, and Spiro (1982) described a community empowerment model in *Neighborhood Networks for Humane Mental Health Care* that utilized strengths of city neighborhoods to mobilize support systems and create linkages between professional and informal service systems; in particular, collaborative linkages with friends, neighbors, natural helpers, and clergy were encouraged in order to empower and build upon community strengths. In *Community Support Systems and Mental Health: Practice, Policy and Research,* Biegel and Naparstek (1982) examined the roles of self-help groups, neighborhood networks, and informal helpers in a variety of contexts as a supplement to professional services; in addition, the ways in which professional services might weaken these natural support systems were also examined. Biegel, Shore, and Gordon (1984) in *Building Support Networks for the Elderly* presented a practitioner-friendly introduction to social networks and social network interventions based upon their extensive experience training and preparing resource materials for human service workers; strategies for neighborhood helping, volunteer linking, mutual aid, and community empowerment were outlined. Whittaker (1986) presented a well-developed conceptual framework for integrating formal and informal social care and introduced the social work role of the "network/system consultant" who works "through a preexisting or contrived support systems to aid an individual client or group of clients" (p. 46). Whittaker also examined management and practice implications for formal and informal helping in child welfare services as part of a "paradigm shift" in human services. Taking the then-current social work landscape into consideration, Meyer (1985, p. 291) concluded:

> The research evidence is in: There is a strong relationship between individual physical-social-psychological health and social supports and between social isolation and the breakdown in these areas or functioning. In view of the importance of natural support networks, social workers can do no less than explore the linkages between them and professional intervention.

Contemporary Applications of Social Networks Within Social Work

A social network approach can be useful to both micro- and macro-oriented social workers alike, providing us with a useful lens through which to view the social environment of our clients, and helpful aids in social work assessment and intervention planning. Social workers have made use of social network mapping techniques as an adjunct to social work assessment and intervention (Antonucci, 1986). Hill (2002) offers a useful description of both social network features and methods for assessing social network features. Important features to assess within social networks include the network structure or shape, interactions between network members, social support functions provided by network members, network composition, and diversity (Hill, 2002). Hill (2002) also outlines the following six types of diagrams commonly used to assess personal social networks:

1. The ecomap—identifies important individuals and visually represents their connections to a central person with lines;
2. Concentric circles—visually represent the emotional or geographic distance between individuals and a central person;

3. The genogram—a visual tree that represents relationships between family members;
4. Life-space representations—uses the important locations in the individual's life to represent the individuals and activities central to that person;
5. Life-course changes—uses visual representations of households and houses in which the individual has lived; and
6. Matrices—uses tables to list the individuals and their importance to a central person.

Many tools are currently available for measuring social support and social networks (see Streeter & Franklin, 1992). Tracy and Whittaker (1990) developed a social network map, drawing on the work of Fraser and Hawkins (1984) and Lovell and Hawkins (1988), which enabled the collection of information on the size and composition of the social network and the nature of relationships within the network. Several pilot studies were conducted in a variety of practice settings in which use of the social network map enabled practitioners to identify and assess strains and resources within the social environment, to understand culturally specific patterns of help giving, and to identify others who could participate in network interventions (Whittaker, Tracy, Overstreet, Mooradian, & Kapp, 1994). More-advanced data analysis techniques (e.g., latent class analysis) are now available to determine underlying patterns in the nature and scope of social support (Buckman, Bates, & Morgenstern, 2008). There is also increased interest in measuring social network changes over the life span and in response to life events (Wrzus, Hanel, Wagner, & Neyer, 2013) as well as treatment services (Stone, Jason, Stevens, & Light, 2014). Best and colleagues (2014) report on an innovative method to visually map therapeutic community members in terms of their recovery capital and social identity; they applied the social identity model of identity change to examine the role of social identity and belonging in life transitions.

Current Policy

The importance of both formal and informal social support and personal social networks has been acknowledged in public policy as well as practice. The President's New Freedom Commission report (2003) highlighted multiple areas where improving social network support and linkages could improve the provision of mental health services to adults and children. The report recommends the involvement of consumer's family members and social supports in care coordination and planning. It also calls for the strengthening of linkages between service systems such as medical service systems, mental health service systems, and schools. The commission also advocated the provision of mental health services within the community and schools, where children spend the majority of their time. Internationally, in the area of child civil rights, the United Nations Convention on the Rights of the Child (1990) also acknowledges the importance of informal social and kinship networks in child development. The Convention recommends that decisions regarding adoption and foster care of children prioritize placements that allow the child to maintain established familial, community, and cultural networks over those that necessitate the dissolution of those networks. This priority is further evidenced in child welfare practices that serve to strengthen the social networks of families at risk (Vonk & Yoo, 2009).

Types of Network-Related Interventions

While interventions with social networks are not as fully developed as person-oriented interventions, Kemp, Whittaker, and Tracy (1997) describe four general approaches to social network interventions. These approaches have a number of social work roles and values in common. *Linking* is an essential practice skill underlying social network interventions; this is similar to resource and referrals skills used by many social workers to locate needed resources, establish a linkage between the client and the resource, and ensure that the linkage will be maintained as planned. Linkages capitalize on the strengths between clients and their social networks, so a basic value undergirding social network interventions is the strengths perspective. Finally, collaborative worker–client relationships are typically a hallmark of social network interventions, with the client fully involved in decision-making and action steps.

With these shared foundations, descriptions of approaches to social network intervention follow.

Natural Helping Networks

People often turn to "natural helpers" for advice and support, as these are people who have often "been there," overcoming life challenges and disappointments (Pancoast, Parker, & Froland, 1983). Natural helper interventions develop consultative relationships with key helpers, or gatekeepers in a community, to extend the services of formal agencies, to reach out to hard-to-reach clients, and for prevention and early intervention services. The classic form of this intervention is described by Collins and Pancoast (1976). Some examples of natural helper interventions include:

1. Assistance provided by hairdresser, barbers, apartment managers, and postal workers to elderly people living in the community (Hooyman & Lustbader, 1986)
2. Community asset assessment of indigenous resources in a Puerto Rican community substance-abuse prevention program (Delgado, 1996)
3. Linking low-income neglectful families with a supportive natural helper in the community (Gaudin, Wodarski, Arkinson, & Avery, 1990–1991)
4. Natural mentoring relationships for youth transitioning out of foster care (Munson & McMillan, 2008)

Network Facilitation

Network facilitation mobilizes the social network as a resource and support for a targeted individual or family, based on an assessment of the needs and resources available. This intervention may take the form of supplementing an existing network or creating a new personal network through recruitment and matching of volunteer helpers. Network meetings are a hallmark of this form of intervention (Morin & Seidman, 1986); during such meetings, all participants discuss the client's situation and develop a plan of action. In this way, some network members may be reconnected in meaningful ways, while other network members may learn to take on new helping roles. In this form of intervention, it is important for personal social network members to be connected to one another, both to communicate and support one another, and to avoid duplication of effort. Some examples of network facilitation include:

1. Family group decision making, in which network members are identified and network meetings are convened to creatively plan for meeting child and family safety congruent with the family's culture. Special attention is paid to the manner in which the conference is initiated and structured so that family ownership and leadership is ensured in the conference deliberations. Both family and "like family" network members are invited to participate. This intervention has been used widely in child protection (Crampton, 2007), but it has also been adapted for use in juvenile justice and domestic violence (Pennell & Anderson, 2005).
2. Social skills training is often a component of network meetings so that network members have the skills required to assume new or expanded helping roles. Tracy and Whittaker (1991) described the importance of teaching communications and social skills (such as initiating conversations, appropriate self disclosure, and saying "thank you") in the context of social network facilitation in family preservation services.
3. Volunteer linking programs increase network size and enhance composition along with increasing community connections (Dunn, 1995; German & Gitterman, 1996). For example, Compeer (Skirboll & Pavelsky, 1984) matches community volunteers with persons with mental illness for friendship, modeling of coping skills, and adapting to community life. Other variants match consumers with one another, as often consumers are in the best position to show others how to negotiate complex service delivery systems.
4. The facilitation of mentoring relationships may also function as a network, facilitating intervention. Zippay (1995), for example, presents a case study in which a mentor program was used to improve both social networks and employment skills for adolescent mothers. Young women were matched with

volunteer mentors whose presence in their lives served to diversify their social networks and expanded their knowledge about employment opportunities and skills.
5. Building community-based social networks can help low-income women develop bridging and bonding social networks on their path out of poverty (Freeman & Dodson, 2014).

Mutual Aid Self-Help Groups

Self-help groups mobilize relationships among people who share common tasks or problems (Silverman, 1980; Gitterman & Shulman, 1986). This approach provides respect for clients as partners, an ongoing source of support, as well as advocacy and empowerment (Mehr, 1988). Self-help groups allow people to learn from one another and to realize that they are not alone, nor are they solely responsible for their problems; such groups allow people to see the political aspects of personal problems. While there are hundreds of self-help organizations nationwide, some examples include the following:

1. People First is a self-advocacy rights organization for people with mental retardation working toward greater self-determination (Shapiro, 1994).
2. Cox (1991) describes a self-help group for women welfare recipients advocating for themselves.
3. Lewis and Ford (1991) show how African American women collectively used social support networks to resolve individual and community level problems.
4. Self-help groups are often an important component of community-building in impoverished communities (Weil, 1996).

Social Network Skills Training

Based on models of life and social skills training and drawing upon cognitive behavioral interventions, social network skills training teaches people ways of establishing and maintaining supportive interactions with each other (Richey, 1994). The intent is to develop a skilled support system and a client with competency to use that support system effectively. Some examples include the following:

1. A Friendship Group offered to families referred from Child Protective Services taught key interpersonal skills for supportive relationships through information, modeling, and behavioral rehearsal (Lovell & Richey, 1991).
2. A social network training module delivered to parents of children enrolled in Head Start was designed to help parents better understand everybody's need for support, how to identify social network membership and social support needs, and specific strategies to change networks. Ferguson, Tracy, and Simonnelli (1992) describe a menu of interventions: linking up with new people or groups, working on changing relationships, getting new skills or experiences, reestablishing old relationships if positive, and asking others for help. Each participant developed a social network plan in conjunction with a parent partner or buddy.
3. A social worker who meets with his mentally ill client's family members encourages them to identify interests and activities that they might engage in together and assists them in improving communication skills to enhance network functioning. Pinto (2006) describe the importance of engaging natural supports such as family members by improving their interpersonal skills, and mobilizing community members as part of support networks in order for clients with mental illness to maintain their functioning within the community.
4. Pettus-Davis et al. (2015) examined the acceptability of a promising manualized 10-week group training program, Support Matters, delivered to reentering prisoners who came to the sessions with a support partner. The program taught both cognitive and relational skills to improve reentering prisoners' ability to engage in positive social supports.

Examples of Social Network Assessment and Intervention

Family Preservation Services

Child welfare services have shifted over time from an overriding emphasis on child placement

to a focus on family support. Supportive family services consisted of forming a partnership with the family, including extended family members and natural helping networks. The goals of in-home family preservation services, which grew dramatically during the 1980's and 1990's, included, among others, helping the family to use of a variety of formal and informal helping resources (Berry, 2005). The impact of these early programs remains to this day: Even though current child welfare policy places more emphasis on safety, well-being, and timely permanence, family programs work closely with community groups, neighborhoods, extended families, and social networks as a means of fostering healthy communities. Family-centered models in child welfare, such as family group decision-making, incorporate the use of social network assessment to enable the extended family to make decisions regarding child safety (Tracy & Piccola, 2006).

Integrated Dual Disorders Treatment (IDDT)

An evidence-based treatment model for intervention with individuals with co-occurring disorders of substance abuse and mental illness, integrated dual disorders treatment (IDDT) utilizes interventions focused on enhancing social supports within families and communities. Viewing all areas of an individual's life as important to maintaining recovery, IDDT interventions engage consumers' family members in psycho-education and skills-building. In this way, social workers enhance the capacity of the family to engage with and support the consumer. Furthermore, IDDT encourages intervention within the consumer's community, as workers establish linkages between individual consumers and community self-help groups or community activities. In these ways, the natural personal social networks of consumers are enhanced through increasing both density and functions within the consumer's network (Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence [Ohio SAMI CCOE], 2008).

Multisystemic Therapy (MST)

Multisystemic therapy (MST) is a home-based treatment model designed to assist adolescents and their families within their natural settings, and it also incorporates interventions at the level of the family's social network. MST social workers intervene in part by identifying the resources and supports already present in the adolescent's life, including extended-family members, neighbors, school personnel, church members, and community members (Borduin et al., 1995). Once network resources are identified, MST workers help adolescents and families strengthen their connections to these individuals or create linkages between these families and potential network members. The goal in this model is to strengthen linkages between parents and social network members who will reinforce parenting efforts and goals.

Future Directions

Overcoming Barriers to Social Network Interventions

In 1986, Whittaker identified a number of barriers to policy and practice implementation in the area of social networks; unfortunately, many of these barriers remain to this day.

Institutional barriers. These include the organizational and administrative complexities of introducing non-salaried informal helpers into formal service plans; e.g., agency liability, clients' rights to privacy, administrative accountability, and lines of authority and supervision.

Economic. Given changes in the economy and social demographics, there is likely to be a diminishing pool of potential informal caregivers and difficulty funding support services for caregivers.

Professional. There may be resistance to changes in worker's roles and unwillingness to share power and authority with informal helpers.

Conceptual. Multiple meanings of constructs and imprecise definitions of social networks and social support make it difficult to articulate practice steps and policy implications.

In an exploratory study of barriers to social network interventions, Biegel, Tracy, and Song (1995) identified paperwork, high caseload, community stigma, and lack of community

resources as the most frequently reported barriers experienced by mental health case managers. A training strategy (e.g., training practitioners in social network intervention techniques) may not be sufficient to overcome such barriers; administrative system changes as well as community organization strategies to develop new programs and resources may be needed to promote an environment more conducive to social network interventions (Tracy & Biegel, 1994).

A challenge for the future is that there are limitations inherent in social network strategies, and a need to weigh the risks and costs of reliance on social networks. Not everyone has a caring social network, or the inclination to utilize social resources. In fact, those most in need of informal helping may lack social resources, may lack networks with the skills and capabilities to render aid, or live in communities with fewer helping resources (Garbarino & Sherman, 1980). The same stressors or conditions that create the need for increased social support may also deplete the resources of those who would otherwise be available to provide informal care.

There is also stress associated with the provision of informal care. The financial and personal costs of caregiving are already high. It is important that policies favoring utilizing informal care from social networks not overload informal helpers even further, debilitating rather than facilitating their support. A critique of family caregiving strategies also points out that reliance on informal helpers has led to increased stress and strain, primarily on women, who provide a disproportionate amount of informal care and already assume multiple caregiving roles; and the lack of supportive services for care providers, such as financial reimbursements and respite care (Graycar, 1983).

Research Implications for Social Work

Recent research on social networks has examined the role of social networks for diverse groups dealing with a myriad of health, mental health, and life stage issues. White and Cant (2003) used social network analysis to explore the role of instrumental and emotional social support in the lives of HIV-positive gay men. Lewandowski and Hill (2009) utilized the Scale of Perceived Social Support (MacDonald, 1998) to examine the relationship between perceived social support and drug treatment completion for women in a residential drug treatment program. Additionally, the role of perceived social network support in the well-being of same-sex and opposite-sex couples was examined (Blair & Holmberg, 2008). Findings indicated the importance of social support as predictive of relationship well-being for both same-sex and opposite-sex couples. Ali et al. (2013) examined how adolescents increased their social network ties through alcohol consumption, illustrating one motivation behind adolescent drinking.

Recent research has also examined the interactions between attachment history, attachment style, and social support, as attachment experiences may influence individual's ability to both perceive support and identify and mobilize social network supports. For example, one study found that at-risk mothers with insecure attachment styles also reported lower social support than those with secure attachment styles (Green, Furrer, & McAllister, 2007). Additionally, for drug-dependent mothers, early attachment experiences mediated their ability to perceive support from their networks (Suchman, McMahon, Slade, & Luthar, 2005). In examining perceptions of support, Collins and Feeney (2004) found that individuals are predisposed to appraise their support experiences in ways that are consistent with their internal working models of attachment relationships, regardless of the actual support provided from network members. Attachment style may also be an important factor in determining how individuals experience daily life stressors, with implications for the importance of social support, especially for individuals with insecure attachment styles. In a study of HIV-positive individuals, those with insecure or highly anxious attachment styles were more likely to perceive their lives as stressful, and were consequently at higher risk for under-utilizing or alienating available social support (Koopman et al., 2000).

Most researchers and practitioners in the area of social support agree that much more research is needed in experimental manipulations of social networks—the sequence, frequency, and intensity of interventions—in

order to better understand the mechanism or process by which social support "works." We also are in need of more information on how to tailor or adapt network interventions to each stage of treatment or change; one size may not fit all. For example, the type and source of support that are helpful may vary as a function of the stage of treatment of the client (Tracy & Johnson, 2007). In a review of social network interventions, Ertel, Glymour, and Berkman (2009) point out the following limitations of social network intervention research: a focus on method of delivery versus timing of delivery, patient samples versus community samples, and failure to measure changes in social networks over time. In spite of many research studies on social support, Sarason and Sarason (2009) conclude that a clear consensus has not been reached on "the definition of social support, how to assess it, select and implement effective research strategies, and interpret the empirical evidence" (p. 114). The ways in which culture may influence how people make use of their social network also need further clarification (Kim, Sherman, & Taylor, 2008). In addition to research that examines factors moderating the effectiveness of social network interventions, research is needed that examines the requisite organizational structure for social network service delivery, the role of community resources, and the impacts of social networks on organizations and communities.

Conclusions

Social network approaches are consistent with social work values and practice approaches and are increasingly recognized and incorporated as active components of current treatment packages and practice models. With a longstanding tradition within social work, social network approaches have been applied broadly across a variety of client populations and service delivery systems. A social network approach allows practitioners to assess and intervene in multiple levels of the client's environment and thus may play a role in supporting and maintaining change efforts. As such, these approaches help bridge the unhelpful division between micro- and macro-practice in social work and offer strategies to fulfill the social work profession's primary mission to improve the quality of life for all persons.

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33

Social Work Practice in the Time of Neuroscience

Robert J. MacFadden

For decades, social work has committed itself to a biopsychosocial perspective, but, with some exceptions, there is very little evidence of the profession's embracing the biological side of this perspective (Saleebey, 1992). Most of the focus in both practice and education has been on the psychological and social dimensions.

The emerging knowledge through neuroscience and neurobiology has recently caught the attention of social workers, and there is interest and beginning efforts to incorporate this perspective into our professional knowledge base, research, and practice (Applegate & Shapiro, 2005). Rosemary Farmer (2009), a social worker, has identified this focus on the brain as the "missing link" for our profession. This new knowledge promises to balance out our professional perspective with an increased focus on and knowledge of neuroscience.

A neuroscience perspective is one of the most important new paradigms for social workers in this century. It promises to provide a common language and understanding that links our profession more closely with other professions, especially those in the allied health sector. Neuroscience's emphasis on the mind, body, brain, and relationships offers a holistic orientation that is appealing to a systemically based profession such as social work.

Focusing on the brain reminds us that all our perceptions, feelings, thoughts, and behaviors have a basis in the brain. An understanding of the brain, how it evolved and how it functions, provides insight into our basic human nature, including the promises and the challenges.

The "social" part of the term "social worker" underscores our profession's recognition of the essential nature of relationships to our existence. Neuroscience, similarly, has revealed how fundamental relationships are to our brains, mind, and bodies. Human connections help shape neural connections. Our brains at birth are immature and require considerable "home assembly." Relationships essentially sculpt our brains. When we are infants, our parents help grow our brain through interactions that also help define our self-worth and the value of others. Like a prosthetic, parents' own brains assist infants in controlling their emotions until their own regulatory systems become active.

Thus the brains of others help our own brains mature. As a species we are "wired to connect" (Dekoven Fishbane, 2007). Louis Cozolino (2010) asserts that there are no single brains, and that the brain, besides its genetic component, is a "social organ" developed through interaction with others.

Daniel Siegel's (2012a, p. 2) seminal definition of the mind, emerging out of an interdisciplinary collaboration, reflects the importance of nature and nurture, of brain and relationships: "A core aspect of the mind is an embodied and relational process that regulates the flow of energy and information." Relationships are being seen as essential in sculpting the brain.

As example of this is the knowledge emerging from recent discoveries such as the existence of "mirror neurons," which are neural components designed to pay attention to the behaviors, feelings, and intentions of others and to provide this information to our brains. This is a type of social wi-fi. When we watch others, the mirror neurons pick up these cues, and through the collaboration of other brain components such as the insula, this information flows throughout our body and brain. Aspects of our body resonate with this information and change parts of our own physiology. These changes are sent up the insula and into our prefrontal cortex, which perceives these changes as a "feeling." Thus, in watching others, we resonate, and our bodies change to attune and to reflect these states in others. We are able to feel empathy for the other. The mirror neuron system in others senses the change in our bodily states and resonates with these changes, and the other "feels felt" by us. These are the neural dynamics of social connection. The therapeutic alliance, a major source of influence in therapeutic change, depends on this empathic connection to have an impact.

Findings in neuroscience research have deepened our understanding of how the fundamental dynamics of attachment work. Siegel, in his book *The Developing Mind* (Siegel, 2012a), describes in detail how attachment is developed and the importance of relationships that offer resonance, attunement, and empathy in developing who we are.

Therapeutic relationships are viewed as forms of attachment relationships that create the conditions for optimal change. Interpersonal relationships involve biochemical changes that result in many things, including new neural connections and learning. This new perspective views social workers as physical change agents involved in stimulating new neural connections. Daniel Siegel (2012b) refers to the acronym SNAG, which stands for Stimulate Neural Activation and Growth.

Evolving neuroscience insights have added new perspectives to how we view human nature and relationships. The following are some examples of these insights.

Besides being social organs, our brains are also historical organs. Our brains and nervous systems have developed over millennia, and many of our current characteristics are a function of what our challenges and environments were like over this large time span.

We have survived by being vigilant and cautious. A central brain component called the "amygdala" is sensitive to situations that are novel and that potentially are dangerous. When a threat is perceived, the amygdala helps activate the stress response, which prepares us to fight, flee, or freeze. A cascade of biochemicals floods our interior quickly, preparing our muscles, digestion, heart, breathing, and other body parts to manage the threat. Part of these biochemicals include cortisol, which helps activate these internal body responses. This sympathetic nervous system involvement is an historical lifesaving process.

Yet modern life does not typically involve threats that can be handled by fighting, fleeing, or freezing. Most of our threats do not involve survival, yet they activate this historic

stress process, and we end up "stewing in our juices." The influence of prolonged and chronic stress impacts some important neural components such as the amygdala and the hippocampus, heavily involved in conscious memory. For instance, children in continuing abusive situations may experience shrinking of the hippocampus and hyper-activation of the amygdala. This can lead to post-traumatic stress disorder (PTSD) symptoms of hypervigilance, and difficulty focusing, thinking, paying attention, and learning. Excessive cortisol dosing can weaken the neural components such as the prefrontal cortex, the anterior cingulate cortex (ACC), and the hippocampus that act as brakes to help us emotionally regulate.

We are beginning to realize the extent to which fear and anxiety are a fundamental part of being human and account for so many of the problems we encounter in maintaining well-being. Hanson and Mendius (2009) describe the brain as having a "negativity bias" that constantly looks for, reacts to, and stores negative experiences, which accounts for much of our pessimism, fear, anxiety, and depression. Hanson depicts the brain as "Velcro" for negatives and "Teflon" for positives. If ten positive things and two negative things happen to us in a day, we tend to focus on the two negative events and overlook the positive experiences.

Neuroscience is refocusing social work into becoming more knowledgeable about the stress process and learning how to help clients manage stress, and to prevent excessive levels that can cause such damage. Cozolino (2010) describes clinicians as needing to become "amygdala whisperers," helping create a safe, secure, and accepting therapeutic relationship that can help reduce fears, decrease vulnerabilities, and build new positive narratives.

Stephen Porges's revolutionary work on the polyvagal theory has expanded our understanding of the sympathetic and parasympathetic systems and how our brain and body connect to regulate our physiological states. He has identified a more evolutionarily recent addition to the way we respond to threats. Porges asserts that our human nervous system is in a constant quest for safety (Porges, 2011). Through the subconscious system of neuroception, we are constantly monitoring threats from internal and external sources, such as our bodies and the environment. Porges describes a hierarchical defense system of neural circuits that can help us restore homeostasis when we become threatened. The first to be employed is the newest, the "social engagement system," whose complexity is a reflection of how our social brain has expanded in sophistication and size to cope with our increasingly social world. We are wired to connect, and we first engage with others to help us manage stress and to develop a sense of safety. The value of social and emotional support from others who resonate and attune and help us "feel felt" is crucial in emotional regulation. If this fails, we mobilize into a "fight or flight" circuit, which readies us to fight off or to flee from a threat. If this fails to restore our homeostasis, our oldest and most primal system becomes activated, the immobilization or freeze system. From Porges's work, we understand why helping clients build a sense of safety is essential for their well-being. Porges notes, for example, that ensuring that clients feel safe about where they are sitting in a room, using a supportive, prosodic voice, ensuring there is no unnecessary noise, especially low-frequency sounds like air conditioners and traffic, can help turn defense systems off (Porges, 2004). Social workers need to regularly check with clients to see how comfortable and safe they feel, since this will affect the quality of the therapeutic relationship.

Besides understanding the centrality of fear and anxiety, and the bias towards negativity, neuroscience is also underscoring how essential positivity is to our existence. A movement associated with the third wave in psychology, called *positive psychology* (Seligman, 2011), is highlighting how positive emotions and optimism fuel well-being. The research work of John Gottman and colleagues (2000, 2004) over three decades of working with couples has also underscored the fundamental importance of positivity in relationships that last. A strong predictor of enduring relationships that promote well-being is the ratio of 5:1, positives to negatives. Couples that have fulfilling, long-term relationships have significantly more positive than negative interactions.

Rick Hanson, in *Hardwiring Happiness* (2013), remarks how unwilling the mind is to

give the gift of a positive experience to itself. Clients would benefit from becoming aware of this gift and identifying and savoring these positive experiences. This includes collecting them and continuing to marinate in them. Hanson uses the acronym of HEAL to suggest the ways to do this: First H-ave and notice the positive experience; E-nrich it through staying with it, increasing the intensity and duration and magnifying its importance; A-bsorb it through visualizing, sensing it and building on it; and, if desired, L-ink these positive experiences gradually with some painful thoughts and feelings, as doing so can act as a natural antidote to these negative thoughts and feelings.

In a startling homage to Sigmund Freud, neuroscience is highlighting the significance of the unconscious in our mental life. It is estimated by some that over 95% of our mental activity is unconscious (Jensen, 2008; Materna, 2007). However, the neuroscience understanding of the unconscious is not the same image that Freud postulated. The unconscious is made up of many different neurocomponents or nuclei that are distributed across the brain. It is estimated that our five senses are receiving more than 11 million pieces of information per second. It is believed we can handle about 40 pieces of information per second consciously (Wilson, 2002). Our unconscious helps us select what is important and what to ignore. It also helps us automatically maintain our fundamental life systems such as breathing, heart rate, body temperature, and immune system. Although important, our consciousness is substantially limited in what it can process and how quickly it can process stimuli.

The systems that make up the unconscious are ready at birth and possibly at some point in utero. At birth, the amygdala is fully formed and allows the infant to react to stimuli. It also is involved in the earliest of memories that capture much of the experience and learning of early life. Unconscious memory forms our earliest knowledge base. It does not require the focal attention that conscious memory requires. Unconscious memory is created through experiences and uses neurotransmitters associated with emotion to stamp experience as positive for survival (remember) or negative (don't remember). Unconscious memory is powerful, quickly retrieved, contains no time and date information, and is difficult to change. These essentially are the biases or knowledge that are stored deep in memory. These biases are mostly positive, helping us decide things quickly, based on what has worked and what we have learned. However, these biases can also be faulty and lead us to make mistakes. Prejudice and stereotyping, as examples, can be contained in this implicit knowledge base. This is knowledge that is learned early, not accessible to consciousness, and can exert important influences on us. A social worker, for example, could work in social justice causes throughout her life and still harbor unconscious biases that are polar opposite to her conscious life and values. As another example, a child welfare worker involved in assessing homes for foster children may unconsciously hold a bias against same-sex parents which may impact her ability to conduct a fair assessment (MacFadden & Schoech, 2010).

Researchers from Harvard and the University of Washington have been working for over a decade, identifying implicit biases of this type, and they have developed a computerized way of identifying both the direction and strength of specific unconscious, implicit biases. Their website allows visitors to assess this: https://implicit.harvard.edu/implicit/.

A focus on emotion has been a hallmark of the social work profession historically, although there has been minimal research in this area by social workers. Neuroscience and research-informed practice have been moving towards a new appreciation of the significance of emotion and its impact on thinking, relationships, decision-making, and learning.

Emotion is now being viewed as a fundamental factor in our thinking and behavior. One of the leading U.S. neuroscientists, Antonio Damasio, describes emotion as a part of the edifice or foundation of reason. He indicates that human beings are not thinking machines. We are feeling machines that think (Damasio, 2001). Schore refers to the paradigm shift in therapy from cognition to emotion, paralleled by a shift from the left hemisphere to the right hemisphere (Schore, 2012; Schore, 2003).

A distinction is made between emotion and feelings. Emotions are unconscious and reflect early decision-making processes. They occur

within the theatre of the body—we can usually see emotions in people's faces and other physiology. Information about these bodily changes is transmitted through the insula to the prefrontal cortex, and these changes are experienced as a feeling—a conscious awareness. Feelings are within the theatre of the mind and reflect an experiencing of a self. As an example of the differences, an individual who sustains a stroke that damages a certain part of the brain may be able to experience an emotion such as anger—you may see a furrowed brow, a flushed face, and tight fists—but information about these changes is blocked from flowing to the prefrontal cortex, and the individual does not experience a feeling of this emotion.

Emotion regulation is increasingly being viewed as central to our well-being, psychologically and socially. Parents pass on the skill for this in the early years. Siegel states that the communication of emotion may be the primary way attachment relationships shape the mind, and that emotion is a central organizing process within the brain that shapes the ability of the mind to integrate experience and to adapt to future stressors (Siegel, 1999). Couples in relationships that last help each other manage their emotions. Susan Johnson (in Fosha, 2009, p. 279), co-founder of emotionally focused therapy, calls emotion "the most powerful force in human behavior."

Emotion regulation can be enhanced by strengthening centers of the brain such as the prefrontal cortex, the anterior cingulate cortex, and the hippocampus. These three parts, along with others, help put the brakes on the amygdala, which helps limit the stress response and the arousal that entails.

Daniel Siegel (2010), a psychiatrist, attachment researcher and founder of an approach to psychotherapy called *interpersonal neurobiology*, researched the role of the middle prefrontal cortex in our mental life and well-being and found that this area of the brain was responsible for nine critical functions: bodily regulation, emotion regulation, intuition, morality, attuned communication, response flexibility, fear modulation, insight, and empathy. Secure attachment has been associated with eight of these nine functions. Intuition and secure attachment has not been formally researched yet.

Social work has become interested in the positive benefits of mindfulness meditation, and neuroscience is identifying how mindfulness meditation has an impact on strengthening aspects of the brain, leading to improved well-being. In a meta-analysis of the effects of mindfulness on the brain, Holzel et al. (2011) identify several brain areas affected by meditation practices. These include the anterior cingulate cortex, the insula, the dorsal prefrontal cortex, the ventromedial prefrontal cortex, the hippocampus, and the cingulate cortex. Strengthening these brain components promotes the following changes: attention-regulation, body awareness, emotion regulation, change in the perspective on the self (e.g., more positive self-concept and self-esteem, stronger acceptance of self), and increased self-compassion.

Neuroscience is also providing some insights into how we learn and related teaching strategies. Few social work educators may be aware of the two to three decades of research on learning and the brain that exists and can be integrated into our educational processes (Jensen, 2005, 2008; Caine & Caine, 2006).

A further significant advantage for social workers of being aware of the neuroscience knowledge related to learning is that both learning and therapeutic change have a common foundation: neural change. Many of the factors that promote optimal learning and therapeutic change are similar. Some insights from neuroscience and learning follow.

Learning is about physical change, the making of new neuronal pathways, strengthening existing pathways, and making more complex neural maps and connections. Learning simply is memory that sticks (Howard, 2006).

Brain-compatible learning is learner-centered, and educators need to begin with what students know and value, and to tie the new learning, whenever possible, to what is known—to the learner's existing neural maps. Getting the attention of the learner is critical, helping the learner to make sense of the content is necessary and helping the learners identify the relevancy of the content is essential.

The educator is a physical agent, and teaching and learning are physical actions. Learners are physically changed if learning occurs. The way the educator sets up the classroom and

communicates with students, the type of content chosen, the method of delivery, and the feedback provided engender a wide range of emotions and feelings that release a cascade of neuropeptides that help alter the body and the mind landscape of the learner. And some changes last a lifetime.

Developing knowledge and skills in constructing a positive emotional climate for learning is at least as important as the quality of the content. Learning rarely surpasses the quality of teaching (Sousa, 2006). To encourage maximum learning, a positive emotional climate within the classroom needs to be created so that students can develop an optimal learning state termed "relaxed alertness" (Caine et al., 2005; Materna, 2007). This state is characterized by low threat and high challenge. In this positive environment, there is an excitement about or interest in learning, and this is accompanied with a feeling of safety that permits learners to take risks in thinking, questioning, and developing new skills. It is a state that engages the executive functions of the brain in analyzing, creating, planning, and taking action.

Educators would benefit from recognizing the importance of unconscious learning and realize that students in a class are learning things consciously and unconsciously. Indeed, Jensen (2008, p. 107) remarks that "the majority of what you and your students are learning . . . was never consciously intended."

Our natural limitations ensure that we only process a limited amount of ideas and memories. Although it varies with motivation, adults can typically process an item in working memory intently for about 10–20 minutes before mental fatigue or boredom sets in and focus weakens (Sousa, 2006). Our neurotransmitters can become depleted and need a rest to rejuvenate and restore these levels. We constantly need to see the meaning and relevance of things, or they won't be attended to or learned.

Sometimes social work educators feel under considerable pressure to "cover" a range of topics that may be too extensive for the number of class sessions. Content is more likely to be added to a curriculum than dropped. Covering the topics through a "content bucket" approach may be unrealistic and not permit time for student reflection, critique, and application of the knowledge. Perhaps educators and curriculum developers need to seriously ask themselves (and students) what content is so important that social workers are likely to use it frequently in their practice. Prioritizing content and ensuring that it is understood by the learner (i.e., it makes sense) and exploring its importance (i.e., why it is relevant) and making connections would increase the chance that it is learned, remembered, and used. Ensuring adequate time and opportunity for reflection (i.e., making neural connections and links with other neural maps) would enhance this process.

Social workers are beginning to integrate neuroscience understandings into their work with all ages of clients. From a psychoeducational perspective, using Daniel Siegel's "hand model of the brain" (Siegel, 2010, p. 15) is enabling social workers to illustrate the different parts of the brain and how each works separately and with the others. It also graphically illustrates how problems with emotional regulation occur and can lead to us "flipping our lids." Siegel demonstrates this online at http://www.youtube.com/watch?v=DD-lfP1FBFk. A psychoeducation perspective is normalizing and allows social workers to move from "a problem with your brain" to "a problem with our brains" when working with clients.

These are some illustrations of how emerging research on neuroscience connects with social work's interests and mandates. For a profession interested in a biopsychosocial perspective, neuroscience provides an important source of knowledge that itself is at an early stage of evolution. While advances in imaging technologies have grown this knowledge exponentially, there is still much that is not known and considerable speculation and inference-making within the field. The promise, however, for the profession of social work is remarkable.

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For a useful web-based resource highlighting social work and neuroscience, visit the author's website at www.robertmacfadden.com.

34

Socially Constructing Social Work

Dan Wulff

Social work as a profession or discipline can be usefully thought of as a socially constructed set of activities that ebb and flow through time and place—social work today bears similarities to how it was articulated and practiced in the past, while also reflecting adjustments that have given it shape and contour reflective of our current time and circumstance. Social work is revealed through "performances" that come to typify what social workers "do" (deMontigny, 1995; Hall, 1997; Parton & O'Byrne, 2000). To "socially construct" social work means that societies, communities, and individuals create/invent social work to accomplish certain goals or tasks. So why might considering social work and its performances as socially constructed be advantageous?

Reminding ourselves that social work is a collection of beliefs and activities that are continuously facing changing conditions of practice in relation to persons and communities that are embedded in a fast-paced world in flux can serve to keep us humble in our work with clients, communities, organizations, or any level of social work activity. It can also invite us to create and occupy postures that can help us become as useful and generative as we can be. Storch and Shotter (2013) eloquently express this by describing a stance they refer to as "poised resourcefulness":

> a capacity to enter each new and unique situation we encounter in our professional practice with a range of relevant responses "at the ready," so to speak, to whatever contingencies, bewilderments, disorientations, puzzlements, feelings, emotions, etc., we might meet there. (p. 16)

Storch and Shotter underscore the importance of relationality by suggesting that we gear

ourselves to be maximally ready to interact with clients and communities in ways that cannot be completely foretold.

Our practices are performed in various locations, contexts, and time periods that provide us with challenges as to how we assess how we are doing, what we might do differently, and how we might create new ways of performing social work. Flexibility and adaptability to better meet the challenges of living together have been long-standing values of social work, and ways to articulate and perform those values in ever-changing contexts may be among the greatest aspects of what we fondly call *social* work.

In 1951, Bertha Reynolds wrote in her dedication in *Social Work and Social Living: Explorations in Philosophy and Practice*, "This book is dedicated to an unbreakable tie with the interests in humanity," highlighting the importance of keeping the focus of social work inextricably linked with humanity and its interests. In her book, she specified many activities and processes deemed essential for social work practice at that time but kept the direction of social work actions directly and uncompromisingly linked to humanity in the largest sense, and to the humanity within all people. Our social justice value requires the same of us today.

As I highlighted in my chapter entitled "Postmodern Social Work" in this volume's previous (fifth) edition,

> postmodernism calls all "givens"—including social work theories—into question. Postmodernism seeks to interrogate the way in which meaning is produced, to uncover the ideologies and vested interests that inform its generation. (Wood & Tully, 2006, p. 17)

All theories, models, practices, and programs are seen as ways of shaping what we do as social workers, and they are each based on assumptions and beliefs about our world, people, and change (Gergen, 2009, 2015). Even postmodernism is examined for what possibilities it opens up and what possibilities may be closed down.

> Nothing can be taken to be politically neutral or theoretically innocent. Always, social work activity is both political and consequential. Always, social workers are complicit in their formulation of problems, their selection of diagnoses, and their choice of practice modalities. (Wood & Tully, 2006, p. 17)

Given that we can lay no claim to being objective or neutral as social workers, we are charged with the responsibility of acknowledging where we stand at any moment regarding any situation or issue and to be able to articulate that location and its foundations.

A chapter on "social constructionism and social work" in a book about social work "treatments" invites a tension between the aim of clearly specifying what "it" is versus allowing the relationship between social constructionism and social work to wax and wane. In my chapter on postmodern social work, I tried to cautiously specify what "it" is. In this chapter, I will work with the phrase "social constructionism" to more specifically locate social work in the practices that "create meaning through our collaborative activities" (Gergen & Gergen, 2004, p. 7). *Social constructionism* as a term more clearly, in my view, directs our attention to the "hows" of social work more than does the term *postmodernism*. I will try to illustrate the slippery relationship between social constructionism and social work and the value in that hard-to-pin-down relationship. I will outline my current version of a socially constructed social work that is formed from a variety of experiences, observations, and practices from my position in my social world—white, middle-class, U.S. citizen, male, living in Canada, married, parent, grandparent, professor, family therapist, ballroom dancer, baby boomer, etc. Note that my depiction of socially constructed social work is time-bound—if I were to write this chapter next year, it would undoubtedly be different. This chapter is written as a companion to and further articulation of my chapter on postmodern social work in the earlier edition of this volume.

The desire or need to understand client situations or contexts in ways that are definitive and can "hold steady" over time are part of our positivist heritage and professional upbringing. Rather than seeing a socially constructed social work that is so "on the move" as to be without foundations, my version of a socially constructed social work sees the constant situatedness of applications as the grounding or footing. Herein lies one of the values of social constructionist thinking for social work—our understanding depends on the context writ

large. To be *in* a situation or experience involves more than an intellectual rendering. Multiple perspectives grant an appreciation of what is going on that no single perspective can produce or support (Bohm, 1996).

Our positivist tendencies seek to define, grasp, and predict behaviors in an accumulative fashion in an attempt to further our mastery of the world. Rather than seek to establish a theoretical or research base that is generalizable across contexts, a socially constructed approach in social work would gravitate more toward the notion of "transferability" as used in qualitative research (Schwandt, 2001). Clear and rich descriptions of what one does allows others to read about those activities in depth and then decide for themselves the merit of importing or transferring those practices into their own context. In a socially constructed social work, there is a relinquishment of the desire to find universal practices that we *know* will work.

The foundation or grounding necessary for socially constructed social work is a connection of what is proposed or being done to a rationale and coherence that fits the local context and the actors involved. This grounding is a negotiated space and understanding that warrants the action and guarantees flexibility across contexts, times, and persons in order to meet the challenges in the current moment. There is no expectation that what works today will work tomorrow or that what works in one client situation will work in another. This willingness to see each situation anew is not to say that all situations will be completely unlike all others. Rather, the aim is to loosen the desire to use standardized or generalized patterns in client contexts and to ready the social worker for uniqueness first, and patterns used previously second.

> It values voices from the marginalized, moves away from the obsession with finding the one "right" answer, and legitimizes (indeed celebrates) diversity. It accepts the messiness of the reality of social work practice and of daily life, and does not insist on imposing a false order on natural chaos. (Ife, 2012, p. 170)

From a socially constructed perspective, social workers approach issues and situations as they occur (with their "messiness") rather than try to simplify for the ease of dispensing services or resources. Hick and Pozzuto (2005) challenge us "to 'unbecome' social workers and then struggle with clients to uncover the contours of the world implicated in a shared, lived reality" (p. xvii)—to continually unpack who we think we are and the impacts we are having in order to, with our clients, make sense of the world we live in and how we should move within it.

While using the term "postmodernism" is a way of critiquing the idea of certainty and universality in many fields and disciplines (including social work), I am working in this chapter with the term "socially constructing" to more directly and specifically talk about some of the *ways* in which individuals and groups participate in the construction of the worlds that they come to value and live within and through. To use a painting metaphor, rather than pointing to some "broad brush" ideas or issues to highlight postmodernist qualities, I will attempt to accentuate some of the colors, contours, and details of a social constructionist rendering of social work. Paintings can be of many styles, and what I present to you, the reader, here, is my watercolor. By no means is this the only painting that could be created from socially constructed notions of social work, but by displaying some of the aspects of my watercolor, I am hoping you might see just how social work can take on many forms and become an ongoing act of creation rather than a rote process that becomes disconnected from the diverse situations and contexts of clients' lives.

It is important for the reader to view this chapter as "painted" by me, bringing my ideas about social constructionism into your sight. This chapter is not offered as an authoritative text on social constructionism or social work—rather, it is one person's thoughts about these two worlds at this moment in time. Rather than seeing my statements here as qualifiers or disclaimers, they are offered as an embracing of some key elements of social construction by me—acknowledging positionality, engaging humility, and appreciating locality. Watch for the ways that relationality between social worker and client or client groups is manifested in my narrative in this chapter and how it plays out in the activities taken up by social workers from this perspective.

Throughout this chapter, I will describe some processes/activities that can become available by seeing social work as socially constructed. My choice of activities in this chapter is based upon my recent efforts to use social constructionist ideas in therapy with my clients and in supervision with students as well as in my role as an academic in the classroom and in doing research. I have been focused on increasing participation wherever and whenever I can, and I have been very interested in connecting research and practice, macro- and micro-, and the academy with the community. Key in this way of talking is the importance of using verbs to highlight the active and creative, as opposed to nouns that consider actions as stable and predictable. So you will see "connecting," "evaluating," "including," "languaging," "applying," "integrating," "being transparent," and "continuing" as the organizing terms for my comments.

Connecting (with Social Work in Earlier Times)

Early experiences of social workers (Ehrenreich, 1985; Lowe & Reid, 1999; Lubove, 1965) framed issues that individuals, families, and communities faced as varied, multidimensional, and unstable. Social workers created responses and resources alongside the troubles people were facing in their communities. An inventiveness was required from social workers due to the situations that individuals and families were facing that were multiple and complex. Living in fast-growing, large cities, issues of economics, culture, language, employment, and mobility were laced together in ways that challenged simple and straightforward remediation. These types of problems were not necessarily new, but the context and intensity of these problems called for responses that were coherent for the situation and those affected. Programs and services that failed to meet the challenge of the burgeoning needs of the communities risked being irrelevant, harmful, and a waste of money. Nowadays, as then, services must be consistently examined to ensure that they are useful for people. This process keeps services in flux as the conditions they are addressing are complex and fluid. Similar to the tightrope walker, in order to stay on the wire without falling requires constant readjusting. To stay upright and moving forward, thousands of small adjustments are demanded constantly.

Evaluating (or Better, Valuing)

The level of bureaucratization and specialization in our contemporary world has grown in an effort to deliver large amounts of services or resources, and so it is with social work. Herein lie serious challenges to delivering services that meet the needs of our clients and their communities. Issues of eligibility and the distributing of apparently limited resources and services tend to override the attention given to assessing the experienced performance of those services in the lives of clients and communities. The proliferation of evaluation research is positioned well to ensure that the performances of the services delivered met the proper standard, but those efforts have tended toward chronicling financial disbursements and using rather "thin" examinations of how the services have impacted clients. Utilization rates and short-term improvements in people's lives are unfortunately the usual fare. The "bigness" of service delivery leads us to valorize efficiency, streamlining, specializing, and documenting, all in the service of maximizing the macro-issue of providing services with the least outlay of effort and cost.

Providing uniform practices or services runs into difficulty when attempting to focus on meeting people "where they are." To provide services based on eligibility requires a system to categorize people, a process that automatically leads to ignoring some aspects of a person's life and situation. Some qualities or characteristics are selected to use, and other qualities or characteristics are ignored. The qualities that were not used were thus marginalized and considered to be non-crucial to decision-making.

In a professional world that increasingly expects and demands scientific explanations and "proof" for its actions, the varied roots of social work provoke us to consider a broader view that extends beyond what science can provide. From a social constructionist lens, science is an important discourse or way of understanding our world that opens up ideas and actions while at the same time closing down other ideas

and actions. For example, predictability and generalizability are important components of scientific thinking and can help in understanding some aspects of our existence, but the attention paid to broad patterns can simultaneously render unique aspects of persons' lives invisible. Without this awareness of strengths as well as shortcomings, science and its products may become a proxy for what is true, overshadowing all other forms of knowledge (e.g., indigenous understandings, client viewpoints and experiences, artful depictions, spiritual insights). From a social constructionist viewpoint, such restrictiveness in seeing our worlds is a serious impediment to understanding our clients as complex, multifaceted beings.

Recent developments in, and publications focused on, indigenous methodologies (Chilisa, 2011; Denzin, Lincoln, & Smith, 2008; Wilson, 2008) have expanded our notions of how human behaviors, institutions, and communications can come to be known. Indigenous ways of knowing stretch our approaches to "evaluating" by reconnecting research with other aspects of living and by not objectivizing persons, practices, and behaviors. Increasing reliance on clients and consumer groups to tell practitioners and services how the services are "working" is another positive sign that evaluation methods are being expanded in ways that add more dimensionality to the results. An added benefit is the perception by consumers that their viewpoints and assessments about the services they receive are valued.

Including

Beyond assessment effectiveness, inclusiveness in participation and decision-making becomes an important component in ensuring that services are wisely delivered and managed. Including consumers of services complicates, but heightens the potential effectiveness of, interventions/actions by enlisting commitment for such actions. Seeing social work as socially constructed allows social workers to examine all practices, large and small, to see how they are working for the people for whom they are intended. This position of inclusivity safeguards that social work programs and initiatives stay grounded in the real world dilemmas that people face. It is relevant to consider how larger systems of service provision and financing must attend to their internal functioning to secure continuance of the system so as to sustain service for their clients, but a delicate balance is required in order to care both for the services/deliverers and for the clients they serve. The scale of providing services is oftentimes so large that many deliverers of service are executives and managers who may not have a close understanding of the people they are serving. Weaving clients into the service delivery process pays dividends in the short and long terms by maintaining the connection between those served and those doing the serving, which can maximize the possibilities for effective service delivery.

> The move to participatory systems of social work aims to achieve the maximum participation of social workers, representatives of the community, and clients in the administration and planning of local welfare services. The aim is inspired by the belief that the most neglected resources in the current system are the ideas and experience of clients, members of the community, basic grade workers, social work assistants, home-makers, home helps, cleaning and maintenance staff, etc. (Rojek, Peacock, & Collins, 1988, p. 179)

> Social work fulfilled an essentially mediating role between those who were—are—actually or potentially excluded and the mainstream of society. Part of what social workers have traditionally sought to do is to strengthen the bonds of inclusive membership by trying to nurture reciprocity, sharing and small-scale redistribution between individuals, in households, groups, communities, and so on. (Jordan & Parton, 2004, p. 23)

The partnering of service users and their communities with all who are involved in delivering services fundamentally alters the helping relationship from one of "power over" to one of "power with." The extraordinary investment in creating a "class" of professionals who help clients (who for all intents and purposes are considered unable to participate in helping themselves) has created barriers for the development of improved lives, which in turn leads to mounting frustrations for those delivering the services.

America Bracho (2013) is a physician living in Los Angeles who has stimulated the

development of a community of health workers (called "Promotores") who have reclaimed their roles with each other in improving health care within their communities. Many of these workers have lived through the same problems they are now helping others in their community with. They have teamed with healthcare professionals as full partners to increase the health and well-being of their neighbors. Bill Doherty and John Carroll have developed what they call "The Families and Democracy Project" (2007) in Minnesota, which reinvigorates persons of all ages in their local communities to work together to improve conditions that are troublesome. As in participatory action research, Bill and John joined a community initiative to offer their services to the work the communities have identified as needing work.

"Languaging"

Including clients with the deliverers depends on using language that has currency with multiple audiences. Professional terminology and conventions in speaking will need to be reinterpreted for clients in a language available to them. Similarly, the everyday language of clients and the communities within which they live and work will need to be understood by the deliverers of services. This is no small task, given the diversity of voices from various disciplines, cultural backgrounds, and life experiences. Attending to language becomes a full-time job that is never completed.

Language comes to be known as more than just the written or spoken word—performances of meaning occur through the arts, through decisions made, and multiple levels of nonverbal expressions. Coming to know someone and then engage with them demands a level of commitment to work through the ebbs and flows of relationships. Short-term engagements with clients work against the kind of relationship development that fosters understanding and commitment. Current-day efforts to provide piecemeal service or brief periods of interaction support the maintenance of distance and lack of investment in the outcome—oftentimes a social worker may not be around to witness the outcomes of the work he/she engaged in with the client.

Applying

Applying is as critical as (if not more critical than) generating knowledge. The emphasis is on producing change, so issues involved in application of knowledge supersede fidelity to an abstract model or protocol. Fidelity to a model or approach does not guarantee that the client involved will benefit (it also does not mean clients *won't* be well-served; rather, it just does not put faith in conformity to an *a priori* approach as the critical element in providing quality service). Too often knowledge that gets generated sits on library shelves waiting for someone to notice it and find a way to make it work in the real world, and sadly it may not happen.

Foreshadowing the next section, the "putting into practice" of knowledge generates further new knowledge. Action research projects conducted in schools, communities, and in therapy offices produce new ideas that are stimulated by the process of implementing. Knowledge generated from the process of implementing has the twin advantages of creating knowledge and impacting conditions of concern, a more fruitful activity than just building upon knowledge bases.

Integrating

Constructing social work to meet challenges posed by individuals and communities need not separate practice from theory, research, policy, or ethics. Specializing social work into separate skills, domains, or initiatives follows a modernist process of breaking events, patterns, or dynamics into component parts to study them more closely and to be able to predict outcomes.

From a social constructionist perspective, to only discuss social work theoretically (like in a book of theories) emphasizes the intellectual, logical, and rational. It is immediately disconnected from practice because it does not relate to the individual "messy" case or situation. It is abstracted and presented in the general form. To be useful in social work practice, it needs to be contextualized, and theory is not involved in that process. To connect theory and practice would drastically change how we approach the idea of theory. The criteria that are used to judge one theory as compared to another would

be altered to include how theory informs practice activities, how readily available a theory is for practical use, or how flexible the theory is in adjusting to practical circumstances. Theory plus practice would be another concept altogether that would relate to the "space in between" theory and practice.

Similarly, seeing research and practice as a joint activity (or perhaps the same activity, only "languaged" differently) requires a shift to see the relational nature of the two. Observing how they work together invites us to look at how generative the research-plus-practice connection is in terms of better outcomes for clients or communities, the degree to which new ideas or programs can be envisioned, or the level of optimism that is created by the combined efforts. I have been involved in developing a research and practice connection that we call "research as daily practice" (St. George, Wulff, & Tomm, 2015; Wulff & St. George, 2014). In this endeavor, we work from the position that research and practice are usefully considered the same process, simply "languaged" differently. Our experience with research as daily practice is that agency practitioners are excellent at investigating their own practices (using the practice skills they already possess), and the results of these projects are immediate and produce multiple effective outcomes in their context.

In a fascinating article, Ken Gergen (2014) makes the case that research is "interventive"—research either supports the status quo or encourages change simply by its focus. Most traditional research studies current or past situations. That focus re-inscribes the issue under investigation. If research focuses on that which is not yet here (or is in short supply), the research serves to stimulate or encourage that focus to become more likely. For example, if researchers focus on depression in immigrants to Canada, depression is reinforced and solidified in our collective thinking. If researchers study resilience in immigrants to Canada, that is similarly encouraged. This suggests that researchers are faced with ethical issues in regard to where they focus their interest—*what* they choose to study matters.

We have also been developing ways for clinical practitioners of social work to more readily consider the macro-influences in the lives of their clients and communities, reversing the split between clinical and community work (Wulff & St. George, 2012). Devising ways for social workers to "talk societal discourses" into their therapeutic conversations tries to demonstrate the ways that macro-influences in our lives are implicated in the troubles individuals and families experience, contradicting the separateness of the public and the private (St. George & Wulff, 2014).

Policy and ethics could each be similarly woven into social work practice, with an accompanying transformation in how we come to know each. Studying an idea "in relation to" another idea emphasizes the nature of the interaction, its performance in the world. This relational aspect is a key element of socially constructed social work.

Being Transparent

In order for a social worker to relate to clients or colleagues in a respectful and trusting manner with clients or colleagues, the notion of being open/transparent regarding her/his intentions, reasoning, and influences is vital. Opening and sharing one's thinking with a client or community is an act of respect toward the client and community and of courage on the part of the social worker. Oftentimes the expert or privileged knowledge of the social work "knower" may suggest or mandate a cloistering of knowledge or processes of deciding, creating a relational gap between social worker and client. Such a gap supports the development of a hierarchy and insinuates a position of greater knowledge or insight in the expert as compared to the client him/herself. Disciplinary knowledges embrace such a distinction, but an unwanted consequence of such distinction-making may be a lessening of interest or involvement of the client in the therapeutic process because the conceptualizing and intervening are the possessions of the expert, perhaps not the client. There seems to be a critical distinction between "knowing" something and finding ways of inviting that knowledge into change processes.

Social workers are embedded in contexts that certify competence, authorize involvements

with clients, pay for services, mandate practices (e.g., report abuse and neglect), and privilege certain behaviors over others, along with engagement with clients and client groups. These contexts oftentimes place competing demands on social workers that require decisions to be made that favor one group over another. Situations may arise that give the appearance that the designated client may not be the primary "client" of the social worker. Because social work practices significantly affect the lives of people, both explicit and implicit drivers of these practices need to be represented in the light of day to allow a broad appraisal of their worth and implications.

From a social constructionist lens, the paternalistic tendencies of social work expressions are displaced by a democratic display. This requires a trust and respect of the persons we serve that is expected by the social work codes of ethics. The "stickiness" of social work situations is respected and faced in its complexity through inclusive participation rather than by expert cloistering. Human dilemmas are recognized for their challenges rather than simplified to help us better manage our responses.

When complex dilemmas are entered into as fully as possible, the responses, outcomes, and consequences provide ready feedback that promotes further developments, the next steps. In this version of a socially constructed social work, there is not an expectation of cure, or of permanent remedies. Because the efforts are always works-in-progress, they are prepared to be altered, they are always being constructed. Using the idea of a scaffolding is a common way to acknowledge the continuous efforts required in doing social work from a social constructionist perspective—the work is never completed. Work is continuous and responsive to the changing circumstances of that work.

Clients are viewed as persons first and foremost, resourceful in their lives. This view stands in distinction from the view of problems or troubles being struggled with as the primary interest. Seeing clients as resourceful encourages their enlistment in the social work enterprise, supporting them to view themselves as capable now and in the future, a useful perspective to mobilize persons to improve their lives and the lives of those around them.

Continuing

The concept of endings in social work insinuates a finality or closing that, albeit convenient compartmentalizing, fails to acknowledge the continuity that persists. When we think of persons and communities, their lives/legacies continue after we, as social workers, leave the scene. Endings in our customary way of understanding the concept are punctuated with ourselves as central. Ending work with a client (or "terminating"—what an awful word) refers more to our situation and life. While we may not see the clients anymore, *their* lives continue. What we may characterize as an ending may be a beginning or continuance from the perspective of the client.

So, in addition to considering multiple viewpoints or perspectives on situations, we also need to examine these events we characterize as endings. Does this chapter end here? What comes next for you, the reader? How might you continue this conversation? The perpetual unfinished nature of social work from a social constructionist perspective can be a source of frustration for some who prefer closure, but given the challenge of working with clients and communities within the complexity of their lives, the social constructionist lens offers the possibility of directing actions that will address these complexities now and into the future.

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35

Solution-Focused Theory

Mo Yee Lee

Solution-focused brief therapy (SFBT) holds clients accountable for solutions rather than responsible for problems. Building on a strengths perspective and using a time-limited approach, SFBT postulates that positive and long-lasting change can occur in a relatively brief period of time by focusing on "solution talk" instead of "problem talk" (Berg, 1994; de Shazer, 1994; de Jong & Berg, 2013; Lee, Sebold, & Uken, 2003). Focusing on and emphasizing solutions, competencies, and strengths in clients must never be equated with a naïve belief in positive thinking. The choice of solution-focused approach in using the language and symbols of "solution and strengths" in treatment is influenced by a systemic perspective (Bateson, 1979), social constructivism (Berg & Luckmann, 1966; Neimeyer & Mahoney, 1993; Rosen & Kuehlwein, 1996), and the work of the psychiatrist Milton Erickson (Erickson, 1985a; Erickson, 1985b). Despite its relatively recent development, this practice model is now widely adopted in diverse social work practice settings, which is partly accounted for by the fact that the assumptions and practice orientation of solution-focused therapy are consistent with social work values as well as the strengths-based and empowerment-based practice in social work treatment.

History of Solution-Focused Brief Therapy

The development of SFBT was inspired by the work of Insoo Kim Berg, Steve de Shazer, and their associates at the Brief Family Therapy Center in Milwaukee, which was first established in 1978 and formally became the home

of solution-focused therapy in 1982. Solution-focused therapy began as an atheoretical practice with a focus on finding "what works in therapy." Trying to not be influenced or limited by the assumptions or the presumptions of many theory-based practice approaches pertaining to clients, problems, and diagnoses, the pioneers of SFBT took a new approach in exploring the therapy process by only asking one simple question: "What works in treatment?"

The original team regularly got together and observed therapy sessions using a one-way mirror. While focusing on observing the therapeutic dialogues and process, the team behind the mirror diligently attempted to observe, discover, and converse about what brought beneficial positive changes in clients and families. In other words, the early development of solution-focused therapy was antithetical to the modernist epistemology of understanding human behavior and change based on a presumed understanding of the observed phenomena. Instead of taking a positivistic, hierarchal, or expert stance, the understanding is accomplished by a bottom-up and grounded approach, which strives for a contextual, local understanding of what works in therapy.

Another major historical root of solution-focused therapy was the brief therapy tradition at the Mental Research Institute (MRI) of Palo Alto, California. The late Steve de Shazer, co-founder of solution-focused therapy, was well trained in brief therapy at MRI. Brief therapy, as practiced in MRI, is based on a systems perspective (Bateson, 1979), social constructivism (e.g., Berger & Luckmann, 1966; Neimeyer & Mahoney, 1993; Rosen & Kuehlwein, 1996), and the work of the psychiatrist Milton Erickson, who was a genius in utilizing what clients brought in to solve their presenting problems and a firm believer that individuals have the strengths and resources to solve their problems (Erickson, 1985a; Erickson, 1985b). These theoretical assumptions clearly had a strong influence on the beliefs, assumptions, and practice of solution-focused therapy. The major difference between MRI and solution-focused therapy is that, while the brief therapy approach developed at MRI focuses on disrupting the problem-maintaining pattern, solution-focused therapy emphasizes the solution-building process. The choice of a focus on the solution-building process, however, has to be understood in view of the power of language over human experience (de Shazer, 1994).

Assumptions and Basic Premises of Solution-Focused Therapy

Insoo Kim Berg and Steve de Shazer strongly emphasized that solution-focused therapy was not just a set of techniques, but a way of thinking (de Shazer, 1985). Knowing the set of techniques is lifeless without an appreciation of the underlying assumptions and beliefs of solution-focused therapy toward clients and change, which is strongly influenced by a systems perspective, social constructivism, and the work of the psychiatrist Milton Erickson. These theoretical influences lead to the following practice assumptions of solution-focused therapy.

A Focus on Solutions, Strengths, and Health: Clients Have the Answer

Solution-focused therapy focuses on what clients can do versus what clients cannot do. Instead of discussing or exploring clients' problems or deficiencies, the focus is on the successes of clients in dealing with their problems, and how to notice and use them more often (Berg & Kelly, 2000; de Shazer, 1985). Focusing on solutions is neither a consequence of "naïve" beliefs regarding strengths in clients nor of simplistic "positive thinking." This approach is supported by repeated clinical observation about how clients discover solutions much more quickly if the focus is on what they can do, what strengths they have, and what they have accomplished (Berg & Dolan, 2001; Berg & Reuss, 1998). The focus on solution-talk to achieve change is also supported by a systems perspective (Bateson, 1979) and the role of language in creating reality (de Shazer, 1994).

A Systems Perspective

One basic assumption of a systems perspective is that change is constant. As such, every problem pattern includes some sort of exception to the rule (de Shazer, 1985). Such a view underlies our beliefs in the strengths and potentials of clients (De Jong & Berg, 2013). Despite

the multi-deficiencies and/or problems clients may perceive that they have, there are always times when they handle their life situations in a more satisfying way or in a different manner. These exceptions provide the clues for solutions (de Shazer, 1985, 1988), and represent the client's "unnoticed" strengths and resources. The task for the therapist is to assist clients in noticing, amplifying, sustaining, and reinforcing these exceptions, regardless of how small and/or infrequent they may be (Berg & Kelly, 2000). Once clients are on the way to a solution-building process, they begin engaging in non-problem behaviors, which are exceptions to the problem pattern (Berg & Steiner, 2003).

A systems perspective also does not assume a one-to-one direct relationship between problem and solution to the problem. Another major assumption of a systems perspective is the interrelatedness of all parts of a system and that everything is connected. Change in one part of a system leads to change in other parts of the system (Bateson, 1972; Becvar & Becvar, 2012; Keeney & Thomas, 1986). The focus is on circular rather than linear relationships among different parts of a system. As such, solutions to a problem can happen in multiple pathways and do not necessarily have to be directly related to the presenting problem. In other words, insight into the problem's origin is not necessary to initiate a process of change in clients.

The choice of not drilling on the history and patterns of problem but focusing on what clients do well is further influenced by the power of language to shape clients' experience of their reality.

Language and Reality

Solution-focused therapy strongly believes that it is ethical and more effective to focus on the therapeutic solution dialogues than on problem dialogues. There is a conscious effort to stay focused on solution-talk and to deemphasize problem-talk. Such a conscious effort grows out of a concern about the role of language in creating or sustaining reality. Such a belief is influenced by social constructivism, which suggests that reality is constructed socially through language (Gergen, 1999). Solution-focused therapy views language as the medium through which personal meaning and understanding are expressed and socially constructed in conversation (de Shazer, 1991, 1994). Furthermore, the meaning of things is always contingent on the contexts and the language within which it is described, categorized, and constructed by clients (Wittgenstein, 1958). Because the limits of reality that can be known and experienced by an individual are framed by the language available to him or her to describe it, and these meanings are inherently unstable and shifting (Wittgenstein, 1958), a major question for the therapist to consider is how to use language in treatment to assist clients in describing and constructing a "beneficial" reality.

Because language is inherently powerful in creating and sustaining realities, the preferred language is the "conversation of change"—conversation that facilitates clients' efforts to create and sustain a solution reality (de Shazer, 1991; Walter & Peller, 1992). Solution-focused therapy prefers to use language that assists clients to "get to the surface of their problems" (de Shazer, 1991). "Get to the surface of problems" should never be equated with being superficial in the solution-finding process. This dialogue avoids going "deep" into the problem, but rather aims to construct meanings and solutions by describing goals, observable behaviors, and progressive lives in new, more beneficial ways that are attainable, in the present, and "on the surface" (De Shazer, 1994; Miller, 1997). Pathology/problem-talk sustains a problem reality through self-fulfilling prophecies and distracts clients' and our attention from developing solutions (Miller, 1997). Solution-focused therapy similarly resists diagnoses or language that label the client's problem as stable and unchanging (de Jong & Berg, 2013; de Shazer, 1994). Pathologizing clients' claims of their problems and drilling on the "deep" causes of problems may serve to further disempower clients. A pathological or deficit approach also focuses therapeutic effort on the problem rather than on what a life free of the problem would be like. The concern about language plays a decisive role in the shift from disrupting the problem-maintaining pattern (as espoused by MRI) to a focus on the solution-building process in solution-focused therapy.

Accountability for Solutions

A de-emphasis on problems/deficits and a focus on health and strengths does not mean that solution-focused therapy is easy. Solution-focused therapy holds the client responsible for solutions, instead of problems. Not focusing on clients' responsibility for problems and/or deficits is a decisive way for the therapist and client to direct all therapeutic energy toward supporting client's responsibility for building solutions. Change requires hard work (Berg & Kelly, 2000). Solutions come neither easily nor effortlessly. De Jong and Berg (2013) describe this as a solution-building process that requires discipline and effort. Clients would not need treatment if they had a clear vision of the solution to their complaints and how to realize it. The "solution" as described by solution-focused therapy is established in the form of a goal that is to be determined and attained by the client (Lee, Uken, & Sebold, 2007). Berg and Miller (1992) described the characteristics of solutions/goals as: personally meaningful and important to the clients; small enough to be achieved; concrete, specific, and behavioral so that indicators of success can be established and observed; positively stated so that the goal represents the presence rather than the absence of something; realistic and achievable within the context of the client's life; and perceived as involving hard work.

Present and Future Orientation

While the problems belong to something in the past, solutions and goals exist in the present and future. Without minimizing the importance of the client's experience and perception of the history of the problem, solution-focused therapists view what is going on in the present and in the future as more important than what caused the problem at the very beginning. The focus of treatment is on assisting clients in their present and future adjustment. The minimization of "problem talk" or drilling on the history and patterns of problem is based on a systems perspective and also the power of language in creating and sustaining reality. Since a complex, interrelated, circular relationship of different parts of systems renders the effort to establish a causal understanding of problems essentially futile, it is almost impossible to precisely ascertain why a problem occurs in the first place. In addition, SFBT assumes that the meanings of a problem are only artifacts of the context (de Shazer, 1991). Since one can never know exactly why a problem exists, and problem perceptions are not objective "realities," insight into the problem's origin is not necessary to initiate a process of change in clients.

Influenced by social constructivism, solution-focused brief family therapy assumes that "the future exists in our anticipation of how it will be" (Cade & O'Hanlon, 1993, p. 109). Instead of delving into the past, which will easily lend itself to discussing the history of the problem, and thereby, problem-talk, the therapist asks questions that will help clients to describe a future that does not contain the problem. The task of therapy, therefore, is to help clients to do something different by changing their interactive behaviors and/or their interpretations of behaviors and situations so that a solution can be achieved (de Shazer, 1991). Treatment helps clients identify the first small step they can take to attain a future without the problem. Such descriptions help clients be hopeful about their future as well as help them discover for themselves specific directions for achieving positive changes in their lives.

Clients Define Their Goals: Solutions as Clients' Constructions

Influenced by social constructivism (Berg & Luckmann, 1966; Neimeyer & Mahoney, 1993; Rosen & Kuehlwein, 1996), solution-focused therapy assumes that solutions are not objective "realities" but are private, local, meaning-making activities by an individual (Miller, 1997). The importance of and the meaning attached to a goal or solution is individually constructed in a collaborative process. A person's orientations to and definition of his or her goals clearly have significant implications for their actions and how they experience life. Because the client is the only "knower" of personal experiences and the sole "creator" of solutions, he or she defines the goals for their treatment and remains the main instigator of change (Berg, 1994). Externally imposed therapeutic goals are often inappropriate or irrelevant to the needs of

clients. In addition, clients are willing to work harder if the goal of therapy is defined by them and is perceived as personally meaningful (Lee et al., 2007).

A Collaborative Therapeutic Relationship

A social constructivist view of solutions has significant implications for client–therapist relationships. Because clients are the "knowers" and the "experts" regarding their individual experiences, realities, and aspirations (Cantwell & Holmes, 1994), their stories, explanations, and narrations become the only valid data to work with in the treatment process. Their stories are no longer data to be filtered through formal treatment theories to help the therapist arrive at a diagnosis and treatment plan. Similarly, the therapists are no longer experts who know the right answer to clients' problems. The therapist provides a therapeutic context for clients to construct and develop a personally meaningful goal. S/he enters into their perspective, adopts their frame of mind, listens to and understands their goals, and looks for strengths instead of weaknesses or labels. In place of a hierarchical therapist–client relationship is a more egalitarian and collaborative relationship (de Jong & Berg, 2013). The client takes the role of expert in determining and achieving goals that will lead to a more satisfying life. The therapist takes the role of expert in constructing a dialogue with the client that focuses on change and solution (Lee et al., 2003). A collaborative approach that respects the expertise and the knowledge of clients about themselves and their strengths helps enhance their motivation to accomplish positive changes in their lives through treatment (Berg, 1994; Lee et al., 2003). Such an approach also aids the process of engagement in treatment because clients feel listened to and of value.

Utilization: A Non-Instructional/ Educational Approach

Milton Erickson believed that individuals have the strengths and resources to solve their problems and that the main therapeutic task is to uncover and activate these resources in clients (Haley, 1973). Influenced by the work of Erickson, solution-focused therapists utilize whatever resources clients bring with them to uncover the solution (de Shazer, 1985). The principle is one of utilizing clients' existing resources, skills, knowledge, beliefs, motivation, behavior, symptoms, social network, circumstances, and personal idiosyncrasies to lead them to their desired outcomes (O'Hanlon & Wilk, 1987). Such a practice orientation is related to our belief in the presence of exceptions in every problem situation (de Shazer, 1985). Instead of attempting to teach clients something new and foreign based on our presumed notions of what is best for them, solution-focused therapists focus on when clients are already engaged in non-problem behaviors. Utilizing and building on these exceptions is a more efficient and effective way for clients to develop solutions that are relevant to and viable in their unique life circumstances. Clients are most invested in solutions that are discovered or identified by themselves. The task for the therapist is to elicit, trigger, reinforce, expand, and consolidate exceptions the client generates. Therapists stay away from teaching clients skills or intervening in their lives in ways that may fit our "model" of what is good, but may not be appropriate or viable in their lives.

Tipping the First Domino: A Small Change

Consistent with the old saying "A journey of a thousand miles begins with one step," the solution-focused approach suggests that the therapist must assist clients in describing the first small step that they need to take if they are to accomplish their goal (Berg & Dolan, 2001). A vision of the ultimate solution without a clear idea of the first small step to achieve it may prove to be too distant and too vague. In other words, it is of foremost importance to assist clients in making the first small step that will show them that they are moving in the right direction—the right direction as defined by them. Small change is more possible and manageable, while consuming less energy. Clients are usually encouraged when they experience successes, even small ones.

A focus on small change is also consistent with a "minimalist" approach to therapy as suggested by brief therapists at MRI, including Bateson (1972), Watzlawick, Weakland,

and Fisch (1974). Based on a systems perspective, they are concerned about introducing any change that may disturb a person's equilibrium in unpredictable ways as a result of reiterating feedback. Repetitive attempts at the same unsuccessful solution are precisely what create problems in the first place (Watzlawick et al., 1974). Following such a concern, solution-focused therapy believes that the best responses to client's problems involve minimal, but personally meaningful, intervention by the therapist into their lives. Clients should determine what constitutes acceptable solutions. The most important thing is for us to help clients identify the first small behavioral step toward desirable change.

Solution-Focused Assessment

Solution-focused therapy views assessment as a significant part of treatment that contributes to positive outcomes in clients. The content and process of solution-focused assessment, however, is distinctively different from conventional social work assessment. Briefly stated, conventional models of assessment focused on the presenting problem that constitutes the primary content of assessment. In terms of the process, social work practitioners assume an expert position in conducting assessment with the purpose of determining a comprehensive treatment plan for each particular client. In addition, assessment is based on expert knowledge and is viewed as notably different and separate from the treatment process.

Solution-oriented assessment involves a different set of assumptions and, as a result, different content and process in conducting assessment (Lee et al., 2003). Solution-oriented social work assumes:

1. There are exceptions to every problem pattern.
2. Language is powerful in creating and sustaining reality. Therefore, the preferred language is the "language of solution and change."
3. It is more helpful to focus on what clients can do and their strengths than on what is lacking and the problems in the change process.
4. Problems and solutions are the client's construction; therefore, the client determines goals of treatment.
5. Everything is connected; therefore, it is not necessary for the solutions to be directly related to the problems, or vice versa (De Shazer, 1985).

These assumptions and beliefs strongly influence how solution-oriented social work approaches the content and process of assessment; such a process is designed to draw out clients' strengths and unique personal features rather than classifying clients based on formal knowledge of problems and diagnoses.

A Focus on What Clients Can Do and Their Strengths

The content of solution-oriented assessment is on what clients can do, their strengths and resources in them or their environment, as opposed to the history of problems, what is lacking, deficits in clients and/or their environment, or the diagnosis. Such a focus is supported by a systems perspective that postulates that everything is connected. Therefore, solution needs not be directly related to problem. As solution-talk is more likely to sustain a solution reality, the preferred content of assessment is on developing an explicit, clear, specific description of a desirable future or a solution picture determined by the client.

Contextualized Understanding: Staying on the Surface

Instead of going deep in search of the history and complexities presented by the problem scenario, solution-oriented social work prefers to stay on the surface in conducting assessment. The "surface" issues include the immediate presentation of the clients, their intention, situational variables, and resources that are squarely rooted in clients' current context. Such "surface" information is far more helpful than diagnoses or an elaborated history of the problem for clients and practitioners, as these are factors that exist in the present and are readily available for client and practitioners to utilize in the process of change (Lee et al., 2003). A contextualized understanding, therefore, brings forth the unique features of individual clients

and their context as opposed to a homogeneous or generalized view of the client as someone with a certain diagnosis or problem. Staying on the surface also has the benefits of not limiting clients to their past histories, which are not changeable. In addition, because contextual and surface factors are more flexible and unstable than historical factors, clients and practitioners have more opportunities to make a shift in describing and constructing a "beneficial" reality.

The Client as Assessor

A distinctive characteristic of solution-oriented assessment is its focus on the client as the assessor (Lee et al., 2003). Influenced by an ecosystems perspective, conventional social work assessment involves a joint effort between the social work practitioner and the client (Karls, 2009). Still, the social work practitioner possesses expert knowledge and is an outsider who has the knowledge to conduct an objective assessment of client's problem. Solution-oriented assessment, as influenced by social constructivism, fundamentally shifts the position of the client to be the center of change. The client is the assessor who constantly self-evaluates what the problem is, what may be feasible solutions to the problem, what the desirable future is, what the goals of treatment are, what strengths and resources s/he has, what may be helpful in the process of change, how committed or motivated s/he is to make change a reality, and how quickly s/he wants to proceed with the change, etc. (Lee et al., 2003). Solution-oriented social work practitioners, on the other hand, are experts on the "conversation of change" who keep the dialogues going in search of a description of alternative, beneficial reality (de Shazer, 1994). Such a view fundamental shifts the relationship between the client and the social work practitioner, which is no longer a hierarchal relationship but a collaborative one, with the client as the assessor and the social work practitioner as an expert of the conversation of change.

Assessment as an Open Process of Self-Evaluations and Choice-Making

More importantly, there is no longer an objective problem or reality to be assessed that exists independently outside the client. In solution-oriented social work, assessment is essentially an ongoing and open process in which the client and the social work practitioner actively engage in describing an inherently unstable reality that is different from the problem reality. Assessment is no longer an alienated procedure operated on the client by an expert. It becomes an open process in which the clients continuously make evaluations and choices. Ownership, options, and choices become an integral part of the assessment (Lee et al., 2003).

Solution-Focused Interventions

Solution-Focused Conversations

The purpose of solution-focused interventions is to co-construct a therapeutic conversation that is conducive to a solution-building process in clients and families. In this conversation, the therapist invites the client to be the "expert" by listening and exploring the meaning of the client's perception of his or her situation. The therapists utilize solution-oriented questions—including exception questions, outcome questions, coping questions, scaling questions, and relationship questions—to assist clients in constructing a reality that does not contain the problem. These questioning techniques were developed by de Shazer, Berg, and their colleagues to fully utilize the resources and potential of clients (e.g., Berg & Kelly, 2000; de Shazer, 1985). Questions are perceived as better ways to create open space for clients to think about and self-evaluate their situation and solutions. The *SFBT Treatment Manual*, endorsed by the Solution-Focused Brief Therapy Association (Bavelas et al., 2013), provides a detailed description of this co-constructive therapeutic process through the steps *listen, select,* and *build* (De Jong and Berg, 2013; de Shazer, 1991, 1994). In this therapeutic conversation, the therapist first listens for and selects the words and phrases from the client's language that represent some aspect of a solution, including things that are important and personally meaningful to the client, past successes, exceptions to the problem pattern, resources, strengths, etc. Building on client's descriptions and paying attention to client's language and frame of

reference, the solution-focused therapist comes up with a next question or other responses that invite the client to further elaborate the solution picture. It is through this continuing process of listening, selecting, and building that therapists and clients together construct new meanings, alternatives, and new possibilities for solutions (Bavelas et al., 2013).

In terms of the therapy process, clients are first oriented to a solution-focused frame in which the aim of therapy is to assist clients in finding solutions to their problems with as few sessions as needed. The clients are immediately encouraged to give a clear and explicit statement of their presenting complaint. Without focusing on the history of the problems, the therapist uses solution-building questions to assist clients in identifying solutions for their problems:

- *Exception questions* inquire about times when the problem is either absent, less intense, or dealt with in a manner that is acceptable to the client (de Shazer, 1985). The therapist presupposes that change is happening in the client's problem situation. Such an effort shakes the rigid frames constructed by many clients with respect to the pervasiveness and permanency of their complaints. Examples of exception questions include: When don't you have this problem? When is the problem less bad? What is different about these times?
- *Miracle question* provide a space for clients to separate themselves from their problem-saturated context and construct a future vision of life without the presenting complaint or with acceptable improvements in the problem. Miracle question fosters a sense of hopefulness and offers an opportunity for clients to develop a beneficial direction for improving their lives. The focus is on identifying small, observable, and concrete behaviors that are indicators of small changes, which make a difference in the client's situation (de Shazer, 1985). A widely used format of miracle question is: "Suppose that after our meeting today, you go home, do your things and go to bed. While you are sleeping, a miracle happens and the problem that brought you here is suddenly solved, like magic. The problem is gone. Because you were sleeping, you don't know that a miracle happened, but when you wake up tomorrow morning, you will be different. How will you know a miracle has happened? What will be the first small sign that tells you that the problem is resolved?" (Berg & Miller, 1992). Variations of the miracle question are the dream question (Greene, Lee, Mentzer, Pinnell & Niles, 1998) and the nightmare question (Reuss, 1997).
- *Coping questions* help clients notice times when they are coping with their problems and what it is they are doing at those times when they are successfully coping. The purpose of asking coping questions is to indirectly reframe the meaning frames of clients who have assumed that they are entirely helpless and have no control over the problem situation (Berg, 1994; Berg & Steiner, 2003). Examples of coping questions include: "How have you been able to keep going despite all the difficulties you've encountered?" "How are you able to get around despite not being able to walk?"
- *Scaling questions* ask clients to rank their situation and/or goal on a one-to-ten scale (de Jong & Berg, 2013). Usually, one represents the worst scenario that could possibly be, and ten is the most desirable outcome. Scaling questions provide a simple tool for clients to quantify and evaluate their situation and progress so that they establish a clear indicator of progress for themselves. For example, a scaling question may be phrased, as "On a one to ten scale, with one being the worst the problem could possibly be and ten as the most desirable outcome, how would you rank yourself on the scale?"
- *Relationship questions* ask clients to imagine how significant others in their environment might react to their problem or situation and changes they make (Berg, 1994; de Jong & Berg, 2013). Relationship questions contextualize, not only problem definitions, but also the client's desired goals and changes. Establishing multiple indicators of change helps clients develop a clearer vision of a desired future appropriate to their real-life context. Examples of relationship questions include: "What would your mother" (or spouse, sister, etc.) "notice that is different about you if you are more comfortable with the new environment?" "How would your

wife" (or other significant others) "rank your motivation to change on a one to ten scale?"

Recognizing the power of language in creating and sustaining realities, the preferred language of SFBT is the "conversation of change." The "conversation of change" prefers using language with the following characteristics (Lee et al., 2003):

- Language that implies the person wants to change
- Language that implies that the person is capable
- Language that implies change has occurred or is occurring
- Language that implies the changes are meaningful
- Language that encourages the person to explore possibilities for change
- Language that suggests that the person can be creative and playful about life
- Language that conveys recognition of the persons' evolution of their personal story
- Language that does not encourage negative, blaming, or self-defeating descriptions

This "conversation of change" uses language that presupposes a possibility of change and thereby induced hopefulness in clients (Lee et al., 2003).

Solution-Focused Tasks and Assignments

A solution-focused approach also uses task assignments to assist clients in noticing solutions in their natural life context (de Shazer & Molnar, 1984). If clients are able to identify behaviors that are an exception to the problem, clients are asked to "do more of what works." For clients who focus on the perceived stability of their problematic pattern and fail to identify any exceptions, an observation task is given: "Between now and next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happen" (Molnar & de Shazer, 1987). Another observation task directs clients' attention to notice what they do when they overcome the temptation or urge to engage in the problem behavior. Other tasks that assist clients in interrupting their problem patterns and developing new solutions include: *Do something different*: "Between now and next time we meet, do something different and tell me what happened"; and the *prediction task* that asks the client to predict his or her behavior by tossing a coin: "If it is heads, do what you normally do; if it is tails, pretend that the miracle day has happened" (Berg, 1994).

The purpose of solution-focused questions and tasks is to assist clients to "notice a difference that can make a difference in their lives" in their natural environment. The therapist cautiously refrains from providing/suggesting any predetermined solutions. The therapist is responsible for creating a therapeutic dialogue in which clients experience a solution-building process that is initiated from within and grounded in clients' cultural strengths as well as a personal construction of the solution reality (Lee, 2003). It is for clients to discover what works for them in their unique life context.

Case Example: Tom

Tom was a 32-year-old man who came in for treatment because of his depressive mood. Tom was an accountant and he had a stable job. He came from a violent family background and witnessed his alcoholic father beating her mother to the point that she was hospitalized for severe injury and not able to take care of him and his younger sister. The parents were divorced afterward, and the children were placed in foster homes consequently. Tom described all these losses as "baggage in life that he can't get over with." His recent depressive episode was triggered by relational problems with his girlfriend, and they were currently in a "cooling down" period. Tom shared that he had been depressed for a while after the death of his mother five years ago. This is the first time that he had sought mental health treatment.

First Session

Solution-focused assessment views clients as the assessors. The assessment offers an opportunity for clients to self-evaluate what are the issues troubling them and what might be the solutions

to their problems. In the first session, clients are encouraged to give a clear and explicit description of their presenting complaint. While it is important to empathetically listen to clients' description of their problem, the focus of treatment is not on exploring history of the problems. The therapist always looks for an opportunity to make a shift from problem-talk to solution-talk, without rushing the process:

Therapist: Why don't you just tell me a little bit about what brings you in here today? What can we work on today that'll be helpful for you?
Tom: Depression.
Therapist: How long can you, could you say you can trace your depression back?
Tom: It's been going on for a while but really, really, really hit me hard when my mother died five years ago.
Therapist: I'm sorry to hear that. That's a real difficult thing to deal with. What made you decide to come in now?
Tom: A relationship.
Therapist: Okay.
Tom: It was the straw that broke the camel's back.
Therapist: When did you start to notice problems in the relationship?
Tom: Three months ago. It's not really a breakup. It's just like slowing down.
Therapist: Okay. So two of you are kind of backing off?
Tom: Yeah.
Therapist: What do you notice about your depression? What tells you that it's depression?
Tom: I am an accountant and I have trouble concentrating, which is really bad for my job.
Therapist: Okay.
Tom: Feeling like crap all the time; dizziness, lightheadedness, loss of appetite. Just on the verge of crying.
Therapist: Kind of tough on you, right.
Tom: We just have a fight, I mean, my girlfriend and me. I'm not sure whether this is a relationship that I should hang on to.
Therapist: So you are somewhat confused about where should you go with this relationship?
Tom: Yeah.
Tom: What've you been doing to try to cope with the depression?

[Coping question uses pre-suppositional language that assumes Tom has already been doing something helpful to deal with his depression.]

Tom: Work.
Therapist: Okay.
Tom: Just grinding through it, just grinding through it. Just trying to forget. It's constantly there so I can't get rid of it. I feel like I'm spinning my wheels.

[While Tom has mentioned work as helping him cope, he still feels like he's spinning his wheels.]

Tom: And it's like all my life I've been able to handle my own problems. You know, I come from a violent family. My dad hit my mom so badly that she was hurt all the time. They finally divorced, and my sister and I ended up in foster care. I've just had to stand up and take care of myself. I haven't had to ask for any help from anybody. And I've come to the point where I can't do it anymore.
Therapist: This is tough. Are you proud of being able to stand up against bad experiences and take care of yourself, even as a child?

[Solution-focused therapist tries not to make assumptions about what is helpful or not. Instead, the therapist uses questions that allow Tom to self-assess whether any behavior is helpful or not. It is more important for Tom to come up with the solution.]

Tom: I mean I've always been the type of tough guy who can handle a lot of problems.
Therapist: Very independent.
Tom: Well, as far as working out problems, yeah.
Therapist: It sounds like it's taken a lot of courage to come in today.

[Reinforcing the motivation to seek help is important, for Tom perceives himself as an independent guy.]

Tom: This definitely makes me feel weak.
Therapist: I think a lot of people sort of feel that way in the beginning, so I think that is pretty normal. I mean, especially for anyone who's had that history of toughing it out.

[At this point, more conversation about the problem might just reinforce depression and Tom's feeling of being weak. This is a time to make a shift and introduce the miracle question to begin helping Tom to visualize the times when he is able to get over his depression.]

Therapist: Let me ask you. It's kind of a hypothetical question. Suppose after you leave this session today and you go about your daily routine, and tonight you go to sleep. When you are sleeping, a miracle happens. This depression that you have

been experiencing is no longer a problem for you. You get up tomorrow morning and things are just better. But because you are asleep, you are not aware that this miracle has actually taken place.

Tom: Okay.

Therapist: What will you notice that's different about yourself? What would be the first small thing that you would be doing tomorrow morning that tells you that you are in a good mood?

Tom: Probably get up, feel good.

Therapist: Suppose that you get up and feel good.

[It is important to use Tom's language.]

Tom: Perhaps sing in the shower.

Therapist: You like singing in the shower?

Tom: Yeah. Feed my dog. Take off for work.

Therapist: Okay. What would be the first small thing you'd do differently at work if you were feeling just a little bit better than you are feeling now? This miracle is happening.

[The therapist continues to use solution-focused questions to help Tom visualize the things that he would do differently when he is no longer depressed. He produces a list that includes "dress well, able to concentrate and perform well at work, reconnect with friends, stop drinking," etc. Tom however, mentions that, "It's like right now I feel like I'm buried. I feel like I'm just in muck." While not focusing on the problem, it is important to help Tom to find a solution to his feeling of buried in muck.]

Therapist: What would be the first thing that you would maybe do to get yourself unburied? What would be your first thing?

Tom: Figure out why I'm feeling this way. What just happened is just the tip of the iceberg. There's been a lot other garbage that I'm carrying around. You know, and I've got to get rid of it.

Therapist: Looking at it from tomorrow, what would be this first thing that you would take away from this sack of garbage that you're carrying around on your shoulders? What's that first piece of garbage that you would just sort of take out of there?

Tom: Losses.

Therapist: What do you think is the first loss that you are dealing with most that you need to pull out of that bag?

Tom: I would say loss of friends and family.

Therapist: What's one piece of it that you can take out of that bag? What would be the smallest piece that would make that load a little lighter?

[This is an illustration of how to process a negative experience in a solution-focused way. Tom began sharing his story of coming from a violent family and ended up in foster care. He felt abandoned and alone.]

Tom: As a child, I felt like I was being left alone.

Therapist: How long have you been carrying this whole feeling of aloneness on your shoulders?

Tom: A long while. I think sometimes when these things happened in life when you're young, it makes you feel alone. There are times even when we get older and these things happen, that feeling of being alone comes back.

Therapist: Again, this miracle happens. What would happen tomorrow that would help you feel a little less alone? What could you do to help yourself or feel a little less alone?

Tom: I would say, having more friends over.

Therapist: Okay. What would be different for you tomorrow? How could you have a friend or a few friends come over tomorrow?

[The conversation moves on around ways that Tom can be more connected with his friends. Tom also mentions his desire to reconnect with his sister to process these loses together.]

Bridging Statement and Solution-Focused Task

Solution-focused therapy utilizes assignments as a way to engage clients in solution-building process in real life context. Prior to sharing the solution-focused assignment with Tom, the therapist summarizes her clinical observation as a bridging statement to the solution-focused assignment.

Therapist: I wish to share with you that I think you exhibit a lot of courage by coming in today. You have certainly touched on some issues that are obviously very close to your heart. There are some things that you need to conclude yourself, which have obviously have been difficult for you. You have dealt with a number of losses. When things like that happen, they can heighten our sense of aloneness, especially when you have been struggling with some depression. But you obviously have had lot of successes. You have a good career. You've always been independent. You also strike me as being a person with great determination; someone who seeks to solve the problems that you face.

[Complimenting has an important place in solution-focused therapy because it brings out the strengths of the client and helps clients build solutions upon their strengths. However, it is imperative that compliments be authentic and built upon the conversation that happens in the session.]

Tom: That's something that I've noticed, too. However, this time, it's like I've let them build up until there are too many and I couldn't handle them all at once. Maybe I've just got to handle them one at a time.

Therapist: It sounds like you are aware of what might be helpful. You know as much as you can, as much as you've been able to do. I sometimes find it helpful to encourage people to act as if it's a miracle day and do things when they are having a miracle day. I would invite you to each morning flip a coin before you get up. If the coin comes up heads, I want you to pretend you're having the miracle day that we have discussed. Like singing in the shower, feeding the dog, going to work, making an effort to be around your co-workers, talking to people, and finding times to have fun with friends, etc. If this is a head and tail of a coin, just do whatever you wish to do that day.

Tom: Okay.

Therapist: While you are doing so, just notice any differences about what you are doing on those days so that we can talk about it next time.

[This is a combined pretending and predicting task. This is especially helpful for clients who believe that they have little control over their situation or get stuck in a situation. The client just pretends to have a good day when s/he gets heads when flipping a coin.]

Second Session

Therapist: So, what's better?

Tom: It is like I am looking at things a little bit differently now. Instead of flipping the coin, like you told me to, I just mentally flipped it and it just always comes up heads.

Therapist: Mentally flipped it. How did you do that?

[The "How did you do it?" is a great solution-focused question that allows Tom to recognize he is the one who is actively making a decision for the positive changes in his life.]

Tom: I just did it.

Therapist: Okay, and what did you do as a result of that?

Tom: So, I had a good day. I have also talked to a few friends about the situation itself. They gave me a few clues on what to do. You know, as far as the girlfriend goes.

Therapist: What else is better when you mentally flipped the coin?

Tom: Well, basically, the fear of being alone. You know. I don't have any fear of being alone at all yet. I just got together with friends when I wished to be with somebody.

Therapist: Wow! What else?

[The therapist continues to help Tom further elaborate on what he's done on the miracle day. It is very important to invite Tom to describe his success in great detail so that he notices and registers his successes.]

Therapist: That's great. But, how did you decide to have a miracle day instead of staying depressed and lonely?

[This is a choice question that helps Tom to take ownership of the change.]

Tom: I just decided to quit screwing around. I was almost feeling sorry for myself about the situation I was in. And it was like, wait a minute. You are supposed to live to the fullest. It is like life is too short not to be happy.

Therapist: Yeah.

Tom: You know, you are supposed to live life to the fullest. And here I am sitting in this muck. Saying, well shit. What am I going to do now?

Therapist: It sounds like you have kind of adopted a new perspective on some things. You have changed your way of thinking a little bit in the last couple of weeks, too. And I think it fits right in with what you said last time when you said that you are very independent and that you are an independent problem-solver. You are very independent and autonomous and have always relied on yourself. Once you made that decision and you said so to yourself, you indeed did that.

[Solution-focused therapy focuses on utilizing client's strengths and resources. It is important, therefore, to recognize and utilize Tom's frame of himself as an independent problem-solver in the treatment process. It also allows space for Tom to begin thinking about what he'll need to do next.]

Therapist: Let me ask you on the same scale we used last time, ten being that you just feel good about the way your life is going now, and one is where you were just before you called in here feeling

depressed and muck. Where would you say you are now?

Tom: I would say at about a seven.

Therapist: A seven. Wow! Okay. If I ask your best friend, where would he say you are on that scale right now?

Tom: He would probably put it at the same place, a seven.

[This is a scaling question that solution-focused therapy uses for clients to self-evaluate their progress, problem state, confidence of change, motivation to change, etc. Oftentimes it is used in conjunction with a relationship question that allows clients to see things from the perspective of other significant people in their lives.]

Therapist: Fantastic. Let me ask you this. What would you need to do that would tell you have moved from a seven to an eight?

Tom: Taking care of myself a little bit better and watching what I am doing, watching my stuff.

Therapist: How exactly that you will be taking better care of yourself that you are not doing now?

Tom: Getting to bed on time, eating right.

Therapist: What time will you be going to bed at night?

Tom: 11:00 pm. I usually go to bed about 1:00 am.

Therapist: That helps you get going the next morning a little bit.

Tom: Oh, yeah.

Therapist: What else? You said eating right. How so, how will you be eating?

Tom: Eating regularly. Instead of just coke, cookies, or choke down a sandwich. Lately, I have been eating a couple of meals, big meals.

Therapist: What else would you like to do differently when you at an eight that you are not doing now?

[The "different question" allows Tom to compare and contrast things that he will do when he is better, which he is not doing now. Different questions facilitate people to develop "creative perception" that allows them to make better decisions and responses to the situation (Lee, 2008).]

Tom: Watching situations a lot more and looking into them instead of looking at the surface of them. I didn't look much into the big picture before I made my decisions. Instead of looking at the whole thing; and that is where I have really screwed myself.

Therapist: What have you done here recently to help yourself look at the big picture instead of just focusing on the small picture or just looking at the surface?

Tom: For instance, the problem I had with my girlfriend. She'll come up and accuse me of something that I should be blamed for. I couldn't think. I couldn't react. I can't say, fire back. I was just upset and let my emotions took up.

Therapist: In other words, you kind of just stopped and looked things over?

Tom: Yes. The more I thought about it, the more I analyzed the situation and all the stuff that happened and all the blame that was being thrown on me. Then I started seeing the other side of the coin. It is, like wait a minute. Maybe I am going to slow down and pull back for a while. I am not going to take that crap, and no one is going to step on me for being good.

Therapist: It sounds like it's more helpful not taking action right away, but pulling back and giving you an opportunity to think things through. Do you notice anything different about yourself when you are able to pull back and give yourself time to think things through?

Tom: Oh yeah. I'm not being impulsive. I am not flying off the handle as much. I don't get upset as much as before. Someone may say something really smart or just jokingly and I don't snap back.

Therapist: This is big. How does that change your relationship with others when you are able to think before reacting?

Tom: You know, my friends said that I'm calmer.

Therapist: Anything else?

Tom: I've noticed something else, too; I quit drinking.

Therapist: Is that what you want, and good for you?

[Again, the therapist does not make assumptions about the effect of quitting drinking on Tom, but lets Tom to elaborate on his desired future and successes.]

At the end of the session, the therapist complimented Tom as a man of action who was already taking helpful steps in a direction that got things better, which was sort of like a domino effect. The therapist also commended Tom as a creative person who mentally flipped the coin in doing the solution-focused homework assignment. As Tom is already on the right track to get over his depression, the solution-focused task is to do it more often: "Continue to do the same things that you have been doing and pay close attention to all the things you have done so that we can talk about them next time when you come back."

Applications and Current Status of Solution-Focused Therapy in the Social Work Profession

The history of solution-focused therapy is relatively recent compared to other established practice approaches in social work treatment, such as cognitive-behavioral approaches, humanistic approaches, task-centered approaches, and psychodynamic approaches. Despite this fact, solution-focused therapy does have an increasing influence on social work treatment, primarily for two reasons. First, compared to many psychotherapy approaches, which are primarily developed by psychologists, social work professionals actively participate in the development and dissemination of solution-focused therapy. The late Insoo Kim Berg and Steve de Shazer, founders of solution-focused therapy, were social work professionals. Peter de Jong, Michelle Weiner-Davis, and Eve Lipchik, who all belonged to the original group at Brief Family Therapy Center (BFTC), were social work professionals. Cynthia Franklin and her social work colleagues have applied solution-focused therapy to family practice and school social work (Franklin & Jordan, 1998; Kelly, Kim, & Franklin, 2008). Mo Yee Lee (this chapter's author), Adriana Uken, and John Sebold are social work professionals using solution-focused therapy to work with domestic violence offenders (Lee et al., 2003). Wally Gingerich, who has done several meta-analyses of solution-focused therapy outcome studies, is a social work professional (Gingerich & Eisengart, 2000; Gingerich & Peterson, 2013). The list is long, as there are many other social work professionals actively applying solution-focused therapy with their client populations in a creative and beneficial manner. Because the founders of solution-focused therapy were social work professionals, it is no accident that the practice orientation of solution-focused therapy is consistent with social work's overarching framework of person-in-environment as well as the social work values of respecting clients' dignity and self-determination (NASW, 2008). The historical roots of solution-focused therapy in social work give rise to its systems-based, collaborative, strengths-based, respectful, pragmatic, and focused style of treatment. To a certain extent, the similarities and consistencies between social work values and the assumptions of solution-focused therapy toward treatment and human change facilitate the adoption of this model by social work professionals in their work.

Second, the focus of the solution-focused approach on solutions, strengths, and health is consistent with the empowerment-based and strengths-based approaches in human services; approaches that have gained increased prominence in the past decade (Saleebey, 2008). While the development of empowerment-based and strengths-based approaches in human services is independent of the development of solution-focused therapy, the increasing recognition of the importance of such a practice in social work treatment does promote the adoption of this practice model. Solution-focused therapy provides a specific set of treatment skills and techniques that operationalizes empowerment-based practice and informs the practice of social work treatment. In other words, solution-focused therapy translates the concept of strengths and empowerment to everyday practice by using the "language of empowerment" (Rappaport, 1985; Rees, 1998) and the "lexicon of strengths" (Saleebey, 2008) in social work treatment.

Currently, solution-focused therapy is increasingly being adopted in different settings in which social work professionals practice (Nelson & Thomas, 2007). These fields include, but are not limited to, the following:

- Child welfare (Berg & Kelly, 2000; Turner, 2007)
- Family practice (Berg, 1994; Franklin & Jordan, 1998)
- Child and adolescent practice (e.g., Berg, & Steiner, 2003; Cepukiene & Pakrosnis, 2011; Selekman, 1993, 1997).
- Schools (Franklin & Gerlach, 2007; Kelly, Kim, & Franklin, 2008; Metcalf, 2008)
- Substance use (e.g., Smock & Trepper et al., 2008)
- Mental health (Knekt & Lindfors, et al., 2008; Knekt & Lindfors, et al., 2011; MacDonald, 2007)
- Domestic violence (Lee et al., 2003; Lee et al., 2007; Lee, 2007)
- Health (O'Connell & Palmer, 2003; Valve, Lehtinen-Jacks, & Eriksson, et al., 2013)

- Administration and management (Lueger & Korn, 2006)
- Culturally competent practice (Lee, 2003; Kim, 2014)
- Supervision (Thomas, 2013; Wheeler, 2007)

Relevant Research and Challenges

With the advent of the evidence-based practice movement, the effectiveness of social work treatment approaches will need to be empirically supported and verified. SFBT is gaining increased recognition as an evidence-based model and has been included in Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices since 2013. In addition, the model is currently under review to be registered at the Office of Juvenile Justice and Delinquent Prevention Model Program. Franklin and her associates have also published the book *Solution-Focused Brief Therapy: A Handbook of Evidence-Based Practice* (Franklin, Trepper, Gingerich, & McCullum, 2012). These are important milestones for SFBT. The challenges encountered by research pertaining to solution-focused therapy have to be understood in its historical development. Solution-focused therapy was developed by social work professionals in practice and not by academia at universities or research institutes. Nonetheless, founders Insoo Kim Berg and Steve de Shazer had a clear vision and support for advancing research in solution-focused therapy (de Shazer & Berg, 1997). The Solution-Focused Brief Therapy Association (SFBTA), which is the professional organization promoting solution-focused therapy in North America since 2002, continues to have a strong vision for developing evidence for solution-focused therapy. Currently, the Research Committee of SBFTA is charged with the mission to promote, strengthen, and disseminate research pertaining to solution-focused therapy. Nonetheless, while the development of research is gaining momentum, the challenges cannot be underestimated.

Outcome Research

Numerous intervention studies have been conducted for solution-focused therapy in diverse practice settings. Compared to the earlier outcome studies that might have been flawed with limited research design, small samples, or a lack of a systematic intervention protocol, there is clearly an encouraging trend that there has been both an increase in the volume of outcome studies as well as the rigor of the research design. The first meta-analysis of solution-focused therapy was conducted by Gingerich and Eisengart based on 15 outcome studies that matched the inclusion criteria (Gingerich and Eisengart, 2000). The outcomes of these studies, however, did not provide adequate empirical support to the efficacy of solution-focused therapy. The primary limitations included limited research design, small samples, and a lack of a systematic intervention protocol (Gingerich & Eisengart, 2000). Johnny Kim has conducted another meta-analysis that consisted of outcome studies between 1988 to 2005 (Kim, 2008). This review included 22 studies that used a control or comparison group in their study design. In addition, this meta-analysis focused on external behavioral outcomes, internal behavioral outcomes, and family/relationship problem outcomes. Findings showed that solution-focused therapy demonstrated small but positive solution-focused therapy treatment effects on all three measured outcomes. However, only internalizing behavior problems indicated a significant difference in treatment effects of solution-focused therapy group compared to the control group. In addition, while the overall mean effect size estimates were small for solution-focused therapy treatment (.13 for externalizing problem outcomes, .26 for internalizing problem outcomes, and .26 for family/relationship problem outcomes), the mean effect size was comparable to outcome studies of psychotherapy conducted in real-life settings, which is .24 (Weisz, McCarty, & Valeri, 2006).

The most recent systematic review on solution-focused therapy was also conducted by Wally Gingerich. Findings of this review were much more encouraging than those of the first meta-analysis (Gingerich & Peterson, 2013). Among the 43 identified studies, 32 studies (74%) reported significant positive benefit from SFBT; 10 (23%) reported positive trends. The strongest evidence of effectiveness came in the

treatment of depression in adults, where four separate studies found SFBT to be comparable to well-established alternative treatments. Three studies examined length of treatment, and all found that SFBT used fewer sessions than alternative therapies. Findings of this review provide strong evidence that SFBT is an effective treatment for a wide variety of behavioral and psychological outcomes and, in addition, it may be briefer and therefore less costly than alternative approaches (Gingerich & Peterson, 2013).

Another advance in research domain is the increased attention paid to strengths-based measurements. Catherine Simmons and Peter Lehmann published the book *Tools for Strengths-Based Assessment and Evaluation* in 2012, which is a comprehensive resource for researchers to locate instruments that focus on strengths-based practices and research. Despite an increase in both the number of rigorous outcome studies on solution-focused therapy, many studies are still limited by small and non-representative samples, lack of randomized controlled procedures, lack of specific manualized protocol, problems with treatment fidelity, and measurement problems, etc. (Gingerich & Peterson, 2013; Kim, 2008; Lee, Uken, & Sebold, 2007). To further develop and strengthen evidence for the efficacy of solution-focused therapy, future studies should consider a more rigorous research design that:

1. uses larger and more representative samples;
2. includes control or comparison groups using randomized assignment procedures;
3. uses standardized measures that are sensitive enough to measure treatment changes;
4. uses observation-based rating systems in data collection when possible and appropriate,
5. further refines and develops the treatment manual for training purposes and fidelity analyses,
6. increases the rigor of the fidelity procedures by using observation-based approaches with a refined, specific, and rigorous fidelity measurement protocol;
7. carefully monitors the data collection process to reduce problems in measurement attrition; and
8. includes research sites that serve ethnically/racially diverse populations.

Process Research

In addition to studies that focus on measuring outcomes and effectiveness, another major research question pertains to the mechanism of change; that is, what treatment components or process contribute to positive outcomes in clients and families. A group of researchers led by Janet Bevalas that includes Peter de Jong, Adam Froerer, Harry Korman, Sara Smock, Christine Tomori, and Sara Healing, has been using contemporary psycholinguistic theory such as microanalysis to study therapeutic communication as a mechanism of change in solution-focused therapy. Their work includes three types of research:

1. Process research (e.g., microanalysis of communication within therapy sessions) that assesses congruence between theory and practice and also reveals similarities and differences in therapeutic approaches (e.g., Bavelas, & Smock, 2014; Korman, Bavelas, & De Jong, 2013; Smock & Bavelas, 2013; Smock, Froerer, & Bavelas, 2013; Tomori & Bavelas, 2007);
2. basic experiments in a laboratory setting that provide evidence supporting fundamental assumptions such as co-construction in the treatment process (e.g., Bavelas, Coates, & Johnson, 2000, 2002); and
3. experiments on therapeutic techniques, which test key techniques such as the miracle question in the laboratory, using non-therapeutic tasks and populations (De Jong, Bavelas & Korman, 2013; Healing & Bavelas, 2011).

This line of research illuminates important mechanisms of change and other process issues involved in treatment. In addition, such an approach introduces novel research methodologies in understanding the therapeutic processes of other types of social work treatment approaches. Knowledge and evidence of this line of research has provided the empirical basis in language use of the co-constructive, solution-focused therapeutic process as Listen, Select, and Build, which is clearly elaborated in the second edition of the *Solution-Focused Therapy Treatment Manual for Working with Individuals* published by SFBTA (Bavelas et al., 2013).

Conclusion

There is much diversity and great differences in how the problems of living should be approached. A solution-focused approach uses the language and symbols of "solution and strengths" in the treatment process. It is part of a pluralistic, professional effort to develop pragmatic solutions to address a wide range of problems of living for clients and families. The use of the language and symbols of "solution and strengths" in treatment is not without controversy. Not focusing on the problem is somewhat unfamiliar to most social work professionals, who are usually trained in the conventional problem-focused or problem-solving models of treatment. On the other hand, solution-focused therapy is well aware of the power of therapeutic dialogues and the potentially harmful effects of a pathology-based and deficits-based perspective in sustaining the problem and disempowering clients. Solution-focused therapy prefers the inclusion of clients' voices as well as their strengths and resources in the search for effective solutions. While doing so, it is important to evaluate the effectiveness of solution-focused therapy and carefully examine the associated mechanisms and processes that contribute to its effectiveness so that treatment is based on an informed position in addition to ethical choices or theoretical preferences.

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36

Task-Centered Social Work

Anne E. Fortune and William J. Reid

Task-centered social work is a time-limited, problem-solving approach to social work practice developed beginning in the 1970s by Laura Epstein (1914–1996) and William J. Reid (1928–2003). Starting with a psychosocial theory base and research evidence on effectiveness of time-limited treatment (Reid & Shyne, 1969), they took a research and development (R&D) approach (Thomas & Rothman, 1994; Thomas, 1984) that tested interventions, assessed results, refined the interventions, tested them again, and so on (Reid & Epstein, 1972). The initial formulation of task-centered casework relied heavily on Hollis's (1964) psychosocial techniques, Perlman's (1957) view of casework as a problem-solving process, and Studt's (1968) notion of the client's task as a focus of service.

Reid and Epstein designed the task-centered model to be an open, pluralistic practice system that could incorporate theoretical and technical contributions from diverse sources. As currently practiced, task-centered casework is not wedded to any particular theory of human functioning. Instead, it provides a core of value premises or basic characteristics; some underlying assumptions about how clients change; a three-stage intervention format that includes structured problem-resolution activities, and suggested strategies for dealing with particular problems. This chapter reviews the current task-centered system in clinical practice; that is, task-centered practice with individuals, families, groups, and in case-management on behalf of clients. The review includes the major theoretical assumptions that underlie the practice

model; the model itself, that is, the problem-solving and task-planning activities that guide work with clients; and task strategies for specific problems. It also includes additional considerations when there are multiple clients, the range and limits of application, and research evidence about effectiveness of the task-centered model.

Basic Characteristics or Value Premises of the Task-Centered Model

Focus on Client-Acknowledged Problems

The focus of service is on resolving specific problems that clients explicitly acknowledge as being of concern to them (problems-in-living). This focus contrasts with personality change, attributed problems, or social justice, but it can include environmental contexts.

Problem-Solving Actions (Tasks)

Change in clients' problems-in living is stimulated primarily through problem-solving actions (tasks) undertaken by clients inside and outside of the intervention session. Particular emphasis is placed on mobilizing clients' actions in their own environments. The primary function of the intervention session is to lay the groundwork for such actions. In addition, practitioner tasks provide a means of effecting environmental change in the clients' interest.

Planned Brevity

Service is generally planned as short-term by design (6–12 weekly sessions within a 4–month period). The short time limits capitalize on the "goal gradient effect," where individuals are motivated by deadlines and clear goals. Extensions beyond these limits are possible.

Collaborative Relationship

Relationships between clients and practitioners are both caring and collaborative. Practitioners share information about assessment and progress and avoid hidden goals and agendas. Clients and practitioners agree explicitly about the target problems, goals, and duration. Extensive client input when developing intervention strategies makes tasks more effective and helps develop the clients' problem-solving abilities. The practitioner role includes structuring sessions for collaborative problem-solving work and occasionally carrying out tasks on behalf of clients.

Systems and Contexts

Problems-in-living occur in a context of multiple systems and environments, including oppressive systems. Consequently, change in the context may be needed for problem resolution or prevention of problem recurrence. Conversely, resolution of a problem may have beneficial effects on its context, and the context may provide resources for problem alleviation.

Structured Intervention

The content of sessions is individualized, including the client problem(s), context, and development of tasks. However, task-centered sessions and intervention processes are structured. Each session in beginning, middle, and ending phases has a specific agenda that guides the client's and practitioner's work. In addition, some intervention processes are packaged and standardized; for example, the task-implementation sequence includes steps appropriate for developing, implementing and evaluating any client or practitioner task. Finally, task strategies can provide a meta-approach that guides a series of interim tasks to deal with specific common problems such as depression, bullying, or moving into a nursing home (Naleppa & Reid, 2003; Reid, 2000). Such task strategies are, whenever possible, based on evidence about effective intervention approaches.

Empirical Orientation

The task-centered model includes an empirical orientation at three levels. First, data from clients guide the treatment plan, evaluation of progress, and termination. All hypotheses and concepts about the client system are grounded in case data at relatively low levels of inference, minimizing speculative theorizing about the client's problems and behavior. Data are collected systematically for assessment and outcome; and the effects of intervention are monitored regularly through

task-accomplishment and goal-attainment ratings. Secondly, approaches and theories supported by empirical evidence are preferred in treatment planning and task strategies. As in today's evidence-based practice (EBP), specific interventions are selected based on the best available evidence and on the clients' desires. Thirdly, the model was developed and sustained through systematic research and development. Numerous studies, including controlled experiments, have been used to test and improve the model (Fortune, 2010; Marsh & Doel, 2005; Reid, 1997).

Integrative Theoretical Stance

The task-centered model draws selectively on empirically based theories and methods from compatible approaches; e.g., problem-solving, cognitive-behavioral, cognitive, and family structural approaches. Within the model's basic framework and structures, practitioners draw on eclectic theories to fashion task strategies and tasks to resolve problems. For example, if a client's problem-in-living includes depression, the approaches may include cognitive behavioral, interpersonal relationship, psychodynamic, and drug therapy, or a combination (Reid, 2000). Again, preference is given to empirical evidence and client wishes.

Underlying Assumptions About Client Change

The essential function of task-centered practice is to help clients move forward with solutions to psychosocial problems that they define and hope to solve. The client is the primary agent of change. The practitioners' role is to help clients bring about changes they desire and are willing to work for.

Psychosocial Problems

Psychosocial problems are difficulties that clients encounter in their interactions with others and the environment, including their own reactions and emotional states. A broad problem classification defines the types of difficulties appropriate for task-centered practice; for example, problems in family and interpersonal relations, in carrying out social roles, in decision making, in securing resources, and emotional distress reactive to situational factors. Although problems are acknowledged at the individual level, the larger context of factors that interact with the problem is taken into account through contextual analysis. Such contexts include obstacles to solving the problem and resources that can be applied to work on it. They reflect almost any aspect of the multiple systems of which clients are a part.

The task-centered model assumes that problems generally reflect temporary breakdowns in problem coping that set in motion forces for change. These forces, which include clients' own motivations to alleviate distress and the resources in the clients' environments, operate rapidly in most cases to reduce the problem to a tolerable level, at which point the possibility of further change lessens.

Opportunity for Change

The planned brevity of the model is based on the proposition that the most benefit from interpersonal treatment will occur within a relatively few sessions and a relatively brief period of time. Research suggests that:

1. Recipients of brief, time-limited treatment show at least as much durable improvement as recipients of long-term, open-ended treatment (Reid & Shyne, 1969);
2. Most of the improvement in long-term treatment occurs soon after treatment has begun (Bloom, Yeager, & Roberts, 2006);
3. Regardless of intended length, most voluntary treatment turns out to be relatively brief—no longer than a dozen sessions or a three-month time span (Fahs-Beck & Jones, 1973; Hansen, Lambert, & Forman, 2002).

Action as a Strategy for Change

The psychosocial problems-in-living that are target problems are the expressions of something that clients want but they do not have. The usual and most effective way to obtain what one wants is to take action to get it. Because clients are human beings, their actions are guided by sophisticated sets of beliefs about themselves and their worlds, beliefs that help them form and

implement plans about what they should do and how they should do it. Their plans and actions usually involve others—the individuals, groups, and organizations that make up their social systems. Clients' perceptions of the social system response in turn shape their actions. Task-centered practice thus does not deal with remote or historical origins of a problem, but rather with current obstacles that may be blocking the resolution or with resources that may facilitate it.

The theoretical assumption about action for change stresses people's autonomous problem-solving capacities—their ability to initiate and carry through intelligent action to obtain what they want (Goldman, 1970). In this conception, the person is less a prisoner of unconscious drives than in psychoanalytic theories and less a prisoner of environmental contingencies than in behavioral theories. Instead, people are viewed as having minds and wills of their own that are reactive but not subordinate to internal and external influences. Their human problem-solving capacities are complex, ingenious, and, in the main, quite effective.

In this view, change is stimulated primarily through problem-solving actions or tasks in the client's environment. Tasks as means of problem resolution are the central and distinctive markers of the task-centered system. The success of these tasks largely determines the benefits that result from use of the task-centered model. The stress on tasks builds on the considerable capacity of human beings to take constructive action in response to difficulty. In effect, the intervention strategy is modeled after the way most people resolve most of their problems—by doing something about them.

The reliance on client action leads to a parsimonious form of intervention that respects clients' rights to manage their own affairs. If clients are clear about what is troubling them and how to resolve the difficulty, the practitioners' role may be limited to providing encouragement and structure for their problem-solving efforts. If more is needed, more is supplied. Even when practitioners' involvement is great, its purpose is to develop and augment the clients' own actions. Practitioners help clients determine what they want (and in the process may need to challenge wants that are unrealizable). Practitioners help clients identify and modify action and interaction sequences contributing to the difficulty, provide corrective feedback on their actions, teach necessary skills, work to alter beliefs that are interfering with problem solving, and bring about changes in the social system and secure resources from it. Practitioners may even suggest specific tasks. But whatever is done is done collaboratively and leads to actions that *must* be agreed to by clients. The decisive actions in most cases are those that clients themselves perform in their own way and on their own behalf.

Enabling clients to take constructive and responsible action in their own interests has an important corollary: the action is more likely to be incorporated as part of their strategies for future coping with their problems. Because clients participate in planning, understand the rationale for tasks, agree to carry them out, actually implement them, and review their results, the action is more a part of them. Thus, the problem-solving action is more likely to be used again than if clients simply followed the practitioners' instructions.

Despite the problem-focused terminology, the task-centered model is an optimistic, strengths-oriented approach. It stresses self-determination and supports clients' empowerment (Rooney, 2010). It assumes that clients have the ability and capacity to improve their situations, and it draws on their problem-solving ideas, resources, and strengths.

The model does not define normative behavior or outcomes. Because clients define the problems and generate tasks that may resolve them, the model can be effective in many situations and cultures (Fortune, 2010; Goeke et al., 2011).

Practitioner–Client Relationship

In the task-centered approach, the relationship between the practitioner and client by itself is not the medium of treatment; instead, the relationship provides a means of stimulating and promoting problem-solving action. Therapeutic sessions set in motion and guide actions through which change will be effected. Problem-solving is facilitated by relationships in which clients feel accepted, respected, liked, and understood.

A good treatment relationship contains both support and expectations (Perlman, 1957).

Within the task-centered model, the practitioners' expectations for work are a therapeutic force at least equal in importance to their support. Clients may reject help, but once contracts are established, they are held accountable for following through. Clients are viewed as persons who can make responsible decisions.

Research on the working alliance supports this view of relationship. The working alliance includes agreement between clinicians and clients on goals, and on therapeutic strategies, and on the client–clinician bond (Horvath & Greenberg, 1989). Evidence suggests that a strong working alliance is positively related to engagement, continuation in treatment, and outcome (Cruz & Pincus, 2014; Falkenström, Granström, & Holmqvist, 2013; Horvath & Greenberg, 1989). The working alliance is not curative in and of itself but interacts with technical aspects of the therapy (such as insight, cognitive methods, or in the task-centered model, tasks and task planning). Client involvement is critical (Trotter, 2002). Even simply agreeing on goals "can result in increased client capacity to collaborate and even to cope independently" (Bordin, 1994, pp. 13–14).

Contextual Change

Although the immediate purpose is to help clients resolve problems-in-living, efforts to do so should also exert a positive influence on the context of the problem. Clients are usually embedded in intertwined systems that either aid or inhibit problem resolution. Contextual change may facilitate solutions, prevent recurrences and side effects, and strengthen clients' problem-solving abilities. Contextual change in the task-centered model is defined and limited by the target problem. It is not just any change that would help clients; it should be related to resolving the target problem.

Contextual change may occur in two ways. First, contextual change can occur as a direct consequence of alleviation of a target problem, "ripple effects," so to speak. Improvement in a pupil's grades may lead to a more positive attitude from his teachers, which, in turn, may result in more cooperative behavior from the child. Second, contextual change may occur in the process of working through obstacles that prevent resolution of target problems. For example, to help a withdrawn college student make friends, the practitioner may deal with the student's poor self-image. However, despite the importance of contextual change, the manifest problem is not seen as a point of entry to the "real difficulties" underneath. The focus of attention is on the target problem even if its resolution requires considerable change in its context.

Structure of the Task-Centered Model: Problem-Solving Activities

The task-centered model assumes that, in general, clients can be helped best if they have an orderly, facilitative structure in which to work out immediate problems and to develop problem-solving skills. The central structure of the model aims to develop effective actions or tasks that clients may use between sessions to resolve the target problems. The current structure is the result of R&D research that showed: (a) that task accomplishment was associated with problem resolution and the overall situation (Reid, 1978; Sinclair & Walker, 1985); (b) that outcome was better when attention focused on how the tasks would be done rather than just what the tasks were to be (task-planning and implementation, Fortune, 2012; Reid, 1978), and (c) that anticipating and preventing or overcoming obstacles was an important technology for assessing "what goes wrong when well-planned goals go awry" (Rooney, 2010, p. 199). Tasks were also broadened to include family system contexts: for example, tasks to resolve a problem while strengthening sibling bonds (Reid, 1985). Tasks were also re-conceptualized as occurring within the session as well as in the environment: for example, paired tasks, the first completed in the session (e.g., a discussion of conflict resolution between parent and child) and the second completed at home after the session (implementing the conflict resolution method; Reid, 1987).

While the content of sessions—client problems, their context, task development, etc.—is individualized, task-centered sessions and intervention processes are structured. Each session in its beginning, middle, and ending phases has a specific agenda that guides the client and practitioner work. In additional, some intervention processes are packaged and standardized; for example, the task implementation sequence includes steps appropriate for developing,

implementing, and evaluating any client or practitioner task. Finally, because tasks are usually interim steps to a broader goal, task strategies are a series of tasks or a meta-approach to deal with specific common problems such as depression, social exclusion, or moving into a nursing home (McLeod, Bywaters, Tanner, & Hirsch, 2008; Naleppa & Reid, 2003; Reid, 2000).

The bare-bones structure of the task-centered model for individuals and families is presented here (see Table 36.1). Again, although sessions follow a particular structure, the content is individualized for clients and their problems.

I. Initial phase (sessions 1 and 2). To engage clients and develop consensus on future work, the initial session(s) include:

1. Discussion of reasons for referral, especially with non-voluntary client(s) (Rooney, 2009; Trotter, 2015).
2. Exploration and assessment of client-acknowledged problems-in-living. The practitioners may contribute their own knowledge to the client's wishes, so the final target problems may include larger contextual issues than the client initially acknowledged.
3. Negotiation and agreement on a service contract, including explicit and concrete statements of problems and goals to be addressed, explanation of treatment methods, and agreement on durational limits.
4. Development and implementation of initial tasks (see II.3).

Table 36.1 Outline of Task-Centered Procedures by Stages

The Task-Centered Model in Clinical Practice: Outline for Complete Cases
I. Initial Phase (Sessions 1–2)
1. Discussion of reasons for referral, especially with non-voluntary client(s)
2. Exploration and assessment of client-acknowledged target problems and their contexts
3. Formation of the service contract, including problems and goals to be addressed, explanation of treatment methods, agreement on durational limits
4. Development and implementation of initial tasks (see II-3 and 4 below)
II. Middle Phase
(Each session follows the format below):
1. Problem and task review
2. Identifying and resolving (actual) obstacles to task accomplishment
3. Task planning and implementation sequence (TPIS):
Task selection
Task agreement
Planning specifics of implementation
Establishing incentives and rationale
Identifying and resolving (anticipated) obstacles
Guided practice, rehearsal
Summarizing and recording the task plan
4. Implementing task(s) (between sessions)
III. Terminal Phase (final session)
1. Assessment of current status of target problems and overall situation
2. Identification of successful problem-solving strategies used by client(s)
3. Discussion of other ways to maintain gains
4. Discussion of what can be done about remaining problems, making use of strategies identified in III-2 above
5. Acknowledge reactions to termination
6. Make decisions about extensions

Adapted from W. J. Reid (1992). *Task strategies: An empirical approach to clinical social work*. New York: Columbia University Press, Table 1.2, p. 6.

Case Example 36.1: Mrs. N. and Mia: Problem Statement

Mrs. N. wanted her two-year-old daughter, Mia, "to mind me like she should." After exploration, Mrs. N. and the practitioner agreed on a target problem: that Mrs. N. has difficulty caring for Mia. The statement and specification were as follows.

Mrs. N. constantly loses her temper with Mia, shouting at her and slapping or shaking her. Mrs. N. quickly becomes irritated whenever Mia won't obey. Mrs. N. generally starts shouting at her when these things happen. If Mia then persists in the behavior or starts to cry, Mrs. N. usually will scream at her and then slap her or shake her. During the past week, Mrs. N. lost her temper with Mia an average of five times a day and slapped or shook her at least once a day.

As the example of Mrs. N. illustrates, problems are spelled out in concrete terms and in language that clients understand. Estimated frequencies of problem occurrence over a specified period add additional precision and provide a baseline against which change in the problem can be measured. Marsh and Doel (2005, p. 36) recommend setting SMART goals: Specific, Measurable, Achievable, Realistic, and Timely. Specificity of goals and problems aids the choice of treatment strategy and makes it easier to measure progress.

Exploration of the context of the problem concentrates on identifying causes that can be changed and on client resources that may assist in making changes. What are the immediate aggravating factors in clients' beliefs, actions, or environment that practitioners or clients can do something about? What strengths can clients bring to bear on the situation? What are resources that can help solve the problem? In Mrs. N.'s case, the sequence of interactions leading to shaking the child was identified. Mrs. N.'s strengths and resources included her general understanding of child development and her concern about her own reactions, as well as the child's overall sturdy health.

In making assessments, practitioners may use a variety of diagnostic theories, but problems are derived empirically from clients' views of their difficulties. Practitioners start with a description of the problem ("Mrs. N. loses her temper with her child") and then scan relevant knowledge, including theories, to locate possible explanations. Guidelines for this eclectic use of theory include these features. (1) Hypotheses selected to explain the problem are evaluated through case data to see if they appear to be correct in the particular case. (2) Preference is given to theories that have been supported by empirical research. (3) The practitioners do not fix on a single explanation but consider alternative explanations in a search for the theory that provides the best fit with the problem and case at hand.

Mrs. N. and Mia: Service Contract and Task Strategies

The practitioner and Mrs. N. decided to work together once a week for 10 weeks. The initial strategy was based on cognitive-behavioral and systems theories and included establishing realistic expectations of a two-year-old, interrupting the problematic interaction sequence, changing Mrs. N.'s irritation by using self-calming techniques, and Mrs. N. learning how to divert Mia's "fussing behavior" before she herself lost her temper.

II. Middle phase (each middle-phase session). Each session in the middle phase, where the bulk of the work occurs, includes the following activities, listed in logical order. While task and problem review should occur toward the beginning in order to focus each session, other activities are often interwoven with each other. Nevertheless, their presence provides the structure for conducting middle-phase sessions.
    1. *Problem and task review*. To determine progress, the current status of the problem, and the accomplishment of tasks from previous sessions, are reviewed at the beginning of each session. The task review provides a record for both the practitioner and the client as to how the task has gone and whether it affected the problem.
    2. *Identifying and resolving obstacles to task accomplishment*. If the client has experienced difficulty with the task, internal and external obstacles are reviewed. If the obstacles cannot be resolved, an alternative task is developed to overcome or avoid the obstacle. For instance, Mrs. N. and the practitioner discussed the meaning of Mia's misbehavior (modifying distorted perceptions) and how much

impulse control to expect from a toddler (assessing unrealistic expectations). One of Mrs. N.'s tasks was to ask herself "Why is this child doing *that*?" before correcting Mia. Obstacles involving the external system, such as childcare or a welfare bureaucracy, may be addressed directly with practitioner and client carrying out tasks to engage the system constructively.

If substantial obstacles appear, contextual analysis can be used to plan how to avoid them, the task may be replaced with a more feasible task, or resources may be found to facilitate progress. Resources include strengths and competencies of individual clients, the ties of loyalty and affection that hold families together, and the intangible and tangible supports provided by external systems. For example, during middle sessions, Mrs. N's commitment to Mia and her obvious affection were a resource that helped her endure misbehavior when Mia did not respond to her distraction strategies.

3. *Task planning and implementation sequence.* The task planning and implementation sequence is central to completing tasks and resolving problems. The more time spent doing task planning, the more likely tasks are to be successful and that problems will be improved (Blizinsky & Reid, 1980; Reid, 1978).
4. *Task selection.* Clients will "buy into" task actions if they are involved in planning the tasks. The practitioner asks such questions as, "What do you think you might be able to do about this problem?" Or, "Of the things you have tried, what worked best for you?" Task selection thus begins by eliciting the client's ideas. The practitioner may build on these ideas or suggest others.

An important source of ideas is task strategies: clusters of tasks or sequences of tasks designed to alleviate particular problems, as much as possible based on evidence of their effectiveness (Naleppa & Reid, 2003; Reid, 1992, 2000). However, even when a well-validated task strategy is proposed, it should be part of a collaborative discussion with the client. The practitioner's suggestions are *ideas* for tasks. Advice, if given, is intended to stimulate the client's own ideas, not to be unilateral "assignments."

5. *Task agreement.* Client commitment to do a task is a critical predictor of success, and commitment is enhanced by engagement in the task-planning process (Reid, 1997).
6. *Planning specifics of implementation.* Once a task has been selected, the practitioner and client work on a plan to carry it out. Tasks suggested by the practitioner should be customized and fleshed out in collaboration with the client. For example, if the practitioner suggests that a client with a drinking problem participate in a self-help program, an implementation plan might involve determining how the program can be located, how the client can learn something about it, when he or she will attend the first meeting, what he or she might say at that meeting, and so on. Normally, the task is implemented prior to the next session.

The practitioner attempts to make sure that the task plan has a high probability of at least some success. It is better to err on the side of having the task be too easy rather than too difficult, because it is important that the client experience success early in working on the problem. Successful performance can create a sense of mastery, which can augment problem-solving efforts. For example, if it seems that the task of attending a self-help meeting has a low chance of being carried out, the task could be revised to "partialize" steps; first locating a group, and then getting information about it.

For the task plan to work, the client must emerge from planning with a clear notion of what he or she is to do. Generally, an effort is made to spell out details of implementation that are appropriate for the task and fit the client's style and circumstances. For some tasks and some clients, a goodly amount of detail and structure may be required. For example, if the client is likely to procrastinate about doing the task, details like the time and place may be spelled out. For other tasks and clients, a minimum of structure and detail may make sense. Planning may then be general and the client may use on-the-spot improvisation to implement it. Either way, the main actions of the task should be clear to the client. For example, if the task calls for a mother to show approval if her daughter cleans her room, ways of showing approval and what is meant by "cleaning the room" could be discussed.

7. *Establishing incentives and rationale.* To enhance commitment and motivation for completing a task, the practitioner and client develop a rationale for carrying out the task (if it is not already clear). What is the potential benefit to be gained from completing the task? What good will come of it? How will it affect the problem? Will it take care of an obstacle? Or will it set the client up for future tasks? The practitioner reinforces the client's perceptions of realistic benefits or points out positive consequences that the client may not have thought about.
8. *Identifying and resolving anticipated obstacles.* An important practitioner function in task planning is to help the client identify potential obstacles to the task and shape plans to avoid or minimize these obstacles. As details of how the tasks are to be done are discussed, possible obstacles can be identified through "What if?" questions. For example, if the task is "Discuss with your partner ways she can help you stay sober," a question might be: "What if your partner starts to lecture you?" More generally, the practitioner can ask the client to think of ways that a task might fail, then discuss how to resolve potential obstacles. If the obstacles appear too formidable, the task can be modified, broken down into steps, or another approach developed. Often a proposed task is similar to previous efforts by the client. Review of those efforts and how they may have fallen short provides another means of identifying potential obstacles. For example, Mrs. N. herself identified her irritation with Mia as an obstacle to changing the interaction. After considering several possibilities (turn her back to Mia, leave the room, ask Mia to leave), Mrs. N. opted to learn self-calming techniques.

The task-centered model is distinctive in including techniques to remedy the failure of an intervention (Rooney, 2010). Identifying and avoiding obstacles both before and after they are encountered increases the likelihood of success, and models useful problem-solving skills.

9. *Guided practice, rehearsal.* To improve client skills or confidence, the practitioner may model possible task behavior or ask the client to rehearse the task. For example, Mrs. N. might practice putting a diversionary toy into Mia's hands. Modeling and rehearsal may be carried out through role-playing, if appropriate. For example, if a young woman has a social phobia, the task might be to "speak up in a class you are attending." The practitioner pretends to be the class instructor, and the client rehearses what she might say. The roles could then be reversed, with the practitioner modeling what the young woman might say.

Guided practice is the performance of the actual (as opposed to simulated) task behavior by the client during the interview; thus, a child may practice reading or a couple may practice communication skills. Guided practice can also be extended to real-life situations; for example, a practitioner might accompany a client to a medical clinic who has a fear of going to doctors.

10. *Summarizing and recording the task plan.* As a final step in task-planning, the practitioner and client summarize the task to clarify what will be done between sessions. Especially for complex tasks, it is useful to elicit from the client the essentials of the plan: "How will you carry out the task?" The practitioner can then underscore the essential elements of the plan or add parts the client has left out. Summarizing the plan clarifies it and also conveys the expectation that the client will indeed carry it out and that his or her efforts will be reviewed. "So you will try to do [thus and so]; I'll do [that and this]. We'll see how it worked out next time we meet." Writing tasks down with a copy for the client and another for the practitioner is also useful, especially when tasks are complex or when several people plan to perform tasks (Marsh, 2007).
11. *Implementing tasks between sessions.* Clients and (depending on the case) practitioners and others carry out tasks in the clients' natural surroundings.

Mrs. N. and Mia: Task Planning and Implementation Sequence

Mrs. N. tried self-soothing talk when Mia fussed ("It's not me she's angry at." "I can handle it." "Be calm." "Smile"). Her first attempt at the task failed;

Mrs. N. was yelling before she remembered to self-soothe. Analysis of obstacles suggested she was not attuned to her own feelings or their triggers. Instead of using her own feelings as a cue, she and the practitioner identified situations that upset her. For her next task, Mrs. N. concentrated on recognizing the situation and self-soothing before she identified feelings of frustration. This strategy worked reasonably well, and the next several sessions focused on recognizing more triggers, linking them to potential emotional responses, and expanding Mrs. N.'s repertoire. As she became more adept at recognizing trigger situations, she added new strategies for diverting Mia. In the last sessions, planned tasks included preventing the worst situations by establishing consistent care routines like regular meal and nap times.

III. Terminal phase (final session or last two sessions). The process of terminating begins in the initial phase when the duration of treatment is set (Fortune, 2009). In middle sessions, mention of the session reinforces the passage of time (and the need to work actively), e.g., "this is the fifth of our eight planned meetings We still need to work on. . . ." Thus, ending is neither a surprise nor a cause for strong reactions.

Termination in the task-centered model has multiple purposes: rationale for ending, assessment of progress, and preparing the client to continue progress and perhaps apply newly learned skills in other settings.

1. *Assessment of current status of target problems and overall situation.* Assessment focusses on the current situation at a level of specificity that permits direct comparison to the original problem statement. Because contexts are typically addressed as well as the target problem, the client's overall situation is also reviewed. Assessment is not merely evaluation, but is also intended to give clients a sense of mastery and control over successful actions, to reinforce skills, and to illustrate how to apply problem-solving in the future (Fortune, 2012, 1985).
2. *Identification of successful problem-solving strategies used by client(s).* Emphasis is on how the client used problem-solving successfully and how such strategies might be used in similar situations.
3. *Discussion of other ways to maintain client gains.* Maintenance may include "fail-safe planning" (what to do if a problem crops up), self-reinforcement, practicing new behaviors in additional situations (generalization), etc.
4. *Discussion of what can be done about remaining problems*, including possible task strategies.
5. *Acknowledge reactions to ending.* Because ending is expected, reactions to termination are more likely to be ambivalent—mixed satisfaction and regret—than negative. These reactions should be acknowledged as normal and healthy, but not as reasons to prolong treatment. In many circumstances, a termination ritual helps bring closure; for example, a memento of the relationship, a review of clients' accomplishments, etc.
6. *Make decisions about extensions.* Decisions are jointly made by client and practitioner. Extensions are usually time-limited and focused on particular problems or goals. In most cases, a single brief extension will suffice, but in some cases additional ones may be needed. The critical consideration is what can be accomplished by extending service. Often cases that show little progress by the twelfth visit will show no more progress by the twentieth.

Mrs. N. and Mia: Ending Phase

Assessment of the target problem in the last interview indicated that Mrs. N. lost her temper less than once a day and slapped Mia only once in the past week. Although this was not a perfect record, the practitioner applauded Mrs. N.'s progress, and they agreed to terminate. Mrs. N. asked to return later, either for a review or if she set more ambitious goals. The review of their work together included how to identify problematic situations (Mia's immediate needs, Mrs. N.'s immediate stressors), a quick rehearsal of self-soothing and distracting, and reinforcement of preventive regimes like household rituals. Mrs. N. also predicted how she could handle herself if her demanding ex-boyfriend came to visit.

Task Strategies

Reid and Epstein (1972, p. 8) initially conceived of task-centered practice as a general model in which "certain fundamental principles can be successfully applied to a broad range of

situations. . . . A practitioner need not master a large assortment of approaches . . . but rather can rely on variations of a single approach." The general model included the basic principles of the task-centered model and the task implementation and planning sequence (TPIS). Once these intervention activities received some empirical support (Reid, 1975, 1978; Reid & Epstein, 1972), development turned from the practitioners' and clients' in-session activities to the broader context of which strategies (clusters or sequences of tasks) were more effective with particular problems. Several task-centered volumes present strategies that are specific to particular problems: sequences of tasks to deal with target problems such as family problems, coping with stress, increasing social involvement, depression, problem drinking, chronic mental illness, health problems, and so on (Naleppa & Reid, 2003; Reid, 1992, 2000). The volumes also include task strategies for resolving obstacles such as poor motivation, distorted beliefs, and lack of skills to complete a task. These compendiums, like other menus of evidence supported practice, are useful references for practitioners, but in a specific case, they are supplements for generating ideas about tasks, not prescriptions or protocols for intervention. As with all good evidence-based practice—and especially with task-centered practice—clients' desires and engagement in task strategies are paramount.

Work with Families, Formed Groups, Case Management, and Clinical Supervision

The task-centered approach outlined for treatment of individual clients can be applied to work with clients in families, in groups formed to resolve individual problems, or with teams of experts managing service to an individual or family. An additional application is educational (student) supervision and clinical supervision.

Families

Treatment of a family unit, like treatment of the individual client, focuses on resolution of specific client-acknowledged problems and associated contextual changes. Problems are viewed in a multi-systems context in which the family is a major, though not always the most critical, system. Research and theory on family interaction as well as specific contributions from behavioral, structural, strategic, and communications schools of family therapy are used to understand problems and their contexts.

In most cases, family members are seen together, and to the extent possible, problems are defined in interactional terms. To be successful, practitioners should avoid accepting one member's definition of a problem and instead define problems consensually (Hoffman & Chu, 2015; Karam, Sprenkle, & Davis, 2014).

Tasks may be carried out by individual family members, the practitioner, and jointly by family members, either in the session or at home. Guided practice through tasks within the session generally involve family members in face-to-face problem-solving efforts, structured and facilitated by the practitioner, who may in addition help family members improve skills in problem-solving communication. Session tasks such as enactments of family interactions or solutions devised by family members during sessions are used as a basis for tasks to be carried out at home. The theme of collaborative effort is continued in these home tasks. Shared tasks, which family members do together, continue the problem-solving at home, enabling family members to work together on practical projects such as home improvements and improving relationships between family members. Reciprocal tasks are exchanges between family members. All participants must be willing to cooperate and must regard the exchange as equitable. In real life, this means that participants must be prepared to accept reasonable approximations of expected behavior rather than perfect performance and must be willing to adjust in the light of unanticipated circumstances. These complications of reciprocal tasks suggest that work in the session should clarify and negotiate conflicts before the task is tried at home. Reciprocal tasks that are "tacked on" at the end of a session without sufficient preparatory work are likely to fail.

Frequently, contextual change is necessary to resolve obstacles in family interaction that may be blocking solutions to problems. For example, a coalition between mother and son may be undermining the father's attempts at discipline. Session and home tasks might be designed

to weaken the mother–son coalition and to strengthen the parental alliance. In this way, the model draws on the strategies of systems-based, and especially structural, family therapy.

A fundamental principle, however, is to concentrate on alleviating target problems through relatively simple, straightforward tasks. Although tasks may be designed to effect contextual change, the target problems are the first priority. Structural dysfunctions, underlying pathologies, and so on, are left alone unless they intrude as obstacles. If they do, practitioners can shift to tasks directed at contextual change. This progression from the simple to the not-so-simple makes the task-centered approach appropriate for a wide range of family types, from normal to highly disturbed, across a wide variety of problems and settings.

Groups

Unlike families, where the expected change includes the interaction among family members outside the session, in a treatment group, the ultimate change target is resolution of the separate problems of each member.

In task-centered group treatment, the group process—norms, interaction patterns, social control, etc.—is used to further the basic activities of the model. Group members, guided by the facilitator, help one another specify problems, plan tasks, rehearse and practice behavior, analyze obstacles to task achievement, review task progress, and so on. A major role for the practitioner is to use group dynamics to focus and enhance the problem-solving efforts of the individuals.

Members of task-centered groups should be relatively similar with respect to target problems, such as problems of academic achievement, post-hospitalization adjustment, or caregiver burden. The homogeneity increases members' ability to contribute to the group. Because they have firsthand knowledge of the kind of problems others are experiencing, they are in a good position to provide support and guidance. Moreover, they can more readily apply lessons learned from the task work of others to their own situations. While work in groups does not permit the kind of sustained, focused attention on individual problems and tasks that is possible in one-to-one treatment, the group mode has certain distinct advantages. Group members in the aggregate may possess more detailed knowledge than the leader about intricacies of the target problems. Thus, group members can often suggest task possibilities that may not have occurred to either the practitioner or the member being helped at the moment. Gaining recognition from a group provides an incentive for task accomplishment that is not available in individual treatment; in particular, a member who carries out a task successfully can serve as a model to others.

These advantages of group work are not always realized, however. Groups may become unfocused and discordant. Members may become competitive and overly critical. Certain participants may become objects of group hostility—the scapegoating phenomenon. To avoid such pitfalls, the group facilitator needs to exert a constructive influence on the dynamics of the group so that its purpose—to help individual members with their target problems—is kept in view.

Thus, practitioners channel communications of the participants to help achieve the group purpose. Beliefs that members have about one another and about appropriate behavior in the group influence the sociometric and normative structures of the group, so they should be functional for the group's purpose: for example, that all participants are worthwhile persons who deserve help in working out their problems; that each has to find a solution that is right for him or her; that each has a right to a fair share of attention and assistance from the leader and the group members. Shared beliefs about how the group should conduct itself become the basis for group control of the behavior of its members. Positive control efforts will maintain focus on problems and tasks; will facilitate sharing of relevant information (but discourage prying into aspects of the members' lives not germane to work on their problems); and will stress constructive reactions to task accomplishment over despondency at task failure. The practitioner also must encourage member leadership roles that enhance group functioning; for example, reducing tension in the group or redirecting members to the business at hand.

The group may use a "hot seat" model where each person in turn is the center of

problem-solving focus, or it may use a "buddy system" where members pair off simultaneously to review tasks and develop new ones. Rooney has developed a series of structural aids that help keep group dynamics positive and solution-focused, such as posters listing group norms, problem- and task-reviews, and instructions for buddies (Hepworth, Rooney, Dewberry-Rooney, & Strom-Gottfried, 2013).

While procedures for forming and conducting groups vary, the following format is typical. Preliminary individual interviews with prospective group members are used to determine if the applicant has a problem that would fall within the prospective focus of the group and to orient the applicants to the general structure and purpose of the group treatment model. In the initial group meeting, clients state the problems they wish to work on and assist one another in problem exploration and specification. A contractual agreement is reached on the purpose of the group and its duration (which is planned short-term as in individual treatment). In subsequent sessions, each member formulates, plans, practices, and reviews tasks using a "hot seat" or buddy model. Practitioners may undertake tasks outside the session on behalf of a single client or the group as a whole, or group members may perform out of session tasks to help one another with their problems.

Case Management

A third variation of the task-centered model is its use for case management when a case involves multiple service providers. For example, work with a troubled child and family may involve a school social worker, one or more teachers, a school psychologist, a school nurse, a probation officer, and a case worker from a county child protection unit. In a mental health setting, the "cast of characters" might include a social worker, a psychiatrist, a clinical psychologist, a mental health aide, a shelter workshop supervisor, an occupational therapist, and the director of a group home. In such multiple-provider cases, a task-centered case-management structure provides a useful device for monitoring and facilitating coordination among different actors (Colvin, Lee, Magnano, & Smith, 2008a, 2008b; Naleppa, 2000; Viggiani, Reid, & Bailey-Dempsey, 2002). In task-centered case management, social workers function as case managers or coordinators. Usually a case-management team meeting brings clients and participants together to discuss aspects of the clients' problems that involve coordination among participants. There needs to be some common agreement on problems, but the strategies and tasks to resolve the problems usually differ by disciplines. Tasks for relevant participants, including clients, are developed. In addition to helping develop tasks, practitioners record the tasks on a sheet, which is distributed to all participants. Social workers may take responsibility for monitoring and recording task progress and for serving as facilitators and coordinators, e.g., giving reminders. Practitioners usually also work directly with the client system, using individual- or family-oriented task-centered methods, as appropriate.

Clinical Supervision

A fourth adaptation of the task-centered model is for educational supervision of clinical students and clinical social workers. Target *goals* replace problems-in-living as the focus of supervisor/supervisee work (Caspi & Reid, 2002). Target goals are "discrete objectives derived from more broadly defined learning and practice goals" (Caspi & Reid, 2002, p. 212). The partialized goals may relate to a student's learning contract, to a program's overall educational objectives, or to management of a particular case (i.e., what to do next in the case; for example, "Supervisee will confront the client directly about her unrealistic expectations of changing her spouse"). Over-reliance on such practice goals risks focusing only on case success, not student development, unless the goals are conscientiously tied to skills the student needs to learn (Tolson, Reid, & Garvin, 1994). However, the inclusion of case-management goals allows supervisors to balance their responsibility for quality of service with the students' learning needs.

New target goals are formulated in each supervisory session, with tasks to address them carried out between supervisory sessions, often in interviews with clients. In addition, the supervision model sets aside time for a "social

stage" when supervisee and supervisor can assess their relationship and acknowledge role constraints. There is also additional time for a "didactic" stage when the supervisor gives information the student needs to know.

In other respects, task-centered supervision follows the same basic premises and steps as the task-centered model for work with clients. The premises include an empirical orientation; planned brevity; supervisee-selected goals; a collaborative relationship between supervisor and supervisee; a structure for sessions that includes reviewing progress, analyzing obstacles (which may include supervisee emotional reactions), and developing tasks (TPIS); and so on.

Another model is Lietz's structured supervision system for child welfare workers (Lietz, 2013; Lietz, Hayes, Cronin, & Julien-Chinn, 2014). It integrates task-centered supervision with reflective critical supervision. The task-centered supervision focuses on case management or practice goals—what happens next in a case—and is seen as appropriate for neophytes and when urgent decisions are being made. The reflective supervision uses critical theory, deconstruction, and understanding of power imbalance to promote analytical thinking (Lietz, 2009), and is seen as appropriate for professional development among child welfare workers. The difference between the two uses of task-centered supervision lies in the area of student/supervisee professional development. In the Caspi model, the focus is on student learning goals or skills; in the Lietz model, the focus of professional development is critical thinking and broader understanding of the context of situations. Both models permit supervision to support both administrative and educational purposes, as well as—one hopes—support of the practitioner.

Range of Application

A question inevitably asked of any treatment system, in one form or another, is "For what kind of case is, and is not, the system applicable?" In answering this question, it is important to distinguish between the task-centered model as a whole and use of its structured activities for task planning, implementation, and review. The latter have, of course, a much wider range of application than the model as a whole. Task strategies or sequences of task-centered activities can be used in almost any form of treatment to enable clients to define and carry through particular courses of action. For example, practitioners working long-term with discharged psychiatric patients integrated task-centered methods to assist patients to reintegrate into social networks (Chapin et al., 2013).

When the task-centered model as a whole is used as the sole or primary method of treatment, its range of application, while narrower, is still broad enough to serve as a basic approach for the majority of clients seen by social workers. The task-centered approach was widely adopted (and adapted) and has been used as the basis of social services or as a stand-alone or component of social work intervention in Europe, the Middle East, the United States, Africa, Australia, and Asia (Fortune, McCallion, & Briar-Lawson, 2010). There are original task-centered publications in at least nine languages. With its emphasis on clients' definitions of problems and on client actions to resolve them, the task-centered model appears robust in many different cultures.

As discussed earlier, the task-centered model was successfully adapted for work with groups, family units, as a method of case management, and as a framework for supervision. Although these applications are less developed, the task-centered model has also used for agency administration (Parihar, 1983, 1994) and community work (Ramakrishnam, Balgopal, & Pettys, 1994). Specific adaptations were developed for most settings in which social workers practice, including child welfare (Rzepnicki, 1985; Trotter, 2002, 2015), public social services (Eriksen, 2010; Marsh & Doel, 2005), schools (Colvin et al., 2008a, 2008b; Magnano, 2009; Viggiani et al., 2002); corrections (Goldberg, Gibbons, & Sinclair, 1985; Huh & Koh, 2010), medical settings (Alley & Brown, 2002; McLeod et al., 2008; Pomeroy, Rubin, & Walker, 1995), geriatric cases (McLeod et al., 2008; Naleppa & Reid, 2003; Rathbone-McCuan, 2014), and mental health (Blakely & Dziadosz, 2014; Chapin et al., 2013; Eriksen, 2014; Garvin, 2010; Kaufman, Scogin, MacNeil, Leeper, & Wimberly, 2010).

Problems and populations with which the task-centered model has been used include suicide and depression, AIDS, addictions, sexual abuse, child neglect, frail elderly and their caregivers, sex offenders, juvenile delinquents, maladaptive youth in treatment centers, persons with serious mental health problems, immigrants, bereaved survivors, family conflict, pregnant adolescents, families of children with developmental disabilities, and aggressive siblings. This is not a comprehensive list, but it is meant to demonstrate the breadth of application of the model.

The task-centered model was also integrated into generalist practice—multilevel, multi-systems intervention (Hepworth et al., 2013; Ramos & Tolson, 2008; Tolson et al., 1994). Recently, it has served as the basis for more ambitious generalist social work models (Langer & Lietz, 2014; Rapoport, 1970; Tolson, 2013). Several innovators report integrating the task-centered model with other specific approaches to practice, including motivational interviewing in substance abuse settings (Fassler, 2008; Fassler & Naleppa, 2011); feminist pedagogy in mentoring groups (Goeke et al., 2011); and social role theory and social role validation in psychiatric rehabilitation (Blakely & Dziadosz, 2014).

Despite the wide use of the task-centered model, there may be clients for whom it may not be optimal. These include:

1. Clients who are not interested in taking action to solve specific problems in their life situations, but who rather want help in exploring existential issues—concerns about life goals or identity—or who wish to talk about stressful experiences, such as loss of a loved one;
2. Clients who are unwilling or unable to utilize the structure of the model—for example, clients who prefer a more casual, informal mode of helping, or clients faced with highly turbulent situations in which it is not possible to isolate and follow through on specific problems;
3. Clients who wish to alter conditions, such as psychogenic or motor difficulties, for which it is not possible to identify problem-solving tasks that the client is able to carry out;
4. Clients who wish no help but may need to be seen for "protective reasons."

The last category—involuntary clients—deserves additional comment because of frequent misunderstandings. The task-centered model can be used with many persons who did not seek social workers' help or who are initially reluctant to accept help. Many of these situations involve "mandated" problems—problems that are defined, not by clients, but by the community and its representatives. Often, work with the client and relevant agencies allows negotiated problem definitions that are acceptable to those involved. Such consensual problem definitions can usually be found, even if no more than that the problem is practitioners' presence in clients' lives; clients and practitioners can then work collaboratively to accomplish what is needed to eliminate the intrusion. Several authors have elaborated on such work with involuntary clients, including techniques for collaborative problem definition (Jagt, 2001; Rooney, 2009; Trotter, 2015).

A very different limitation of the task-centered model is noted by Peter Marsh (2007): it is difficult to train practitioners to use it, perhaps because the model is complex and takes a high level of skill and thoughtful practice. The idea that the task-centered model is simplistic is erroneous; it is elegant in that it appears simple and ingenious. On the other hand, the conceptual clarity and structural framework for problem-solving can give novice practitioners who are muddling through the guidance they need to reach acceptable outcomes.

Effectiveness

At least 12 controlled group experiments have suggested the effectiveness of individual, family, and group forms of the task-centered model to alleviate specific problems of living (Gibbons, Bow, & Butler, 1985; Gibbons, Butler, Urwin, & Gibbons, 1978; Harris & Franklin, 2001; Kaufman et al., 2010; Larsen & Mitchell, 1980; Lee, 2005, as cited in Huh & Koh, 2010; Magnano, 2009; Newcome, 1985; Reid, 1975, 1978; Reid & Bailey-Dempsey, 1995; Reid, Bailey-Dempsey, Cain, Cook, & Burchard, 1994; Reid, Epstein, Brown, Tolson, & Rooney,

1980). All but one of these studies found improvements in target problems and, in some cases, improvements in more general measures such as self-efficacy, social problem-solving, or grades. Sample sizes ranged from 15–400. Populations in these studies included psychiatric patients, distressed marital couples, sick elderly patients, pregnant adolescents, families seeking to regain their children from foster care, schoolchildren with academic and behavioral problems, and delinquents in a residential center. The one study without effects showed no improvement in behavior in either the experimental or control students; it involved task-centered case management with teachers and parents of severely disturbed children in special classrooms (Magnano, 2009).

Less rigorous research designs also suggest positive outcomes for those receiving task-centered services. These include quasi-experimental designs, where comparison groups were formed without random assignment (Colvin et al., 2008b, comparable school district; Pomeroy et al., 1995, wait list; Viggiani et al., 2002, comparable classrooms) and a variety of uncontrolled (pre- and post-test only) group evaluations (Chapin et al., 2013; Colvin et al., 2008a; Epstein & Brown, 2002; Epstein, Brown, Alley, & Cotton, 2002; Epstein, Brown, & Parsseghian, 2002; Eriksen, 2014; Fassler, 2008; Goldberg & Stanley, 1985; Huh & Koh, 2010; Kaufman et al., 2010; McLeod et al., 2008; Sinclair & Walker, 1985; Trotter, 2010). Much of the literature describing adaptations of the model to particular populations also used either controlled single-case experiments or systematic R & D research to formulate and validate the adaptations.

Thus, there is reasonable support for the effectiveness of the task-centered model in alleviating problems-in-living, and modest evidence that directly related characteristics such as coping, stress, or self-control can be improved. However, problem alleviation is not problem resolution. Frequently, the effects of the model are confined to reduction in clients' difficulties, or better ability to cope with them. Moreover, knowledge of the long-term impact of the model is still limited. Only four studies followed clients after treatment. Three of these found that gains were sustained for between 30 days and 18 months. For example, the target problems of school children and psychiatric outpatients remained the same or continued improvement (Reid, 1978); self-poisoning clients held gains in depression, social relations, and problems with significant others, but not with changes in social problems (neither task-centered nor service-as-usual had an effect on practical difficulties like employment or housing, Gibbons et al., 1985); and pregnant adolescents maintained gains on school attendance and social problem-solving (Harris & Franklin, 2001). However, Reid and Bailey-Dempsey (1995) found that middle-school girls' gains in attendance and grades did not carry over to the following year; the authors were not able to follow up on measures of problem reduction, self-esteem or family functioning. Quite possibly, the durability of effects of the model varies with the kind of population or problem to which it is applied. This issue is among the many to be addressed in future research.

Case Example 36.2

The following case illustrates basic features of the model as well as its application to work with families. Mrs. Johnson contacted a family agency because of problems concerning her 16-year-old daughter, Nancy, and the resulting fighting in her family. In an initial interview with the parents, Nancy, and her 14-year-old brother, Mark, the family members presented their views of their problems. Mr. Johnson began the session with a stream of complaints about Nancy. Her "attitude" toward him and his wife was "hostile." She did not accept his beliefs or standards. Any attempt to communicate with her was futile. He then turned to the problem that had precipitated their contact with the agency: Nancy's insistence that her boyfriend, Mike (age 19), be allowed to visit in their home over the weekend.

Mr. Johnson had objected to Nancy's relationship with Mike ever since Nancy's pregnancy and abortion about six months previously, but had accepted it because Nancy was determined to see Mike anyway. Mr. Johnson even tolerated Mike's coming to their home but did not want him there all weekend. Mr. Johnson saw Mike as an unwelcome intruder whose presence deprived Mr. Johnson of his privacy.

Joining in, Mrs. Johnson complained of Nancy's nagging her to get permission to do things her father might not allow. If Mrs. Johnson refused, Nancy would become belligerent and insulting. On top of this, Mrs. Johnson would usually be the one to patch things up between Nancy and her father. Nancy said little but expressed bitterness that her parents were trying to disrupt her relationship with Mike. When asked about his views of the problem by the practitioner, brother Mark commented in a somewhat detached way that the fighting between his mother and Nancy was the main difficulty.

From the family's presentation of the problems and their interactions in the session, the practitioner was impressed with the father's lack of real control and Nancy's efforts to get what she wanted through her mother, who was put in the middle. Further exploration made clearer the mother's "peacekeeping" role and her discontent with it. The practitioner presented this picture as an additional problem to be considered. In ranking the problems that had been brought up, the family agreed that the issue of greatest priority concerned the conflict over Mike's visiting. They accepted the practitioner's formulation of "Mother's being in the middle" as a second problem.

The family was seen for seven additional sessions. The main interventions were structured around problem-solving tasks in the session and at home. These tasks were designed to achieve a compromise around Mike's visiting and, in the process, to work on the dysfunctional interaction patterns that had been identified. Initially, these tasks were designed to bring about more direct communication between Nancy and her father as well as more cooperation between the two parents. It became apparent, however, that the interaction pattern was more complex than originally thought. Mrs. Johnson was not the only peacemaker. Mr. Johnson frequently assumed this role with Nancy and her mother. The parents were then coming to each other's rescue without taking responsibility either individually or jointly for dealing with Nancy's behavior. In subsequent family problem-solving, the parents jointly developed rules that each could apply consistently in dealing with Nancy.

Midway in treatment, a compromise was reached on Nancy's relationship with Mike. Mike could spend one night a week at the Johnson's home but would not be there on the weekend. Interestingly enough, the solution was suggested by Mark, who had remained somewhat on the sidelines in the family discussions. The plan was implemented and, perhaps to everyone's surprise, held up. The case ended on a positive note. The immediate problem had been worked through and the family members, in their evaluation of treatment, indicated that their situation as a whole was better. In the final session, the family discussed how to remember the consistent discipline for Nancy, and what to do if Mike started coming over more often. In her consumer questionnaire, Mrs. Johnson commented that the experience had been a "good lesson in problem working."

The case illustrates several features of the model. Focus was on the specific problem the family wanted most to solve. The major intervention strategy was based on tasks in which family members struggled toward a solution in their own way. At the same time, contextual analysis identified dysfunctional patterns that might underlie this and other problems. The family helped identify these and worked on the patterns as a part of the problem-solving tasks. Not all cases present such opportunities to achieve contextual change within the context of family problem solving. In this case, they were present and were well utilized by the family and practitioner.

Conclusion

Task-centered social work treatment is a system of brief, time-limited practice that emphasizes helping clients with specific problems of their own choosing through discrete client and practitioner actions or tasks. Treatment interviews are devoted largely to the specification of problems, and to the identification and planning of appropriate tasks, which are then carried out between sessions. Sessions are structured by problem-solving activities. The middle sessions are devoted to task planning and implementation activities, which have been elaborated through developmental research. Although there are limits on its range of application, the task-centered model can be—and is—offered as a basic service for the majority of clients dealt with by clinical social workers. The core methods of the approach—problem-solving and task planning and implementation—can be used within most long- or short-term practice frameworks. The model has a better base of research support than most social work intervention models and is appropriate for many cultures.

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37

Trauma-Informed Social Work Treatment and Complex Trauma

Dennis Kimberley and Ruth Parsons

Historical Contexts of Interventions with Emotional Distress, Trauma, and Complex Trauma[1]

The closest analogies to these conditions of our neurotics are furnished by the types of sickness which the war has just now made so frequent—the so-called traumatic neuroses. Even before the war there were such cases after railroad collisions and other frightful occurrences which endangered life. . . . The traumatic neuroses show clear indications that they are grounded in a fixation upon the moment of the traumatic disaster. In their dreams these patients regularly live over the traumatic situation; where there are attacks of an hysterical type, which permit of an analysis, we learn that the attack approximates a complete transposition into this situation. It is as if these patients had not yet gotten through with the traumatic situation, as if it were actually before them as a task which was not yet mastered. . . .

The traumatic experience is one which, in a very short space of time, is able to increase the strength of a given stimulus so enormously that its assimilation, or rather its elaboration, can no longer be effected by normal means.

Sigmund Freud (1920)

Before the conceptual codification of trauma observations, clinical hypotheses, and diverse attempts at analytic treatment, by Breuer and Freud in the late 1800s and early 1900s, out of which some social work foci developed,[2] the historical contexts of some social reforms, associated with the articulation of social work as a vocation and a discipline, included: poems, novels, biographies, plays, music, and treatises, which promoted collective consciousness of social realities, as well as the collective will to promote social change. Social reform

interventions focused on individual and collective change to promote and support justice and more equality, prevention of personal and social ills, amelioration of maltreatment, and collective meeting of common human needs—including social supports for human growth and development (e.g., Pimlott, 1935). Among the themes of some popular 17th to 19th century writers, associated with humanitarian commentary on the human condition and distressing social situations, were: social consciousness (e.g., John Donne, 1624), social advocacy (e.g., John Stuart Mills, 1869), expressed concerns about social deficits and maltreatment associated with poverty, privilege, disadvantage, exploitation, child maltreatment, prostitution, violence, war, torture, injustice towards women, the mistreatment of criminals, and other diverse unjust cultural practices including slavery (e.g., Victor Hugo, 1862; Wilson, 2015). Popular writing, in various languages, described social realities of what Breuer and Freud came to describe as "traumatic" situations and experiences (1891; and Breuer & Freud, 1959), including diverse depictions of impacts and long-term outcomes (e.g., anxiety and hysteria). Arguably, in the Western world, the writings of Charles Dickens (1838), Elizabeth Barrett Browning (1843), Hans Christian Anderson (1845), Victor Hugo (1862), Thomas Hardy (1892), and George Bernard Shaw (1893), which described and lamented the maltreatment of women and children, including descriptions of "The Cry of the Children" (Browning, 1843) the sequelae, and their distressful social situations and related physical and psychological suffering, all had an impact on the development of child and youth protection services and calls for undertaking social responsibility for the care and well-being of vulnerable and needy social groups. What would be labelled today as "trauma" was treated descriptively in artistic interpretations of situational risks, threats, deprivations, harm, and resilience of the human spirit associated with overwhelming emotional distress and social disadvantage, in works such as *The Little Match Girl, Oliver Twist*, and *Les Misérables" and "Children of the Guetto. (Zangwill, 1892).*

Before social work became more professionalized, those who set the stage for undertaking active social responsibility and social care, often with religious and political mandates, addressed the needs of persons, and societal "social ills" (today framed as injustices, oppressions, and situationally compromised personal and social functioning) (Jennison & Lundy, 2011). Among their foci were those who had experienced, or who were experiencing, high distress and what would be labeled today as "threat or reality-based anticipation of exposure to traumatic situations" (e.g., child maltreatment; war), "personalized and direct traumatic experiences" (e.g., rape; child abuse; familial violence),[3] "common trauma impacts" (e.g., numbing-dissociation; maladaptation; "madness"), "vicarious trauma" (e.g., secondary trauma; compassion fatigue), and post-trauma developmental sequelae (e.g., hysteria, shell shock, significantly compromised personal and social functioning). Socially and clinically significant descriptors informed the conceptual roots of what became codified in *The Diagnostic and Statistical Manual of Mental Disorders III* (DSM-III) as *post-traumatic stress disorder* (PTSD).[4] It is not surprising, given the range of human suffering social workers faced in their missions, that they contributed to the development and use of evolving stress and trauma theory and concepts—partly derived from their interventions in children's protection, rape crises, and family violence (Rapoport, 1962; Faller, 1981; Mengeot, 1982; van Dalen, 1989).

In the 17th and 18th centuries, those providing social care, often under the sanction of religious institutions, addressed the needs of abandoned and orphaned children, abandoned and homeless mentally disturbed persons, as well as vulnerable persons such as prostitutes and slaves. Collective extra-familial or extra-tribal social supports and social care unfolded and were expressed in diverse cultural traditions for meeting the needs of those who had experienced the terror and effects of: degenerative chronic health stressors (e.g., tuberculosis; syphilis), mental health challenges (e.g., what came to be defined as "psychoses"), maltreatment (e.g., abandoned and abused children; exploited domestic servants), significant disadvantage (e.g., hunger, homelessness), as well as the shock of violence, including war (e.g., rape; disabled veterans). By the late 1800s and

early 1900s, some thinkers, such as Breuer and Freud, made postulations about developmental traumatic experiences, post-trauma effects, and impacts of extreme emotional distress. Among these foci included mental health challenges (e.g., hysteria) and longer-term sequelae (neuroses), especially in matters of human development and personal and social functioning, with increasing attention to risky life situations and social environments (e.g., incest; and families facing pervasive crises and related stress)—with special reference to vulnerabilities, experiences, harm, and needs associated with women and children.[5] The themes of highly emotional "pressures" and "stressors," "stressful situations," "overwhelming stimuli," distresses and reactive "maladaptations," with the person needing "support" with problems of "everyday living," including "environmental modification," had been reflected in social work treatment much before the codification of extreme distress in terms of PTSD gained currency (Friedlander, 1958, pp. 23–52, 79, 101–115; Golan, 1978). Extreme, repeated, relational, and overwhelming stress themes, experienced by many social work clients, fell within the semantic field of "trauma," as has been analyzed in current writings on trauma-informed practice (Knight, 2015), modern attachment theory within the context of trauma (James, 1994; Schore & Schore, 2008).

Understandings of the human condition, human contexts, and common human risks, needs, and unjust, or otherwise challenging, social-structural situations, including assuming social responsibility for attending to social-situational factors and social change, social supports, and social care-interventions, which social workers continue today, are informed by over 100 years of experience, study, and practice wisdom. The activities of social workers, included collective will and social action, supporting social reform to: undertake social and psychosocial analysis (French, 1940; Cork, 1969); challenge risks and harm associated with distress (Richmond, 1917; Friedlander, 1958); confront disadvantage, marginalization, exploitation, and maltreatment (Richmond, 1917; Addams, 1912); challenge social injustices (Addams, 1912; Follett, 1942); support families in distress (Montalvo, 1982), and respect strengths and potential (Satir, 1972). Beyond raising social consciousness, social workers joined in the humanitarian belief in human agency and collective social responsibility for social action and providing social supports, social care, therapeutic interventions, social protections, and advocacy (Addams, 1912; Franklin, 1986),[6] including crisis intervention (Parad & Caplan, 1960; Golan, 1986; Parad & Parad, 1990; Yeager, & Roberts, 2015). By the early 1900s, social workers were clearly active in postwar stress and neurosis interventions (Maas, 1951; Scott, 1990); family violence and distress, including the impacts of military service on families (Cork, 1969; Jehu, Gazan, & Klassen, 1985); mental health (Jarrett, 1918; French, 1940; Grinker, MacGregor, Selan, Klein, & Kohrman, 1961); as well as sexual exploitation and child sex abuse, before those terms were more prevalent in professional discourse (Addams, 1912; Bagley, 1969; Jehu, Gazan, & Klassen, 1985; Dawson, 1987; Bagley & Thomlison, 1991; Coates, 2010). Conradi, Wherry and Kisiel, clearly link child welfare with mental health concerns (2011).

In the era when social work was becoming more professionalized, and when emotional stress and trauma were identified and described through "hysteria" (Breuer & Freud, 1893), "stress and distress" (Selye, 1936), "acute grief" (Lindeman, 1944), "crisis" and "crisis state" (Parad & Caplan, 1960; Yeager & Roberts, 2015), and similar descriptors, rather than applying the specific clinical label "trauma," social workers were actively helping persons who had experienced overwhelming traumatic situations, contexts, and sequelae (Bagley, 1969; Mengeot, 1982). The depictions included direct and relational trauma (e.g., rape, child abuse, incest, war), or through threat (e.g., family conflict, workplace oppression), or through directly observing or otherwise being made aware of some form of disturbing maltreatment (e.g., children who had observed violent parents, or those who were vicariously traumatized by the maltreatment of residents of institutions such as orphanages or "Indian" Residential Schools).[7] Those in search of beginning professional-theoretical understandings of crises, stress, and trauma had access to clinically significant

observations and working hypotheses (Breuer & Freud, 1893–1895, 1959; Friedlander, 1958; Parad & Caplan, 1960; Bagley, 1966; Kadushin & Martin, 1981; Mengeot, 1982), which have been codified and expanded upon since the 1980s. Social workers were among the societal leaders advocating for social reform and social care for those who were in oppressive situations, who faced overwhelming distress,[8] including those who experienced what came to be labelled as abuse, maltreatment, exploitation, stress, crises, trauma, and complex trauma (e.g., van Dalen, 1989). Some of this work was informed by social work traditions defined as "crisis intervention" (Golan, 1978; Newhill, 1989), as well as an analytic tradition informed by psychoanalysis (Breuer & Freud, 1891; Schneider, 1991), sexual assault-exploitation interventions (Addams, 1912), and family incest (Tormes, 1968; Rank, 1974; Dominelli & McLeod, 1989; Nin, 1992), child abuse amelioration, and family violence (Cork, 1969; Kadushin & Martin, 1981; Crosson-Tower, 2014), including attention to recovery, healing, strengths, and resilience (Harms, 2015).

Themes related to trauma have appeared in statements and writings associated with social work organizations. The Council on Social Work Education in the United States has produced guidelines for social work in the field of trauma practice (CSWE.org); British authors have suggested that trauma work should be an organizing principle for the profession of social work (Joseph & Murphy, 2014); the International Association of Social Workers has made many commentaries on social workers undertaking important crisis and trauma interventions internationally, citing human displacement and human trafficking as key examples (IASSW.org). Some schools of social work offer specialized trauma education such as the National Center for Social Work Trauma Education and Workforce Development (fordham.edu). Volumes dedicated to the scopes of practice of social work include sections on traumatic stress (Corcoran & Roberts, 2015; Regehr & Glancy, 2014). Much evidence supports the conclusion that intervening with and on behalf of highly distressed persons, typically dealing with traumatic situations and experiences, has been part of the scope of social work practice since its beginnings with social workers like Florence Rush (1980) who was a pioneer in work with child sex abuse and advocated defining the child as a victim. Since 1980, trauma assessment and treatment have taken on the status of both more systematic trauma-informed general practice and social care, as well as a specialized practice in social work, sometimes within a high-risk field (e.g., addictions; child abuse) in addressing through assessment and treatment, overwhelming human suffering (e.g., rape; human trafficking) and social injustices, which often signal complex traumas.[9]

Selected Trauma Conceptualizations and their Application

Trauma is a word that refers to a serious wound; it was adapted from medicine, to refer to a psychic-emotional wound or shock, by Breuer and Freud in 1893–1895. The psychosocial impacts of trauma experiences (e.g., sex abuse; violence) and exposure to such situations (e.g., observing violence) were labelled as reflecting "traumatic neuroses" characterized by fears and symptoms of distress (e.g., "dissociation"), which were evident even when the traumatic event or threat was over. After World War II (1945), the notions of "crisis state," "war neurosis," and combat-related "stress" were used as concepts applied in assessment paradigms and various strategies of intervention (Scott, 1990). By the end of the Vietnam war (1975), the immediate and developmental sequelae of a traumatic situation and experience were synthesized as a mental disorder under the label of post-traumatic stress disorder, and those who mirrored similar parallel symptoms based on providing care to those traumatized came to be defined as being "burnt out" or suffering associated with "vicarious trauma" (DSM-III; Boniello, 1990). Today, words with similar denotation, but less emotive loading, such as "operational stress injury" (OSI) rather than PTSD, and "compassion fatigue" rather than "vicarious trauma," may be more acceptable in some military and first-responder contexts, as well as in the helping professions. Additionally, as research and practice wisdom has grown with

regard to trauma assessment and treatment, trauma paradigms have expanded to include heuristic, non-exclusive and overlapping conceptualizations of trauma, dynamic elements, and sequelae, among which are included the themes which follow.

Preverbal trauma: This concept is applied when referring largely to nonverbal presentations of common self-expressed trauma symptoms, often by very young children, signaling trauma experiences and associated sequelae, such as modelling experienced maltreatment and aggression or observed maltreatment and aggression; symptoms of PTSD may be observed in infants, including in the second half of their first year (Gaensbauer, 1995; DSM-5, 2013; Mengeot, 1982). Interventions with children typically include active therapies, such as play therapy and attachment-oriented therapies attending to security and ameliorative social bonds (Webb, 2015; Malchiodi & Crenshaw, 2013; Ford & Courtois, 2013). Children who have experienced severe neglect or abuse "show many PTSD symptoms. . . . the nervous system responds inappropriately, as if severe stressors were present, especially dissociation and hyper-arousal" (Davies, 2011, p. 52); activity and sensory-oriented therapies have been found to moderate some of the neurological maladaptations associated with early trauma (Steele & Malchiodi, 2012; Silberg, 2013; Teicher et al., 2003).[10]

Peritraumatic dissociation: This concept refers to disconnecting, or disassociating from the present, in the sense of the current real time and place, and associating with another timeframe, or unconsciously "numbing" one's senses, or reliving the past trauma in the present. As Marmar, Metzler, and Otte (2004) conclude: "Trauma victims, not uncommonly, will report alterations in the experience of self, time, place and meaning, which confer a sense of unreality to the event as it is occurring" (p. 146). Some of these patterns appear to be related to self-protection and avoidance within the context of overwhelming sensory, emotional, and/or cognitive experiences that are congruent with a real-time trauma, or relatively recent trauma (e.g., "observing" real-time abuse as if it were happening to someone else, sometimes labelled as "depersonalization") and may develop into experiences of loss of awareness of present surroundings (p. 162). Peritraumatic dissociation is often correlated with the later development of PTSD and dissociative identity disorder (Marmar, Metzler, & Otte, 2004; Briere, Scott, & Weathers, 2005; van der Hart et al., 2008). Interventions typically emphasize safe social support, therapeutic support, and security, as well as grounding strategies to get the client connected with "here and now," living in the present, sometimes referred to as "being present"—common with trauma-informed practices. In the beginning of supportive treatment, some more directive therapeutic strategies may be justified and needed in order to stabilize a disturbed and agitated client (e.g., "Please take this chair; please sit!"), and to enable progress towards experiencing stress in present (e.g., "While the loud sounds bother you, they are not threatening here and now," . . . "How can I help you settle, . . . soothe . . . and calm yourself?"), or recollections of the past (e.g., "Let me remind you that you are here with me; . . . your troubling memories do not mean that you are under threat right now! . . . you have the strength to talk about them when you are ready!"), without becoming overwhelmed and resorting to dissociation (Marmar, Metzler, & Otte, 2004, p. 158). Long-term goals often include supporting the development of self-integration, which includes the traumatized self without the sense of a damaged self becoming one's primary identity (e.g., a rape survivor who defines herself as "damaged goods whom no one will want").[11]

Post-traumatic stress disorder: This diagnostic classification refers to multiple, interactive, and often overwhelming symptoms that persist and most often influence varied dimensions of personal and social functioning (e.g., social bonds, cognitive functioning, affect regulation, harmful actions). Symptoms are observable many weeks after the traumatic event is over and no longer an imminent threat.[12] DSM-5 (Washington D.C.: American Psychiatric Association, 2013) symptom sets for PTSD include[13] evidence of exposure to: one or more traumatic experiences, threat of trauma, trauma narratives of significant others, or "extreme exposure to aversive details . . . [or] cues that symbolize or resemble

an aspect of the traumatic events" (e.g., fears of having a bathroom door closed). Among clinically significant "intrusion symptoms" are included "recurrent, involuntary and distressing memories . . . distressing dreams . . . dissociative reactions" such as flashbacks, and adaptations to avoid "external reminders" of traumatic experiences, which often precipitate overwhelming negative emotions. Other clinically significant symptoms are articulated as: "negative alterations" of cognitions (e.g., unjustified negative self references) and "problems with concentration"; negative affect (e.g., justified fear of bedrooms) and "inability to experience positive emotions" (e.g., loss of feelings for positive social bonds); as well as related negative or otherwise compromised behaviors (e.g., "reckless or self-destructive behavior"); all "beginning or worsening after the traumatic event(s)." At the level of posttrauma, alterations in behaviors are clinically significant action patterns, among which are included: persistent dysregulation[14] issues with anger and aggression (e.g., fear-based aggression to purposely socially distance others); high risk self-destructive behavior (e.g., addictions); "hypervigilance" (e.g., excessive and unjustified caution when with persons who are relatively likely to be safe); "exaggerated startle response" (e.g., to normative-range sounds of a non-threatening person near a door); and "sleep disturbances" (e.g., fear of falling asleep, while desiring sleep). Children may model behavior that parallels their trauma experiences and the meaning they assign to the trauma and associated sequelae (e.g., urinating on a toy and claiming it is "just like when daddy peed milk on me"). Besides application of common interpersonal relational factors in treatment, building, and sustaining a client's trust are needed in order to assess and process how the trauma of the past, metaphorically, still "lives " through its influence in the present. Integration of multiple intervention theories: concrete and directive, dynamic and emotive, relational and psychosexual, self-integrating and respecting multiple identities, and behavioral, may be needed (Schore & Schore, 2008; Briere & Scott, 2015), as well as systemic changes (e.g., removing an alleged perpetrator from a home or school). Children often require active assessment and treatment (e.g., play therapy; music therapy; art therapy; dance therapy; outdoor or sports activity).

PTSD—limitations in application with children: While childhood trauma has been studied at least since the analytic report on the patterns of expression of "war children," by Freud and Burlingham (1943), the study of childhood psychic trauma has received more ongoing attention, since symptoms were described by Lenore Terr (1981, 1983) in her studies of children involved in a school bus kidnapping. However, there remain significant gaps concerning the connection between trauma symptoms, diagnosis of PTSD, and developmentally appropriate interventions. Researchers and clinicians have raised concerns that DSM diagnostic criteria for PTSD, developed based on data for patients aged 15 years and older, do not adequately take into account developmental considerations (Teicher et al., 2003; van der Kolk, 2005; Pynoos et al., 2009; van der Kolk et al., 2009; De Young, Kenardy, & Cobham, 2011; Sheeringa et al., 2011; Blom & Oberink, 2012). Significant efforts were made to have these concerns addressed prior to the completion of DSM-5 in 2013, with proposals for the inclusion of a developmentally appropriate diagnosis for childhood trauma. These efforts were unsuccessful; the current criterion for diagnosis of PTSD in DSM-5 mostly ignores experiences of disruptions in attachment relationships, which can lead to some of the most complicated trauma-related symptoms and sequelae, including dissociation and affect dysregulation (Schore & Schore, 2008; McDonald et al., 2014). Additionally, the accumulation of traumatic experiences in childhood could result in unique symptoms beyond and/or separate from symptoms of PTSD (McDonald et al., 2014). PTSD criteria do not sufficiently address the symptom presentation of children and adolescents with complex trauma histories (Schmid, Petermann, & Fegert, 2013; McDonald et al., 2014). In fact, many stressful childhood experiences may not qualify as reflecting a traumatic disorder, based on application of DSM-5 criteria, and thus erroneous assessments or underdiagnoses are a risk (McDonald et al., 2014). Many examples of lack of fit for children and youth with formally accepted disorders criteria

are evident within developmentally specific presentations in children and adolescents, of trauma and complex trauma and biopsychosocial sequelae.

C*omplex trauma*: This assessment and treatment framework, described as *cumulative trauma* in 1982 by one social worker (Mengeot)[15] congruent with much social work practice in the 20th century (e.g., children's protection, family violence, rape, war), refers largely to multiple, repeated, most often interpersonal, or otherwise compounding and interactive exposures to one type of trauma (e.g., incestuous sex abuse) or diverse traumatic events (e.g., physical abuse, emotional abuse, sexual abuse, exploitation, failures to protect, and neglect, such as with human trafficking). These experiences, interacting with impacts and developmental sequelae, often occur over clinically significant and multiple time periods, associated with converging harmful and interactive sequelae (e.g., dissociation, substance abuse, and concurrent disorders). It would not be uncommon that there would be some chronicity, including interactions with clinically significant compromises in attachments (e.g., disinhibited attachments), emotional dysregulation (e.g., numbing) and negative identity transformation (e.g., "boy-toy"; "daddy's little whore")—including unstable or disintegrated identity. For some, there are also persistent traumatic threats, even during periods when traumatic events cease being perpetrated (e.g., daily threats of sibling rape, or partner rape; daily threats of maltreatment or vicarious trauma [secondary trauma] in Indian Residential Schools).

Complex trauma conceptually and dynamically brings with it compromised attachments and bonds, often based on the clinically significant relational aspects of the trauma. The interpersonal dynamics of violation of trust, and engendering distrust, are among the most damaging effects of relational maltreatment, which complicates the child's ability to respond to treatment, as the needed therapeutic support is itself based on potentially healing relational dynamics. Treatment of childhood trauma requires a safe therapeutic relationship, aimed at reestablishing physical, psychological, relational, and situational safety within which to process the child's traumatic experiences and how they have compromised biopsychosocial development, whether framed as vulnerabilities or resiliences (Schore & Schore, 2008). Al Krenawi and Kimberley (2015) have supported the likelihood that appreciating the dynamic interplay among trauma effects, trauma sequelae, *and* associated resilient adaptations and maladaptations, are in the best interests of helping those living in trauma, rather than *either* a trauma focus *or* a resilience focus.

As well, children's response to trauma and to interventions to treat the trauma are mediated through their age and stage of development as it unfolds or is compromised by trauma, physically, cognitively, emotionally, and socially, often while living within a family system (Shaw, 2003). Clinicians working with children who have experienced trauma must do so with the support of trauma-informed organizational and intervention systems, enabling developmentally appropriate interventions as the child's developmental path is also compromised. Knowledge and practice wisdom are required for integrating social workers' understanding of trauma and developmental interactions, with children's meanings as ascribed to the role of trauma and complex trauma in a child's expressions of psychopathology, thereby serving to ameliorate sequelae (e.g., disorganized attachment) and prevent compounding sequelae (e.g., affect dysregulation), while supporting pathways for normative development (Schore & Schore, 2008).

Complex trauma theory has been welcomed by social workers as an iteration that transcends some of the limitations of the narrower PTSD classification, and respects more the complex interactions, and difficult paths to recovery, healing, and thriving, faced by too many social work clients. The reader should recognize that a significant amount of the professional scholarship arose out of concern that the limited boundaries of PTSD diagnoses did not serve maltreated children and youth well (Steele & Malchiodi, 2012; Ford & Courtois, 2013). In current practice, "complex trauma" is also applied to adults whose life experience, personal and social functioning, attachments, relational patterns, affect regulation, and sense of self have been altered by multiple experiences of trauma influencing compounded and interactive sequelae (Courtois

& Ford, 2009). Courtois and Ford (2009, p. 2) alert us to the seriousness in the following conclusion: "Core problems in need of treatment include affect dysregulation, structural dissociation, somatic dysregulation, impaired self-concept and self-development, and disorganized attachment patterns, *in addition to* symptoms of PTSD and any other associated conditions and comorbidities." Of interest to some social workers are the themes of "spiritual alienation" (Courtois & Ford, 2009, p. 1) and existential issues such as chronic feelings of emptiness and isolation, and self or existence being defined as hopeless (Briere & Scott, 2015, pp. 7, 107).[16] The authors are familiar with moments where clients define unbearable and unresolved trauma, often the case in complex trauma and relational trauma, as "soul death."

Relational trauma,[17] often considered an expression of complex trauma (Schore, 2013), refers largely to trauma perpetrated in interpersonal relationships where the perpetrator is known and is in a position of both trust and power. Relational trauma may include sexual traumas, which could compound compromises to neurological development and attachment and bonding capacities of the child and youth. Relational damage, including physical and emotional neglect, is often associated with significant neurological alterations, which may be somewhat modified through active-experiential interventions, but may be expressed in adult years as compromising interpersonal relationship patterns, which often include intimacy and sexual expression (Crosson--Tower, 2015; Davies, 2011, 2015; Maltz, 1991). In children who have been sexually abused, an additional complex outcome might be age-stage premature eroticization and sexualization where the child defines typically normative social bonds in a maladaptive and sexualized-eroticized manner (Kimberley, 2012). Relational traumas have been found to have deep roots, which include neurobiological changes associated with personality development, dissociation, and interpersonal dynamics, including compromised attachments, which in turn interact with affect regulation and relationship dynamics, going forward (Steele, van der Hart, & Nijenhuis, 2005; Schore & Schore, 2008; Schore, 2013). Attachments may not only be insecure and disorganized, but may contribute to disinhibited social engagement patterns associated with significantly insufficient care and neglect; of special concern to social workers is that these patterns and risks may persist, "even in children whose caregiving environment become markedly improved" (DSM-5, pp. 268–270).[18]

Creating an active, safe, secure interpersonal social environment and interpersonal relationship rebuilding (e.g., family, foster family, supportive social work treatment) enables the client to stabilize sufficiently to reflect on living in trauma (processed with children as activities). This secure interpersonal base supports the client in working through strong emotions and increasing the capacity for their regulation, in an adaptive fashion, without being rushed or overwhelmed. Continued progress includes neither denying nor otherwise distorting the traumatic experiences, allowing the person to get on with their lives and thrive while not ignoring lasting impacts—in effect, strengthening adaptive affect regulation and social bonds.

The leaning in treatment is to enable an alliance of the client with supportive familial figures who are safe, and in a secure relationship with the social worker which acts as a relational model, which may enable the child, teen, or adult to undertake some developmental work with respect to attachments and social bonding, as well as with emotional processing. The pace, place, and dynamics of positive relational adaptations may benefit from experiential and sensory therapeutic strategies, including active therapies informed by neurobiological development considerations (Schore & Schore, 2008; Schore, 2013; Steele & Malchodi, 2012)

Developmental trauma[19] refers largely to sequelae of traumatic experiences, most often complex trauma, which compromise biopsychosocial development throughout the life cycle, including in lag time, but sometimes beginning as early as the notion is that maternal trauma impacts the child from fetus to as an adolescent (Yehuda, Halligan, & Brierer, 2001; Schore, 2013; Silberg, 2013). Schore (2013; p. 10) adds that there is a "strong link between dissociative-like maternal behavior and disorganized infant attachment", supporting the concerns of social workers with transgenerational issues associated with trauma (Al

Krenawi & Kimberley, 2015; Cohen, Hien & Batchelder, 2008). At the biological level Schore (2013, pp. 4–5) articulates as an "interpersonal neurobiological" model of child development which acknowledges the influence of traumatic relationships in compromising child development, he adds: "It is now clear that the developing brain is not 'resilient' but 'malleable' and that 'relational trauma impacts the developmental trajectory." Trauma affects brain development, and both the traumatic experience and the changes in the brain influence emotional attachment dynamics; caregivers' actions or the lack thereof impact both the patterns of attachment and amelioration of damage. The development of desired affect regulation capacities is compromised by the dysregulation of affective states, with one outcome being numbing and shutting down emotionally, dissociation being one example; at the other end of the spectrum, hyperarousal associated with hypervigilance, as another example. The therapeutic milieu may be used to enable adaptive progress that addresses age-stage appropriate developmental stages, with due sensitivity to the fact that neurobiological processes have altered the brain and may require some experiential therapy activities as well as attention to emotional development.

Within a broader context of complex trauma, one likely outcome of developmental traumas is alterations in the identity of the traumatized person (Courtois & Ford, 2013). In contexts of interpersonal maltreatment from trusted persons, a relational trauma theme, the relational aspects of identity are likely to be distorted ("How can I be Daddy's little girl and Daddy's 'sexy thing' at the same time?"). Ameliorative treatment may take place as part of trauma-informed treatment in general practice (e.g., creating safe and accepting environments and not overwhelming the client); more focused practice such as trauma-informed child protection or addictions services (e.g., processing how addiction risks and trauma sequelae interact); highly specialized trauma treatment in dedicated trauma programs (e.g., complex trauma play therapy in children's mental health; complex trauma group therapy for Indian Residential School survivors).

Cultural traumas and *historical traumas* are those associated with actions of collective threat and trauma aimed at genocide, eroding culture, and altering individual and collective identity, such as the impacts of Indian Residential Schools (Alexander, 2004). These collective traumas may be conceptualized as historical traumas or political traumas (Al Krenawi & Kimberley, 2015), which have been experienced transgenerationally and are cumulative in the pervasiveness of impact (Palestinian isolation in Gaza; "Indian Residential School syndrome"). These notions of trauma fall within the semantic field of prolonged exposure to multiple traumas—often transgenerationally. Social workers have worked with: individuals as children exposed to traumas in such cultural-historical contexts (e.g., being forced to watch others being beaten or murdered); families where parents are unjustifiably separated from their children (e.g., detaining children and young teens for long periods without cause); communities (e.g., the loss of community identity when there is forced relocation; communities where members anticipate perpetual traumas, to be processed through complex traumas and their sequelae); and societies (e.g., in truth and reconciliation processes). The authors have found that such levels of complexities of trauma as lived transgenerationally require a combination of skills in individual, family, group, and community interventions, with due respect to age and stage, which can create pathways to process collective trauma and diverse personal experiences of those traumas within the cultural, historical, political, and religious-spiritual contexts of those at risk (Al Krenawi & Kimberley, 2013; Al Krenawi & Kimberley, 2015).

Other terms that have been posited that make trauma assumptions and have meaning to many social work clients include: "battered woman syndrome," which refers to a pattern, typically of multiple traumas, associated with repeated partner abuse, with compounded negative post-trauma effects; similarly "rape trauma syndrome" (Burgess & Holmstrom, 1974), which places rape in the semantic field of trauma concepts; and "Residential School Syndrome," which has come to be used to signal the range of traumas found in Indian Residential Schools survivors. It is beyond the scope of this analysis to develop each of these themes in its own right. Most of the treatment skills required for

trauma-informed practice and complex trauma treatment have been adapted to these areas. The group treatment literature is especially rich to enable mutual aid for each of these groups.

The semantic field of trauma as applied in social work and trauma-informed practice may benefit from understanding and applying a wide range of trauma concepts and integrated therapies, which signal justified concerns for informed professional awareness, comprehensive assessment, and opportunities for supportive interventions, including an appreciation for common and diverse adaptive capacities (e.g., strengths, resilience, potential) and maladaptive patterns (e.g., pathology, deviance, and compromised personal and social functioning). As well, Al Krenawi and Kimberley (2015) and Harms (2015) discuss the dynamic interplay of trauma pathology and trauma resilience; integrative approaches promote "both-and" thinking as opposed to rushing to premature "either-or" conclusions.

Trauma-Informed Practices

A strong case has been made that social workers and allied human service providers develop the knowledge and skills associated with trauma assessment and early intervention, which would be wise to apply in competent general practice as well as within more specialized practices (Knight, 2015; Steele & Malchiodi, 2012). When children, youth, and adults are assessed and treated in health systems, mental health systems, justice systems, education systems, disability supports, services for the aged, supports for the homeless, victim services, aboriginal services, and other forms of social care, assessments too often neglect undertaking trauma-informed assessments; they often reduce clinical attention to narrow foci (e.g., addictions). In health services, for example, maternal health may be addressed without reference to impacts of partner violence on a pregnant woman who has experienced traumatic situations, or to the developmental impacts of maternal trauma on the fetus (Yehuda, Halligan, & Brierer, 2001; O'Connor, Heron, Golding, & Glover, 2003). In mental health systems, men may be assessed as having "addictive disorders" and women as having "personality disorders" when an overarching childhood sexual trauma has not been explored and complex trauma effects have not been addressed adequately. In addiction services, focus on the patterns of substance use or non-chemical addictions often fail to integrate the interaction of addictions and trauma (Dayton, 2000). Justice systems may focus on an offender's misbehaviors without considering the depth of relational trauma associated with clinically significant patterns, including, but not limited to, impulse control, anger, aggression, and violence (Carlson & Shafer, 2010). In contrast, victim services may define the targeted partner as needing to be more assertive and "make better decisions about violent partners," without linking low self-confidence and compromised decision-making to repeated traumatic experiences, including complex trauma sequelae. Education systems are known for their focus on the school environment and academic-performance-related behaviors, without considering that a child may arrive at school with PTSD symptoms that mirror attention-deficit (e.g., dissociation would increase inattention), or that the child may experience sequelae such as hypervigilance, social withdrawal, and attempted suicide associated with traumatic experiences and threats, such as school-based bullying. Persons who are disabled are at high risk for maltreatment associated with trauma, and their symptoms are often misassessed as indicators of cognitive-developmental challenges, and their trauma experiences and sequelae may be dismissed. Services for the aged are sensitive to elder-abuse risks but may not consider PTSD associated with war trauma where the incidents were experienced three to five decades ago (Boscarino, 2006). Homeless persons are over-represented by those who have experienced trauma and evidence clinically significant trauma effects that are not addressed; organizational and service sensitivity is proposed, starting with an organizational review applying the "Trauma Informed Organizational Toolkit for Homeless Services" (familyhomelessness.org). When faced with Aboriginal persons with concurrent mental health risks (e.g., depression and suicidal ideation) and addiction risks (e.g., alcohol and solvents), the concurrent disorder is often treated in isolation from complex trauma, historical trauma, cultural

trauma, residential school syndrome, and "intergenerational" trauma, all of which are likely to converge on transgenerational trauma effects. With military and first-responder services there may be a culture of acknowledging the PTSD or operational stress injury (OSI), or compassion fatigue-vicarious trauma risks, but the pervasiveness of complex trauma symptoms and compromises in social functioning outside of the workplace, such as co-parenting, may be minimized at best, and denied at worst (Rubin, Weiss, & Coll, 2012). The case for social work, as a trauma-contextualized practice profession, having a responsibility to provide trauma-informed services is difficult to refute.

In considering integrating trauma work, the following statement by Knight (2015, p. 25) provides a grounding synthesis:

> The social worker neither ignores nor dwells exclusively on the past trauma. Rather trauma-informed practitioners are sensitive to ways in which the client's current difficulties can be understood in the context of the past trauma. Further, they validate and normalize the client's experiences. Trauma-informed practice requires the practitioner to understand how the working alliance, itself, can be used to address the long term effects of the trauma. Emphasis is placed on helping survivors understand how their past influences the present and on empowering them to manage their present lives more effectively, using the core skills of social work practice.

Among *core skills*, framed in terms of trauma-informed social work, are included the following skill sets.[20]

Creating and Sustaining Safety: Relationship Building, Engagement, and Living in the Moment

Engaging the client and building a relationship where the client and the social worker enter into an alliance, *short term* (e.g., intake and screening) or *longer term* (e.g., victim services) take on enhanced meaning in trauma-informed practice. Given that clients who have experienced trauma and post-trauma effects often evidence hypervigilance associated with anxiety, changes in neuropsychological structures and neurosocial processes, insecurity and distrust, often compounded by compromised capacities to form and sustain healthy attachments and amplified by shame and embarrassment, thwart disclosure, thus significant effort must be focused on creating:

- physical, emotional, and relational safety with due respect to optimal comfort of space and place (e.g., an office or in vivo environment, or the types of art or posters with information that are on a wall);
- safety and comfort in the use of an interview or observation space, such as creating a safe distance, as well as reaching for a comforting-supportive distance;
- safety in therapeutic practice, including the use of age-stage congruent language (e.g., the use of the words like "wife battering," "battered woman," or "victim," may be alienating to some)[21];
- safety in time and timing of social worker's comments and depth of exploration (e.g., moving at the client's pace and not overwhelming the client)[22];
- reinforcing safety by expressing non-threatening and boundary-respecting warmth, grounding in the present, and enabling comfort;
- tuning into, and reaching into silences in supportive ways that enable trauma secrets and associated emotions to be articulated as well as engaged with more security and stability (e.g., the guilt of child sex abuse and early eroticization; the shame of rape);
- using the helping relationship to enable the client to choose to move closer and to withdraw, thus, in real time, testing her/his thoughts, sensations, feelings, actions, and relational patterns as she/he evaluates safety, trust, trustworthiness, and receiving social-emotional support while also being accepted, despite having rejected support opportunities when feeling less safe—whether empirically justified or not.

Empathy and Affirmation

Beginning where the client is, evidencing empathetic understanding, and not only listening actively but affirming the client's trauma as lived and narrated[23] ("Being sexually abused by your foster mom and foster dad seems to have

made you feel both very insecure and alone [pause]: What words would you use?") signals accurate and client-centered empathy, which is significant because perpetrators often use narcissistic and strategic empathy to manipulate victims. Also, the social worker would affirm and normalize client adaptations of strength and resilience ("It appears that you have focused on doing very well in school . . . "), while paradoxically affirming and normalizing maladaptive patterns ("It makes sense that you would think it odd for you to have problems concentrating in class even though you like the subject and the instructor. . . . When you are ready, we can look at how disconnecting from the present can be normal for teens who have experienced trauma"). It is also important for the social worker, with due respect to client readiness, to not deny or minimize adaptations that may signal risk, harm, developmental harm, as well as "pathology" or "deviance" (e.g., "What concerns me most right now is how flashbacks, nightmares, and generally interrupted sleep get in the way of you being alert and focused in your work term . . . your re-experience of your trauma, as if living in your present, is to be expected"). With children, the social worker may try to verbalize nonverbal active therapy expressions as messages, including embedded empathy, such as "Your picture" (in play reflecting experiential and sensory methods that address neurological changes and affect regulation issues, associated with trauma) "looks like it has a scary face; I would like to understand more about it." The social worker may judge certain traumatic experiences and developmental sequelae as evidence of vulnerability. Empathetic understanding of the client's path of healing, as a victim and as a survivor, reflecting a strength of spirit and positive potential, must also be acknowledged while not denying harm and imminent risks. Reflecting both vulnerability and resilience signals an appreciation of the felt reality of many clients experiencing the dynamic interplay among resilience (strengths) and vulnerability (threats and impacts) as well as potential (James, 1994; Harms, 2015; Al Krenawi & Kimberley, 2015). As one young adult who was treated by professionals as if she was only "strong" and "resilient," sternly quipped: "MY RESILIENCE RUNS THIN." She was not feeling the empathy for her suffering, vulnerabilities, or challenges, while she did appreciate, and was not denying, her strengths and healing.

Staying with the Client While Challenging and Pushing the Edges of Comfort Zones

An alliance of increased trust permits the social worker to use her relational strengths to refer the client either for more advanced trauma treatment, or for more sustained trauma treatment integrated services. Sustained trust may influence growth in the client–worker alliance (e.g., achieving optimal trust), empowerment of client personal and social functioning (e.g., reducing indiscriminate attachment risks), or in reducing risks in the client's social situations (e.g., not returning to an increasingly violent and retraumatizing relationship), through challenging the client in a respect for, supportive, emotionally congruent, and timely manner, with due respect for trauma-compromised cognitive functioning. Pushing the edges of sensory and emotional comfort zones, without overwhelming the client, is an important skill in trauma work, especially given that most clients feel overwhelmed by the trauma and the tasks of linking traumas to: biological functioning (e.g., neuropsychological restructuring), psychological functioning (e.g., high anxiety), social functioning (e.g., attachment challenges), and spiritual connection (e.g., reaching for meaning in life; trusting a higher power). Pushing edges of comfort also supports focusing on sensitive issues where negative and positive factors converge with dimensions of personal and social functioning, such as addictions or concurrent disorders. Insight and reframing challenges may enable exploration of new understandings (e.g., knowledge about dissociation which transcends the notion of "just zoning out"), to develop new skills (e.g., self-grounding by looking at one's watch and getting in touch with oneself in the moment), and to create paths of healing and growth through new discovery and wisdom combined with existing strengths (e.g., "dissociation may be both a strength and a vulnerability . . . it is normal and may be exaggerated in people who have experienced trauma, and you could learn to manage it with less fear

and more confidence"). Supporting enough comfort to process intense emotions without dissociating, or otherwise avoiding thoughts and feelings that one wishes to manage better, is one treatment outcome expected.

One of the frustrations in trauma work, especially when interacting with patterns of self-expression associated with persons diagnosed with "personality disorders," is that the client may become "stuck" (fixated) and have a difficult time sustaining progress, and may even regress (e.g., in dynamic terms) or may "relapse" (e.g., in behavioral terms). Staying with the client while staying present and grounded implies more demands on the flexibility and adaptability of the social worker. Treatment may further contextualize the latter in terms of modelling flexibility and adaptability as part of the use of self to enable the client to test out different aspects of him/herself, in the here-and-now time frame of the process of receiving help, including learning to be flexible and adaptive and regulate affect in a relatively secure and stable manner.

Linking the Trauma and Its Sequela to Presenting Problems and Felt Concerns

It is not uncommon for clients' presenting concerns to not include complaints regarding past traumas and their sequelae. Some may consciously avoid talking about the past and believe that they can "just forget the past and get on with" their lives; they may have to be educated in the reality that trauma issues such as terrifying dreams, memories, insecurities, dissociation, and maladaptive patterns may appear or reappear in lag time. Also, a current, relatively minor cue stimulus (e.g., seeing someone who resembles a past partner from a violent marriage), or a real but lesser trauma in the present (e.g., observing a child being spanked in a mall) may trigger an exaggerated emotional response associated with the client's own traumatic experiences and sequelae from decades past. As well, the client probably expresses herself with both adaptive and maladaptive patterns of affect, thought, behavior, relational patterns, situational reactivity, and motivational patterns for which she may have little current awareness of associations with past traumas. As the client shares even hints of past trauma, the social worker has an opportunity to explore, reach deeper, "tune in" to affect, and assess the potential links with current personal and social functioning. The links may be interpreted through simple reframes (e.g., "Have you considered that your expressed fear of your nine-year-old male child, when you try to direct him, may be related to your maltreatment and sense of powerlessness at the hands of your first husband—his father?"). The links between the past traumas and current personal and social functioning may unfold as more complex and mutually interactive, as reflected in the following case, which included a developmental history of compounding sequelae of complex trauma.[24]

Case Example

T, a 29-year-old married woman with two children under the age of 12, and an employed husband, self-referred to addiction services, expressing concerns associated with alcohol abuse, the misuse of prescription medications, "doctor shopping," "being hooked" on cola drinks, and having "problems sleeping." She agreed to try an addictions group for women, with individual therapy in parallel. T's presentation of herself as being very distrustful, hypervigilant, reactive to abrupt and unexpected noises, "zoning out" (dissociation), and complaining of chronic nightmares, during treatment, led the social worker to carefully explore trauma links. T gave the therapist a natural opening in an individual session when she stated, "Just like G. in our girls group, I can't block out the past and I should be able to . . . my husband and my kids love me."

The social worker interpreted: "It's not unusual that *people* who have had some emotional shock earlier in their lives relive some of the overwhelming feelings in the present. They may even have bad dreams that remind them of the past, or see events in the present that may bring them back to past; *you* might have even experienced reliving, in your mind and feelings, past experiences that you believe to be true—even when you are not completely certain."

The strategic transition from "people" to "you" enabled the client, slowly with many silent pauses, to summarize a life of multiple directly experienced traumas, vicarious traumas and threats of abuse (sexual,

physical, emotional), over 23 years, with compounding effects reflected at various levels[25]:

- Biological levels (e.g., numbing of body sensations in her arms, as her first sexual perpetrator caressed her arms when he groomed her as a ten-year-old; dissociation and hypervigilance[26]);
- Emotional levels (e.g., exceptionally high anxiety-insecurity, and problems with affect regulation and quickly feeling overwhelmed ["panicky"] even in current secure contexts; immobilizing depression and irritability, even though she now had much of what she "hoped for" in life);
- Cognitive levels (e.g., dissociation[27] and issues with memory, attention-concentration, reasoning, decision making, and insight [comprehension], confirming a self-identity of "scatter brain . . . can't decide a thing . . . can't understand me," and suicidal thoughts);
- Relational levels (e.g., attachment difficulties, especially with her male child; avoiding the closeness she desired with her husband—described as a "patient and gentle" person; having a sense of "belonging to no one" and having "no place to belong" . . . a definition of alcohol as "my best friend ever");
- Sexual expression levels (e.g., defining herself as having sex interest but feeling strong guilt and shame because she was "Daddy's sexy thing . . . even my brud hit on me");
- Developmental levels (e.g., compromised sexual development and adult sexual functioning; disorganized attachment and bonding; resilience with a presentation of self as stable, under conditions of duress);
- The level of identity (e.g., presenting with high self-confidence in social contexts such as her children's school, but perceiving herself as low in self-worth and as a failure as a partner and mother; disintegrated identity compounded by dissociation—"Like there is the real me, the addicted me and the zoned-out me");
- Motivational levels (e.g.,"too much need" to relieve emotional discomfort and distress with drugs, juxtaposed with courage, strength, and desire to change—"now . . . before I lose my family");
- Behavioral levels (e.g., self-medication; agitation associated with both fear and anger; strong avoidance of social exposure and social bonds);
- Situational levels (T feared the loss of her husband and children, and "never being able to hold down a job" if she "did not get her brain straight" and get her misuse of substances under control).

After learning more about past and recent traumas and how they converged with her life challenges in the present, and after acknowledging her resiliences, strengths, and vulnerabilities, T and her social worker decided to: 1. deal with the addiction issues primarily in the women's group; 2. to integrate the addictions treatment with trauma treatment by having an addictions worker who was a trained trauma specialist join both of them in the individual work, and then take over the individual work when the client was ready.

The addictions treatment unit in the above case applied trauma-informed principles; the social worker had had some trauma treatment training and access to a contract trauma specialist. All faced the complex trauma and addictions in an integrated fashion as opposed to working on each sequentially—as recommended in concurrent disorder treatment (Kimberley & Osmond, 2010). The client's treatment included themes of integrative therapy, trauma-informed practice, complex trauma, and concurrent disorder. Complex trauma work typically does not benefit from short-term therapies, which are more suitable for crises and peritraumatic contexts.[28]

Conclusions

Before the professionalization of social work and psychology practice, in the early days of psychoanalysis, the arts represented psychosocial distress and challenges to personal and social functioning in some of their depictions. Many cultures created ways and means for the pursuit of knowledge and wisdom that led some to profess insight into life's overwhelming challenges, which caused psychic injury that left scars, much as would a physical injury. Religions and philosophies dealt with mindful pain and suffering as part of the human condition; they offered a range of spiritual supports and prescriptions, including celebration of the strengths of the human spirit.

Psychoanalysis attended to understanding the internal dynamics of persons and collectives and unconscious as well as conscious distress; the mutual and reciprocal positive and negative influences of social relationships; problems, risks, and needs arising out of what were defined as traumatic situations, traumatic experiences, and traumatic sequelae described in terms of stressors, overwhelming personal

distress, and subsequent personal challenges, including fundamental changes in personality. While many persons managed their own challenges or used informal social support, analysts developed relational approaches to treatment to enable self-reflection, to raise self-awareness, and to help persons and collectives reflect on overwhelming challenges, their adaptations and maladaptations, in their social contexts.

Suffering, trauma, and human agency themes made sense to early social workers who observed a range of personal and collective struggles, both private and public, throughout the life cycle and within contextualized historical situations. For over 100 years, social workers have contributed to the understanding of stressful and traumatic situations, traumatic experiences, traumatic sequelae, and supports for healing, recovery, growth, human potential, and supportive systemic change. Combining language from social discourse across eras, social workers have been attentive to life's challenges and traumatic events and have been active in preventing suffering and ameliorating distress and the impacts of overwhelming distress—reflected in trauma theory and complex trauma practices. Social workers can take pride in the claim that social work is a trauma-oriented profession with knowledge and skills to offer trauma-informed practice and trauma treatment, with cumulative and complex traumas, as well as social action in preventing the oppressions of preventable traumas.

This chapter is dedicated to those who suffered in painful silence and who rose and taught us so much when they invited us to join them on their path of pain, healing and resilience.

Notes

1. One of the intentions of this analysis is to integrate information about trauma concepts and theory, in discussions about traumatic events, impacts on clients, and trauma contexts of practice that have been, and are reflective of, social work practice situations and dynamics in both general practice (e.g., family support clinical), specialty practice (e.g., addictions), and trauma practice (e.g., trauma centers; rape crisis centers; critical stress programs). Case examples are based on diverse social work cases and are neither intended as biased statements against any minority, nor as selective exclusions of any oppressed minority.
2. Renowned trauma psychiatrist Judith Herman reflected (1992, p. 19) that one of Breuer's analysands, Bertha Pappenheim, in early 1900s Germany, "became a prominent feminist social worker, intellectual, and organizer . . . to campaign against the exploitation of women and children." Also, of interest is that Professor Emerita Sophie Freud, Sigmund's granddaughter, became a highly respected clinical social worker and social work educator. Sigmund's daughter Anna Freud, with Dorothy Burlingham (1943), also wrote about children who had experienced war trauma, and they described symptoms that today would fall under the label "dissociation" and acting out the trauma in play. See also Pappenheim (1924).
3. See, for example, Burgess and Holmstrom, 1974; Ehrenkranz et al., 1989.
4. While trauma, stress, and post-trauma sequelae such as hysterical neuroses, asthenic personality, depersonalization neuroses, and adjustment reactions were expressed in DSM-II (Washington, D.C.: American Psychiatric Association, 1968), the synthesis of some aspects of these patterns within the bounds of the classification PTSD appeared in the DSM-III (Washington, D.C.: American Psychiatric Association, 1980); that edition as well as DSM-IIIR and DSM-IV had significant social work input from Dr. J. B. W. Williams, Professor Emeritus of Clinical Psychiatric Social Work, Columbia University, and other social workers. One socio-political context of including PTSD in the DSM was post–Vietnam War politics and the desire to include observable phenomena that had been denoted by the termed "war neurosis" (Scott, 1990) within a sanctioned diagnostic classification. The PTSD codification came to be used to better respect the overwhelming struggles of battered children, battered women, victims-survivors of rape, and distressed first responders. Application of trauma theory and practice wisdom was expanded to respect the complexities of trauma and sequelae as experienced and expressed by many social work clients (Mengeot, 1982; Courtois and Ford, 2009).
5. One summary of the social, political, and clinical history of the development of trauma theory and the treatment of trauma is offered by Judith Herman (1992). Wilson and Keane (2004) also place PTSD and early complex trauma thinking in historical contexts: pp. 1–44.
6. The work of Franklin was significant in that it enabled social workers and policy makers to balance the rights of the parents and the rights of the child in situational context. It challenged the relative importance of blood relationships and family preservation in cases of intrafamilial sex abuse, based on the needs and rights of the child as victim.

7. Persons who have been residents of "total institutions" (Goffman, 1961), including venues such as orphanages and mental hospitals, where many social workers have provided services, are at high risk for maltreatment trauma and posttrauma effects, as reflected in current investigations of impacts of Indian Residential School syndrome.
8. As some stress is perceived to be positive and supportive of adaptation, distress may signal the expressions of stress associated with sickness and pathology. Selye, the father of stress theory as applied in biology and then adapted to psychiatry and social work (Rapoport, 1962) predicted many of the patterns that have been associated with trauma, PTSD, and complex trauma (Selye, 1936; Grinker & Spiegel, 1945).
9. Of 159 entries in the *Social Worker's Desk Reference* by Corcoran and Roberts (2015) over 20 address traumatic contexts, trauma-informed social work, trauma-related disorders (e.g., dissociation), and forensic social work in fields of practice over-represented by those who live with trauma effects.
10. Some significant study has been undertaken to better understand the developmental impacts of maternal traumatic experience, as well as prenatal stressful environments, on the biopsychosocial development of the fetus. An analysis of this significant work is not the focus of this chapter.
11. It is beyond the scope of this chapter to expand on the assessment and treatment of dissociative identity disorder. Social workers wishing to specialize in trauma assessment and treatment are encouraged to gain more knowledge and skills for helping those managing more than two identities. It is also important to consider that persons diagnosed with personality disorders are over-represented among those who experience PTSD and dissociation (DSM-5, p. 279 and p. 665). Briere and Scott, 2015, p. 55, conclude: "Borderline personality traits may be largely posttraumatic in nature."
12. Persistent and disturbing symptoms may appear in lag-time, many months or even years, after the traumatic events and situations. Past traumas may not be presenting problems: mental health (e.g., depression), addictions (e.g., prescription and street drugs), and relational issues (e.g., intimacy and sexual expression) have ascendency, sometimes all converging, as presenting problems. Some scholarship posits that the use and abuse of substances in persons living with posttrauma effects are at least partially motivated by the desire to avoid thoughts and feelings associated with traumatic events.
13. This section reflects reduced and paraphrased material, integrating short quotes, from 309.81, pp. 271–274, DSM-5, 201[2013 is correct]
14. In social work practice, assessments of personal and social functioning may consider the paradox of justified and functional aspects of repeated and apparently maladaptive thought and patterns of self-expression, as well as unconscious patterns associated with trauma and human development.
15. Mengeot (1982) was a British social worker who adapted the psychoanalytic thinking of M. R. Khan, 1963, to her social work thinking about early trauma.
16. For a fuller exploration of trauma as part of the human condition, existential contexts of trauma, existence in trauma, and relational aspects of trauma, including those living in trauma (versus with trauma) and healing, or not, through human existence in relationship, see Stolorow, 2007.
17. Within the context of child abuse, Kadushin and Martin (1981) reflected on the interpersonal relational aspect of child abuse in their application of the theme that child abuse is interactional.
18. Anna Freud and Dorothy Burlingham (1944) described these patterns, and declared that some of the disinhibited expressions of children in need of family attachments were sexualized—as observed in their work with institutionalized children. Minti and Pattinson, 1994, made the case that emotional and physical neglect, independent of poverty, must be given more clinical significance in child abuse interventions by social workers.
19. Schmid, Peterman and Fegert (2013) explored the pros and cons of defining this class within a diagnostic term, "developmental trauma disorder."
20. For discussions of practice skills and common practices in counselling and therapy, the reader is referred to Shulman, 2012, and Sprenkle, Davis, and LeBow, 2009. Briere and Scott (2015) apply some similar themes in their analytic synthesis of trauma treatments. Common skills, many of which are based on interpersonal relational processes, have been found to have more treatment effect than any more specific methods-base such as solutions therapy, cognitive-behavioral approaches, narrative or psychodynamic practices. That is not to say that specific methods should be dismissed; the creative task is to integrate them in the clients' interests as opposed to applying them in the theory's interests. The integration of broad process variables, and some

more focused common factors, with more specific trauma assessment and treatment knowledge and skills, respects more ranges of client risks, needs, impacts, supports, adaptations, and maladaptations as presented and assessed.

21. Given that children often communicate and express the experiences of trauma and the sequelae of trauma through nonverbal expression, social workers, often in play therapy contexts using sensory activities, must be very diligent in tuning in to cues of the child's meanings, potential meanings, and readiness to express "self" through play, nonverbal communication, and through verbal expression.
22. Some survivors of trauma have problems with attention, comprehension, confusion, memory, reasoning, decision making, and sustaining motivation and action, which are reflective of post-trauma effects expressed in compromised cognitive functioning—often interacting with labile emotional expression, compromised affect regulation, and an ambivalent approach-avoidance pattern in accepting or resisting help.
23. Social workers must consider the advantages of treating the client's trauma and related impact narratives as both a reflection of truth in life as lived, as well as reflecting social constructions of reality subjected to the vagaries of word meanings and metaphors applied to subjective assignments of meaning.
24. Case descriptors have been modified sufficiently to ensure that clients and associated persons are not identifiable. The authors apply a biopsychosocial-interactional paradigm to organizing complex realities associated with complex trauma treatment.
25. This analysis is organized around the current iteration of a bio-psycho-social-spiritual paradigm as articulated by Kimberley and Osmond (2009).
26. Hypervigilance also appears to have some neurosocial underpinnings.
27. The reader should be aware that dissociation also appears to have neurological and emotive dimensions.
28. Those who wish to specialize in trauma practice are referred to Briere and Scott, 2015, for a synthesis of treatment themes in trauma practice.

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Emerging Theories: Electronic Exchanges

Emilia E. Martinez-Brawley

If theory helps us explain the reality at hand and "expands our horizons as we fit the implications of some observation that does not appear to fit what we know or have experienced before" (Turner, 2011, p. 9), then the need is to develop basic theoretical principles of electronic communication for practice in social work. This chapter does not select a single theory; rather, it focuses on the interlocking of many theoretical principles from linguistics, communications, relational, and other theories in social work practice in the electronic age. The chapter examines the social dynamics of electronic exchanges and the effects that email and texting have on the linguistic, relational, and clinical aspects of the profession. What are the gains and losses of the broad use of electronic devices in lay and professional communication? Will our current intense use of electronic communication be detrimental to the demeanor of future practitioners, their use of language, and their ability to establish close personal relationships? The chapter discusses linguistic and behavioral changes in social work in light of the ubiquity of email and texting.

Electronic Systems

The positives of electronic systems in data gathering, processing, and disseminating information have been broadly recognized in social work. Gould (2003), Parrott and Madoc-Jones (2008), and others have described how, in welfare services, information and communication technologies (ICT) moved from the use of mainframe client-based systems (for example, Social Security), to stand-alone databases (for example, in child welfare), to integrated management

tools. Many authors have addressed how social work has changed dramatically in the age of electronic communication (Finn, 2006; Parton, 2008). Others offer practical solutions for managing the email client (Zur, 2011), and still others promote the use of electronic communication to empower clients (Parrott & Madoc-Jones, 2008). These topics will not be the point of discussion here.

In many ways, the reality of electronic communication among forthcoming generations of social workers and clients is irrefutable. This chapter takes a different stance, developing a critique of how electronic communication is affecting the very essence of social work practice principles in terms of relationships, language use, and context. This chapter interlocks principles from many theories, primarily linguistics, relational and interpersonal communication, with social work as an artistic practice. It focusses on the social dynamics of electronic exchanges, primarily email and texting, and examines their effects on the clinical aspects of the profession. The chapter does not propose single answers; rather, in the postmodernist tradition, it presents the findings of many thinkers and questions whether the profession should embrace all electronic changes; it encourages the judicious examination of their usage and suggests the development of basic principles of social work theory for the age of electronic communication.

Communication, Intimacy, and Social Interaction

Lewis (1982) once stated that practitioners "should know that [their] observations are not simply casual scannings" (p. 6). Their eyes and ears are trained to reveal meanings and exploratory guidelines for practice. In the past decade or so, professors, supervisors, and senior practitioners have attested to the fundamental changes in written and oral communication, demeanor and affect of many students and newcomers to the field. It is hard to ascertain whether the communication problems exhibited in the field today are the result of poor language training, inattention, discomfort with others, or simply consequences of electronic communication. A general observation is that, regardless of context, everyone wants to "save time." Words have become fleeting signals, as short-lived as a quick text-message between friends. Expressions of sentiments are often trivialized, thus it is difficult to ascertain their seriousness. Baron (2000), a linguist, argues that our new use of language (including symbols on the internet such as the ubiquitous smiling face) is affecting not only the linguistic but also the social dimensions of human interaction (p. 29). These are serious concerns that should be examined in relation to social work.

The decline of writing skills and concomitant analytical and critical thinking among young people has received broad consideration by specialists in the writing craft (Baron, 2000, 2008, 2009; Rosen, 2012; Tait, 2000). Many student papers today are written as if they were emails or text messages, offering streams of consciousness that pay scant attention to selecting the most appropriate ways or phrases in order to convey difficult concepts. The main problem seems to be that there is no "mulling over" or thoughtful concern for the impact words have upon the reader. Communication and social work scholars have commented that students and often professionals today seem unaware that writing is important in itself, because we live in a society where writing has become too practical and utilitarian (Dietrich, 1977; Fabricant,1985; Parton, 2008; Taylor, 2008; Webb, 2006).

The electronic age also pivots on ways of interacting without sound. Ong (1982) reflected that there has been a language wherever human beings existed, and in every instance, language exists basically in the world of sound. He suggests that gesture, no matter how rich in its present elaboration, remains dependent on oral speech systems:

> Because in its physical constitution as sound, the spoken word proceeds from the human interior and manifests human beings to one another as conscious interiors, as persons, the spoken word forms human beings into close-knit groups. (Ong, 1982, p. 72)

Ong (1982) would have probably taken issue with the onset of email as the preferred communication in today's workplace, particularly in social work, because ultimately he viewed the written word as unresponsive. Without sound,

he believed, it is easy to lose the awareness that we are always connected to others (a matter sign-language experts might dispute). He stated,

> If you ask a person to explain his or her statement, you can get an explanation; if you ask a text, you get back nothing except the same, often stupid, words which called for your question in the first place. In the modern critique of the computer, the same objection is put, "Garbage in, garbage out." (Ong 1982, p. 78)

Even if we disagreed with Ong—and many social workers do—we are aware of other challenges. Rodriguez (2011) discussed the use of silence in multiracial settings. As Rodriguez observed, with people of color, silence "often serves as speech or as a means of 'saying'" (Rodriguez, 2011, p. 112). Trinh (2009) has also suggested that "silence as a refusal to partake in the story sometimes provides us with a means to gain a hearing" (p. 148). The meanings of silence are many and extremely useful in the social work relationship, but to be productive, silence must be observed with the same intensity that speech must be heard, or not heard (Foucault, 1990).

After electronic communication became pervasive, young people began to communicate through separate generational layers, their networks being reduced to their peers with whom they develop their own systems of electronic intimacy. Such age-segregated systems of electronic intimacy require little awareness or expansion of one's own general milieu. In fact, as Wilson suggests, although electronic chatting "at first glance appears to help maintain in-depth personal relationships, in actuality, it facilitates the opposite" (Wilson, 2011, pp. 1–2). Furthermore, Wilson predicts difficulties with and fear of face-to-face relationships in the next generation. Turkle (2012) rightly asserted how this instant communication has created a culture of distraction in the young and the old. Her research on parents and children suggests that from the moment children "meet this [electronic] technology," they enter a culture of competition. Parents text games instead of taking precious moments to talk to their children as they watch them on the playground, the back of the car, etc. In Turkle's view, children and parents "suffer the slings and arrows of not having" each other's attention from the earliest possible interactions (Turkle, 2012, pp. 1–22). This inability to attend to others, in the deepest sense, has severe implications for social work, whether at the individual, cross-generational, cross-racial, or multicultural community levels, the latter being particularly challenging. Observation of the verbal, the nonverbal, and the tone are most helpful in aiding the limitations of language, particularly in translation.

> New electronic media show little respect for cumulative wisdom of past generations, preferring to communicate many messages quickly over vast spaces allowing little time for absorption or reflection. . . . The quantity and speed do not allow for sustained gazes into the depths of history or into the richness of particular ethnic, racial, or religious traditions. (Schultze, 1991, p. 58)

Recently, I observed a year-old child playing with an iPad at a doctor's waiting room. The child brilliantly imitated all the movements adults make at a small computer: the position of the fingers, the swiping, etc. The child could even hold a phone between his head and neck while playing with the iPad. The mother appeared to be caring but only related to the child when the iPad images failed. I was amazed but could not help but wonder about the consequences of such precocity!

No one will dispute Rosen's (2012) assertion that "we are living in an age of electronic intimacy; its hallmark is "instantaneous global communication" (p. 49). But this so called "instant intimacy" implies, for many, the removal of the "other," the obliviousness that there are other human beings involved in the interaction, and most importantly, in the context in which these interactions take place. On the internet, we are not aware that we are with other human beings. In many ways, "we are disinhibited from taking into full account that we are in the presence of another human being" (National Public Radio, 2012, p. 15). In her research, Baron (2008) found that there are real differences in numbers between "Facebook" friends and "real friends," namely, those that include personal interaction. Our electronic interactions are decontextualized. We have not only removed the presence of another human being but also ambient awareness. It does not really matter how we physically present ourselves (our dress, our expression,

gestures, rituals, etc.), all elements that have traditionally been important in the social work relationship.

Text, Language, Context, and Affect in Social Work

Language has always been an essential element of social work interactions. As Hartman (1991) succinctly put it in *Social Work*, "Words create worlds," and discounting the power of language is shortsighted, particularly in a multicultural world. Language, whether spoken or written, does not only report information but analyzes and synthesizes how that information is perceived by the observer. How we express ourselves reveals our worldview. That is one reason social work in translation is a difficult art to practice. In a multi-language context, the translator must take into account, not only how something can be said in the other language, but also how it could be perceived in the different cultural context. Is the social worker treating the client, or is the translator? What information has been included, and what has been left behind in translation? (But these matters require a separate discussion.) Here, my concerns are simply to stress the importance of coupling verbal and nonverbal cues in social work practice.

The emphasis on "evidence-based" practice has affected social work writing, which appears to have lost its philosophical and humanist thrust and been reduced to serviceable and mechanistic brief entries through computer-directed recordings (Parton, 2008; Webb, 2006, Witkin, 2000; Martinez-Brawley & Zorita, 2014). Computer-directed case recording offers little analysis or reflective wisdom by the worker. These entries have adopted the language of science because, in such a style of writing, "it is commonly thought the writer is simply recording the natural facts" (Bazerman 1988, p. 14). The recordings of encounters with clients are too brief to capture full elements of ambience or context and mood, whether expressed verbally or nonverbally, because the text is so limited. The story appears to have been relegated to secondary status, as a lesser form of data (Taylor, 2008). The art of social work (Goldstein, 1992; Hartman, 1991; England, 1986; Martinez-Brawley & Zorita, 1998; Witkin, 1998), the humanistic emphasis on process and story, on affect among participants, seem to have lost vitality, affecting the way in which social workers think, explore new subjects, and develop practice and policies (Webb, 1996, 2006). There is no apparent desire to appeal to the sensibilities of the reader through the words or descriptions of context. Recordings are most frequently done in computer-generated forms, which are dry and short, and resemble emails. For Tait (2000), a writing expert, these forms fall short in tone, subtlety, spontaneity, and creativity, which affect mood. In narrative theory (White & Epsom, 1990; Kelley, 2011), individuals, including clients, organize their lives according to the stories they have constructed, whether they are positive or negative. Understanding those stories can lead to liberating changes. Stories tend not to have a place in today's computer-generated recordings. In anthropological terms, such recordings will only contain *thin* descriptions (Geertz, 1973) of the reality at hand. Certainly, narrative and strength-based theories in social work emphasize the value of "thick" description (White & Epston, 1990; Kelley, 2011; Saleebe, 1997; Payne et al., 2002).

In Turner's (2011) book on social work treatment, Shepherd Cowley and Derezotes (2011) write about a transpersonal and integrative theoretical model for practice. They warn practitioners about ignoring the physical dimensions in clinical intervention:

> Observation of body language gives us an accurate understanding of another person, since it can reveal much that is left unsaid. If practitioners do less than a thorough assessment of the physical dimension, they risk missing data important to understanding bio-physical problems like brain tissue damage, neurological disorders . . . and other forms of chemical imbalance. (2011, p. 559)

Clearly, the concern of social workers about the importance of context in interactions is still, at least in theory, very important. We have seen how sound, "unsound," tone, body language, and demeanor are all elements of the rich context that facilitates the social work relationship. When they are missing, as in email and texting, social work must reflect on how they can be recaptured. Furthermore, from an ethical social

work perspective, Reamer (2013) raises a number of concerns regarding the missing ambience awareness that often follows intensive electronic communication.

> Social workers who have extensive electronic contact with clients outside the normal working hours (for example, when a social worker and client exchange email, social network postings, or text messages late at night) may give clients the impression that their relationship is fluid and not bound by the parameters that historically have defined professional–client relationships. (Reamer, 2013, p. 13)

Lack of ambient awareness seems pervasive. As a social work professor, I have observed that when students are given group assignments that require that they coordinate with each other and contact external sources, they tend to handle such interaction in the same way they handle writing. Not just students, but often new professionals choose not to communicate in person, even when crisscrossing text messages and emails create confusion. Issues are seldom fully cleared. In spite of the usual and valid concerns about time, easy access, etc., the current reluctance of many social workers to become involved in personal interactions appears to indicate that at least some workers are very uncomfortable with direct verbal communication in an age of instant responses. Social workers who use electronic communication with frequency, are concerned about the "radical change in expectations due to ICT. Indeed, practitioners are concerned with the expectations by young people today that their texts to others would be answered 'within minutes'" (Mishna et al., 2014, p. 183). These expectations of speed and immediacy have created new ethical concerns for practitioners who must revisit the issue of boundaries with great frequency (Mishna et al., 2014; Reamer, 2013a, 2013b; Zur, 2011). Reamer commented:

> The recent and dramatic emergence of digital and other electronic technology in social work as it is practiced in many nations—such as online counseling, video counseling and e-mail therapy—has tested and challenged the profession's long standing and widely accepted perspectives on the nature of both clinical relationships and ethical issues. Indeed, these remarkably novel forms of clinical social work—what truly amounts to a paradigmatic shift . . . demand a full and diligent reexamination of the profession's understanding of core ethics concepts and principles. (Reamer, 2013a, p. 3)

During a recent community study in one of my classes, a group of graduate social work students complained about their own reliance on emails and the confusion emails created. "Emailing felt like a barrier to me at times. I mistakenly believed the tasks were getting accomplished based on what individuals were telling me they had completed," commented one student. "All the communication was done over email, which became quite hectic," reported another. "The individuals in my group expressed lack of time to meet in person . . . [but] everyone was sending emails . . . making it hard to know what my group was doing specifically." Many more examples showed that the students felt trapped; on one hand, email helped them communicate wholesale, but such willy-nilly contacts hindered progress in more meaningful ways.

In spite of the efficiency ethos of today, face-to-face interactions in social work theory are not marginal but valuable opportunities to learn about others. Affectivity has been identified as a primary mechanism motivating behavior. Kaufman (1989) stated: "It is affect that gives texture to experience, urgency to drives, satisfaction to relationships and motivating power to purposes envisioned in the future" (1989, p. 11). It is true that there are those who feel that electronic and instant communication allow us to personalize more because we are able to connect with ease. But it is often in the process or struggle of attempting to reach someone that we were able to engage at a deeper level.

In an interesting brief essay, Libresco (2014) suggested: "the ease of on-line search may be streamlining serendipitous conversations out of fashion. If all information is a Google search away, asking another person for help can feel like delegating a clerical task". Could Google just take the place of social workers? There is even a page in Google ("Let me Google that for you," LMGTFY.com), Libresco adds, where people who ask too many questions can be directed, thus dis-enabling the possible bonds of friendship, neighborliness, empathy, and affection that seeking and responding personally generate. In "Ask.com," a popular search engine started in 1995, the search for information was done

through "Ask Jeeves," and required users only to ask a question of the internet. The title "Ask Jeeves" was intended to make people feel that the internet could respond to them as persons, like the quintessential "gentleman's gentleman." Questions to Jeeves were posed in everyday language without traditional keyword searching. Today, however, there is no more fictional Jeeves in the clouds. The verb "to Google," referring to the impersonal search engine, has entered both the *Oxford English Dictionary* (2006) and *Merriam Webster's Dictionary* (2006).

Lexical, Syntactic, and Formality Changes

Baron (2000) has suggested a number of dimensions in human communication that play a role in the social dynamics of any exchange. She mentions the "the lexical and syntactic aspects of the message"; she also mentions the style; that is, "the choices users make about how to convey semantic intent"; she further discusses "the physical parameters" of the message and the "relationships between the participants in the exchange" (p. 250). These useful dimensions, intended primarily for linguistic analysis, can be used as the facets of a prism in looking at the consequences of electronic communication (recording, email, and text messaging) as they relate to social work today. To begin, let's examine changes in the formality of relationships between participants and concomitant lexical changes.

A couple of decades ago, email, for example, appeared more like writing. Email was used in business, and when used elsewhere, it had many of the formal contract-like qualities that made the participants relatively careful. In sociological terms, the communication was generally between subordinate and superordinate and retained many of these belaboring features. Practitioners in social work used emails to immediately record serious concerns with their supervisors; professors in social work seldom used it outside administrative or peer communication. Social work students seldom emailed their professors with simple matters that could easily be asked of a peer. They certainly never emailed or "texted" other students in classes and were careful about the nature of the communication. Email in agencies, if used at all, was more formal, inasmuch as everybody knew that while the other person could not be seen, the words on the page were not fleeting or disappearing signals and therefore had to be written with some care. The parties in the early email exchanges kept a certain level of formality and conveyed a certain demeanor. Email as a medium was not pervasive and certainly not mandatory. But with broad dissemination of the emails, the social dynamics and the relationships in the exchanges were transformed. The exchanges increased dramatically in numbers, speed and frequency of access were enhanced, but style became more casual, less complex; individuals became less mindful of the other person's responses, less concerned about demeanor, whether collegial or hierarchical.

Linguistic theory points out that "normativeness" in language and social interaction goes in cycles. The use of words, the style, tone, and formality of the prose bring about changes in social interaction and differ among cultures. Standards are set by those we work for, correspond with, by the media, etc., and they definitely change through time. Although the object here is to relate "normativeness" to the use of language in social work, it cannot be denied that there is a pervasive lack of normativeness that can be observed daily in the behavior of politicians, public servants, and many others who can influence societal norms for good or evil. Sometimes the behavior is so offensive that it has to be legally restrained. Other times, it only creates disturbance and discomfort and exhibits lack of judgment. Normativeness and demeanor have particular significance in intercultural communication. All cultures and groups have "normative" language and demeanor, which outsiders must maintain to arrive at successful communication. Social workers have the ethical responsibility of understanding and demonstrating the norms of a client's culture (Reamer, 2006). What has been referred to as "culturally sensitive practice" is practice that is made evident when a social worker has had to accept a new language "normativeness" driven by the culture of the client. Email messages can help or hinder this process, depending on the client's culture, sense of timing, formality, and adroitness with the linguistic nuances that often come

with electronic communication. Email and texting do not offer the practitioner the ability to enhance or detract from the impact words may have upon the client.

Computers and Changing Relationships in the Human Services

Between the early days of email and today, there came enormous changes in the use of computers in human services. We have already referred to Gould's (2003) stages in the progression of electronic communication in social work. Critiques about lack of transparency in record-keeping in contacts between workers and clients, for example, brought about, not only greater scrutiny, but also further "technocratization" (Parton, 2008). Workers were handed computers and forms that could be taken to home visits, and the nature of the relationships and contacts with clients was changed with the computer as an intermediary. Today, while encounters appear—and in many cases are—more transparent, they are prescribed and recorded according to preestablished categories. Only certain highlights can be "objectively" noted in the record; those are typically overtly observable and easy to include in a checklist. What can be recorded in a form becomes the center of the interview. These steps have made the transition to informal communication via emails or texting less traumatic for the workers. Furthermore, agencies today are governed by a business or efficiency ethos, and workers, pressed for demands for fast "productivity," have become convinced that shedding the burden of personal interaction with clients and colleagues is not only required for efficiency, but valuable and praiseworthy.

In 2001, Fabricant wrote about the "industrialization of social work," documenting the loss of the craft and artistic elements in favor of bureaucratic responses and "one size fits all" solutions (p. 390). Howe (1992) warned that our focus on speed, forms, and procedures had resulted in an emphasis on "the visible surface of social behavior . . . and not the internal workings of psychological and sociological entities" (Howe, 1992, p. 88).

The trend toward standardization and technocratization was part of the fiscal ethos in the 1980s and 1990s. Clients, even in human service organizations, began to be regarded as the raw material in an assembly line that counted inputs and outputs. Perforce, the emphasis was placed on the individual characteristics of the client rather than on the social milieu; individual concerns could be documented much faster and "devolved" to professionals who carried out very specific functions within very specialized "silos" in the agency structure. Social workers moved from a more contextual and holistic paradigm to one that focused on specificity and fast communication. Parton (2008) documented this state of affairs. He stated:

> A central part of my argument is that the nature of practice and the knowledge which both informs and characterizes it is increasingly less concerned with the relational and social dimensions of the work and more with the informational. Increasingly, it seems that the key focus of activity of social work and social care agencies is concerned with the gathering, sharing and monitoring of information. . . . It is not my argument that these are new activities but that they have taken on a much greater significance in recent years because of the growing importance of ICTs . . . (Parton, 2008, p. 254).

These developments minimized, not only the artistic ties of social work, but also its relational aspects (Goldstein, 1992; Witkin, 1998, 2000; Witkin & Harrison, 2001; Martinez-Brawley & Zorita, 1998). This is commented upon even by authors who can be said to "favor" the broad application of technology in social work. Parrot and Madoc-Jones (2008), for example, recognize that social workers have to comply with predefined technical processes. A problem has to be understood as technically neutral or all other processes become more problematic. In managed care, states Harris (1998), compliance to meet the technical processes of the computerized care-management system is required. But, as Taylor points out, this adherence to severe technical language modifies the nature as well as the purpose and utility of case records. She offers examples of disembodied language from real social work records (Taylor, 2008). They are written in the passive voice and are "characterized by the absence of direct comment by the narrator about what is recounted" (Taylor, 2008, p. 32). Social workers' skills and judgment are severely constrained, since the process itself

limits professional freedom and directs actions only towards "approved" activities.

Speed and reductionist thinking coincided with the broad spread of computers and emails. Agencies invested heavily in electronic equipment and workers, sometimes reluctantly and sometimes willingly, became acculturated to the new systems. Speed won out over reflection. Nowadays, there is no time for relationship building within agencies, and relationships and communication with others thus appear somewhat antiquated. Workers cannot afford to develop sound judgment through reflection and circumspection: "Reflective judgment, which represents the virtuous man, is a sifting process of circumspection. It develops wisdom by engaging us in the process of the cultivation of good judgment" (McBeath and Webb, 2002, p. 1024).

Additionally, the physical parameters of the message have changed. Colleagues who are placed next to each other in an office may not talk to each other or show camaraderie but are encouraged to email each other. The implication is that the less a social worker is influenced by a colleague, the more neutral the message and the record will remain. Webb (2006) suggests that these practices are the consequence of "social work in a risk society," wherein there has been a "de-skilling" of social work, which he laments. But both, de-skilling because of managerial control and the heavier use of computers, seem to have strangely coincided as a trend and have fed each other.

Emails in agencies are also used for other purposes. When addressed to a manager or supervisor, they allow workers to document that they have taken action, or have "devolved" the case to a "specialist" and can then close it promptly. Emails to supervisors indicate the timing of various actions, thus showing the level of efficiency of the action.

The advent of the personal computer that could be carried everywhere and the smartphone, with which people can instantly reach one another by email or text, like all other devices, facilitate information exchanges but also encourage atomistic behavior. Emails are not intended to express complex thoughts, and texting is not required to be literary. The nature of the new systems of communication also encourages grammatical deterioration. In Baron's linguistic scheme, "the lexical and syntactic aspects of the message" are no longer a major concern. Speed and simplicity were and continue to be their advantage. In case recording, complex thoughts are reduced to form-like categories. Categorization always requires reductionist thinking. As in science writing, style is focused on brief, factual observations (Taylor, 2008). The choices users "make about how to convey semantic intent" cannot be focused on smoothness or softer tones. The flow of the prose in electronic communication is not intended to be literary. Of course, all these apparently strictly linguistic dimensions have serious consequences for the way the public and social workers approach the world of relationships (Harlow & Webb, 2003; Abbott, Klein, & Ciechomski, 2008).

Social Work Relationships in the Electronic Age

Personal relationships have been traditionally the means through which basic social needs are expressed and potentially satisfied; they are also the cornerstone of social work practice. Professional social workers study families, friendships, and networks of community members as basic units that offer social and emotional support. Until recently, when our understanding of community evolved from the locality to include professional, religious, or other affinity networks too diffuse to be location-based, we counted on human, personal communication as the main means to share, resolve, or alleviate our social concerns. Families, villages, neighborhoods, and other social organizations were the grounds where individuals exercised their human capacity to communicate with others, and those communications were personal. Social workers are reported to have been reluctant to use the telephone in the early 1900s (Parrott & Madoc-Jones, 2008). But, for many decades now, social workers in the industrial world have had to expand notions of social support beyond the radius "where a good neighbor could deliver a plate of hot soup to someone in need" to include larger and less personal networks. Yet, until very recently, they still counted on some form of direct communication and

contact with other human beings. An emphasis on direct communication, preferably verbal communication in person or at least by phone, was the *sine qua* non of doing social work.

Social work theory has always addressed problems within their social context, even when the problems might have appeared to be primarily intrapsychic. Social workers emphasize the social and interactional dimensions of being. Social work theory always included close networks of support, whether for acculturating the young or the newly arriving immigrant, or for offering material and emotional support to the poor, the sick, the emotionally frail, the elderly, or the lonely. International standards of social work training stress the importance of the various signals of communication—the voice, the words, the gestures, the gaze, how practitioners invite or reject closeness from someone with whom dialogue is established, the empathy they can communicate or the distance they can unintentionally create. Basic social work theory has always maintained that practitioner–client relationship, with its key elements of eye contact, active listening, personal nurturing, and physical proximity, is the crux of practice. In multicultural settings, social workers debate the cultural nuances of native and acquired languages, the gestures that accompany speech in various cultures, and even the use of translation in direct practice because they doubt the fidelity of negotiating close communication through intermediaries, who necessarily add or detract dimensions to the interactional equation.

Locke (1998) discussed the evolution and role of verbal language to satisfy social needs. He suggested that our hunter-gatherer ancestors would not have required our modern linguistic breadth (words, syntax, expression, tone, etc.) to satisfy their needs. He commented that we got very good at language on the sweat of our ancestors and that "language as speech, enabled social work—allowed people to persuade others to do things—and that this increased [verbal] fitness" (p. 90). This is doubly true of another critical area of social work—avoidance and resolution of conflict. Locke (1998) further commented that contemporary technology is encouraging a trend towards increased depersonalization in communication. In fact, his book was called the *De-Voicing of Society* and was subtitled *Why We Don't Talk to Each Other Anymore* (1998). As these societal trends continue, by using not just the telephone, but voice mail, email, and texting, we are constantly decreasing the nonverbal signals we normally use in the act of communicating with each other (Baron, 2000). We are also impoverishing the repertoire of understandings on which social work theory is based.

Towards the Development of Social Work Theory for the Electronic Age

Most of us agree that e-communication is an easy and fast way to increase disclosure, to experience "mind-to-mind" connections with others within the context of "the unique behavior and interactions engendered in cyberspace" (Barak, 2008; Finn, 1999). The technological innovations of the 21st century have certainly maximized the number of people one can contact at one time, saving us from repeating the same basic messages all over again to many individuals (Wilson, 2011). But "any economist would tell you that you should always perform a cost benefit analysis and the influence of electronics in the information age has severe opportunity costs"(Wilson, p. 1) A few social work thinkers have been performing such cost-benefit analyses, but their writings are not well disseminated. In fairness, there is still a great deal of debate as to whether our ever-increasing use of technological means to communicate with others has increased or decreased personalization, whether it has made society more or less anomic, and whether it has helped or hindered the ability of individuals to resolve interactional problems. The literature on the consequences of technology in professions such as social work is not abundant and often contradictory. Authors such as Barnett-Queen, 2001; Brownlee et al., 2010; Parton, 2008; Howe, 1996; Webb, 1996, 2006; Finn et al., 2004; Parrott and Madoc-Jones, 2008, and a few others have approached the subject often from quite opposite points of view. Many have addressed the potential value of technology for management and recording, but even in rural areas, where practitioners are scarce and electronic messages can increase the frequency of contacts, there is still the doubt that standardized solutions have much merit.

Belanger (2013) has suggested that technology has removed jobs from rural areas and has lifted local responsibility, which is, after all, the first line of defense when serious mental health, health, or social service issues arise (Kowalenko et al., 2003). Others have expressed serious concerns about the changes that technology has required in the practice priorities and modus operandi of social workers (Frennert, Forsberg, & Östlund, 2013). This chapter has discussed the issues associated with language, demeanor, text—in both client's narrative and social work recordings—and context. The chapter has discussed how social work practice has become standardized and depersonalized and questioned this model for the future of social work.

Our current societal attitude towards e-communication appears to be deterring professionals in human services from modeling the difficult social roles that practitioners undertake, the care with which they should express themselves, and the need to practice the skill of face-to-face relationships. The speed of our communication has resulted in an extraordinary proliferation of text, surprisingly badly honed and carelessly prepared. The email entices writers to hit "send" whether the text conveys the message or not, and in spite of the current aversion to risk-taking, regardless of whether the "downsides" of the communication have been carefully considered. Yet, there is also evidence of the merits of electronic communication in many practice situations, primarily in mental health in rural areas, where face-to-face communication is often impossible. But all merits should be taken cautiously in practice, because for every merit there seems to be a parallel demerit. Furthermore, professionals are aware that the clients of social work are often isolated or estranged from direct human interaction and frequently uncomfortable with communicating in written text.

In spite of many concerns, the effects of electronic communication in social work have not been studied thoroughly. Neither have the consequences of electronic communication on the nature and quality of the language used, or the demeanor shown between client and worker or among colleagues. These areas have significant effects in social work practice and training. Professional educators can no longer placidly observe the distancing of social work practice from the most fundamental human aspects of helping. In the case of email and texting, "the fundamental transaction of message sent and received does not presuppose that communication has occurred" (Pfeiffer, 1998, p. 1) or that practice has been improved.

This chapter has posed many questions that will require serious and honest dialogue about what can and cannot be done electronically in social work without compromising the integrity of the practice. Language, demeanor, and context have always been fundamental tools in service delivery and effective human service communication, and care should be exercised in relegating them to a marginal place in social work theory. Social work theory has been unique among other psychological theories because of the importance it ascribed to context, networks, and community. Finally, the narrative, which has always been an important part of the therapeutic interaction, cannot be readily dismissed. In Taylor's words, "texts are active in influencing and structuring the world and this applies as much to social work as to everyday activities in modern society" (2008, p. 25).

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Epilogue: *Social Work Treatment*, Sixth Edition: Some Final Comments

Now that I have finished the sixth edition of *Social Work Treatment*, some final comments are once again in order. As the process continues I ask myself, What did I learn from the task of preparing yet another edition of this book? I am aware that I have learned much about the continuing evolution of our theoretical base, and I have the realization that the process is an ongoing and ever expanding one.

My goal has been to identify some important developments that are taking place in our repertoire of theories in a format of use to practitioners, students, and academics. I believe I have observed several important realities in the present edition that are influencing the growth of theory.

One of the most important things I have learned in this process is to continuously ask what theoretically developments are taking place that could aid us to better serve clients. An area in which we all need at least a beginning level of competence is Crisis Theory. It is scarcely possible to turn on or make use of our highly efficient communication media without hearing about yet another person or situation of individuals or groups in crisis. Another area of considerable importance is the ongoing development of our broader theoretical base as it relates to the rapid expansion of knowledge, which is highly relevant to social workers and needs to be included in our training, teaching, and practice.

In the near future, we are going to have to play a role in the rapid development of space travel. Already many disciplines are involved in highly extended space journeys in which small group of people live in concentrated living conditions for long periods of time. Social work knowledge of small-group living in highly restricted environments in journeys to other parts of the solar system is already a reality. We can make a contribution with our knowledge by helping people make optimal use of these non-traditional environments. If there is another edition of this book, I am quite sure it will include a chapter on the theory of practice in the space age.

Through all our presentation of 39 chapters about various social work theoretical orientations, there is a pervasive need for research to ensure these new developments become incorporated in our daily practice. One final comment that touches almost every one of us on a daily basis is the impact of the computer on everyday clinical social work. As every adolescent knows, it is possible to exchange intensive and intimate data on a worldwide basis with resources available to virtually everyone in the world. Dr. Brawley raises this question very clearly as to what is an interview, who participates in it, and who knows who is participating. This reality appears to be affecting therapeutical activities in very dramatically ways. Thus it is no longer sufficient to ensure that our colleagues are knowledgeable about a broad range of theories; intense attention needs to be given to the potential impact on a very broad basis of cyber effects.

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