SWHS 300: INTRODUCTION TO SOCIAL WORK/HUMAN SERVICES



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SWHS 300: Introduction to Social Work/Human Services

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UNIT 1: THE PROFESSION OF SOCIAL WORK

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1: CHAPTER 1

1.1: Introduction to Social Work
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1.1: Introduction to Social Work

The History of Social Work in the United States

Interactive Element

Video: Legacies of Social Change vimeo.com/104132906

The inception of the social work profession in the United States can be traced back to the late 1800's beginning with charity work performed by local churches and communities seeing to meet the needs of the poor. Some of the earliest social work interventions were designed to meet basic human needs of populations and placed great value in providing support, assistance, and resources to families and communities in an attempt to alleviate suffering (Nsonwu, Casey, Cook & Armendariz, 2013). The profession now known as social work ultimately began as a result of a practice originally known as "helping" others to improve the well being of individuals, families, and communities. Throughout the years the social work profession played vital roles in the facilitation of social changes aimed at diminishing inequalities among various populations. Through the practice of "helping," social workers were able to address many social problems that plagued vulnerable populations through facilitating, advocating, and influencing individuals, communities, politicians, and law makers (Langer & Leitz, 2014).

Throughout the progressive movement era, many social workers emerged and were identified as key players known to have advanced the profession. These individuals came to be known as *pioneers* of the social work profession as their careers were devoted to improving the well being of individuals, families, and communities. In an effort to help conceptualize the social work profession, we will look closer at the origin of the social practice, as well as discuss a few pioneers and their contributions to the social work profession (Hansan, 2013).

In the early 20th century, Robert Hunter's book *Poverty* was published. Hunter's book placed a spotlight on America's poor and challenged society's long held belief that poverty signified moral failure (Hansan, 2013). Hunter's book demonstrated a critical need to implement specific social measures in order to prevent the destruction of the working class population on the verge of poverty. Hunter additionally identified conditions known to breed poverty calling into question the need but also the tolerance for these unjust conditions particularly by a professed Christian population (Hunter, 1904).

Another known pioneer of the social work profession is Mary Richmond. Throughout her career, Richmond searched for answers surrounding the reasons and causes of poverty while also examining the interactions between individuals and their environments. Richmond believed that interventions and treatment approaches needed to be focused on the person within their environment. As a result of this belief, Richmond developed the circle diagram as a way to help her clients identify sources of power available to them within their own environment. One of Richmond's biggest contributions to the social work profession was her book *Social Diagnosis* which was published in 1917. Richmond's book focused on the practice of casework with individuals and was the first book to identify a systematic and methodological way to document and diagnose clients (*Social Welfare History Project*, 2011).

Jane Addams is another well-known pioneer to the social work profession. Addams, along with Ellen Gates Starr, founded Hull-House in 1889. Hull-House was a successful settlement house located in an area of Chicago that was largely populated by immigrants. Residents of Hull-House were provided with multiple services which included daycare and kindergarten facilities for the children of the residents. Throughout her career Addams' continued to contribute to the social work profession by advocating for the rights and well-being of women and children on several important issues, one of those issues being the implementation of child labor laws (Hansan, 2010).

Jane Hoey's career as a social worker began in 1916 when she was appointed as the Assistant Secretary of the Board of Child Welfare in New York City. Throughout the course of her career she would work in multiple social welfare agencies: serving as the Director of Field Service for the Atlanta Division of the American Red Cross, the Secretary of the Bronx Committee of the New York TB and Health Association, the Director of the Welfare Council of New York City, and ultimately as the Director of the Bureau of Public Assistance. Hoey is best known for her role in the enactment of the Social Security Public Assistance Act which became law in 1935. Following the law's enactment, Hoey became the Director of the Bureau of Public Assistance within the Social Security Administration and was responsible for organizing and implementing the distribution of the public welfare provisions (*Social Welfare History Project*, 2011).

Additional Reading Material

Mary Richmond's *Social Diagnosis* : https://archive.org/details/socialdiagnosis00richiala

Robert Hunter's *Poverty* : https://archive.org/details/povertypoor00huntuoft

Social Work: What is it?

For over a century the answer to this question has been not only varied but also debated among members of the general public as well as in the professional social work community. The definition of "social work" may not be as clear as one may think when attempting to understand the meaning of social work. Embedded within these definitions of "social work" are common themes which can help to conceptualize social work. Although there are many varying definitions used to describe social work, what matters the most is the purpose of social work and what guides and directs social work practice. According to the Council on Social Work Education (CSWE), the purpose of the social work profession is to "promote human and community well-being"; which can be achieved through promoting social and economic justice and preventing conditions that limit human rights for all people.

Even after defining social work and identifying the purpose of the social work profession, there continues to be some misalignment among the profession with the overall mission of social work. This is not surprising considering the increasingly diverse populations being served by the profession. What is becoming increasing clear as the diversity of client systems continues to expand, is the critical importance of professional competence in order to meet the unique needs of individuals as well as emerging social issues. In an effort to better prepare new social workers to respond to these new challenges and social issues, the CSWE adopted a competency-based education framework, Educational Policy and Accreditation Standards, which gives students the opportunity to demonstrate and integrate social work knowledge and skills in various practice settings. More than ever social work requires a broad knowledge base in order to effectively meet the needs of others but also to help clients find hope in the process. Finding hope is essential to the social work practice as hope helps to empower diverse populations facing unique challenges (Clark & Hoffler, 2014).

The feelings associated with a sense of hope are considered to be fundamental to the social work practice. Hope is essential to social work as it allows those facing challenges to believe in a positive outcome and hope can play a major role in how the challenges/circumstances are viewed. A sense of hope is as essential to clients as it is for social workers who are helping clients. Social workers struggling to feel hope may communicate this verbally and non-verbally in their approach with their clients, ultimately impacting the effectiveness of the intervention. This is one of several reasons individuals wishing to pursue a career in social work should explore their personal values, overall worldview, beliefs, abilities, skills, and priorities as well as personal and career goals. This type of exploration is essential to determining whether or not a career in the social work field will be a good fit. In addition, individuals should also consider the demands, stressors, and challenges common to the social work practice giving serious consideration to whether helping the most vulnerable populations will negatively impact their own physical and/or mental health and overall quality of life (Sheafor, Horejsi, & Horejsi, 2000).

Additional Activities:

When in Doubt, Give Hope. (Speech starts at 2:20)

Allison Brunner a newly graduated MSW talks about her anxieties and doubts that recent graduates feel with their professional responsibility to hold hope for their clients. She describes her own doubts as a social worker, relates those to her personal moments of doubt and shares how she drew from those experiences to help her client. Using our experiences to benefit our clients rather than ourselves, is what we call "professional use of self." And as Carl Rogers demonstrated many years ago, bringing our genuine self to the clinical relationship is one of the most important things we can do to help our clients.

Retrieved from: http://www.socialworkpodcast.com/GraduationSpeech2009.mp3

Bachelors of Social Work (BSW) versus Masters of Social Work (MSW)

According to the Bureau of Labor Statistics, the minimum pre-requisite needed to gain employment in the social work profession is a Bachelor's Degree in Social Work (BSW). However, those with specific career goals may be required to obtain a higher level of education. Therefore, some may wish to pursue a Master's Degree in Social Work (MSW).

Social workers may serve in all of these different roles in varying degrees at any time in their career.

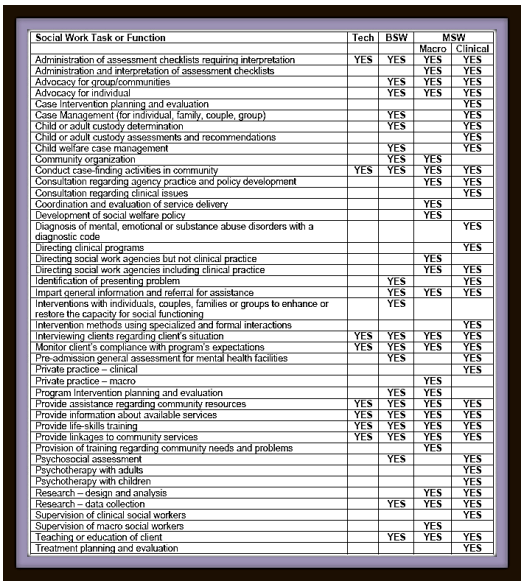
There are some similarities between the two degrees which include the expectation that both BSW and MSW students complete supervised field placements within a social service type agency. The requirements related to the length of placement, expected tasks, and/or hours may vary based on degree. Common social service agency placements for both BSW and MSW students include places such as hospitals, schools, or mental health or substance abuse clinics. In addition to this requirement, both BSW and MSW graduates must be granted a license in the state they wish to practice. Licensure for an MSW requires a minimum of 2 years of supervised clinical experience following graduation and a passing score on the Association of Social Work Boards (ASWB) licensing examination.

There are several key differences between BSW and MSW degrees. One of the first differences is the pre-requisite for entrance into the programs. Typically the only requirement needed to enter into an accredited BSW program at a college or university is that the candidate has declared social work as their major. This differs from an MSW program as MSW candidates apply for entrance into the program after already having obtained a Bachelor's Degree in which the graduate has likely earned credits in coursework areas related to psychology and sociology.

Another difference is the coursework required based on the desired degree. The Council on Social Work Education (CSWE), which accredits U.S. social work programs, designates BSW undergraduate programs teach students about diverse populations, human behavior, social welfare policy, and ethics in social work. Additionally, students are required to complete a supervised field placement at a social service agency. Baccalaureate social workers have the ability to obtain specialty certification in certain areas through their state chapter of the National Association of Social Workers (NASW), which offers specialty certification available in child, youth and family social work, gerontology, casework, and hospice, and palliative care. Master's degree programs focus on developing clinical assessment and management skills and prepare students for work in a more targeted areas depending on the student's interest.

The other important differences between the two degrees involves the type of employment each degree holder is eligible for and the earning potential based on the degree. MSW graduates typically earn a significantly higher salaries than BSW graduates. Individuals with a BSW degree tend to be employed in entry level jobs as caseworkers and are expected to provide direct services to clients through assessing, coordinating, and referring to area resources. The Michigan Board of Social Workers outlines the scope of practice/expected duties for social workers based on education and designated practice area (see chart below).

MSW graduates are often employed in clinical settings such as a hospital or a private practice setting and also in various administrative positions. MSW graduates can obtain either a Macro or Clinical license. The scope of practice differs depending on the type of MSW license. According to the National Association of Social Workers (NASW), a licensed Master Social Worker with macro designation can expect to be involved in administration, management, and supervision of human service organizations and perform functions that seek to improve the overall population's quality of life through a policy/administrative perspective. These tasks range from collaboration, coordination, mediation, and consultation within organizations and/or communities, community organizing and development, research and evaluation, and advocacy/social justice work through involvement in the legislative process. A licensed Master Social Worker with a clinical designation (micro) typically work directly with individuals, families, and/or groups in an effort to improve the client's overall quality of life. Social workers can expect to perform the following tasks/functions: advocating for care, protecting the vulnerable, providing psychotherapy as defined as "assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other biopsychosocial problems."



Social Work Task or Function	Tech	BSW	MSW	
			Macro	Clinical
Administration of assessment checklists requiring interpretation	YES	YES	YES	YES
Administration and interpretation of assessment checklists			YES	YES
Advocacy for group/communities		YES	YES	YES
Advocacy for individual		YES	YES	YES
Case Intervention planning and evaluation				YES
Case Management (for individual, family, couple, group)		YES		YES
Child or adult custody determination		YES		YES
Child or adult custody assessments and recommendations				YES
Child welfare case management		YES		YES
Community organization		YES	YES	
Conduct case-finding activities in community	YES	YES	YES	YES
Consultation regarding agency practice and policy development			YES	YES
Consultation regarding clinical issues				YES
Coordination and evaluation of service delivery			YES	
Development of social welfare policy			YES	
Diagnosis of mental, emotional or substance abuse disorders with a diagnostic code				YES
Directing clinical programs				YES
Directing social work agencies but not clinical practice			YES	
Directing social work agencies including clinical practice			YES	YES
Identification of presenting problem		YES		YES
Impart general information and referral for assistance		YES	YES	YES
Interventions with individuals, couples, families or groups to enhance or restore the capacity for social functioning		YES		
Intervention methods using specialized and formal interactions				YES
Interviewing clients regarding client's situation	YES	YES	YES	YES
Monitor client's compliance with program's expectations	YES	YES	YES	YES
Pre-admission general assessment for mental health facilities		YES		YES
Private practice – clinical				YES
Private practice – macro			YES	
Program intervention planning and evaluation		YES	YES	
Provide assistance regarding community resources	YES	YES	YES	YES
Provide information about available services	YES	YES	YES	YES
Provide life-skills training	YES	YES	YES	YES
Provide linkages to community services	YES	YES	YES	YES
Provision of training regarding community needs and problems			YES	
Psychosocial assessment		YES		YES
Psychotherapy with adults				YES
Psychotherapy with children				YES
Research – design and analysis			YES	YES
Research – data collection		YES	YES	YES
Supervision of clinical social workers				YES
Supervision of macro social workers			YES	
Teaching or education of client		YES	YES	YES
Treatment planning and evaluation				YES

Social Work Scope of Practice, created by the Michigan Department of Licensing and Regulatory Affairs (LARA). For a pdf of this chart, please see: www.michigan.gov/documents/mdch/mdch_sw_swgridforscopeofpractice_216194_7.pdf

What is a client? What's in a name?

It is important that the social work profession accurately define and describe the relationship that exists between those who receive services and those who provide services (social workers). Over the years many terms have been used to describe the service-recipient relationship. Many of these terms have been scrutinized as failing to accurately describe the relationship that exists between the social worker and the service recipient. McLaughlin (2008) identified four terms commonly used to describe the social worker-service user relationship as patients, consumers, and service users. It is important to explore the language used to conceptualize this relationship because the social work profession seeks to empower the most disadvantaged and vulnerable of the population the language we use matters.

Client is the most widely used term used to describe the social work relationship.

The meaning and implications of the term "client" have been questioned as it gives the impression that the social worker is in a position of power over the client. In this instance a client would be viewed as someone who needs help but does not have the ability to help themselves, due to some deficiency either a lack of skills or ability, and therefore requires the knowledge of a social worker (McLaughlin, 2008).

The term "consumer" has been used to describe the relationship of those who use services the state offers. The meaning and implications of using the term "consumer" suggests that those receiving services has options and choices and the social worker is acting as a manager or a monitor of services and/or resources (McLaughlin, 2008).

The term "service user" has also been used in various social work settings. However "service user" may not be appropriate for use in all types of social work practice. For example social workers working in the arena of children's protective services are mandated to respond to child abuse and neglect based on agency and state law. In this situation the service user would most likely object to the social worker's response, therefore the service user would not be officially involved in the decision making process. Over the years social workers have been given a major role in the assessment of needs and risks over client groups and this role is often associated with a policing or surveillance role. In this way the relationship that exists between the client and social worker may get confusing and ambiguous (McLaughlin, 2008).

Common Roles of Social Workers

Over the course of their career, a social worker at any one time may perform multiple roles to varying degrees. The difficulty for many social workers is that over time the roles that involve direct case work have lessened; often social workers will find themselves in a position that involves little client involvement. One of the most difficult situations social workers will experience

in their careers is the conflict they face while fulfilling some of the following roles often expected of a social worker at one time.

Broker

A social worker acting as a broker assists and links people with services or resources. In this role social workers assess the needs of the individual while also taking into account the client's overall capacity and motivation to use available resources. Once the needs are assessed and potential services identified, the broker assists the client in choosing the most appropriate service option. The social worker as a broker role is also concerned with the quality, quantity, and accessibility of services. This role is expected to be up-to-date on current services and programs available, as well as familiar with the process for accessing those resources and programs (Zastrow, 2016).

Case Manager

A social worker acting as a case manager identifies the needs as well as the barriers of their clients. Occasionally case managers may also provide direct service to their clients. Case managers often engage with clients who require multiple services from a variety of agencies and work with the client to develop goals and implement interventions based on the identified goals. Social workers acting as case managers remain actively engaged with clients throughout the process by identifying and coordinating services, monitoring identified services and providing support when necessary, and finally providing follow-ups to ensure services are being utilized (Zastrow, 2016).

Advocate

A social worker as an advocate seeks to protect client's rights and ensure access and utilization of services they are entitled to receive. Social workers may perform advocacy work by advocating for a single client or by representing groups of clients with a common problem or identified need. Social workers may advocate with other organizations/providers and encourage their clients to advocate for themselves in order to address a need or obtain a service. Advocacy is an integral and fundamental role in the social work profession as it is necessary to promote overall wellbeing. The National Association of Social Workers (NASW) (2015) "has specified social workers' responsibility to the community and broader society since its adoption in 1960, and in 1996, strengthened its call to require *all* social workers to "engage in social and political action" to "expand choice and opportunity" and "equity and social justice for all people" (p. 27). Social workers acting in this capacity may advocate in varying capacities but often times may find themselves in a position of educating the public in order to garner support to seek changes in laws that are harming and impacting the wellbeing of clients. Social workers acting as advocates should always consider whether they are acting and advocating in a way that maximizes client self-determination (Zastrow, 2016).

Educator

Social workers acting as a teacher or educator often help in times of crisis for many clients. In this role social workers help clients develop insight into their behaviors through providing education aimed at helping clients learn skills to handle difficult situations and identify alternative life choices. In this role social workers aim to increase their client's knowledge of various skills some of which include: budgeting, parenting, effective communication, and/or violence prevention (Zastrow, 2016).

Counselor

A social worker acting as a counselor helps clients express their needs, clarify their problems, explore resolution strategies, and applies intervention strategies to develop and expand the capacities of clients to deal with their problems more effectively. A key function of this role is to empower people by affirming their personal strengths and their capacities to deal with their problems more effectively (Zastrow, 2016).

Risk Assessor

Social workers acting as risk assessors have been given a major role in the assessment of needs and risks over a variety of client groups. Assessment is a primary role for social workers and often times is what dictates the services and resources identified as needs for clients. Often time's social workers acting in this role find themselves in precarious situations as the relationship between the client and social worker may be conflicting, especially when working in the mental health field. While working as a risk assessor in the mental health field the social worker may experience conflict between encouraging client self-determination and addressing safety risks.

Mediator

It is common that social workers act as mediators and negotiators as conflict is the root of many areas of social work. Social

workers acting in these roles are required to take a neutral stance in order to find compromises between divided parties. In this role social workers seek to empower the parties to arrive and their own solutions in order to reconcile differences and reach a mutually satisfying agreement (Stoesen, 2006).

Researcher

A social worker in the role of researcher or program evaluator uses their practice experience to inform future research. The social worker is aware of current research and able to integrate their knowledge with the current research. Social workers acting in this capacity are able to utilize the knowledge they have obtained through gathering and examining the research to inform their practice interventions (Grinnell & Unrau, 2010).

Group Leader

Social workers who play the role of group leader or facilitator can do so with groups of people gathering for purposes including; task groups, psychoeducational groups, counseling groups, and psychotherapy groups. Task groups are like the name infers task oriented and social workers facilitate that process by understanding group dynamics. Psychoeducational groups are led by social workers who focus on developing members' cognitive, affective, and behavioral skills in an area group members are deficient through integrating and providing factual information to participants. Social workers who facilitate counseling groups help participants resolve problems in various areas that can include: personal, social, educational, or career concerns. In psychotherapy groups social worker address psychological and interpersonal problems that are negatively impacting member's lives (Corey, Corey, & Corey, 2014).

Additional Suggested Readings

Kerson, T. S., & McCoyd, J. (2013). In response to need: An analysis of social work roles over time. *Social work, 58*(4), 333-343. doi: 10.1093/sw/swt035

Gibelman, Margaret (1999). The search for identity: defining social work – past, present, future. *Social Work, 44*(4), 298-310. doi: 10.1093/sw/44.4.298

Characteristics and Skills of Effective Social Workers

Much like the definition of the term "social work," the characteristics and skills required to become an effective social worker are also hard to define and require versatility in this complex and constantly changing environment. Competent and effective social workers are expected to have knowledge in varying intervention strategies and skills in order to enhance functioning and empower others. Effective social workers also must be willing to consider the needs of those being served when designing interventions seeking to enhance the wellbeing of others. In doing so many social workers may adopt specific roles or a combination of roles in order to effectively and efficiently meet the identified need(s). Some common elements and skills have been identified as effective across micro and macro practice settings. It is important to remember that when we are discussing effective social workers it is not just about *what* they do, it is also about *how* they do it (Sheafor, Horejsi & Horejsi, 2000).

Self-Awareness

One of the most important skills necessary for becoming a competent and effective social worker is self-awareness. Self-awareness starts with getting to know yourself and requires clarifying one's own values and assumptions. Every day we are learning and changing as a result of our experiences, therefore self-awareness is a lifelong process that cannot be acquired through education and readings alone. This process requires understanding of past experiences and reflecting on the impacts of those experiences in relation to your world view and view of yourself. People who practice self-awareness can recognize, understand, and regulate their emotions. Self-awareness allows individuals to maximize their strengths by acknowledging their weaknesses. By recognizing areas of both strength and weakness, self-aware people can take proactive steps to manage their weakness and avoid setbacks (Sheafor, Horejsi & Horejsi, 2000).

Competence

Competence is essential in the social work world as there are numerous treatment approaches and intervention strategies available for clients. That being said, it is impossible for a social worker to be competent in every intervention strategy or treatment option. Social workers are expected to be knowledgeable in areas and intervention strategies they will be utilizing with their clients. According to Sheafor, Horejsi, and Horejsi (2000), generalist practice social workers need to be prepared to treat a

diverse population of clients, which requires knowledge in a variety of assessment and intervention techniques.

Effective social workers can identify personal values, political beliefs and assumptions but also are willing to develop knowledge of other cultures through formal education and interaction. Professional development allows social workers to develop skills that will enable them to implement successful interventions. Cultural competence is also an area that should be considered when determining effectiveness. All social workers should continually seek cultural knowledge; through education and direct interaction. Culture is an area that is constantly changing and social workers should be prepared to engage in life-long learning in order to seek competence.

Empathy

One of the most critical elements is the relationship between the social worker and the client. Specifically whether or not the client feels the social worker is genuine, supportive and empathetic towards them. A sense of empathy from the social worker increases the chances of building a therapeutic relationship with the client. Because of this, ability to empathize is essential for social workers. Dr. Brown (2013) suggests that empathy is the best way to ease someone's pain and suffering and is the skill that fuels connections. Empathy is a choice that requires individuals to acknowledge their own vulnerabilities which is often why the ability to empathize is considered a difficult skill to develop.

Critical thinking

The ability to critically think is crucial to the social work profession. Social workers use critical thinking skills on a daily basis to problem solve issues. Critical thinking skills include the ability to ask thoughtful and appropriate questions aimed at empowering others to find their own solutions. It is by applying critical thinking skills that social workers are able to make accurate observations, evaluate client abilities/limitation and/or agencies abilities/limitations. Critical thinking skills can also help social workers generate possible solutions and identify appropriate interventions to implement based of their critical evaluation of the issues and known barriers. Critical thinking skills also aid in the social worker's ability to examine and evaluate the effectiveness of the interventions (Sheafor, Horejsi & Horejsi, 2000).

Communication skills

Communication in the social work profession encompasses a wide-range of activities beyond the ability to communicate effectively with their clients and other professionals. Determining the best approach to utilize when communicating with clients and other professionals will require the use of critical thinking skills. Many social workers are often working in the role of helping others who are seeking to make changes. Therefore, effective social workers will use a combination of different strategies to help move clients towards change. Social workers with effective communication skills avoid directly telling other's what to do and rely heavily of their ability to communicate in order to empower clients to identify their own solutions. Developing and utilizing effective communication skills help clients establish trust and promotes rapport building between the social worker and the client which increases the chances of a successful intervention.

It is important to understand that effective communication skills go beyond one's ability to communicate verbally and includes the ability to communicate through written reports as well as non-verbally while displaying active listening skills. Effective non-verbal communication requires the social worker to portray and display an empathetic, non-judgmental attitude when listening and engaging with clients. Effective written communication skills include the ability to communicate concisely, professionally, and honestly in various written formats as there are multiple mediums in which a social worker must be able to communicate. Because of this, competency in using word processors, email systems, spreadsheets, databases and knowledge of grammar and spelling are an important communication skill. These tasks may seem simple and appear obvious, however may prove challenging. Over time communication skills can be learned with practice, regular reflection, and self-assessment (Sheafor, Horejsi & Horejsi, 2000).

Additional readings

D'Aprix, A. S., Dunlap, K. M., Abel, E., & Edwards, R. L. (2004). Goodness of fit: Career goals of MSW students and the aims of the social work profession in the United States. *Social Work Education*, *23*(3), 265-280. dx.doi.org/10.1080/0261547042000224029

Supplemental Activities

Brené Brown's TED Talk: *The Power of Vulnerability* : https://www.ted.com/talks/brene_brown_on_vulnerability

Brené Brown on Empathy (2:53)

YouTube Video

This interactive element is not available in this format. Visit the link or scan the QR code to access it online.

View this YouTube Video online

Challenges Ahead

Rothman and Mizrahi (2014) identified a need to rectify an imbalance that exists between micro and macro social work practice to not only strengthen the profession, but to overcome the multitude of problems facing society. Historically the social work profession has addressed the needs of the population with a dual approach, encompasses both macro and micro practice social workers to achieve social progress. This approach requires involvement from social workers at every level of practice to bring about social reform as well as meet the needs of individuals and families.

Currently, the American Academy of Social Work and Social Welfare (AASWSW) is pioneering an innovative approach to achieving social progress powered by science called "The Grand Challenges of Social Work." The AASWSW identifies 12 challenges and major social problems impacting today's society. Today's social workers will need to address and implement effective approaches known to improve individual and family wellbeing in order to begin strengthening the social fabric of America.

The 12 challenges are as follows:

1. *The challenge to ensure healthy development for all youth:* The AASWSW has identified the need to prevent behavioral health problems emerging in over six million young people yearly. Evidence has identified several effective prevention based approaches to address the severe mental, emotional, and behavior problems affecting today's youth.
2. *The challenge to close the health gap:* More than 60 million Americans have inadequate access to basic health care. Even more disturbing – the majority of people with inadequate access also experience discrimination and poverty. There is an extreme need to develop new strategies targeted at improving the health of our society.
3. *The challenge to stop family violence*: Assaults by parents, partners, and adult children are common American tragedies that often result in serious injury, including death. This type of violence impacts society through various arenas. Effective intervention strategies have been identified and if implemented could help break the cycle of violence for many families.
4. *The challenge to advance long and productive lives:* Through identifying and engaging individuals with healthy and productive activities, overall health and well-being can be improved.
5. *The challenge to eradicate social isolation:* Social workers can help with this challenge by educating the public about the impacts of social isolation as well as, promote effective ways to make social connections.
6. *The challenge to end homelessness:* Over 1.5 million American's experience homelessness at least one night a year. Homelessness affects health and well-being and often has lasting impacts on personal development. The challenge will be to implement and expand on proven approaches as well as, implement policies that promote affordable housing.
7. *The challenge to create social responses to a changing environment:* Climate change and urban development exacerbate the already existing social and environmental inequalities of marginalized communities. The challenge will be to develop improved social responses based on this knowledge as well as, helping those impacted by the changing environment through developing policies specific to helping those in need.
8. *The challenge to harness technology for social good:* A unique opportunity to access and target various populations and social problems exists because of advances to technology. The challenge will be for social workers to find ways to use technology to not only access knowledge, but to gain expertise for the advancement of the social work profession.
9. *The challenge to promote "smart decarceration":* With the United States having the world's largest percentage of its population behind bars this could prove to truly be a grand challenge. "Smart Decarceration" calls for a reduction in the number of people imprisoned, as well as the willingness of a nation to embrace a new and proactive way of addressing safety.
10. *The challenge to reduce extreme inequality:* One out of every five children live in poverty, while the top 1% owns almost half of the wealth in the U.S. Poor health outcomes and decreased overall well-being have been documented results of living in poverty. Inequality can be reduced through increased access to education, wages, tax benefits, and/or home ownership. Social workers should seek to adopt policies that promote equality.
11. *The challenge to build financial capability for all:* Nearly half of all American households are financially insecure, which means they do not have adequate savings to meet their basic living expense for three months. By adopting policies that support

security in retirement accounts as well as, access to financial services that provide for financial literacy there can be a significant reduction in the economic hardships faced by families.

12. *The challenge toachieve equal opportunity and justice:* Historic and current prejudice and injustice in the United States impacts several groups of people by impeding and excluding access to education and employment. In order to overcome this challenge social workers must embrace and appreciate diversity and begin shedding light onto unfair practices.

Additional Reading/ Activities

Bent-Goodley, T.B. (2017). Readying the profession for changing times. *Social Work, 62*(2), 101-103. doi: 10.1093/sw/swx014

Singer, J. B. (Producer). (2016, March 28). #103 – The Grand Challenges for Social Work: Interview with Dr. Richard P. Barth [Audio Podcast]. *Social Work Podcast*. Retrieved from http://www.socialworkpodcast.com/2016/03/grand-challenges.html

Activities for Chapter One

Activity #1

25 questions to help you get to know yourself

http://www.mistysansom.com/know-who-you-are-with-these-25-questions

- What does your ideal day look like?
- What did you want to be when you were younger?
- Who are you most inspired by? Why?
- Who would you love to meet? What would you ask?
- What habit would you most like to break? What habit would you most like to start?
- Think of a person you truly admire. What qualities do you like about that person?
- How do you like to relax?
- When was the last time you did something you were afraid of?
- What are you most proud of?
- What are you most afraid of?
- If life stopped today, what would you regret not doing?
- Who would you like to connect (or reconnect) with? Why?
- What qualities do you admire in others?
- What practical skills do you wish you had?
- Imagine you're in your 90s. What memories would you like to have? What stories do you want to tell?
- What is your favorite book/movie/song? Why?
- If you could make one change in the world, what would it be?
- What do you love to do for, or give to others (not an object – something from you personally)?
- What excites you?
- What do you wish you did more of?
- Pretend money is no object. What would you do?
- What area of your life, right now, makes you feel the best? Which area makes you feel the worst? Why?
- Let's jump forward a year. What would you like to have achieved in the past year?
- What piece of advice would you give to five year old you? Sixteen year old you? Twenty-one year old you? Right now?
- How do you want to be remembered in life?

Activity #2:

The Five Minute Personality Test

http://www.sagestrategies.biz/documents/FiveMinutePersonalityTestforclass.pdf

Activity #3:

Character Strengths Survey

PODCASTS

Singer, J. B. (Producer). (2014, July 8). #87 – Beginnings, middles, and ends: Stories about social work from Ogden Rogers, Ph.D.

[Audio Podcast]. *Social Work Podcast*. Retrieved from http://socialworkpodcast.blogspot.com/2014/07/ogden.html

Brunner, Allison (2009). When In doubt, give hope." *Social Work Podcast*. Retrieved from http://www.socialworkpodcast.com/GraduationSpeech2009.mp3

Singer, J. B. (Producer). (2016, March 28). #103 – The Grand Challenges for Social Work: Interview with Dr. Richard P. Barth [Audio Podcast]. *Social Work Podcast*. Retrieved from http://www.socialworkpodcast.com/2016/03/grand-challenges.html

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1.2: American Psychological Association (APA) Style

Learning Objectives

1. Define APA style and list several of its most important characteristics.
2. Identify three levels of APA style and give examples of each.
3. Identify multiple sources of information about APA style.

What Is APA Style?

APA style is a set of guidelines for writing in psychology and related fields. These guidelines are set down in the **Publication Manual of the American Psychological Association** (APA, 2010)[1]. The *Publication Manual* originated in 1929 as a short journal article that provided basic standards for preparing manuscripts to be submitted for publication (Bentley et al., 1929)[2]. It was later expanded and published as a book by the association and is now in its sixth edition. The primary purpose of APA style is to facilitate scientific communication by promoting clarity of expression and by standardizing the organization and content of research articles and book chapters. It is easier to write about research when you know what information to present, the order in which to present it, and even the style in which to present it. Likewise, it is easier to read about research when it is presented in familiar and expected ways.

APA style is best thought of as a "genre" of writing that is appropriate for presenting the results of psychological research—especially in academic and professional contexts. It is not synonymous with "good writing" in general. You would not write a literary analysis for an English class, even if it were based on psychoanalytic concepts, in APA style. You would write it in Modern Language Association (MLA) style instead. And you would not write a newspaper article, even if it were about a new breakthrough in behavioral neuroscience, in APA style. You would write it in Associated Press (AP) style instead. At the same time, you would not write an empirical research report in MLA style, in AP style, or in the style of a romance novel, an email to a friend, or a shopping list. You would write it in APA style. Part of being a good writer in general is adopting a style that is appropriate to the writing task at hand, and for writing about psychological research, this is APA style.

The Levels of APA Style

Because APA style consists of a large number and variety of guidelines—the *Publication Manual* is nearly 300 pages long—it can be useful to think about it in terms of three basic levels. The first is the overall organization of an article (which is covered in Chapter 2 "Manuscript Structure and Content" of the *Publication Manual*). Empirical research reports, in particular, have several distinct sections that always appear in the same order:

- **Title page.** Presents the article title and author names and affiliations.
- **Abstract.** Summarizes the research.
- **Introduction.** Describes previous research and the rationale for the current study.
- **Method.** Describes how the study was conducted.
- **Results.** Describes the results of the study.
- **Discussion.** Summarizes the study and discusses its implications.
- **References.** Lists the references cited throughout the article.

The second level of APA style can be referred to as **high-level style** (covered in Chapter 3 "Writing Clearly and Concisely" of the *Publication Manual*), which includes guidelines for the clear expression of ideas. There are two important themes here. One is that APA-style writing is formal rather than informal. It adopts a tone that is appropriate for communicating with professional colleagues—other researchers and practitioners—who share an interest in the topic. Beyond this shared interest, however, these colleagues are not necessarily similar to the writer or to each other. A graduate student in British Columbia might be writing an article that will be read by a young psychotherapist in Toronto and a respected professor of psychology in Tokyo. Thus formal writing avoids slang, contractions, pop culture references, humor, and other elements that would be acceptable in talking with a friend or in writing informally.

The second theme of high-level APA style is that it is straightforward. This means that it communicates ideas as simply and clearly as possible, putting the focus on the ideas themselves and not on how they are communicated. Thus APA-style writing minimizes literary devices such as metaphor, imagery, irony, suspense, and so on. Again, humor is kept to a minimum. Sentences are short and direct. Technical terms must be used, but they are used to improve communication, not simply to make the writing sound more "scientific." For example, if participants immersed their hands in a bucket of ice water, it is better just to write this than to write that they "were subjected to a pain-inducement apparatus." At the same time, however, there is no better way to communicate that a between-subjects design was used than to use the term "between-subjects design."

APA Style and the Values of Psychology

Robert Madigan and his colleagues have argued that APA style has a purpose that often goes unrecognized (Madigan, Johnson, & Linton, 1995)[3]. Specifically, it promotes psychologists' scientific values and assumptions. From this perspective, many features of APA style that at first seem arbitrary actually make good sense. Following are several features of APA-style writing and the scientific values or assumptions they reflect.

APA style feature	Scientific value or assumption
There are very few direct quotations of other researchers.	The phenomena and theories of psychology are objective and do not depend on the specific words a particular researcher used to describe them.
Criticisms are directed at other researchers' work but not at them personally.	The focus of scientific research is on drawing general conclusions about the world, not on the personalities of particular researchers.
There are many references and reference citations.	Scientific research is a large-scale collaboration among many researchers.
Empirical research reports are organized with specific sections in a fixed order.	There is an ideal approach to conducting empirical research in psychology (even if this ideal is not always achieved in actual research).
Researchers tend to "hedge" their conclusions, e.g., "The results *suggest* that..."	Scientific knowledge is tentative and always subject to revision based on new empirical results.

Another important element of high-level APA style is the avoidance of language that is biased against particular groups. This is not only to avoid offending people—why would you want to offend people who are interested in your work?—but also for the sake of scientific objectivity and accuracy. For example, the term *sexual orientation* should be used instead of *sexual preference* because people do not generally experience their orientation as a "preference," nor is it as easily changeable as this term suggests (APA Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients, 2000)[4].

The general principles for avoiding biased language are fairly simple. First, be sensitive to labels by avoiding terms that are offensive or have negative connotations. This includes avoiding terms that identify people with a disorder or other problem they happen to have. Instead, refer to the individual, what the APA *Publication Manual* refers to as putting the "person first." For example, *people diagnosed with schizophrenia* is better than *schizophrenics*. Second, use more specific terms rather than more general ones. For example, *Chinese Americans* is better than *Asian Americans* if everyone in the group is, in fact, Chinese American. Third, avoid objectifying research participants. Instead, acknowledge their active contribution to the research. For example, "The *students completed* the questionnaire" is better than "The *subjects were administered* the questionnaire." Note that this principle also makes for clearer, more engaging writing. Table 1.2.1 shows several more examples that follow these general principles.

Table 1.2.1: Examples of Avoiding Biased Language

Instead of...	Use...
man, men	men and women, people
firemen	firefighters
homosexuals, gays, bisexuals	lesbians, gay men, bisexual men, bisexual women

Instead of...	Use...
minority	specific group label (e.g., African American)
neurotics	people scoring high in neuroticism
special children	children with learning disabilities

The previous edition of the *Publication Manual* strongly discouraged the use of the term *subjects* (except for nonhumans) and strongly encouraged the use of *participants* instead. The current edition, however, acknowledges that *subjects* can still be appropriate in referring to human participants in areas in which it has traditionally been used (e.g., basic memory research). But it also encourages the use of more specific terms when possible: *university students*, *children*, *respondents*, and so on.

The third level of APA style can be referred to as **low-level style** (which is covered in Chapter 4 "The Mechanics of Style" through Chapter 7 "Reference Examples" of the *Publication Manual*). Low-level style includes all the specific guidelines pertaining to spelling, grammar, references and reference citations, numbers and statistics, figures and tables, and so on. There are so many low-level guidelines that even experienced professionals need to consult the *Publication Manual* from time to time. Table 1.2.2 contains some of the most common types of APA style errors based on an analysis of manuscripts submitted to one professional journal over a 6-year period (Onwuegbuzie, Combs, Slate, & Frels, 2010)[5]. These errors were committed by professional researchers but are probably similar to those that students commit the most too. See also Note 11.8 "Online APA Style Resources" in this section and, of course, the *Publication Manual* itself.

Table 1.2.2: Top 10 APA Style Errors

Error type	Example
1. Use of numbers	Failing to use numerals for 10 and above
2. Hyphenation	Failing to hyphenate compound adjectives that precede a noun (e.g., "role playing technique" should be "role-playing technique")
3. Use of *et al.*	Failing to use it after a reference is cited for the first time
4. Headings	Not capitalizing headings correctly
5. Use of *since*	Using *since* to mean *because*
6. Tables and figures	Not formatting them in APA style; repeating information that is already given in the text
7. Use of commas	Failing to use a comma before *and* or *or* in a series of three or more elements
8. Use of abbreviations	Failing to spell out a term completely before introducing an abbreviation for it
9. Spacing	Not consistently double-spacing between lines
10. Use of "&" in references	Using *&* in the text or *and* in parentheses

Online APA Style Resources

The best source of information on APA style is the *Publication Manual* itself. However, there are also many good websites on APA style, which do an excellent job of presenting the basics for beginning researchers. Here are a few of them.

APA Style

http://www.apastyle.org

Purdue Online Writing Lab

http://owl.english.purdue.edu/owl/resource/560/01

Douglas Degelman's APA Style Essentials

> http://www.vanguard.edu/psychology/faculty/douglas-degelman/apa-style/
>
> *Doc Scribe's APA Style Lite*
>
> http://people.cs.ksu.edu/~huichen/APA%20Lite%20Writing%20Guidelines.pdf

APA-Style References and Citations

Because science is a large-scale collaboration among researchers, references to the work of other researchers are extremely important. Their importance is reflected in the extensive and detailed set of rules for formatting and using them.

References

At the end of an APA-style article or book chapter is a list that contains **references** to all the works cited in the text (and *only* the works cited in the text). The reference list begins on its own page, with the heading "References," centered in upper and lower case. The references themselves are then listed alphabetically according to the last names of the first named author for each citation. (As in the rest of an APA-style manuscript, *everything* is double-spaced.) Many different kinds of works might be cited in APA-style articles and book chapters, including magazine articles, websites, government documents, and even television shows. Of course, you should consult the *Publication Manual* or Online APA Style Resources for details on how to format them. Here we will focus on formatting references for the three most common kinds of works cited in APA style: journal articles, books, and book chapters.

Journal Articles

For journal articles, the generic format for a reference is as follows:

Author, A. A., Author, B. B., & Author, C. C. (year). Title of article. *Title of Journal, volume*(issue), pp–pp. doi:xx.xxxxxxxxx

Here is a concrete example:

Adair, J. G., & Vohra, N. (2003). The explosion of knowledge, references, and citations: Psychology's unique response to a crisis. *American Psychologist, 58*(1), 15–23. doi: 10.1037/0003-066X.58.1.15

There are several things to notice here. The reference includes a hanging indent. That is, the first line of the reference is not indented but all subsequent lines are. The authors' names appear in the same order as on the article, which reflects the authors' relative contributions to the research. Only the authors' last names and initials appear, and the names are separated by commas with an ampersand (&) between the last two. This is true even when there are only two authors. Only the first word of the article title is capitalized. The only exceptions are for words that are proper nouns or adjectives (e.g., "Freudian") or if there is a subtitle, in which case the first word of the subtitle is also capitalized. In the journal title, however, all the important words are capitalized. The journal title and volume number are italicized; however, the issue number (listed within parentheses) is not. At the very end of the reference is the digital object identifier (DOI), which provides a permanent link to the location of the article on the Internet. Include this if it is available. It can generally be found in the record for the item on an electronic database (e.g., PsycINFO) and is usually displayed on the first page of the published article.

Books

For a book, the generic format and a concrete example are as follows:

- Author, A. A. (year). *Title of book*. Location: Publisher.
- Kashdan, T., & Biswas-Diener, R. (2014). *The upside of your dark side.* New York, NY: Hudson Street Press.

Book Chapters

For a chapter in an edited book, the generic format and a concrete example are as follows:

- Author, A. A., Author, B. B., & Author, C. C. (year). Title of chapter. In A. A. Editor, B. B. Editor, & C. C. Editor (Eds.), *Title of book* (pp. xxx–xxx). Location: Publisher.
- Lilienfeld, S. O., & Lynn, S. J. (2003). Dissociative identity disorder: Multiple personalities, multiple controversies. In S. O. Lilienfeld, S. J. Lynn, & J. M. Lohr (Eds.), *Science and pseudoscience in clinical psychology* (pp. 109–142). New York, NY: Guilford Press.

Notice that references for books and book chapters are similar to those for journal articles, but there are several differences too. For an edited book, the names of the editors appear with their first and middle initials followed by their last names (not the other way around)—with the abbreviation "Eds." (or "Ed.," if there is only one) appearing in parentheses immediately after the final editor's name. Only the first word of a book title is capitalized (with the exceptions noted for article titles), and the entire title is italicized. For a chapter in an edited book, the page numbers of the chapter appear in parentheses after the book title with the abbreviation "pp." Finally, both formats end with the location of publication and the publisher, separated by a colon.

Reference Citations

When you refer to another researcher's idea, you must include a **reference citation** (in the text) to the work in which that idea originally appeared and a full reference to that work in the reference list. What counts as an idea that must be cited? In general, this includes phenomena discovered by other researchers, theories they have developed, hypotheses they have derived, and specific methods they have used (e.g., specific questionnaires or stimulus materials). Citations should also appear for factual information that is not common knowledge so that other researchers can check that information for themselves. For example, in an article on the effect of cell phone usage on driving ability, the writer might cite official statistics on the number of cell phone–related accidents that occur each year. Among the ideas that do not need citations are widely shared methodological and statistical concepts (e.g., between-subjects design, *t* test) and statements that are so broad that they would be difficult for anyone to argue with (e.g., "Working memory plays a role in many daily activities."). Be careful, though, because "common knowledge" about human behavior is often incorrect. Therefore, when in doubt, find an appropriate reference to cite or remove the questionable assertion.

When you cite a work in the text of your manuscript, there are two ways to do it. Both include only the last names of the authors and the year of publication. The first method is to use the authors' last names in the sentence (with no first names or initials) followed immediately by the year of publication in parentheses. Here are some examples:

Burger (2008) conducted a replication of Milgram's (1963) original obedience study.

Although many people believe that women are more talkative than men, Mehl, Vazire, Ramirez-Esparza, Slatcher, and Pennebaker (2007) found essentially no difference in the number of words spoken by male and female college students.

Notice several things. First, the authors' names are treated grammatically as names of people, not as things. It is better to write "a replication of Milgram's (1963) study" than "a replication of Milgram (1963)." Second, when there are two authors the names are not separated by commas, but when there are three or more authors they are. Third, the word *and* (rather than an ampersand) is used to join the authors' names. Fourth, the year follows immediately after the final author's name. An additional point, which is not illustrated in these examples but is illustrated in the sample paper in Section 11.2 "Writing a Research Report in American Psychological Association (APA) Style", is that the year only needs to be included the first time a particular work is cited in the same paragraph.

The second way to cite an article or a book chapter is parenthetically—including the authors' last names and the year of publication in parentheses following the idea that is being credited. Here are some examples:

- People can be surprisingly obedient to authority figures (Burger, 2008; Milgram, 1963).
- Recent evidence suggests that men and women are similarly talkative (Mehl, Vazire, Ramirez-Esparza, Slatcher, & Pennebaker, 2007).

One thing to notice about such parenthetical citations is that they are often placed at the end of the sentence, which minimizes their disruption to the flow of that sentence. In contrast to the first way of citing a work, this way always includes the year—even when the citation is given multiple times in the same paragraph. Notice also that when there are multiple citations in the same set of parentheses, they are organized alphabetically by the name of the first author and separated by semicolons.

There are no strict rules for deciding which of the two citation styles to use. Most articles and book chapters contain a mixture of the two. In general, however, the first approach works well when you want to emphasize the person who conducted the research—for example, if you were comparing the theories of two prominent researchers. It also works well when you are

describing a particular study in detail. The second approach works well when you are discussing a general idea and especially when you want to include multiple citations for the same idea.

The third most common error in Table 1.2.2 has to do with the use of *et al*. This is an abbreviation for the Latin term *et alia*, which means "and others." In APA style, if an article or a book chapter has *more than two authors but fewer than six*, you should include all their names when you first cite that work. After that, however, you should use the first author's name followed by "et al." If the article has only two authors then both should be included in every citation. If an article has six or more authors then you should only list the name of the first author followed by et al. each and every time you cite that work (even the first time). Here are some examples:

Recall that Mehl et al. (2007) found that women and men spoke about the same number of words per day on average.

There is a strong positive correlation between the number of daily hassles and the number of symptoms people experience (Kanner et al., 1981).

Notice that there is no comma between the first author's name and "et al." Notice also that there is no period after "et" but there is one after "al." This is because "et" is a complete word and "al." is an abbreviation for the word *alia*.

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2: CHAPTER 2

2.1: NASW Code of Ethics

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2.1: NASW Code of Ethics

Social Work Mission: “To enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (Cournoyer, 2011, p. 160).

Ethics



NASW logo

Social work is considered a helping profession. Like many other helping professions such as nursing, counseling, teaching, and psychiatry, social work has ethical guidelines that help direct us in our work. Social workers are a vital membesr of the helping community and can be seen assisting many other helping professions (Cournoyer, 2011). Helping professions address a multitude of problems or dilemmas often involving a person’s physical, mental, social, intellectual, and spiritual well-being.

Therefore, as a social worker in the helping profession, you are responsible for many legal and important decisions. Often these decisions involve ethical choices in the best interest of clients’ lives. These decisions can be extremely difficult and emotionally charged and they may not always be the choices you are comfortable making.

The National Association of Social Work (NASW) Code of Ethics serves as guidelines for professional practice. It is relevant to all social workers, social work students, and social work educators regardless of their specific duties or settings. One should certainly use and become familiar with this website as a guide for learning about the Code of Ethics.

The NASW Code of Ethics can be found at www.socialworkers.org/pubs/code/default.asp

To be an ethical and professional social worker one must have a thorough understanding of the Code of Ethics and the legal obligations social workers are responsible for (Cournoyer, 2011). When encountering specific dilemmas, you as a social worker are responsible for knowing what ethical principle or value best applies to that situation. You must also be able to think critically to determine the best outcome for all parties involved (Woodcock, 2011).

The purpose of this chapter is to provide you with a brief understanding of the NASW Code of Ethics as you begin your journey through a social work program. This chapter is designed to help explore and provide a base understanding of these terms and overall principles. The goal is to prepare you for future courses and your future career so you are familiar with the general concepts. You will continue to explore the NASW Code of Ethics throughout your education, and will become much more applicable through continuing courses. **(keywords: ethics, values, obligations and duties)**

Establishment of the Code of Ethics

Social work is grounded on the concepts of social justice and fairness and the idea that all people should be treated equally. Clearly, when looking at the history of our nation, not all people have been treated equally. In the nineteenth century, social work became known as the calling that responded to the needs of vulnerable populations and those living in poverty. Through the rise of settlement houses and charity organization societies in the twentieth century and during the Great Depression, social workers promoted and provided new ways to address structural problems (Reamer, 2006)

As social work endeavored to gain recognition as a profession, the need arose for a formal code of ethics. While there were many social workers who helped pave the way, Mary Richmond is considered to be one of the most important. In 1920, Mary Richmond provided an experimental Code of Ethics which served as a base for many other social workers seeking social justice, equality, and fairness for vulnerable and oppressed populations (Reamer, 2006). Richmond's Code of Ethics served as a guide to the first edition of the NASW Code of Ethics which was constructed in October of 1960. This document, developed by the NASW's Delegate Assembly of the National Association of Social Workers, officially defined the ***duties and obligations*** for which a social worker is responsible. The 1960 edition defined fourteen responsibilities social workers were obligated to fulfill based on the mission of social work, and even included a discrimination clause. With the first revision in place the social work profession established a sense of professionalism.



Mary Richmond. Mary Richmond, a significant person in establishing social work as a profession. For more information on Mary Richmond, see http://socialwelfare.library.vcu.edu/social-work/richmond-mary

The NASW Code of Ethics continues to be updated. Many significant revisions have been created as the needs of the increasingly diverse population social workers serve continue to change. Shortly after the publishing of the 1960 Code of Ethics, social workers became concerned with the Code's suggestions for handling ethical dilemmas. In an effort to address these concerns, a task force was established to revise the original Code of Ethics (Reamer, 2006). In 1979, the NASW Delegate Assembly continued to work on the revisions as needed. It was not until the 1990's when the NASW Code of Ethics was significantly modified again.

During the 1990's the Code of Ethics had several impactful changes that were centered on the relationship between clients and social workers (Reamer, 2006). The profession began to stress the importance of maintaining professional boundaries with clients as social workers started to become more involved in clients' lives. Five new principles were also included in the Code of Ethics that were centered on social work impairment and dual relationships. This lead to a major revision due to the profession's developing understanding of ethical issues previously not addressed resulting in the public and media paying more attention to the NASW Code of Ethics.

In 2008, a major advancement occurred which incorporated the terms sexual orientation, gender identity, and immigration status into the non-discrimination standards in the Code of Ethics. This was a significant update because for a long period of time these groups of people have been heavily discriminated against in the United States and throughout the world.

Provided is a link with all updated changes: www.socialworkers.org/nasw/ethics/ethicshistory.asp

Overview of NASW Code of Ethics: Four Sections



Ethics highlighted

The NASW Code of Ethics consists of four sections:

- Preamble
- Purpose of the NASW Code of Ethics
- Ethical Principles
- Ethical Standards

(Woodcock, 2011).

The first section, the preamble, is intended to outline Social Work's mission and core values while the second section provides a purpose and overview of the NASW Code of Ethics and how to handle or deal with ethical dilemmas (Woodcock, 2011). The third section, which is labeled Ethical Principles, helps define ethical principles based on Social Work's six core values. Finally, the fourth section provides detailed ethical standards for which social workers are held accountable. It is important that as future social workers you are familiar with all four sections as they are intended to serve as guidelines for practice.

Preamble

Social Work's mission is "to enhance human well-being and help meet the basic human needs of all people, with attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (Cournoyer, 2011, p. 160). With this mission, social workers should have a clear indication of what is expected when entering the field and practicing as a social worker. The six core values of Social Work are derived from the mission statement. These values will be further discussed in the chapter, but keep in mind the preamble section is rooted in these values.

Social workers should take pride in their work as they are seeking to improve the lives of others, and enhance the well-being of society. It is important to recognize social work's primary mission, but as social workers you will also need to best represent the agency or organization you are working for. Every agency or organization will have their own guidelines or rules; it is then your responsibility to incorporate those guidelines along with the NASW Code of Ethics. Social workers have many different roles and can be found in many areas of work, but the primary goal is to endorse social justice (Woodcock, 2011).

Purpose of the NASW Code of Ethics

The purpose of the NASW Code of Ethics is to hold social workers to a high standard of professionalism.

The *NASW Code of Ethics* serves six purposes:

1. The *Code* identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code*, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

(NASW, 2008)

The NASW Code of Ethics cannot guarantee all ethical behavior, therefore it is up to you as a social worker to follow the Code of Ethics and best represent the profession. Become familiar with the Code of Ethics and continue to stay familiarized with them even beyond your education. There are going to be times when you as a social worker will not be sure what to do or what decision to make. This can be very frustrating. The Code of Ethics are intended to guide you through the process of difficult decision making so that you do come to the correct or best conclusion. Working closely with a supervisor will also be important.

When making ethical decisions where there is no clear answer on what to do, it becomes a difficult process. The simple answer is not always going to be present. Later in this chapter we will discuss ethical dilemmas, but remember to let the six core values, the NASW mission statement, and the Code of Ethics guide you in selecting the appropriate choice.

Ethical Principles

The ethical principles are based on the six core values of social work. These six values are important for all social workers to recognize and apply to their practice. They should help direct you in all ethical decisions or dilemmas you encounter. Social workers should also be conscientious of these values when working with clients, talking with co-workers, writing grants, or any other role a social worker performs, even if an ethical dilemma does not present itself. During your education, these six values will become much more significant than you may have imagined. You will learn true definitions of these terms and how to apply them to your practice.

How do you define value? What are important values in your life?

Today the term value is used in a variety of ways with many meanings. In the field of social work the six core values provide a framework for us that are connected in three important ways. First, the six core values have a direct relationship with clients, colleagues, and members of the broader society. Secondly, these six values derive from social works overall mission statement, and lastly, these six values relate to the resolution of ethical dilemmas and interventions that social workers use in their work (Reamer, 2006).

The six core values of social work are listed as:

- Service
- Social Justice
- Dignity and Worth of a Person
- Importance of Human Relationships
- Integrity
- Competence

Service

One of social work's primary goals is to help people who are in need and to address social problems (Cournoyer, 2011). This value defines what social workers should be responsible for and the dedication to their job. As a social worker, you are encouraged to volunteer your time and professional skills with no expectation of significant financial return (Reamer, 2011). Social workers need to be dedicated to their delivery of services and be fully committed to assisting to a client's needs.

Social Justice

Social Justice is a significant value for all social workers, as we seek to promote equality for all people. This is often done by advocating for fair laws or policies, on behalf of clients (Cournoyer, 2011). When promoting social justice, social workers have a specific focus on vulnerable and oppressed individuals or groups of people (Reamer, 2006).

Dignity and Worth of a Person

As a social worker, you must respect that individuals come from a variety of different backgrounds and cultures and that all people deserve to be treated with respect. Social workers should certainly support equality without assigning levels of worth to an individual or group and it is important to honor in the uniqueness of all individuals. Social workers should also be consistent with all values, ethical principles, and ethical standards of the profession when working with clients (Reamer, 2006). As social workers, one of your duties is to help others find their worth as a person.

Importance of Human Relationships

While recognizing the worth of all individuals, social workers should also respect the relationship of humans as they are important for change or working through dilemmas (Reamer, 2011). Social workers should work to strengthen relationships among people of all backgrounds. Relationships are a key in being successful in the field and promoting all ethics and values.

Integrity

Integrity is a significant value as it underlines the trustworthy manner all social workers should demonstrate. Social workers should be honest, responsible, and promote the ethical practices to the fullest (Reamer, 2006). You should also be aware of the profession's mission, vision, values, and ethical standards and apply them in a consistent manner as well as promote all ethical practices for any agency they are affiliated with. Social workers should take pride in their work.

Competence

Social workers should frequently enhance their professional knowledge and skills. As a social worker, it is important to continue to strive to best serve clients and represent the profession. Social workers must be competent in their practice and also know when they do not have the knowledge base or skill set, and therefore must refer out for services.

Ethical Standards

The ethical standards of social work consist of six important criteria for which all social workers are held responsible. They are social workers' ethical responsibilities:

- To clients
- To colleagues
- In practice settings
- As professionals
- To the social work profession
- To broader society

This link from the NASW website specifically lists all ethical standards under the six criteria: www.socialworkers.org/pubs/code/code.asp

Common ethical violations to be aware of consist of the following:

- Sexual activity with clients and colleagues
- Dual relationship
- Boundary violations
- Failure to seek supervision
- Failure to use practice skills
- Fraudulent behavior
- Premature termination
- Inadequate provisions for case transfer or referral
- Failure to discuss policies as part of informed consent with clients

(Cournoyer, 2011)

Summary

The NASW Code of Ethics is a living document and will continue to be adjusted as new developments and issues arise. Therefore, as a social worker, you are responsible to stay updated on all changes that are made and apply them to your practice. The Code of Ethics enforces the belief that the public will not be taken advantage of by the work of social workers for their own benefit and that clients will be treated fairly.

Legal Duties/Obligations

Another critical role of becoming a social worker is the legal obligations or duties you are responsible for. These duties are very serious and all social workers must abide by them. These duties or obligations consist of the:

- Duty to maintain confidentiality
- Duty to report
- Duty to inform
- Duty to respect privacy
- Duty to warn and protect

Duty to Maintain Confidentiality

Another important term in this chapter is the term confidentiality**.** Confidentiality, is extremely important for social workers as they have a **duty to maintain confidentiality** with all clients and the conversations they have with them. The term confidentiality indicates that any information shared by a client or pertaining to a client will not be shared with third parties (Cournoyer, 2011). It must remain between the social worker and the client. If confidentiality is broken, it can be a serious violation.

When meeting with clients for the first time it is mandatory to inform the client of their rights of confidentiality. No matter who is trying to seek information about a client you are working with, you must follow your duty to maintain confidentiality. Even if a client is deceased, you as the social worker are still obligated to protect the information you have obtained. Social workers should not only protect the information gained from clients, but they should also respect information shared by colleagues.

An important confidentiality law that you are likely to encounter as a social worker is the U.S. Health Insurance Portability and Accountability Act (HIPAA) which is commonly found in the health profession. HIPAA assures that client information will remain private and between them and the professional, and includes provisions for the protection of health information, records, or other information (Cournoyer, 2011). If a client wishes to give consent for their information to be shared, then they will be asked to sign a release form provided by the social worker giving permission to share that information.

Duty to Report

There are times when a social worker is required to break the confidentiality rule. These circumstances are the only time that a social worker is legally obligated to breach confidentiality agreements and must be taken very serious. This is known as **duty to report**. As a social worker, you are a *mandated reporter* and have a legal obligation to report to the designated authority if a client disclosed any of the following:

- they are going to harm or kill another person or indications of outrages against humanity
- abuse or neglect of a child, disabled person or senior citizen
- have a plan to commit suicide and admit to wanting to commit suicide

(Cournoyer, 2011)

For example, if a client discloses they have or plan to abuse a child or if a person's life is at imminent risk, then you are required to act. These are the times when confidentiality agreements are broken and the social worker must report to a supervisor or the proper authority, so the authority can take further action. If not reported, the social worker can face serious legal offenses. Upon taking a job and throughout your education you will learn who the proper person or agency is that you should report to.

At times, it may be difficult to determine if you should report or not report. This can be known as an ethical dilemma. Throughout your education you will better learn about the times when you as a social worker will be required to breach confidentiality. For now it is extremely important to understand that as a social worker there are times when it is necessary to report.

Duty to Inform

Another important duty you will be obligated to abide by is **duty to inform**. As a social worker, you are required to educate clients concerning the scope of your services. This consists of informing the client about confidentiality, duty to report, but also the cost, length of treatment, risks, alternative services and anything else your agency requires (Cournoyer, 2011). When you are hired by an agency they will certainly walk you through the steps of your duty to inform and what they require, but it is your obligation as a social worker to best inform the client of your role. This is often completed early in the process when you are first meeting with a client.

If you are taking any actions regarding the care of client, it is your job to inform them and consult with the client first. It is best to inform the client in advance and have informed consent. Not informing a client of your role can be a form of malpractice.

Duty to Respect Privacy

When becoming a social worker, it is extremely important to follow your **duty to respect the privacy** of the people you serve and work with. As a social worker, you should protect all information obtained during services and respect the client's right to privacy. Privacy differs from confidentiality because it refers to the client's right to choose what to share and what to not share with a social worker. Social workers must respect that there may be things the client does not wish to disclose and we must not force them to do so.

Often social workers help or assist people during vulnerable times and become a part of many people's lives. As a social worker, it is your duty to respect the relationship you have with clients and to not intrude on their lives outside of your sessions. For example, if you are working in a small town and run into a client you regularly meet with at the grocery store it is in your best interest as a social worker to respect the privacy of that individual and not approach them. Nor should you approach them and begin talking about what you previously talked about during one of your sessions together. You should discuss these possibilities with your client so they are aware of how you will react to them if you meet them in a public setting.

Duty to Warn and Protect.

Another duty social workers take on is the responsibility to warn potential victims a client may harm (Cournoyer, 2011). Along with many other helping professions a social worker is obligated to act to insure that anybody who may be in danger is aware of the possible danger. Therefore, as a social worker you must take serious action in deciding if a client is serious about harming another person. This is a great example of an ethical dilemma, deciding if the client is serious and has intent. If they do, then you are obligated to **warn and protect**. It is best to consult with a supervisor if there is any indication a client has stated he or she is going to act out and kill or harm another individual.

Case Study: *Tarasoff v. Regents of the University of California*

A case to be familiar with is the well-known *Tarasoff v. Regents of the University of California* case that helped ensure helping professions become obligated to act and protect the lives of third parties. Tatiana Tarasoff was a student studying at the University of California Berkley who met a fellow student named Prosenjit Poddar. The two briefly shared a romantic interaction, but Tarasoff decided to inform Poddar she wanted to date other men.

Afterward, Poddar became aggravated by this and he decided to see a psychologist by the name of Dr. Lawrence Moore. During sessions with Dr. Moore, Poddar mentioned that he intended to harm and kill Tatiana Tarasoff. After receiving a mental health diagnosis and held for a short time, Poddar was released and later killed Tatiana Tarasoff. At no point did Dr. Lawrence inform Tatiana or her parents of the possible danger Poddar had disclosed. After the murder of Tatiana Tarasoff, her parents brought the case against the Regents, in which the Supreme Court ruled that mental health professionals have a duty to protect individuals of a third party who may be threatened or at harm by a client, in which now is known as duty to warn and protect.

From (Dolgoff, Harrington, & Loewenberg, 2009).

Malpractice



Malpractice definition image

Another key term to be aware of related to the NASW Code of Ethics is **malpractice**. Malpractice can be defined as a form of negligence which occurs when a licensed social worker is not consistent with the professions' Code of Ethics, standards of care, and is negligent to his or her legal duties and obligations (Reamer, 2006). Often this involves poor delivery of services or a social worker failing to meet the standard of care at his or her agency.

Malpractice is one reason why social workers need to be conscious of the Code of Ethics and make sure they are doing everything ethically correct. Malpractice lawsuits are common among many helping professions, not just social work, but due to the nature of and intimacy of social workers' roles it is extremely important to best represent the NASW Code of Ethics. If not, serious consequences can follow.

Three common forms of malpractice include:

- Malfeasance: when the social worker intentionally engages in practice known to be harmful
- Misfeasance: when the social worker makes a mistake in the application of an acceptable practice
- Nonfeasance: when the social worker fails to apply standard and acceptable practice if the circumstances include such practice

(Cournoyer, 2011).

Clearly, malpractice can occur even if one intentionally or unintentionally is aware of the wrongdoing. For example, a genuine mistake social workers make is simply forgetting to obtain a client's consent before sharing confidential records with third parties. This alone can lead to serious civil lawsuits and can jeopardize your social work license. When these mistakes occur, the social worker does not intend to provide harm, but due to the many responsibilities social workers have it is easy to forget and unintentionally make this mistake (Reamer, 2006).

Some common examples of malpractice include the following (Reamer, 2006; Cournoyer, 2011):

- Failure to report abuse of neglect of a child
- Failure to consult or refer other health professionals
- Failure to prevent a client from committing suicide
- Failure to warn or protect third parties of harm or abuse
- Failure to diagnose or incorrectly diagnosis for treatment
- Failure to provide treatment without consent
- Failure to renew their social work license

- Inappropriate or inaccurate billing of services
- Breach of confidentiality, even if the client is deceased
- Being sexually involved with a client
- Professional incompetence

It is your job as a social worker to know exactly what kinds of unethical behavior or misconduct result in malpractice. Simply acting inconsistent with the professions standard of care can place you in a civil lawsuit you may have never thought possible (Reamer, 2006). As a practicing social worker, it is important to have insurance coverage to protect you in case of a lawsuit. You will often be covered by your agency, and the NASW also provides legal coverage to social workers.

Ethical Dilemmas

Discussed earlier, as a social worker you are likely to face a situation where there is no clear answer or a time when you as a social worker are forced to choose between two or more decisions, but contradictory decisions with often undesirable outcomes for one or more persons (Dolgoff, Harrington, & Loewenberg, 2009). These are known as ethical dilemmas.

Dilemmas will occur often and you must be prepared to handle them. Whether you are working with individual clients, families, small groups, or community organizations in policy and planning, administration, or research and evaluation there will be ethical decisions/dilemmas along the way (Reamer, 2006).

Some social workers are uncomfortable with making difficult ethical decisions and ignore them while other social workers have no problem making a difficult decision (Dolgoff, Harrington, & Loewenberg, 2009). Ethical dilemmas are often known as the grey area of social work. Therefore, as a social worker, you must know yourself very well; be conscious of the Code of Ethics and let it guide you in making these decisions.

Some common ethical dilemmas include:

- Confidentiality and privacy issues
- Divided loyalties
- Professional boundaries with clients (this is a common and one of the most difficult dilemmas)
- Delivery of services
- When to terminate services
- Budget cuts (administration positions)
- Hiring and firing of staff members (administration positions)
- Conflicts of interest
- Relationship between professional and personal values

(Reamer, 2006)

Discussion Question: Why are professional boundaries so important?

There are many tips and suggestions for ethical problem solving, Dolgoff, Harrington, & Lowewenberg (2009) suggest considering the following when making ethical decisions:

- Who is my client?
- What obligations do I owe my client?
- Do I have professional obligations to people other than my clients? If so what are my obligations?
- What are my own personal values? Are these values compatible with the professions six core values?
- What are my ethical priorities when these value sets are not identical?
- What is the ethical way to respond when I have conflicting professional responsibilities to different people?

Often social workers are alone when they must make difficult choices and can't always seek supervision right away. Therefore, you must be prepared to handle these situations on your own. After encountering an ethical decision alone, it is still a great idea to seek supervision afterward and talk the process over with a supervisor.

Social workers are encouraged to adopt this model; it is very helpful when struggling with ethical dilemmas, (Cournoyer, 2011; Congress, 2000, p. 10):

ETHIC Model of Decision Making
E—Examine relevant personal, societal, agency, client, and professional values
T—Think about what ethical standard of the NASW Code of Ethics applies, as well as relevant laws and case decisions
H—Hypothesize about possible consequences of different decisions
I—Identify who will benefit and who will be harmed
C—Consult with supervisor and colleagues about the most ethical choice

The following are great examples of ethical decisions you may encounter. Use these dilemmas as practice to work through a situation (Dolgoff, Harrington, & Loewenberg, 2009):

- A client tells you that he intends to embezzle funds from his employer. (What do you do?)
- A client who is HIV positive tells you that he has unprotected sex with his partners because he does not want his partners to know about his medical condition. (What do you do?)
- You discover that another social worker knows about a child abuse situation and has not yet reported the case to Child Protective Services (CPS), which is required by law. (What do you do?)
- You are a medical social worker and a surgeon at a children's hospital strongly recommends that a child have surgery. The parents of the child refuse to consent with the surgery due to the complications and risks. The surgeon asks you to convince the parents to agree to let him operate regardless of the parents' concerns. (What do you do?)
- A client has disclosed he is very angry with his cousin and wants to hurt him. (Do you breach confidentiality?)
- A previous client of mine has passed away, is it okay to talk about what that client has disclosed?

Summary

The NASW Code of Ethics does not list any value or ethic as more important than the next; you must consider all values and ethics as equal. To be a professional social worker you should be well acquainted with the Social Work Code of Ethics along with the six core values. Mentioned earlier, it is necessary to be familiar with the Code of Ethics to be an ethical social worker and to able to work with clients (Cournoyer, 2011). The NASW Code of Ethics is not something to take lightly and as you advance through your social work education these values and ethics will become much more ingrained. Having a copy of the NASW Code of Ethics with you or in your office is certainly a useful idea. Keep in mind that simply forgetting or unintentionally providing a standard of care can result in a malpractice lawsuit.

Ethical decision-making takes skill and practice, and is a never-ending process (Reamer, 2006). The more you prepare yourself, know yourself, and follow the Code of Ethics the greater skill you will obtain as a professional social worker (Cournoyer, 2011). There will always be ethical dilemmas during your career no matter the setting of your work. It is important to treat each dilemma as its own by using the suggested tips. Consulting with a supervisor before or after an ethical dilemma is a great suggestion. Supervisors are there to help and support you through difficult times.

Remember the Code of Ethics and values originated from the idea that all people are equal and deserving of the same entitlements. As a social worker, you are responsible for continuing and promoting social justice. In addition, you should always apply the ethical standards and legal duties to your work.

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3.1: Cultural Competence

"I believe that strong and vibrant cultures themselves nurture tolerance and justice. All cultures worth the name protect support and encourage diversity; and justice is the practical mechanism which enables them to do so." *—Dr. Nafis Sadik, former UNFPA Executive Director*

Introduction

What is culture? Many individuals think of culture as something that is different from them. They may think of culture as something they desire to have; they mistakenly do not realize that everyone has culture. Culture is something that all of us have but because we live it, we do not realize that it is there. When we think of culture, we think of many different ways of life for others; we often neglect to understand that what we do in our everyday lives is different than others. We simply think of our lifestyles as "normal," not cultured.

This chapter will explore various aspects of human diversity with a focus on the importance of understanding culture specifically for social workers to perform their ethical responsibility to be culturally competent. In this chapter we will clarify basic concepts, define key terms, discuss a variety of different cultures and begin to understand why this topic is of utmost importance to the social work profession. Let's begin with defining culture.



Culture

Culture

Many different disciplines perceive culture and cultur al identity differently ; therefore we will begin with a general definition the n expand to a more specific definition as it relates to social work.

General Definition

Several general definitions of culture include:

1. A configuration of learned behaviors and results of behavior whose component elements are shared and transmitted by the members of a particular society (Linton, 1945)
2. The shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them (Lederach, 1995)
3. Learned and shared human patterns or models for living; day-to-day living patterns, these patterns and models pervade all aspects of human social interaction (Damen, 1987)

Culture has been defined in a number of ways, but most simply as the learned and shared behavior of a community of interacting

human beings (Useem & Useem, 1963).

Social Work Definition

There is no standard popular definition or explanation of 'culture' in social work literature. **Culture** is often used synonymously and confusingly with the word 'ethnicity'. From a social work perspective, culture has been defined well by Cindy Garthwait, MSW (2012) as: customs, beliefs, ideology, world-view, and values common to a group of people and which guide their individual and social behavior. More specifically, it is the product of the values, ideas, perceptions, and meanings which have evolved over time. These values, ideas, perceptions, and meanings constitute the individual's knowledge and understanding of the world in which he or she lives.

They derive from:

- physical environment of birth and upbringing
- language
- institutions
- family and social relationships
- child rearing
- education
- systems of belief
- religion, mores and customs
- dress and diet
- particular uses of objects and material life

Culture embraces all of these, and the individual may regard each of them, or any number of them, as culturally significant. There is some consensus that culture is shared patterns of behavior and interactions, cognitive constructs and understanding that are learned by socialization. No matter the culture of an individual, one thing is for certain, it will change. Culture appears to have become key in our interconnected world which is made up of so many ethnically diverse societies, but also riddled by conflicts associated with religion, ethnicity, ethical beliefs, and the elements which make up culture. Culture is no longer fixed, if it ever was. It is essentially fluid and constantly in motion. This makes it difficult to define any culture in only one way.

Race and Ethnicity

Now that we have an understanding of the concept of culture, let's discuss race and ethnicity. First, we need to have a basic understanding of ethnocentrism and how it affects our thinking and judgments. **Ethnocentrism** is a commonly used word in circles where ethnicity, inter-ethnic relations, and similar social issues are of concern. The usual definition of the term is "thinking one's own group's ways are superior to others" or "judging other groups as inferior to one's own." "Ethnic" refers to cultural heritage, and "centrism" refers to the central starting point... so "ethnocentrism" basically refers to judging other groups from our own cultural point of view. But even this does not address the underlying issue of why people misjudge others.

Most people, using a superficial definition, believe that they are not ethnocentric, but are rather "open minded" and "tolerant." However, everyone is ethnocentric and there is no way not to be ethnocentric; it can neither be avoided because we only know what we have experienced in our own reality nor can it be willed away by a positive or well-meaning attitude. Yet this can have consequences within our own society and in international relations. We may be well meaning in inter-ethnic relations, for example, but can unintentionally offend others, generate ill feelings, and even set up situations that harm others. For example, it is easy *not* to see the life concerns of others (particularly minorities and the disadvantaged) or conversely to pity them for their inabilities to deal with life situations (like poverty or high crime rates). How do *we* feel when someone doesn't recognize our concerns or feels sorry for us because we can't "just let go" of a stressful situation?

A lack of understanding can also inhibit constructive resolutions when we face conflicts between social groups. It is easy to assume that others "should" have certain perspectives or values. How often are *we* prone to address conflicts when others tell us how we should think and feel? It can, however, be an opportunity to recognize and resolve our own biases and to learn more about potentials we all have for being human... a lifelong process of learning and growth.

What is the difference between race and ethnicity? Many people tend to think of race and ethnicity as one and the same. Often the words are used interchangeably. Looking up the definition in a dictionary doesn't usually make it any clearer. However, these two words do have separate meanings. Understanding their distinctions is significant and increasingly important, particularly because

diversity in the world is continuing to grow. This is especially important as social workers in terms of advocating and practicing non-discrimination.

What Is Race?

Race is a powerful social category forged historically through oppression, slavery, and conquest. Most geneticists agree that racial taxonomies at the DNA level are invalid. Genetic differences within any designated racial group are often greater than differences between racial groups. Most genetic markers do not differ sufficiently by race to be useful in medical research (Duster, 2009; Cosmides, 2003).

Stated simply, race is the word used to describe the physical characteristics of a person. These characteristics can include everything from skin color, eye color, facial structure, or hair color. This term is physiological in nature and refers to distinct populations within the larger species. Race was once a common scientific field of study. Today, however, most scientists agree that genetic differences among races do not exist which means we are all the same inside. Clearly, we all have the same make-up which consists of vitamins, minerals, water, and oxygen.

What Is Ethnicity?

Ethnicity denotes groups, such as Irish, Fijian, or Sioux, for example, that share a common identity-based ancestry, language, or culture. It is often based on religion, beliefs, and customs as well as memories of migration or colonization (Cornell & Hartmann, 2007). In scientific analysis, it can be important to distinguish between race and ethnicity. Biological anthropologist, Fatimah Jackson (2003), provides a pertinent example of cultural practices being misread as biological differences. Micro ethnic groups living in the Mississippi Delta, she writes, use sassafras in traditional cooking. Sassafras increases susceptibility to pancreatic cancer. Medical practitioners who do not carefully disaggregate cultural and biological traits might interpret a geographic cluster of pancreatic cancer as related to a genetic or racial trait when, in fact, the disease is produced by cultural practices—in this case, shared culinary habits.

Ethnicity, on the other hand, is the word used to describe the cultural identity of a person. These identities can include language, religion, nationality, ancestry, dress, and customs. The members of a particular ethnicity tend to identify with each other based on these shared cultural traits. This term is considered anthropological in nature because it is based on learned behaviors.

Difference between Race and Ethnicity

One example of the difference between these two terms can be seen by examining people who share the same ethnicity. Two people can identify their ethnicity as American, yet their races may be black and white. Additionally, a person born of Asian descent that grew up in Germany may identify racially as Asian and ethnically as German. People who share the same race may also have distinct ethnicities. For example, people identifying as white may have German, Irish, or British ethnicity.

Socially Constructed Differences

Some researchers believe that the idea of race and ethnicity has been socially constructed. This is because their definitions change over time, based on widely accepted public opinion. Race was once believed to be due to genetic differences and biological morphologies. This belief gave way to *racism*, the idea of racial superiority and inferiority. For example, when Italian immigrants began arriving in the United States, they were not considered part of the “white race.” The same is true of Irish and Eastern European immigrants. The widely accepted view that these individuals were not white led to restrictions of immigration policies upon the arrival of “non-white” immigrants. In fact, during this time, people from these areas were considered of the “Alpine” or “Mediterranean” races. Today these race categories no longer exist. Instead, due to policy changes, people from these groups began to be accepted into the wider “white” race. They are now identified as individual *ethnic groups*. This shows that, like the idea of race, the idea of ethnicity also changes over time based on widely held public opinion.

Humans vary remarkably in wealth, exposure to environmental toxins, and access to medicine. These factors can create health disparities. Krieger (2000) describes disparities that result from racial discrimination as “biological expressions of race relations.” African Americans, for example, have higher rates of mortality than other racial groups for 8 of the top 10 causes of death in the U.S. (Race, Ethnicity, and Genetics Working Group, 2005). Although these disparities can be explained in part by social class, they are not reducible to class distinctions.

When we talk about power and privilege, we talk in terms of race, ethnicity, gender and class. And with good reason as these are some of the strongest cases of privilege in our culture. We also need to understand that one of the strongest aspects of power and privilege is that very often those who have it are not even aware of the extent of their privilege.

Racism and Prejudice

According to Gordon Allport, an American psychologist, **Prejudice** is an affective feeling toward a person or group member based solely on their group membership. The word is often used to refer to preconceived, usually unfavorable, feelings toward people or a person because of their beliefs, values, race/ethnicity, or other personal characteristics (Allport, 1979). In this case, it refers to a positive or negative evaluation of another person based on their perceived group membership.

If you open a dictionary, the definition that typically falls under "**racism**" is: a belief or doctrine that inherent differences among the various human racial groups determine cultural or individual achievement, usually involving the idea that one's own race is superior and has the right to dominate others or that a particular racial group is inferior to the others.But racism is a lot more complicated than that. Racism is a "learned" form of hate that can be unlearned. It is systemic and institutional; basically it is prejudice plus power (influence, status and authority). Laws, restrictions and other norms in our society have been created by the majority in order to create these prejudices against another, differing group. For example, these things can include: slavery, wage gap, workplace and employment discrimination, police brutality, and so on.

There are many other definitions and concepts that make up this giant, tangled web. For example, with "**white privilege**," people who are white benefit from societal structures simply by existing in them. Of course, some people do not consciously choose to benefit, but that doesn't mean there isn't a type of advantage for them. You may not hate someone for the color of his/her skin, but you may benefit from the systems that have been set up.

White privilege does not mean that white people have or grew up with everything handed to them. Being privileged does not mean someone had or has an easy life. The thing about privilege is that it can make people blind to struggles they are not aware of.

In 1989, Wellesley College professor Peggy McIntosh wrote an essay called "White Privilege: Unpacking the Invisible Knapsack." McIntosh observes that people who are white, in the U.S. are "taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance on my group." To illustrate these invisible systems, McIntosh wrote a list of 26 invisible privileges whites benefit from.

McIntosh' White Privilege Checklist: www.sap.mit.edu/content/pdf/white_privilege_checklist.pdf

McIntosh (1989) further describes white privilege as an "invisible package of unearned assets, which one can count on each day. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, code books, visas, clothes, tools, and blank checks."

Minority Groups

The term "**minority**" is applied to various groups who hold few or no positions of power in a given society. The term minority doesn't necessarily refer to a numeric minority. Women, for example, make up roughly half the population but are often considered a *minority group*.

Minority does not just refer to a statistical measure and can instead refer to categories of persons who hold few or no positions of social power in a given society. For example: gender and sexuality minorities, religious minorities, and people with disabilities.

Gender and Sexuality Minorities



Gender Equality Symbol

Recognition of lesbian, gay, bisexual, and transgender people as a minority group or groups has gained prominence in Western culture since the nineteenth century. The abbreviation "LGBTQ" is currently used to group these identities together. The term queer is sometimes understood as an umbrella term for all non-normative sexualities and gender expressions but does not always signify a minority; rather, as with many gay rights activists of the 1960s and 1970s, it sometimes represents an attempt to highlight sexual diversity in everyone.

There is a growing realization that sexual and gender minorities face discrimination, violence, and criminalization. For example, nearly eighty countries criminalize homosexuality in some way (Park, 2016). Cultural stigma prohibits sexual and gender minorities from reaching their full potential. **Stigma** is an attribute, or mark on, another person. In the context of social interaction, it is a shared belief about someone's characteristics and traits.

For example, the attribute might be wearing a turban. Many people might share a belief that a man wearing a turban is dangerous. Stigma assigns meaning to an otherwise meaningless attribute such as wearing a turban equates to certain political beliefs.

Gender minorities can be identified and grouped according to any one of the three different categories:

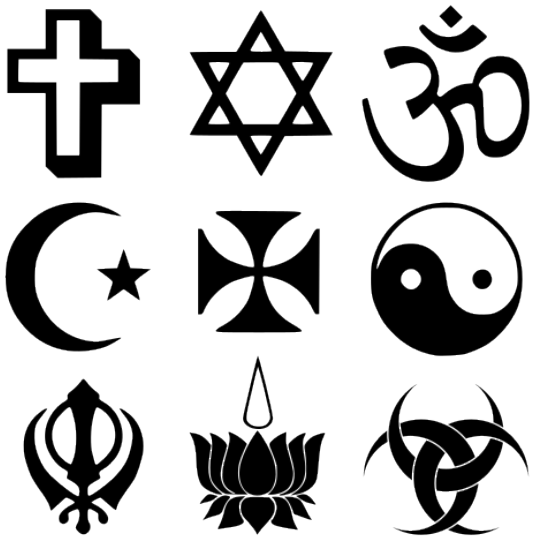
- People whose inter self-identity does not match gender assigned at birth
- People whose gender expression (or socially assigned gender) does not match gender assigned at birth
- People whose social expression does not conform to relevant cultural norms and expectations of gender.

Sexual minorities can be identified and grouped according to:

- People who describe themselves using sexual minority terminology
- People whose sexual partners are the same gender, or a minority gender
- People who experience attraction to individuals of the same or a minority gender

While in most societies the numbers of men and women are roughly equal, the status of women as an oppressed group has led some, such as feminists and other participants in women's rights movements, to identify them as a minority group.

Religious Minorities



Symbols of many different religions

Persons belonging to religious minorities have a faith which is different from that held by the majority population or the population group that is in power. It is now accepted in many multicultural societies around the world that people should have the freedom to choose their own religion as well as including not having any religion (atheism or agnosticism), and including the right to convert from one religion to another. However, in some countries, this freedom is still either formally restricted or subject to cultural bias from the majority population.

For example, Burma's population is 90 percent Theravada Buddhist, a faith the government embraces and promotes over Christianity, Islam and Hinduism. Minority populations that adhere to these and other faiths are denied building permits, banned from proselytizing and pressured to convert to the majority faith. Religious groups must register with the government, and Burmese citizens must list their faith on official documents. Burma's constitution provides for limited religious freedom, but individual laws and government officials actively restrict it (U.S. Commission on International Religious Freedom, 2016).

People with Disabilities



The disability rights movement has contributed to an understanding of people with disabilities as a minrity or a coalition of minorities who are disadvantaged by society, not just as people who are disadvantaged by their impairments. Advocates of disability rights emphasize differences in physical or psychological functioning rather than inferiority: for example, some people with autism argue for acceptance of neuro-diversity in the same way opponents of racism argue for acceptance of ethnic diversity. The deaf community is often regarded as a linguistic and cultural minority rather than a group with disabilities, and some deaf people do not see themselves as having a disability at all. Rather, they are disadvantaged by technologies and social institutions that are designed to cater to the dominant, hearing-unimpaired group.

Immigration

Immigration involves the permanent movement from one country to another. Social workers are often called upon to work with immigrants. Immigrants represent a significant portion of the U.S. population. In 2010, 40 million people (12.9%) of the total population were foreign-born (U.S. Census Bureau, 2010).

People with different national origins often find it difficult to integrate into mainstream culture, especially when language barriers exist or they experience immigration issues. Social workers play a crucial role in many immigration cases. A social worker is often the first person people talk to about their immigration struggles. Social workers often help clients gather key evidence, write detailed evaluations, assist with citizenship or change of legal status, or are the primary contact with police officers. There is a range of immigration status which immigrant children, youth and parents may hold. Immigrants may fall into one of the following categories:

- legal permanent residents
- naturalized citizens
- refugees
- undocumented persons

Each category or status can carry different legal rights and access to services.

Asylum	Provides specific protections to individuals who have reason (e.g. political, economic, etc.) to fear returning to their native country.
Deferred Action	Provides individuals who came to the US under the age of 16, protection from CHILDHOOD ARRIVALS deportation and an opportunity to receive employment authorization to two (DACA) 2 years. At the end of the two year period, individuals may apply for renewal.
Special Immigrant	Provides lawful permanent residence to immigrant children and youth who JUVENILE STATUS (SUS) are under the jurisdiction of the juvenile court and who have not been able to reunify with their families as a result of abuse, neglect or abandonment. Timing is critical; the SUS application must be processed while the child or youth is under the jurisdiction of the court.
T-VISA	Provides immigration relief to human trafficking victims who can demonstrate they have suffered tremendous hardships. Victims must have cooperated with reasonable requests during the investigation or in the prosecution of the accused.
U-VISA	Provides temporary visas to victims of crime. Victims must possess information related to the criminal activity and must cooperate with the criminal investigation and prosecution of the accused.

VIOLENCE AGAINST	Provides an abused victim an opportunity to seek permanent residency under WOMEN ACT (VAWA) the immigration provisions of the Violence Against Women Act (VAWA). The victim is eligible if he or she experiences abuse at the hands of a US citizen or permanent resident parent or stepparent.

Source: NASW Quick Resource Guide, 2013

A large number of immigrant households are comprised of mixed-status families (Capps & Passel, 2004; Torrico, 2010) which can mean that only some family members can access public funded services. For many immigration cases, it is important that a knowledgeable social worker be involved in the process.

Cultural Competency

It is important for social workers to have an understanding of the concept of culture in order to have **cultural competence**. This can be defined as a set of behaviors, attitudes, and policies that come together in a system, agency, or program. It can also be among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among, and between groups. Another way to describe cultural competence is a point on a continuum that represents the policies and practices of an organization, or the values and behavior of an individual which enable that organization or person to interact effectively in a culturally diverse environment. The competency of social workers is limited when they do not possess tools of acknowledgment that can affect them when working with diverse populations.

The social work profession is built upon culturally sensitive practices that advocate for social and economic justice for those who are disadvantaged, oppressed, and/or discriminated against. Standard 1.05(c) in the National Association of Social Workers' (NASW) Code of Ethics (NASW, 2008), reminds social workers of their duty to be culturally competent and to purposefully "obtain education about and seek to understand the nature of social diversity and oppression." NASW's National Committee on Racial and Ethnic Diversity (NASW, 2001) highlights this necessity by identifying standards that make up culturally competent practices, including self-awareness, cross-cultural knowledge, skills, and leadership.

Although "diversity is taking on a broader meaning to include the sociocultural experiences of people of different genders, social classes, religious and spiritual beliefs, sexual orientations, ages, and physical and mental abilities" (p. 8), the historical impact of race on American society continues to play an integral part in the development and effectiveness of culturally competent practice. Having cross cultural sensitivity and cultural competence remains challenging as the concept of culture and how it relates to individuals continues to evolve.

Social workers must possess the skills to be able to understand a broad spectrum of varying cultures and have an understanding of important and influential beliefs related to that specific culture. An informed social worker will better understand how culture and diversity may impact how we present services and treatment and what interventions could produce better outcomes for those we serve. It would be useful for a social worker to be bilingual but not required as most agencies have access to interpreters.

Ethnic and Cultural Differences

We've established that understanding and appreciating diversity are essential for social workers to practice effectively with clients. The following section discusses some of the values, beliefs, and perspectives assumed by several cultural groups in our society: Hispanic, Native Americans, African Americans, Asian Americans, and Muslim Americans.



Celebration of Hispanic American Heritage

Hispanics

As we know, no one term is acceptable to all groups of people. Hispanic and Latino/Latina have generally been used to refer to people originating in countries in which Spanish is spoken. However, we have also established that the terms refer to people originating in a wide range of places. Others prefer to be addressed by their specific countries of origin. For example, people from Puerto Rico prefer to be addressed as Puerto Ricans. The three primary Hispanic groups in the United States in terms of size are Mexican Americans (over 66% of all Hispanics), Puerto Ricans (almost 9%), and Cuban Americans (almost 3.5%) (U.S. Census Bureau, 2010). Other groups include those from the Dominican Republic and from other countries in Central and South America (Santiag-Rivera, Arredondo, & Gallardo-Cooper, 2002). It's important not to make stereotyped assumptions about such a diverse group.

Specific variations exist within the many sub-groups; we will discuss some cultural themes important to Hispanic families in general. Hispanic heritage is rich and diverse, but the groups tend to share similarities in terms of values, beliefs, attitudes, culture, and self-perception. These include the significance of a common language, the importance of family and other support systems, spirituality, and the traditional strictness of gender roles.

The first theme important in understanding the environment for children growing up in Hispanic families is the significance of a common language. According to the Pew Research Center, almost 60% of Latinos/Latinas indicate they speak English only or speak it fluently; however, almost 32% of Latinos/Latinas indicate they speak Spanish fluently. (Krogstad, Stepler, & Lopez, 2015).

A second theme reflecting a major strength in many Hispanic families is the significance placed on relationships with nuclear and extended family, including aunts, uncles, cousins, and grandparents, as well as close friends.

A third theme characterizing many Hispanic families is the importance of spirituality and religion. Catholicism is a defining role for family and gender roles for Latino or Hispanic people.

A fourth theme often characterizing Hispanic families is the strict gender roles. This is reflected in two major concepts: *Machismo* is the idea of male "superiority" that "defines the man as provider, protector, and head of the household", *marianismo,* on the other hand, is the idea that, "after the Virgin Mary," females are valued for their "female spiritual sensitivity and self-sacrifice for the good of husband and children"??? (Santiago-Rivera, Arredondo, and Gallardo-Cooper, 2002).

For more information on Hispanic Americans: www.dimensionsofculture.com/2011/03/cultural-values-of-latino-patients-and-families/

Native Americans



End of the Line

In the United States, there are about 700 native groups (Indian and Eskimo) that still exist. Of that number, about 556, including some 223 village groups in Alaska, are formally recognized. (For a listing of federally recognized groups, log on to www.doi.gov/bia/tribes/entry.html) (Sutton, 2004).

Each Native American group has always had a name for itself – a name that often translates to something like "The People." However, groups have often been known to the outside world by other names (i.e. American Indian, Native American, and First Nation's Peoples) (Weaver, 2008). Whenever possible, it's best to identify the participants' specific group. As part of their increasing pride and power, many groups are trying to revive their original names and asking that these be used instead of other names. For example, the Chippewa, Ottawa, and Potawatomi want to be called Anishinaabe ("The People from Above").

Several themes characterize many Native American people. These include the importance of extended family and respect for older adults, noninterference, harmony with nature, the concept of time, and spirituality.

As with Hispanic people, family ties including those with extended family, are very important. The sense of self is secondary compared to that of the family and of the tribe. It is tradition to consult tribal leaders, elders, and spiritual leaders when conflicts emerge. It is also very common to have extended family members living together in one household.

Children receive supervision and instruction not only from their parents but also from relatives of several generations. In the Anishinaabe culture, it is the aunts and uncles who provide the discipline. The idea is that parents love their children and do not have the capability to see the "naughty" in their children. Aunts and uncles, who also love the children, have the ability to recognize when a child needs guidance and are obligated to provide it.

A second significant concept in Native American culture involves the emphasis on noninterference. The highest form of respect for another person is respecting their natural right to self-determination. For example, Native parents use noncoercive parenting styles that encourage the child's self-determination. Unlike many other cultures, it is not uncommon to see children running around during religious ceremonies instead of sitting and paying attention. The hope is that the children will pick up on different things, said and done, and someday decide to participate.

A third theme that characterizes Native American culture is that of harmony with nature. Western culture generally tends to measure its advancement by the distance it places between itself and nature. In contrast, Native cultures tend to view greater closeness to the natural world and its cycles as a measure of significant achievement.

A fourth concept basic to Native people's lives, and related to harmony with nature, is the concept of time, often termed "Indian Time". Time is considered an aspect of nature which flows along with life. It is not something that should take precedence over relationships. It is more important to have human relationships rather than to be punctual. The idea is that it will happen when it

is supposed to, not because of a certain time.

For more information on Native Americans: http://pluralism.org/religions/native-american-traditions/

African Americans



The flag of the US and Ghana

There are about 41.8 million African Americans in the United States (U.S. Census Bureau, 2010). African Americans, like other racial, cultural, and ethnic groups, reflect great diversity. Despite this diversity four general commonalities exist: importance of extended family, role flexibility, high respect for older adults, and strong religious beliefs and a close relationship with the church.

Like Hispanic and Native Americans, extended family ties are very important for African American families. Often children are raised not only by the nuclear family consisting of parents and children but also by extended family members (Martin, 1980). Children often receive nurture and support from multiple caring family members, who also provide each other with mutual aid.

A second theme characterizing African American families is role flexibility. Often time's mothers play both roles of mother and father (Barbarin, 1983). Older children are also accustomed to being the parent figure so that the parents can work. Sometimes older African American children drop out of school so they can go to work and help their families financially.

A third theme common among African American families is respect for older adults. Older adults are held in high regard. It is a belief that older adults should be provided in home care by their children.

A fourth theme in African American life involves strong religious beliefs and a close relationship with the church. Many African American families consider the church to be a part of the extended family. Religion is considered to be what contributed to their resilience, their survival of slavery, and their ability to overcome struggles.

For more information on African Americans: African Americans in U.S. History in Context

Asian Americans



Painted Indian Elephant Figurines

In 2001, Asian Americans in the United States numbered more than 12.5 million and represented more than thirty different nationalities and ethnic groups, including Samoan, Tongan, Guamanian, and native Hawaiian from the Pacific Islands; Lao, Hmong, Mien, Vietnamese, Cambodian, Thai, Burmese, Malay, and Filipinos from Southeast Asia; Pakistani, Bangladeshi, Indian, and Sri Lankan from South Asia; Afghani and Iranian from Central Asia; and Korean, Japanese, and Chinese from East Asia. In 2000, the three largest Asian nationalities in the United States were Chinese, Filipinos, and Asian Indians. The diversity of Asian Americans, in terms of their various languages, cultures, and histories, is remarkable (Kiang, 2017). Obviously, there is a huge variation among these groups despite the fact that they are clustered under the same umbrella term *Asian Americans*.

All U.S. Asians –17,320,856

Chinese	4,010,114
Filipino	3,416,840
Indian	3,183,063
Vietnamese	1,737,433
Korean	1,706,822
Japanese	1,304,286
Pakistani	409,163

Cambodian	276,667
Hmong	260,073
Thai	237,583
Laotian	232,130
Bangladeshi	147,300
Burmese	100,200
Indonesian	95,270
Nepalese	59,490
Sri Lankan	45,381
Malaysian	26,179
Bhutanese	19,439
Mongolian	18,344
Okinawan	11,326

Source: *The Asian Population: 2010*, U.S. Census Bureau, Retrieved March 2012

Four themes tend to be similar throughout the diverse groups. These include family as the primary unit and individuality as secondary in importance, interdependence among family, filial piety, and their involvement in patriarchal hierarchy.

Like previous cultures discussed, Asian families stand out for their strong emphasis on family. More than half (54%) say that having a successful marriage is one of the most important things in life. Two-thirds of Asian-American adults (67%) say that being a good parent is one of the most important things in life (Pew Research Survey, 2012). Their living arrangements align with these values.

A second theme, related to the significance of the family, involves interdependence. For example, they are more likely than the general public to live in multi-generational family households. Some 28% live with at least two adult generations under the same roof. This is slightly more than the share of African-Americans and Hispanics who live in such households.

A third theme concerns a strong sense of *filial piety*—"a devotion to and compliance with parental and familial authority, to the point of sacrificing individual desires and ambitions." About two-thirds say parents should have a lot or some influence in choosing one's profession (66%) and spouse (61%) (Pew Research Survey, 2012).

A fourth theme characterizing many Asian American families involves the vertical family structure of patriarchal lineage and hierarchal relationships. This is common in traditional Asian-American families, but there is diversity in practice across cultures. Based on the teachings of Confucius, responsibility moves from father to son, elder brother to younger brother, and husband to wife. Women are expected to be passive, and nurture the well-being of the family. A mother forms a close bond with her children, favoring her eldest son over her husband.

For more information on Asian Americans: http://www.asian-nation.org

Muslim Americans



Muslim-American Flag

Since the U.S. Census Bureau does not ask questions about religion, there is no official government count of the U.S. Muslim population. It has been estimated, by Pew Research, in 2015 that there were 3.3 million Muslims of all ages in the United States. Islam is the second largest religion in the world and third largest in the United States (Lipka, 2017). As a social worker, it is likely that you will work with an individual who identifies as a Muslim.

It is important to understand that, unlike the previous cultures discussed, we are attempting to give a brief overview of the religion Islam and not the people. Like any religious group, religious beliefs and practices of Muslims vary depending on many factors including where they live. Each of these cultures practices Islam to a different degree just as many Christians practice their religion at different degrees. For example, a Muslim individual from Saudi Arabia may be very strict with the way that women should dress while an individual from Turkey may be more relaxed.

Social values are divided into three groups: necessities (*dharuriyyat)*; convenience (*hajiat)*; and refinements *(kamaliat).* Human basic values consist of life (al nafs), reason (al'aql), descent (nasab), property (al mal) and religion (al din) (Akunduz, 2002). Islam protects these primary human values and prohibits any violation of them.

Muslims around the world are almost universally united by a belief in one God and the Prophet Muhammad, and the practice of certain religious rituals.

For a brief introduction to Islam go to: http://www.islamicity.com/mosque/Intro_Islam.htm

Islam emphasizes practice as well as belief. Law rather than theology is the central religious discipline and locus for defining the path of Islam and preserving its way of life.

The essential duties of all Muslims, the Five Pillars (Bala, 2017), are:

- The Shahadah (Witness)
- The Salat (Prayer)
- The Zakat (Alms)
- The Sawm or Siyam (Fasting)

- The Hajj (Pilgrimage)

Islam law states there is no god but God and Muhammad is the messenger of God (Shahadah), worship or prayer should occur five times daily with community prayers at the mosque on Fridays (salat), charity (zakah), fasting during the month of Ramadan(siyam), and pilgrimage (hajj) to Mecca at least once in a lifetime. Jihad, or struggle in the way of God, is sometimes considered the sixth pillar. Jihad includes both internal spiritual struggles and external war waged in defense of the Muslim community (Bala, 2017).

Women are the dominant players in family and home. Men are considered to be the economic providers. Women are expected to cover their bodies, except their hands and faces, in front of men other than than their brothers, husbands, fathers and sons. This is an expression of modesty so as not to sexually provoke or invite unacceptable sexual behavior.

Of course, any discussion of these general cultural themes of values and behaviors is just that—general. Actual practices vary dramatically from one ethnic group to another and from one family to another. It's important not to make assumptions about an individual's values and expectations simply because that person belongs to a different group.

For more information on Muslim Americans: www.cfr.org/backgrounder/muslims-united-states

Case Study: Lia Lee

This true story involves the life of Lia Lee, a Hmong child who is epileptic, which was made famous by the author Anne Fadiman in her book "The Spirit Catches You and You Fall Down". Lia began having epileptic seizures when she was about three months old. The Hmong regard this disease with ambivalence. They acknowledge that it is potentially dangerous and life threatening, but they also consider it to be an illness of some distinction, an illness in which a healing spirit enters the body. The Hmong saw it as divine, because many of their shamans (spiritual leaders) were afflicted with it.

Over the first few months of her life, Lia had over twenty seizures which made her parents (Foua-mother and Nao Kao-father) take her to the emergency room. There was obviously a great difference between American doctors and Hmong shamans. A shaman might spend eight hours in a Hmong home while an American doctor demanded the patient come to the hospital where the doctor might only see him for twenty minutes. Shamans could render an immediate diagnosis while the doctors had to run many tests and then sometimes didn't know what was wrong anyway. Shamans never undressed their patients while doctors, on the other hand, put their hands and fingers into body orifices. Most significantly, shamans knew you had to treat the soul as well as the body unlike American doctors.

Besides the differences between doctors and shamans, there was a feeling among the Hmong that doctors' procedures were actually more likely to threaten their health than to restore it. For example, the Hmong believe that there is only a finite amount of blood in the body, and doctors are continually taking it. Hmong people believe that when they are unconscious, their souls are at large, so anesthesia may lead to illness or death. Surgery is taboo and so are autopsies and embalming for the Hmong. The only form of medical treatment that was gratefully accepted by the Hmong was antibiotics. They had no fear of needles and frequently practiced dermal treatments like acupuncture, massage, pinching, scraping the skin, heating a cup to the skin or even burning the skin. The fact that epilepsy has a divine nature to them and the fact that the doctors see it only as a disease to be either cured or controlled foreshadows problems yet to come between the two cultures.

The greatest problem, for both the Lees and the hospital, was Lia's medication. Most of the time, she was on a combination of several different medications. By the time she was four, she had changed prescriptions 23 times. Add to this the fact that Lia's parents were illiterate in both English and Hmong; they often forgot what the doctors told them. The doctors never assumed anything other than that the Lees would give Lia her medicines properly, but time soon proved that Lia's mother especially was either confused or lying about how she administered the medicines. This is where the hospital social worker (Jeanine Hilt) initially stepped in to help. Jeanine worked with the Lee family to simplify the medication regimen.

Later, the Lee's had come to the conclusion that the medicines were causing the seizures and fever therefore, they refused the medications. The nurses soon come to the realization that the Lees were non-compliant. Due to the parent's non-compliance, the doctor felt he had no choice but to refer Lia's case to the health department and child protective services. He recommended she be placed in a foster home so that compliance of medications could be obtained. The Superior Court of the State of California immediately acted upon his request and declared that Lia should be removed from the custody of her parents.

Months later, with the efforts of social worker Jeanine, Lia is reunited with her family. The family is overjoyed to have her home again. However, the celebratory mood soon began to dissipate as the Lees realized that Lia had been returned to them in damaged condition. She didn't know people she had known before, and she could speak very little. From their perspective, the courts and the foster care system had made her sicker, but of course, the doctors felt it was due to the damage done when the Lees failed to comply with their orders. As a result of Lia's condition, the Lees stepped up her traditional medicine.

Lia's family spent large amounts of their money on such things as amulets. They tried every known cure in their medical library even to the point of changing Lia's name to Kou on the premise that the *dab* (spirit) that stole her soul would be tricked into thinking she was someone else, and the soul could return. They even took her to a shaman in Minnesota for help.

The doctors would have been surprised to learn that the Hmong actually took their children's health seriously since they so readily spurned American care. At the hospital, Lia's case metastasized into a mass of complaints that grew angrier with each passing year. Especially the nurses were angry that the Lees were so ungrateful for the $250,000 worth of care they received for free. They were angry that the Lees had been noncompliant and believed that Lia did not need to be in the state she was in. They believed the Lees just hadn't given her the medication.

Lia's brain impairment is never resolved and she eventually becomes vegetative for the rest of her life. Lia is taken home by her parents to be loved and cared for by them. The doctors in Merced and other medical communities begin to realize that understanding the cultural differences of an immigrant must be considered when treating them as patients. However, in the end, the doctors still believe that the bottom line means save the patient's life while the Hmong believed that it was the patient' soul.

When the author of the book asked why the doctors never asked the Hmong how they treated their illnesses, he replied that because they dressed in American clothing, had American driver's licenses and shopped in supermarkets, it never occurred to the medical staff that they might practice unconventional healing arts. Jeanine Hilt was the only one who ever asked the Lees how they were treating Lia's developmental delays. She is the only person who fought against the medical establishment on Lia's behalf. She had simplified Lia' medication regimen, secured them their disability money and advocated to the courts for her return home and she never described them as closemouthed and dim.

Case study from: Fadiman, A. (1997). *The Spirit Catches You and YouFall Down*. New York: Farrar, Straus and Giroux

Summary

Being culturally competent and having cross-cultural awareness is an ongoing process. It is helpful in understanding the circumstances and social issues from a client's perspective. Competency is also important as social workers must attend to their own perspectives about their own cultural identity and how the client may view us. The need to assess all aspects of a client's belief system, values, and how they view themselves within their own culture is as important as assessing their whole bio-psychosocial history. By having some understanding of and sensitivity to other cultures means that we can also help others learn about different views and perspectives. Most importantly, we can dispel any generalizations or myths about a certain culture. With better insight we can appropriately match client's needs in respect to resources and services.

A social worker's aim is to advance social justice, equality and to end discrimination. In many ways, it has been observed, that a person's or group's culture has played a large part of many incidents of inequality and disenfranchisement in the past, both in our country's history and across the globe. One of our most important goals is to be the voice of our client(s) whether it is for an individual, a group, a neighborhood, or organization, in order to make sure that their rights are not violated and they are treated with dignity and respect. Learning to deal with how and what types of social issues regarding injustices exist, will help when we are dealing with real life discrimination and inequality that occurs and may be affecting our clients. By understanding and identifying social injustice and inequality, we can offset mechanisms of oppression and how they work.

Having cross cultural sensitivity and cultural competence remains challenging as the concept of culture and how it relates to individuals continues to evolve. Social workers must possess the skills to be able to understand a broad spectrum of varying cultures and have an understanding of important and influential beliefs related to that specific culture. An informed social worker will better understand how culture and diversity may impact how we present services and treatment and what interventions could produce better outcomes for those we serve.

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3: CHAPTER 3

3.1: Cultural Competence

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3.2: CULTURE

Culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving. Culture is the systems of knowledge shared by a relatively large group of people.

3.2.1: Introduction to Culture

3.2.2: What Is Culture?

3.2.3: Elements of Culture

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3.2.1: Introduction to Culture



People adhere to various rules and standards that are created and maintained in culture, such as giving a high five to someone. (Photo courtesy of Chris Barnes/flickr)

What are the rules when you pass an acquaintance at school, work, in the grocery store, or in the mall? Generally, we do not consider all of the intricacies of the rules of behavior. We may simply say, "Hello!" and ask, "How was your weekend?" or some other trivial question meant to be a friendly greeting. Rarely do we physically embrace or even touch the individual. In fact, doing so may be viewed with scorn or distaste, since as people in the United States we have fairly rigid rules about personal space. However, we all adhere to various rules and standards that are created and maintained in culture. These rules and expectations have meaning, and there are ways in which you may violate this negotiation. Consider what would happen if you stopped and informed everyone who said, "Hi, how are you?" exactly how you were doing that day, and in detail. You would more than likely violate rules of culture and specifically greeting. Perhaps in a different culture the question would be more literal, and it may require a response. Or if you are having coffee with a good friend, perhaps that question warrants a more detailed response. These examples are all aspects of culture, which is shared beliefs, values, and practices, that participants must learn. Sociologically, we examine in what situation and context certain behavior is expected, and in which situations perhaps it is not. These rules are created and enforced by people who interact and share culture.

In everyday conversation, people rarely distinguish between the terms *culture* and*society,* but the terms have slightly different meanings, and the distinction is important to a sociologist. A society describes a group of people who share a community and a culture. By “community,” sociologists refer to a definable region—as small as a neighborhood (Brooklyn, or “the east side of town”), as large as a country (Ethiopia, the United States, or Nepal), or somewhere in between (in the United States, this might include someone who identifies with Southern or Midwestern society). To clarify, a culture represents the *beliefs and practices* of a group, while society represents the *people* who share those beliefs and practices. Neither society nor culture could exist without the other. In this chapter, we examine the relationship between culture and society in greater detail and pay special attention to the elements and forces that shape culture, including diversity and cultural changes. A final discussion touches on the different theoretical perspectives from which sociologists research culture.

Glossary

culture
: shared beliefs, values, and practices

society
: people who live in a definable community and who share a culture

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3.2.2: What Is Culture?

Humans are social creatures. Since the dawn of *Homo sapiens* nearly 250,000 years ago, people have grouped together into communities in order to survive. Living together, people form common habits and behaviors—from specific methods of childrearing to preferred techniques for obtaining food. In modern-day Paris, many people shop daily at outdoor markets to pick up what they need for their evening meal, buying cheese, meat, and vegetables from different specialty stalls. In the United States, the majority of people shop once a week at supermarkets, filling large carts to the brim. How would a Parisian perceive U.S. shopping behaviors that Americans take for granted?

Almost every human behavior, from shopping to marriage to expressions of feelings, is learned. In the United States, people tend to view marriage as a choice between two people, based on mutual feelings of love. In other nations and in other times, marriages have been arranged through an intricate process of interviews and negotiations between entire families, or in other cases, through a direct system, such as a "mail order bride." To someone raised in New York City, the marriage customs of a family from Nigeria may seem strange or even wrong. Conversely, someone from a traditional Kolkata family might be perplexed with the idea of romantic love as the foundation for marriage and lifelong commitment. In other words, the way in which people view marriage depends largely on what they have been taught.

Behavior based on learned customs is not a bad thing. Being familiar with unwritten rules helps people feel secure and "normal." Most people want to live their daily lives confident that their behaviors will not be challenged or disrupted. But even an action as seemingly simple as commuting to work evidences a great deal of cultural propriety.



How would a visitor from the suburban United States act and feel on this crowded Tokyo train? (Photo courtesy of simonglucas/flickr)

Take the case of going to work on public transportation. Whether people are commuting in Dublin, Cairo, Mumbai, or San Francisco, many behaviors will be the same, but significant differences also arise between cultures. Typically, a passenger will find a marked bus stop or station, wait for his bus or train, pay an agent before or after boarding, and quietly take a seat if one is available. But when boarding a bus in Cairo, passengers might have to run, because buses there often do not come to a full stop to take on patrons. Dublin bus riders would be expected to extend an arm to indicate that they want the bus to stop for them. And when boarding a commuter train in Mumbai, passengers must squeeze into overstuffed cars amid a lot of pushing and shoving on the crowded platforms. That kind of behavior would be considered the height of rudeness in the United States, but in Mumbai it reflects the daily challenges of getting around on a train system that is taxed to capacity.

In this example of commuting, culture consists of thoughts (expectations about personal space, for example) and tangible things (bus stops, trains, and seating capacity).Material culture refers to the objects or belongings of a group of people. Metro passes and bus tokens are part of material culture, as are automobiles, stores, and the physical structures where people worship.

Nonmaterial culture, in contrast, consists of the ideas, attitudes, and beliefs of a society. Material and nonmaterial aspects of culture are linked, and physical objects often symbolize cultural ideas. A metro pass is a material object, but it represents a form of nonmaterial culture, namely, capitalism, and the acceptance of paying for transportation. Clothing, hairstyles, and jewelry are part of material culture, but the appropriateness of wearing certain clothing for specific events reflects nonmaterial culture. A school building belongs to material culture, but the teaching methods and educational standards are part of education's nonmaterial culture. These material and nonmaterial aspects of culture can vary subtly from region to region. As people travel farther afield, moving from different regions to entirely different parts of the world, certain material and nonmaterial aspects of culture become dramatically unfamiliar. What happens when we encounter different cultures? As we interact with cultures other than our own, we become more aware of the differences and commonalities between others' worlds and our own.

Cultural Universals

Often, a comparison of one culture to another will reveal obvious differences. But all cultures also share common elements. Cultural universals are patterns or traits that are globally common to all societies. One example of a cultural universal is the family unit: every human society recognizes a family structure that regulates sexual reproduction and the care of children. Even so, how that family unit is defined and how it functions vary. In many Asian cultures, for example, family members from all generations commonly live together in one household. In these cultures, young adults continue to live in the extended household family structure until they marry and join their spouse's household, or they may remain and raise their nuclear family within the extended family's homestead. In the United States, by contrast, individuals are expected to leave home and live independently for a period before forming a family unit that consists of parents and their offspring. Other cultural universals include customs like funeral rites, weddings, and celebrations of births. However, each culture may view the ceremonies quite differently.

Anthropologist George Murdock first recognized the existence of cultural universals while studying systems of kinship around the world. Murdock found that cultural universals often revolve around basic human survival, such as finding food, clothing, and shelter, or around shared human experiences, such as birth and death or illness and healing. Through his research, Murdock identified other universals including language, the concept of personal names, and, interestingly, jokes. Humor seems to be a universal way to release tensions and create a sense of unity among people (Murdock 1949). Sociologists consider humor necessary to human interaction because it helps individuals navigate otherwise tense situations.

IS MUSIC A CULTURAL UNIVERSAL?

Imagine that you are sitting in a theater, watching a film. The movie opens with the heroine sitting on a park bench with a grim expression on her face. Cue the music. The first slow and mournful notes play in a minor key. As the melody continues, the heroine turns her head and sees a man walking toward her. The music slowly gets louder, and the dissonance of the chords sends a prickle of fear running down your spine. You sense that the heroine is in danger.

Now imagine that you are watching the same movie, but with a different soundtrack. As the scene opens, the music is soft and soothing, with a hint of sadness. You see the heroine sitting on the park bench and sense her loneliness. Suddenly, the music swells. The woman looks up and sees a man walking toward her. The music grows fuller, and the pace picks up. You feel your heart rise in your chest. This is a happy moment.

Music has the ability to evoke emotional responses. In television shows, movies, even commercials, music elicits laughter, sadness, or fear. Are these types of musical cues cultural universals?

In 2009, a team of psychologists, led by Thomas Fritz of the Max Planck Institute for Human Cognitive and Brain Sciences in Leipzig, Germany, studied people's reactions to music that they'd never heard (Fritz et al. 2009). The research team traveled to Cameroon, Africa, and asked Mafa tribal members to listen to Western music. The tribe, isolated from Western culture, had never been exposed to Western culture and had no context or experience within which to interpret its music. Even so, as the tribal members listened to a Western piano piece, they were able to recognize three basic emotions: happiness, sadness, and fear. Music, it turns out, is a sort of universal language.

Researchers also found that music can foster a sense of wholeness within a group. In fact, scientists who study the evolution of language have concluded that originally language (an established component of group identity) and music were one (Darwin 1871). Additionally, since music is largely nonverbal, the sounds of music can cross societal boundaries more easily than words. Music allows people to make connections, where language might be a more difficult barricade. As Fritz and his team found, music and the emotions it conveys can be cultural universals.

Ethnocentrism and Cultural Relativism

Despite how much humans have in common, cultural differences are far more prevalent than cultural universals. For example, while all cultures have language, analysis of particular language structures and conversational etiquette reveal tremendous differences. In some Middle Eastern cultures, it is common to stand close to others in conversation. North Americans keep more distance and maintain a large “personal space.” Even something as simple as eating and drinking varies greatly from culture to culture. If your professor comes into an early morning class holding a mug of liquid, what do you assume she is drinking? In the United States, it’s most likely filled with coffee, not Earl Grey tea, a favorite in England, or Yak Butter tea, a staple in Tibet.

The way cuisines vary across cultures fascinates many people. Some travelers pride themselves on their willingness to try unfamiliar foods, like celebrated food writer Anthony Bourdain, while others return home expressing gratitude for their native culture’s fare. Often, people in the United States express disgust at other cultures’ cuisine and think that it’s gross to eat meat from a dog or guinea pig, for example, while they don’t question their own habit of eating cows or pigs. Such attitudes are an example ofethnocentrism, or evaluating and judging another culture based on how it compares to one’s own cultural norms. Ethnocentrism, as sociologist William Graham Sumner (1906) described the term, involves a belief or attitude that one’s own culture is better than all others. Almost everyone is a little bit ethnocentric. For example, Americans tend to say that people from England drive on the “wrong” side of the road, rather than on the “other” side. Someone from a country where dog meat is standard fare might find it off-putting to see a dog in a French restaurant—not on the menu, but as a pet and patron’s companion. A good example of ethnocentrism is referring to parts of Asia as the "Far East." One might question, "Far east of where?"

A high level of appreciation for one’s own culture can be healthy; a shared sense of community pride, for example, connects people in a society. But ethnocentrism can lead to disdain or dislike for other cultures and could cause misunderstanding and conflict. People with the best intentions sometimes travel to a society to “help” its people, because they see them as uneducated or backward—essentially inferior. In reality, these travelers are guilty of cultural imperialism, the deliberate imposition of one’s own cultural values on another culture. Europe’s colonial expansion, begun in the sixteenth century, was often accompanied by a severe cultural imperialism. European colonizers often viewed the people in the lands they colonized as uncultured savages who were in need of European governance, dress, religion, and other cultural practices. A more modern example of cultural imperialism may include the work of international aid agencies who introduce agricultural methods and plant species from developed countries while overlooking indigenous varieties and agricultural approaches that are better suited to the particular region.

Ethnocentrism can be so strong that when confronted with all of the differences of a new culture, one may experience disorientation and frustration. In sociology, we call thisculture shock. A traveler from Chicago might find the nightly silence of rural Montana unsettling, not peaceful. An exchange student from China might be annoyed by the constant interruptions in class as other students ask questions—a practice that is considered rude in China. Perhaps the Chicago traveler was initially captivated with Montana’s quiet beauty and the Chinese student was originally excited to see a U.S.-style classroom firsthand. But as they experience unanticipated differences from their own culture, their excitement gives way to discomfort and doubts about how to behave appropriately in the new situation. Eventually, as people learn more about a culture, they recover from culture shock.

Culture shock may appear because people aren’t always expecting cultural differences. Anthropologist Ken Barger (1971) discovered this when he conducted a participatory observation in an Inuit community in the Canadian Arctic. Originally from Indiana, Barger hesitated when invited to join a local snowshoe race. He knew he’d never hold his own against these experts. Sure enough, he finished last, to his mortification. But the tribal members congratulated him, saying, “You really tried!” In Barger’s own culture, he had learned to value victory. To the Inuit people, winning was enjoyable, but their culture valued survival skills essential to their environment: how hard someone tried could mean the difference between life and death. Over the course of his stay, Barger participated in caribou hunts, learned how to take shelter in winter storms, and sometimes went days with little or no food to share among tribal members. Trying hard and working together, two nonmaterial values, were indeed much more important than winning.

During his time with the Inuit tribe, Barger learned to engage in cultural relativism.Cultural relativism is the practice of assessing a culture by its own standards rather than viewing it through the lens of one’s own culture. Practicing cultural relativism requires an open mind and a willingness to consider, and even adapt to, new values and norms. However, indiscriminately embracing everything about a new culture is not always possible. Even the most culturally relativist people from egalitarian societies—ones in which women have political rights and control over their own bodies—would question whether the widespread practice of female genital mutilation in countries such as Ethiopia and Sudan should be accepted as a part of cultural tradition. Sociologists attempting to engage in cultural relativism, then, may struggle to reconcile aspects of their own culture with aspects of a culture that they are studying.

Sometimes when people attempt to rectify feelings of ethnocentrism and develop cultural relativism, they swing too far to the

other end of the spectrum. Xenocentrism is the opposite of ethnocentrism, and refers to the belief that another culture is superior to one's own. (The Greek root word *xeno*, pronounced "ZEE-no," means "stranger" or "foreign guest.") An exchange student who goes home after a semester abroad or a sociologist who returns from the field may find it difficult to associate with the values of their own culture after having experienced what they deem a more upright or nobler way of living.

Perhaps the greatest challenge for sociologists studying different cultures is the matter of keeping a perspective. It is impossible for anyone to keep all cultural biases at bay; the best we can do is strive to be aware of them. Pride in one's own culture doesn't have to lead to imposing its values on others. And an appreciation for another culture shouldn't preclude individuals from studying it with a critical eye.

OVERCOMING CULTURE SHOCK

During her summer vacation, Caitlin flew from Chicago to Madrid to visit Maria, the exchange student she'd befriended the previous semester. In the airport, she heard rapid, musical Spanish being spoken all around her. Exciting as it was, she felt isolated and disconnected. Maria's mother kissed Caitlin on both cheeks when she greeted her. Her imposing father kept his distance. Caitlin was half asleep by the time supper was served—at 10 p.m.! Maria's family sat at the table for hours, speaking loudly, gesturing, and arguing about politics, a taboo dinner subject in Caitlin's house. They served wine and toasted their honored guest. Caitlin had trouble interpreting her hosts' facial expressions, and didn't realize she should make the next toast. That night, Caitlin crawled into a strange bed, wishing she hadn't come. She missed her home and felt overwhelmed by the new customs, language, and surroundings. She'd studied Spanish in school for years—why hadn't it prepared her for this?

What Caitlin hadn't realized was that people depend not only on spoken words but also on subtle cues like gestures and facial expressions, to communicate. Cultural norms accompany even the smallest nonverbal signals (DuBois 1951). They help people know when to shake hands, where to sit, how to converse, and even when to laugh. We relate to others through a shared set of cultural norms, and ordinarily, we take them for granted.

For this reason, culture shock is often associated with traveling abroad, although it can happen in one's own country, state, or even hometown. Anthropologist Kalervo Oberg (1960) is credited with first coining the term "culture shock." In his studies, Oberg found that most people found encountering a new culture to be exciting at first. But bit by bit, they became stressed by interacting with people from a different culture who spoke another language and used different regional expressions. There was new food to digest, new daily schedules to follow, and new rules of etiquette to learn. Living with this constant stress can make people feel incompetent and insecure. People react to frustration in a new culture, Oberg found, by initially rejecting it and glorifying one's own culture. An American visiting Italy might long for a "real" pizza or complain about the unsafe driving habits of Italians compared to people in the United States.

It helps to remember that culture is learned. Everyone is ethnocentric to an extent, and identifying with one's own country is natural.

Caitlin's shock was minor compared to that of her friends Dayar and Mahlika, a Turkish couple living in married student housing on campus. And it was nothing like that of her classmate Sanai. Sanai had been forced to flee war-torn Bosnia with her family when she was fifteen. After two weeks in Spain, Caitlin had developed a bit more compassion and understanding for what those people had gone through. She understood that adjusting to a new culture takes time. It can take weeks or months to recover from culture shock, and it can take years to fully adjust to living in a new culture.

By the end of Caitlin's trip, she'd made new lifelong friends. She'd stepped out of her comfort zone. She'd learned a lot about Spain, but she'd also discovered a lot about herself and her own culture.



Experiencing new cultures offers an opportunity to practice cultural relativism. (Photo courtesy of OledSidorenko/flickr)

Summary

Though “society” and “culture” are often used interchangeably, they have different meanings. A society is a group of people sharing a community and culture. Culture generally describes the shared behaviors and beliefs of these people, and includes material and nonmaterial elements.. Our experience of cultural difference is influenced by our ethnocentrism and xenocentrism. Sociologists try to practice cultural relativism.

Section Quiz

1. The terms _____ and _____ are often used interchangeably, but have nuances that differentiate them.
   A. imperialism and relativism
   B. culture and society
   C. society and ethnocentrism
   D. ethnocentrism and xenocentrism

   Answer

   B

2. The American flag is a material object that denotes the United States of America; however, there are certain connotations that many associate with the flag, like bravery and freedom. In this example, what are bravery and freedom?

   A. Symbols
   B. Language
   C. Material culture
   D. Nonmaterial culture

   Answer

   D

3. The belief that one’s culture is inferior to another culture is called:
   1. ethnocentrism
   2. nationalism
   3. xenocentrism

4. imperialism

Answer

C

4. Rodney and Elise are U.S. students studying abroad in Italy. When they are introduced to their host families, the families kiss them on both cheeks. When Rodney's host brother introduces himself and kisses Rodney on both cheeks, Rodney pulls back in surprise. Where he is from, unless they are romantically involved, men do not kiss one another. This is an example of:
   A. culture shock
   B. imperialism
   C. ethnocentrism
   D. xenocentrism

Answer

A

5. Most cultures have been found to identify laughter as a sign of humor, joy, or pleasure. Likewise, most cultures recognize music in some form. Music and laughter are examples of:
   A. relativism
   B. ethnocentrism
   C. xenocentrism
   D. universalism

Answer

D

Short Answer

Examine the difference between material and nonmaterial culture in your world. Identify ten objects that are part of your regular cultural experience. For each, then identify what aspects of nonmaterial culture (values and beliefs) that these objects represent. What has this exercise revealed to you about your culture?

Do you feel that feelings of ethnocentricity or xenocentricity are more prevalent in U.S. culture? Why do you believe this? What issues or events might inform this?

Further Research

In January 2011, a study published in the Proceedings of the National Academy of Sciences of the United States of America presented evidence indicating that the hormone oxytocin could regulate and manage instances of ethnocentrism. Read the full article here: http://openstaxcollege.org/l/oxytocin

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Glossary

cultural imperialism
: the deliberate imposition of one’s own cultural values on another culture

cultural relativism
: the practice of assessing a culture by its own standards, and not in comparison to another culture

cultural universals
: patterns or traits that are globally common to all societies

culture shock
: an experience of personal disorientation when confronted with an unfamiliar way of life

ethnocentrism
: the practice of evaluating another culture according to the standards of one’s own culture

material culture
: the objects or belongings of a group of people

nonmaterial culture
: the ideas, attitudes, and beliefs of a society

xenocentrism
: a belief that another culture is superior to one’s own

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3.2.3: Elements of Culture

Values and Beliefs

The first, and perhaps most crucial, elements of culture we will discuss are its values and beliefs. Values are a culture's standard for discerning what is good and just in society. Values are deeply embedded and critical for transmitting and teaching a culture's beliefs.Beliefs are the tenets or convictions that people hold to be true. Individuals in a society have specific beliefs, but they also share collective values. To illustrate the difference, Americans commonly believe in the American Dream—that anyone who works hard enough will be successful and wealthy. Underlying this belief is the American value that wealth is good and important.

Values help shape a society by suggesting what is good and bad, beautiful and ugly, sought or avoided. Consider the value that the United States places upon youth. Children represent innocence and purity, while a youthful adult appearance signifies sexuality. Shaped by this value, individuals spend millions of dollars each year on cosmetic products and surgeries to look young and beautiful. The United States also has an individualistic culture, meaning people place a high value on individuality and independence. In contrast, many other cultures are collectivist, meaning the welfare of the group and group relationships are a primary value.

Living up to a culture's values can be difficult. It's easy to value good health, but it's hard to quit smoking. Marital monogamy is valued, but many spouses engage in infidelity. Cultural diversity and equal opportunities for all people are valued in the United States, yet the country's highest political offices have been dominated by white men.

Values often suggest how people should behave, but they don't accurately reflect how people do behave. Values portray an ideal culture, the standards society would like to embrace and live up to. But ideal culture differs from real culture, the way society actually is, based on what occurs and exists. In an ideal culture, there would be no traffic accidents, murders, poverty, or racial tension. But in real culture, police officers, lawmakers, educators, and social workers constantly strive to prevent or repair those accidents, crimes, and injustices. American teenagers are encouraged to value celibacy. However, the number of unplanned pregnancies among teens reveals that not only is the ideal hard to live up to, but the value alone is not enough to spare teenagers the potential consequences of having sex.

One way societies strive to put values into action is through rewards, sanctions, and punishments. When people observe the norms of society and uphold its values, they are often rewarded. A boy who helps an elderly woman board a bus may receive a smile and a "thank you." A business manager who raises profit margins may receive a quarterly bonus. People sanction certain behaviors by giving their support, approval, or permission, or by instilling formal actions of disapproval and nonsupport. Sanctions are a form of social control, a way to encourage conformity to cultural norms. Sometimes people conform to norms in anticipation or expectation of positive sanctions: good grades, for instance, may mean praise from parents and teachers. From a criminal justice perspective, properly used social control is also inexpensive crime control. Utilizing social control approaches pushes most people to conform to societal rules, regardless of whether authority figures (such as law enforcement) are present.

When people go against a society's values, they are punished. A boy who shoves an elderly woman aside to board the bus first may receive frowns or even a scolding from other passengers. A business manager who drives away customers will likely be fired. Breaking norms and rejecting values can lead to cultural sanctions such as earning a negative label—lazy, no-good bum—or to legal sanctions, such as traffic tickets, fines, or imprisonment.

Values are not static; they vary across time and between groups as people evaluate, debate, and change collective societal beliefs. Values also vary from culture to culture. For example, cultures differ in their values about what kinds of physical closeness are appropriate in public. It's rare to see two male friends or coworkers holding hands in the United States where that behavior often symbolizes romantic feelings. But in many nations, masculine physical intimacy is considered natural in public. This difference in cultural values came to light when people reacted to photos of former president George W. Bush holding hands with the Crown Prince of Saudi Arabia in 2005. A simple gesture, such as hand-holding, carries great symbolic differences across cultures.



In many parts of Africa and the Middle East, it is considered normal for men to hold hands in friendship. How would Americans react to these two soldiers? (Photo courtesy of Geordie Mott/Wikimedia Commons)

Norms

So far, the examples in this chapter have often described how people are expected to behave in certain situations—for example, when buying food or boarding a bus. These examples describe the visible and invisible rules of conduct through which societies are structured, or what sociologists call norms. Norms define how to behave in accordance with what a society has defined as good, right, and important, and most members of the society adhere to them.

Formal norms are established, written rules. They are behaviors worked out and agreed upon in order to suit and serve the most people. Laws are formal norms, but so are employee manuals, college entrance exam requirements, and "no running" signs at swimming pools. Formal norms are the most specific and clearly stated of the various types of norms, and they are the most strictly enforced. But even formal norms are enforced to varying degrees and are reflected in cultural values.

For example, money is highly valued in the United States, so monetary crimes are punished. It's against the law to rob a bank, and banks go to great lengths to prevent such crimes. People safeguard valuable possessions and install antitheft devices to protect homes and cars. A less strictly enforced social norm is driving while intoxicated. While it's against the law to drive drunk, drinking is for the most part an acceptable social behavior. And though there are laws to punish drunk driving, there are few systems in place to prevent the crime. These examples show a range of enforcement in formal norms.

There are plenty of formal norms, but the list of informal norms—casual behaviors that are generally and widely conformed to—is longer. People learn informal norms by observation, imitation, and general socialization. Some informal norms are taught directly—"Kiss your Aunt Edna" or "Use your napkin"—while others are learned by observation, including observations of the consequences when someone else violates a norm. But although informal norms define personal interactions, they extend into other systems as well. In the United States, there are informal norms regarding behavior at fast food restaurants. Customers line up to order their food and leave when they are done. They don't sit down at a table with strangers, sing loudly as they prepare their condiments, or nap in a booth. Most people don't commit even benign breaches of informal norms. Informal norms dictate appropriate behaviors without the need of written rules.

BREACHING EXPERIMENTS

Sociologist Harold Garfinkel (1917–2011) studied people's customs in order to find out how societal rules and norms not only influenced behavior but also shaped social order. He believed that members of society together create a social order (Weber 2011). His resulting book, *Studies in Ethnomethodology*, published in 1967, discusses people's assumptions about the social makeup of their communities.

One of Garfinkel's research methods was known as a "breaching experiment," in which the researcher behaves in a socially

awkward manner in order to test the sociological concepts of social norms and conformity. The participants are not aware an experiment is in progress. If the breach is successful, however, these “innocent bystanders” will respond in some way. For example, if the experimenter is, say, a man in a business suit, and he skips down the sidewalk or hops on one foot, the passersby are likely to stare at him with surprised expressions on their faces. But the experimenter does not simply “act weird” in public. Rather, the point is to deviate from a specific social norm in a small way, to subtly break some form of social etiquette, and see what happens.

To conduct his ethnomethodology, Garfinkel deliberately imposed strange behaviors on unknowing people. Then he observed their responses. He suspected that odd behaviors would shatter conventional expectations, but he wasn’t sure how. For example, he set up a simple game of tic-tac-toe. One player was asked beforehand to mark Xs and Os not in the boxes but on the lines dividing the spaces instead. The other player, in the dark about the study, was flabbergasted and did not know how to continue. The second player's reactions of outrage, anger, puzzlement, or other emotions illustrated the existence of cultural norms that constitute social life. These cultural norms play an important role. They let us know how to behave around each other and how to feel comfortable in our community.

There are many rules about speaking with strangers in public. It’s OK to tell a woman you like her shoes. It’s not OK to ask if you can try them on. It’s OK to stand in line behind someone at the ATM. It’s not OK to look over his shoulder as he makes his transaction. It’s OK to sit beside someone on a crowded bus. It’s weird to sit beside a stranger in a half-empty bus.

For some breaches, the researcher directly engages with innocent bystanders. An experimenter might strike up a conversation in a public bathroom, where it’s common to respect each other’s privacy so fiercely as to ignore other people’s presence. In a grocery store, an experimenter might take a food item out of another person’s grocery cart, saying, “That looks good! I think I’ll try it.” An experimenter might sit down at a table with others in a fast food restaurant or follow someone around a museum and study the same paintings. In those cases, the bystanders are pressured to respond, and their discomfort illustrates how much we depend on social norms. Breaching experiments uncover and explore the many unwritten social rules we live by.

Norms may be further classified as either mores or folkways. Mores (mor-ays) are norms that embody the moral views and principles of a group. Violating them can have serious consequences. The strongest mores are legally protected with laws or other formal norms. In the United States, for instance, murder is considered immoral, and it’s punishable by law (a formal norm). But more often, mores are judged and guarded by public sentiment (an informal norm). People who violate mores are seen as shameful. They can even be shunned or banned from some groups. The mores of the U.S. school system require that a student’s writing be in the student’s own words or use special forms (such as quotation marks and a whole system of citation) for crediting other writers. Writing another person’s words as if they are one’s own has a name—plagiarism. The consequences for violating this norm are severe and usually result in expulsion.

Unlike mores, folkways are norms without any moral underpinnings. Rather, folkways direct appropriate behavior in the day-to-day practices and expressions of a culture. They indicate whether to shake hands or kiss on the cheek when greeting another person. They specify whether to wear a tie and blazer or a T-shirt and sandals to an event. In Canada, women can smile and say hello to men on the street. In Egypt, that’s not acceptable. In regions in the southern United States, bumping into an acquaintance means stopping to chat. It’s considered rude not to, no matter how busy one is. In other regions, people guard their privacy and value time efficiency. A simple nod of the head is enough. Other accepted folkways in the United States may include holding the door open for a stranger or giving someone a gift on their birthday. The rules regarding these folkways may change from culture to culture.

Many folkways are actions we take for granted. People need to act without thinking in order to get seamlessly through daily routines; they can’t stop and analyze every action (Sumner 1906). Those who experience culture shock may find that it subsides as they learn the new culture’s folkways and are able to move through their daily routines more smoothly. Folkways might be small manners, learned by observation and imitated, but they are by no means trivial. Like mores and laws, these norms help people negotiate their daily lives within a given culture.

Symbols and Language

Humans, consciously and subconsciously, are always striving to make sense of their surrounding world. Symbols—such as gestures, signs, objects, signals, and words—help people understand that world. They provide clues to understanding experiences by conveying recognizable meanings that are shared by societies.

The world is filled with symbols. Sports uniforms, company logos, and traffic signs are symbols. In some cultures, a gold ring is a symbol of marriage. Some symbols are highly functional; stop signs, for instance, provide useful instruction. As physical objects,

they belong to material culture, but because they function as symbols, they also convey nonmaterial cultural meanings. Some symbols are valuable only in what they represent. Trophies, blue ribbons, or gold medals, for example, serve no other purpose than to represent accomplishments. But many objects have both material and nonmaterial symbolic value.

A police officer's badge and uniform are symbols of authority and law enforcement. The sight of an officer in uniform or a squad car triggers reassurance in some citizens, and annoyance, fear, or anger in others.

It's easy to take symbols for granted. Few people challenge or even think about stick figure signs on the doors of public bathrooms. But those figures are more than just symbols that tell men and women which bathrooms to use. They also uphold the value, in the United States, that public restrooms should be gender exclusive. Even though stalls are relatively private, most places don't offer unisex bathrooms.



Some road signs are universal. But how would you interpret the signage on the right? (Photo (a) courtesy of Andrew Bain/flickr; Photo (b) courtesy of HonzaSoukup/flickr)

Symbols often get noticed when they are out of context. Used unconventionally, they convey strong messages. A stop sign on the door of a corporation makes a political statement, as does a camouflage military jacket worn in an antiwar protest. Together, the semaphore signals for "N" and "D" represent nuclear disarmament—and form the well-known peace sign (Westcott 2008). Today, some college students have taken to wearing pajamas and bedroom slippers to class, clothing that was formerly associated only with privacy and bedtime. Though students might deny it, the outfit defies traditional cultural norms and makes a statement.

Even the destruction of symbols is symbolic. Effigies representing public figures are burned to demonstrate anger at certain leaders. In 1989, crowds tore down the Berlin Wall, a decades-old symbol of the division between East and West Germany, communism, and capitalism.

While different cultures have varying systems of symbols, one symbol is common to all: language. Language is a symbolic system through which people communicate and through which culture is transmitted. Some languages contain a system of symbols used for written communication, while others rely on only spoken communication and nonverbal actions.

Societies often share a single language, and many languages contain the same basic elements. An alphabet is a written system made of symbolic shapes that refer to spoken sound. Taken together, these symbols convey specific meanings. The English alphabet uses a combination of twenty-six letters to create words; these twenty-six letters make up over 600,000 recognized English words (OED Online 2011).

Rules for speaking and writing vary even within cultures, most notably by region. Do you refer to a can of carbonated liquid as "soda," pop," or "Coke"? Is a household entertainment room a "family room," "rec room," or "den"? When leaving a restaurant, do you ask your server for a "check," the "ticket," or your "bill"?

Language is constantly evolving as societies create new ideas. In this age of technology, people have adapted almost instantly

to new nouns such as “e-mail” and “Internet,” and verbs such as “downloading,” “texting,” and “blogging.” Twenty years ago, the general public would have considered these nonsense words.

Even while it constantly evolves, language continues to shape our reality. This insight was established in the 1920s by two linguists, Edward Sapir and Benjamin Whorf. They believed that reality is culturally determined, and that any interpretation of reality is based on a society’s language. To prove this point, the sociologists argued that every language has words or expressions specific to that language. In the United States, for example, the number thirteen is associated with bad luck. In Japan, however, the number four is considered unlucky, since it is pronounced similarly to the Japanese word for “death.”

The Sapir-Whorf hypothesis is based on the idea that people experience their world through their language, and that they therefore understand their world through the culture embedded in their language. The hypothesis, which has also been called linguistic relativity, states that language shapes thought (Swoyer 2003). Studies have shown, for instance, that unless people have access to the word “ambivalent,” they don’t recognize an experience of uncertainty from having conflicting positive and negative feelings about one issue. Essentially, the hypothesis argues, if a person can’t describe the experience, the person is not having the experience.

In addition to using language, people communicate without words. Nonverbal communication is symbolic, and, as in the case of language, much of it is learned through one’s culture. Some gestures are nearly universal: smiles often represent joy, and crying often represents sadness. Other nonverbal symbols vary across cultural contexts in their meaning. A thumbs-up, for example, indicates positive reinforcement in the United States, whereas in Russia and Australia, it is an offensive curse (Passero 2002). Other gestures vary in meaning depending on the situation and the person. A wave of the hand can mean many things, depending on how it’s done and for whom. It may mean “hello,” “goodbye,” “no thank you,” or “I’m royalty.” Winks convey a variety of messages, including “We have a secret,” “I’m only kidding,” or “I’m attracted to you.” From a distance, a person can understand the emotional gist of two people in conversation just by watching their body language and facial expressions. Furrowed brows and folded arms indicate a serious topic, possibly an argument. Smiles, with heads lifted and arms open, suggest a lighthearted, friendly chat.

IS THE UNITED STATES BILINGUAL?

In 1991, when she was six years old, Lucy Alvarez attended a school that allowed for the use of both English and Spanish. Lucy’s teacher was bilingual, the librarian offered bilingual books, and many of the school staff spoke both Spanish and English. Lucy and many of her classmates who spoke only Spanish at home were lucky. According to the U.S. Census, 13.8 percent of U.S. residents speak a non-English language at home. That’s a significant figure, but not enough to ensure that Lucy would be encouraged to use her native language in school (Mount 2010).

Lucy’s parents, who moved to Texas from Mexico, struggled under the pressure to speak English. Lucy might easily have gotten lost and left behind if she’d felt the same pressure in school. In 2008, researchers from Johns Hopkins University conducted a series of studies on the effects of bilingual education (Slavin et al. 2008). They found that students taught in both their native tongue and English make better progress than those taught only in English.

Technically, the United States has no official language. But many believe English to be the rightful language of the United States, and over thirty states have passed laws specifying English as the official tongue. Proponents of English-only laws suggest that a national ruling will save money on translation, printing, and human resource costs, including funding for bilingual teachers. They argue that setting English as the official language will encourage non-English speakers to learn English faster and adapt to the culture of the United States more easily (Mount 2010).

Groups such as the American Civil Liberties Union (ACLU) oppose making English the official language and claim that it violates the rights of non-English speakers. English-only laws, they believe, deny the reality of our nation’s diversity and unfairly target Latinos and Asians. They point to the fact that much of the debate on this topic has risen since 1970, a time when the United States experienced new waves of immigration from Asia and Mexico.

Today, a lot of product information gets written in multiple languages. Enter a store like Home Depot and you’ll find signs in both English and Spanish. Buy a children’s product, and the safety warnings could be presented in multiple languages. While marketers are financially motivated to reach the largest number of consumers possible, this trend also may help people acclimate to a culture of bilingualism.

Studies show that most U.S. immigrants eventually abandon their native tongues and become fluent in English. Bilingual education helps with that transition. Today, Lucy Alvarez is an ambitious and high-achieving college student. Fluent in both English and Spanish, Lucy is studying law enforcement—a field that seeks bilingual employees. The same bilingualism that contributed to her

success in grade school will help her thrive professionally as a law officer serving her community.



Nowadays, many signs—on streets and in stores—include both English and Spanish. What effect does this have on members of society? What effect does it have on our culture? (Photo courtesy of istolethetv/flickr)

Summary

A culture consists of many elements, such as the values and beliefs of its society. Culture is also governed by norms, including laws, mores, and folkways. The symbols and language of a society are key to developing and conveying culture.

Section Quiz

1. A nation's flag is:
   A. A symbol
   B. A value
   C. A culture
   D. A folkway

   Answer

   A

2. The existence of social norms, both formal and informal, is one of the main things that inform _____, otherwise known as a way to encourage social conformity.
   A. values
   B. sanctions
   C. social control
   D. mores

   Answer

   C

3. The biggest difference between mores and folkways is that
   A. mores are primarily linked to morality, whereas folkways are primarily linked to being commonplace within a culture
   B. mores are absolute, whereas folkways are temporary
   C. mores refer to material culture, whereas folkways refer to nonmaterial culture

D. mores refer to nonmaterial culture, whereas folkways refer to material culture

Answer

A

4. The notion that people cannot feel or experience something that they do not have a word for can be explained by:
   A. linguistics
   B. Sapir-Whorf
   C. Ethnographic imagery
   D. bilingualism

   Answer

   B

5. Cultural sanctions can also be viewed as ways that society:
   A. Establishes leaders
   B. Determines language
   C. Regulates behavior
   D. Determines laws

   Answer

   C

Short Answer

What do you think of the Sapir-Whorf hypothesis? Do you agree or disagree with it? Cite examples or research to support your point of view.

How do you think your culture would exist if there were no such thing as a social "norm"? Do you think chaos would ensue or relative peace could be kept? Explain.

Further Research

The science-fiction novel, *Babel-17*, by Samuel R. Delaney was based upon the principles of the Sapir-Whorf hypothesis. Read an excerpt from the novel here:http://openstaxcollege.org/l/Babel-17

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Glossary

beliefs
tenets or convictions that people hold to be true

folkways
direct, appropriate behavior in the day-to-day practices and expressions of a culture

formal norms
established, written rules

ideal culture
the standards a society would like to embrace and live up to

informal norms
casual behaviors that are generally and widely conformed to

language
a symbolic system of communication

mores
the moral views and principles of a group

norms
the visible and invisible rules of conduct through which societies are structured

real culture
the way society really is based on what actually occurs and exists

sanctions
a way to authorize or formally disapprove of certain behaviors

Sapir-Whorf hypothesis
the way that people understand the world based on their form of language

social control
a way to encourage conformity to cultural norms

symbols
gestures or objects that have meanings associated with them that are recognized by people who share a culture

values
a culture's standard for discerning what is good and just in society

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3.2.4: Pop Culture, Subculture, and Cultural Change

It may seem obvious that there are a multitude of cultural differences between societies in the world. After all, we can easily see that people vary from one society to the next. It's natural that a young woman from rural Kenya would have a very different view of the world from an elderly man in Mumbai—one of the most populated cities in the world. Additionally, each culture has its own internal variations. Sometimes the differences between cultures are not nearly as large as the differences inside cultures.

High Culture and Popular Culture

Do you prefer listening to opera or hip hop music? Do you like watching horse racing or NASCAR? Do you read books of poetry or celebrity magazines? In each pair, one type of entertainment is considered high-brow and the other low-brow. Sociologists use the termhigh culture to describe the pattern of cultural experiences and attitudes that exist in the highest class segments of a society. People often associate high culture with intellectualism, political power, and prestige. In America, high culture also tends to be associated with wealth. Events considered high culture can be expensive and formal—attending a ballet, seeing a play, or listening to a live symphony performance.

The term popular culture refers to the pattern of cultural experiences and attitudes that exist in mainstream society. Popular culture events might include a parade, a baseball game, or the season finale of a television show. Rock and pop music—"pop" is short for "popular"—are part of popular culture. Popular culture is often expressed and spread via commercial media such as radio, television, movies, the music industry, publishers, and corporate-run websites. Unlike high culture, popular culture is known and accessible to most people. You can share a discussion of favorite football teams with a new coworker or comment on *American Idol* when making small talk in line at the grocery store. But if you tried to launch into a deep discussion on the classical Greek play *Antigone*, few members of U.S. society today would be familiar with it.

Although high culture may be viewed as superior to popular culture, the labels of high culture and popular culture vary over time and place. Shakespearean plays, considered pop culture when they were written, are now part of our society's high culture. Five hundred years from now, will our descendants associate *Breaking Bad* with the cultural elite?

Subculture and Counterculture

A subculture is just what it sounds like—a smaller cultural group within a larger culture; people of a subculture are part of the larger culture but also share a specific identity within a smaller group.

Thousands of subcultures exist within the United States. Ethnic and racial groups share the language, food, and customs of their heritage. Other subcultures are united by shared experiences. Biker culture revolves around a dedication to motorcycles. Some subcultures are formed by members who possess traits or preferences that differ from the majority of a society's population. The body modification community embraces aesthetic additions to the human body, such as tattoos, piercings, and certain forms of plastic surgery. In the United States, adolescents often form subcultures to develop a shared youth identity. Alcoholics Anonymous offers support to those suffering from alcoholism. But even as members of a subculture band together, they still identify with and participate in the larger society.

Sociologists distinguish subcultures from countercultures, which are a type of subculture that rejects some of the larger culture's norms and values. In contrast to subcultures, which operate relatively smoothly within the larger society, countercultures might actively defy larger society by developing their own set of rules and norms to live by, sometimes even creating communities that operate outside of greater society.

Cults, a word derived from culture, are also considered counterculture group. The group "Yearning for Zion" (YFZ) in Eldorado, Texas, existed outside the mainstream and the limelight, until its leader was accused of statutory rape and underage marriage. The sect's formal norms clashed too severely to be tolerated by U.S. law, and in 2008, authorities raided the compound and removed more than two hundred women and children from the property.

THE EVOLUTION OF AMERICAN HIPSTER SUBCULTURE

Skinny jeans, chunky glasses, and T-shirts with vintage logos—the American hipster is a recognizable figure in the modern United States. Based predominately in metropolitan areas, sometimes clustered around hotspots such as the Williamsburg neighborhood

in New York City, hipsters define themselves through a rejection of the mainstream. As a subculture, hipsters spurn many of the values and beliefs of U.S. culture and prefer vintage clothing to fashion and a bohemian lifestyle to one of wealth and power. While hipster culture may seem to be the new trend among young, middle-class youth, the history of the group stretches back to the early decades of the 1900s.

Where did the hipster culture begin? In the early 1940s, jazz music was on the rise in the United States. Musicians were known as "hepcats" and had a smooth, relaxed quality that went against upright, mainstream life. Those who were "hep" or "hip" lived by the code of jazz, while those who were "square" lived according to society's rules. The idea of a "hipster" was born.

The hipster movement spread, and young people, drawn to the music and fashion, took on attitudes and language derived from the culture of jazz. Unlike the vernacular of the day, hipster slang was purposefully ambiguous. When hipsters said, "It's cool, man," they meant not that everything was good, but that it was the way it was.



In the 1940s, U.S. hipsters were associated with the "cool" culture of jazz. (Photo courtesy of William P. Gottlieb/Ira and Leonore S. Gershwin Fund Collection, Music Division, Library of Congress)

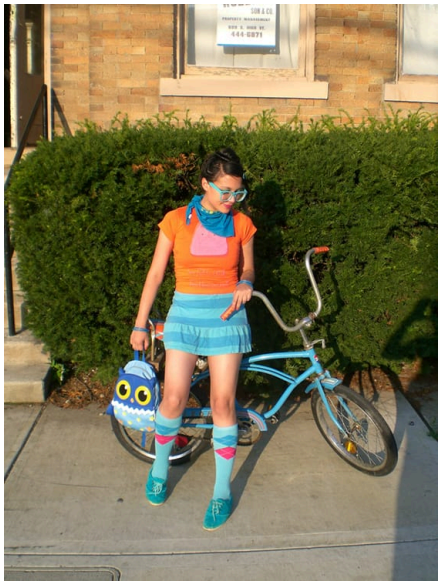
By the 1950s, the jazz culture was winding down and many traits of hepcat culture were becoming mainstream. A new subculture was on the rise. The "Beat Generation," a title coined by writer Jack Kerouac, were anticonformist and antimaterialistic. They were writers who listened to jazz and embraced radical politics. They bummed around, hitchhiked the country, and lived in squalor.

The lifestyle spread. College students, clutching copies of Kerouac's *On the Road*, dressed in berets, black turtlenecks, and black-rimmed glasses. Women wore black leotards and grew their hair long. Herb Caen, a San Francisco journalist, used the suffix from *Sputnik 1*, the Russian satellite that orbited Earth in 1957, to dub the movement's followers "Beatniks."

As the Beat Generation faded, a new, related movement began. It too focused on breaking social boundaries, but it also advocated freedom of expression, philosophy, and love. It took its name from the generations before; in fact, some theorists claim that Beats themselves coined the term to describe their children. Over time, the "little hipsters" of the 1970s became known simply as "hippies."

Today's generation of hipsters rose out of the hippie movement in the same way that hippies rose from Beats and Beats from hepcats. Although contemporary hipsters may not seem to have much in common with 1940s hipsters, the emulation of nonconformity is still there. In 2010, sociologist Mark Greif set about investigating the hipster subculture of the United States and found that much of what tied the group members together was not based on fashion, musical taste, or even a specific point of contention with the mainstream. "All hipsters play at being the inventors or first adopters of novelties," Greif wrote. "Pride comes from knowing, and deciding, what's cool in advance of the rest of the world. Yet the habits of hatred and accusation are endemic to hipsters because they feel the weakness of everyone's position—including their own" (Greif 2010). Much as the hepcats of the jazz era opposed common culture with carefully crafted appearances of coolness and relaxation, modern hipsters reject mainstream values with a purposeful apathy.

Young people are often drawn to oppose mainstream conventions, even if in the same way that others do. Ironic, cool to the point of noncaring, and intellectual, hipsters continue to embody a subculture, while simultaneously impacting mainstream culture.



Intellectual and trendy, today's hipsters define themselves through cultural irony. (Photo courtesy of Lorena Cupcake/Wikimedia Commons)

Cultural Change

As the hipster example illustrates, culture is always evolving. Moreover, new things are added to material culture every day, and they affect nonmaterial culture as well. Cultures change when something new (say, railroads or smartphones) opens up new ways of living and when new ideas enter a culture (say, as a result of travel or globalization).

Innovation: Discovery and Invention

An innovation refers to an object or concept's initial appearance in society—it's innovative because it is markedly new. There are two ways to come across an innovative object or idea: discover it or invent it. Discoveries make known previously unknown but existing aspects of reality. In 1610, when Galileo looked through his telescope and discovered Saturn, the planet was already there, but until then, no one had known about it. When Christopher Columbus encountered America, the land was, of course, already well known to its inhabitants. However, Columbus's discovery was new knowledge for Europeans, and it opened the way to changes in European culture, as well as to the cultures of the discovered lands. For example, new foods such as potatoes and tomatoes transformed the European diet, and horses brought from Europe changed hunting practices of Native American tribes of the Great Plains.

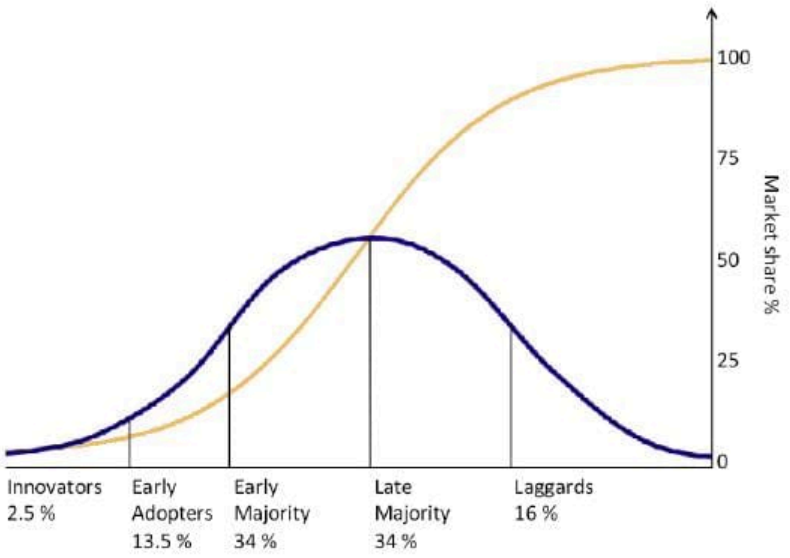
Inventions result when something new is formed from existing objects or concepts—when things are put together in an entirely new manner. In the late 1800s and early 1900s, electric appliances were invented at an astonishing pace. Cars, airplanes, vacuum cleaners, lamps, radios, telephones, and televisions were all new inventions. Inventions may shape a culture when people use them in place of older ways of carrying out activities and relating to others, or as a way to carry out new kinds of activities. Their adoption reflects (and may shape) cultural values, and their use may require new norms for new situations.

Consider the introduction of modern communication technology, such as mobile phones and smartphones. As more and more people began carrying these devices, phone conversations no longer were restricted to homes, offices, and phone booths. People on trains, in restaurants, and in other public places became annoyed by listening to one-sided conversations. Norms were needed for cell phone use. Some people pushed for the idea that those who are out in the world should pay attention to their companions and surroundings. However, technology enabled a workaround: texting, which enables quiet communication and has surpassed phoning as the chief way to meet today's highly valued ability to stay in touch anywhere, everywhere.

When the pace of innovation increases, it can lead to generation gaps. Technological gadgets that catch on quickly with one

generation are sometimes dismissed by a skeptical older generation. A culture's objects and ideas can cause not just generational but cultural gaps. Material culture tends to diffuse more quickly than nonmaterial culture; technology can spread through society in a matter of months, but it can take generations for the ideas and beliefs of society to change. Sociologist William F. Ogburn coined the term culture lag to refer to this time that elapses between the introduction of a new item of material culture and its acceptance as part of nonmaterial culture (Ogburn 1957).

Culture lag can also cause tangible problems. The infrastructure of the United States, built a hundred years ago or more, is having trouble supporting today's more heavily populated and fast-paced life. Yet there is a lag in conceptualizing solutions to infrastructure problems. Rising fuel prices, increased air pollution, and traffic jams are all symptoms of culture lag. Although people are becoming aware of the consequences of overusing resources, the means to support changes takes time to achieve.

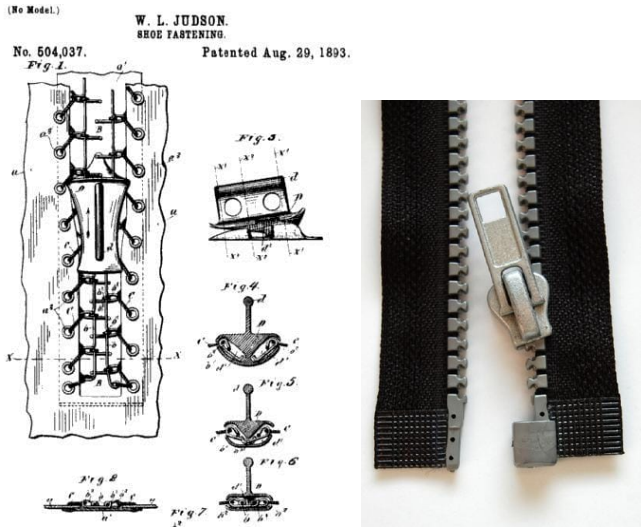


Sociologist Everett Rogers (1962) developed a model of the diffusion of innovations. As consumers gradually adopt a new innovation, the item grows toward a market share of 100 percent, or complete saturation within a society. (Graph courtesy of Tungsten/Wikimedia Commons)

Diffusion and Globalization

The integration of world markets and technological advances of the last decades have allowed for greater exchange between cultures through the processes of globalization and diffusion. Beginning in the 1980s, Western governments began to deregulate social services while granting greater liberties to private businesses. As a result, world markets became dominated by multinational companies in the 1980s, a new state of affairs at that time. We have since come to refer to this integration of international trade and finance markets as globalization. Increased communications and air travel have further opened doors for international business relations, facilitating the flow not only of goods but also of information and people as well (Scheuerman 2014 (revised)). Today, many U.S. companies set up offices in other nations where the costs of resources and labor are cheaper. When a person in the United States calls to get information about banking, insurance, or computer services, the person taking that call may be working in another country.

Alongside the process of globalization is diffusion, or the spread of material and nonmaterial culture. While globalization refers to the integration of markets, diffusion relates to a similar process in the integration of international cultures. Middle-class Americans can fly overseas and return with a new appreciation of Thai noodles or Italian gelato. Access to television and the Internet has brought the lifestyles and values portrayed in U.S. sitcoms into homes around the globe. Twitter feeds from public demonstrations in one nation have encouraged political protesters in other countries. When this kind of diffusion occurs, material objects and ideas from one culture are introduced into another.



Officially patented in 1893 as the "clasp locker" (left), the zipper did not diffuse through society for many decades. Today, it is immediately recognizable around the world. (Photo (a) courtesy of U.S. Patent Office/Wikimedia Commons; Photo (b) courtesy of Rabensteiner/Wikimedia Commons)

Summary

Sociologists recognize high culture and popular culture within societies. Societies are also comprised of many subcultures—smaller groups that share an identity. Countercultures reject mainstream values and create their own cultural rules and norms. Through invention or discovery, cultures evolve via new ideas and new ways of thinking. In many modern cultures, the cornerstone of innovation is technology, the rapid growth of which can lead to cultural lag. Technology is also responsible for the spread of both material and nonmaterial culture that contributes to globalization.

Section Quiz

1. An example of high culture is _____, whereas an example of popular culture would be _____.
   A. Dostoevsky style in film; "American Idol" winners
   B. medical marijuana; film noir
   C. country music; pop music
   D. political theory; sociological theory

   Answer

   A

2. The Ku Klux Klan is an example of what part of culture?
   A. Counterculture
   B. Subculture
   C. Multiculturalism
   D. Afrocentricity

   Answer

   A

3. Modern-day hipsters are an example of:
   A. ethnocentricity
   B. counterculture
   C. subculture
   D. high culture

Answer

C

4. Your eighty-three-year-old grandmother has been using a computer for some time now. As a way to keep in touch, you frequently send emails of a few lines to let her know about your day. She calls after every email to respond point by point, but she has never emailed a response back. This can be viewed as an example of:
   A. cultural lag
   B. innovation
   C. ethnocentricity
   D. xenophobia

Answer

A

5. Some jobs today advertise in multinational markets and permit telecommuting in lieu of working from a primary location. This broadening of the job market and the way that jobs are performed can be attributed to:
   A. cultural lag
   B. innovation
   C. discovery
   D. globalization

Answer

D

6. The major difference between invention and discovery is:
   A. Invention is based on technology, whereas discovery is usually based on culture
   B. Discovery involves finding something that already exists, but invention puts things together in a new way
   C. Invention refers to material culture, whereas discovery can be material or theoretic, like laws of physics
   D. Invention is typically used to refer to international objects, whereas discovery refers to that which is local to one's culture

Answer

B

7. That McDonald's is found in almost every country around the world is an example of:
   A. globalization
   B. diffusion
   C. culture lag
   D. xenocentrism

Answer

B

Short Answer

1. Identify several examples of popular culture and describe how they inform larger culture. How prevalent is the effect of these examples in your everyday life?
2. Consider some of the specific issues or concerns of your generation. Are any ideas countercultural? What subcultures have emerged from your generation? How have the issues of your generation expressed themselves culturally? How has your generation made its mark on society's collective culture?
3. What are some examples of cultural lag that are present in your life? Do you think technology affects culture positively or negatively? Explain.

Further Research

The Beats were a counterculture that birthed an entire movement of art, music, and literature—much of which is still highly regarded and studied today. The man responsible for naming the generation was Jack Kerouac; however, the man responsible for introducing the world to that generation was John Clellon Holmes, a writer often lumped in with the group. In 1952 he penned an article for the *New York Times Magazine* titled, "This Is the Beat Generation." Read that article and learn more about Clellon Holmes and the Beats: openstaxcollege.org/l/The-Beats

Popular culture meets counterculture in this as Oprah Winfrey interacts with members of the Yearning for Zion cult. Read about it here: openstaxcollege.org/l/Oprah

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Glossary

countercultures
: groups that reject and oppose society's widely accepted cultural patterns

culture lag
: the gap of time between the introduction of material culture and nonmaterial culture's acceptance of it

diffusion
: the spread of material and nonmaterial culture from one culture to another

discoveries
: things and ideas found from what already exists

globalization
: the integration of international trade and finance markets

high culture
: the cultural patterns of a society's elite

innovations
: new objects or ideas introduced to culture for the first time

inventions
: a combination of pieces of existing reality into new forms

popular culture
: mainstream, widespread patterns among a society's population

subcultures
: groups that share a specific identification, apart from a society's majority, even as the members exist within a larger society

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3.2.5: Theoretical Perspectives on Culture

Music, fashion, technology, and values—all are products of culture. But what do they mean? How do sociologists perceive and interpret culture based on these material and nonmaterial items? Let's finish our analysis of culture by reviewing them in the context of three theoretical perspectives: functionalism, conflict theory, and symbolic interactionism.

Functionalists view society as a system in which all parts work—or function—together to create society as a whole. In this way, societies need culture to exist. Cultural norms function to support the fluid operation of society, and cultural values guide people in making choices. Just as members of a society work together to fulfill a society's needs, culture exists to meet its members' basic needs.

Functionalists also study culture in terms of values. Education is an important concept in the United States because it is valued. The culture of education—including material culture such as classrooms, textbooks, libraries, dormitories—supports the emphasis placed on the value of educating a society's members.



This statue of Superman stands in the center of Metropolis, Illinois. His pedestal reads "Truth—Justice—The American Way." How would a functionalist interpret this statue? What does it reveal about the values of American culture? (Photo courtesy of David Wilson/flickr)

Conflict theorists view social structure as inherently unequal, based on power differentials related to issues like class, gender, race, and age. For a conflict theorist, culture is seen as reinforcing issues of "privilege" for certain groups based upon race, sex, class, and so on. Women strive for equality in a male-dominated society. Senior citizens struggle to protect their rights, their health care, and their independence from a younger generation of lawmakers. Advocacy groups such as the ACLU work to protect the rights of all races and ethnicities in the United States.

Inequalities exist within a culture's value system. Therefore, a society's cultural norms benefit some people but hurt others. Some norms, formal and informal, are practiced at the expense of others. Women were not allowed to vote in the United States until 1920. Gay and lesbian couples have been denied the right to marry in some states. Racism and bigotry are very much alive today. Although cultural diversity is supposedly valued in the United States, many people still frown upon interracial marriages. Same-sex marriages are banned in most states, and polygamy—common in some cultures—is unthinkable to most Americans.

At the core of conflict theory is the effect of economic production and materialism: dependence on technology in rich nations versus a lack of technology and education in poor nations. Conflict theorists believe that a society's system of material production has an effect on the rest of culture. People who have less power also have less ability to adapt to cultural change. This view contrasts with the perspective of functionalism. In the U.S. culture of capitalism, to illustrate, we continue to strive toward the promise of the American dream, which perpetuates the belief that the wealthy deserve their privileges.

Symbolic interactionism is a sociological perspective that is most concerned with the face-to-face interactions between members of society. Interactionists see culture as being created and maintained by the ways people interact and in how individuals interpret each other's actions. Proponents of this theory conceptualize human interactions as a continuous process of deriving meaning from both objects in the environment and the actions of others. This is where the term symbolic comes into play. Every object and action has a symbolic meaning, and language serves as a means for people to represent and communicate their interpretations of these meanings to others. Those who believe in symbolic interactionism perceive culture as highly dynamic and fluid, as it is dependent on how meaning is interpreted and how individuals interact when conveying these meanings.

We began this chapter by asking what culture is. Culture is comprised of all the practices, beliefs, and behaviors of a society. Because culture is learned, it includes how people think and express themselves. While we may like to consider ourselves individuals, we must acknowledge the impact of culture; we inherit thought language that shapes our perceptions and patterned behavior, including about issues of family and friends, and faith and politics.

To an extent, culture is a social comfort. After all, sharing a similar culture with others is precisely what defines societies. Nations would not exist if people did not coexist culturally. There could be no societies if people did not share heritage and language, and civilization would cease to function if people did not agree on similar values and systems of social control. Culture is preserved through transmission from one generation to the next, but it also evolves through processes of innovation, discovery, and cultural diffusion. We may be restricted by the confines of our own culture, but as humans we have the ability to question values and make conscious decisions. No better evidence of this freedom exists than the amount of cultural diversity within our own society and around the world. The more we study another culture, the better we become at understanding our own.



This child's clothing may be culturally specific, but her facial expression is universal. (Photo courtesy of Beth Rankin/flickr)

Summary

There are three major theoretical approaches toward the interpretation of culture. A functionalist perspective acknowledges that there are many parts of culture that work together as a system to fulfill society's needs. Functionalists view culture as a reflection of society's values. Conflict theorists see culture as inherently unequal, based upon factors like gender, class, race, and age. An interactionist is primarily interested in culture as experienced in the daily interactions between individuals and the symbols that comprise a culture. Various cultural and sociological occurrences can be explained by these theories; however, there is no one "right" view through which to understand culture.

Section Quiz

1. A sociologist conducts research into the ways that Hispanic American students are historically underprivileged in the U.S. education system. What theoretical approach is the sociologist using?
   A. Symbolic interactionism

B. Functionalism
C. Conflict theory
D. Ethnocentrism

Answer

C

2. The Occupy Wall Street movement of 2011 grew to be an international movement. Supporters believe that the economic disparity between the highest economic class and the mid to lower economic classes is growing at an exponentially alarming rate. A sociologist who studies that movement by examining the interactions between members at Occupy camps would most likely use what theoretical approach?
   A. Symbolic interactionism
   B. Functionalism
   C. Conflict theory
   D. Ethnocentrism

   Answer

   A

3. What theoretical perspective views society as having a system of interdependent inherently connected parts?
   A. Sociobiology
   B. Functionalism
   C. Conflict theory
   D. Ethnocentrism

   Answer

   B

4. The “American Dream”—the notion that anybody can be successful and rich if they work hard enough—is most commonly associated with which sociological theory?
   A. Sociobiology
   B. Functionalism
   C. Conflict theory
   D. Ethnocentrism

   Answer

   C

Short Answer

Consider a current social trend that you have witnessed, perhaps situated around family, education, transportation, or finances. For example, many veterans of the Armed Forces, after completing tours of duty in the Middle East, are returning to college rather than entering jobs as veterans as previous generations did. Choose a sociological approach—functionalism, conflict theory, or symbolic interactionism—to describe, explain, and analyze the social issue you choose. Afterward, determine why you chose the approach you did. Does it suit your own way of thinking? Or did it offer the best method to illuminate the social issue?

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3.3: Video- Cultural Humility

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UNIT 2: SOCIAL WORK PRACTICE

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4: CHAPTER 4

4.1: Generalist Practice

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4.1: Generalist Practice

When looking at generalist practice primary theories, the first question that may come to mind is *what is generalist practice?* Generalist practice introduces students to the basic concepts in social work which includes promoting human well-being and applying preventative and intervention methods to social problems at individual (micro), group (mezzo), and community (macro) levels while following ethical principles and critical thinking (Inderbitzen, 2014).

Now that you have some insight on what generalist practice is, we should discuss what a social work generalist does. A social work generalist uses a wide range of prevention and intervention methods when working with families, groups, individuals, and communities to promote human and social well-being (Johnson & Yanca, 2010).

Being a social work generalist practitioner prepares you to enter nearly any profession within the social work field, depending on your population of interest (Inderbitzen, 2014).

Micro, Mezzo, Macro Levels of Social Work

Micro level social work is the most common practice scenario and happens directly with an individual client or family; in most cases this is considered to be case management and therapy service. Micro social work involves meeting with individuals, families or small groups to help identify, and manage emotional, social, financial, or mental challenges, such as helping individuals to find appropriate housing, health care, and social services. Micro-practice may even include military social work like helping military officials and families cope with military life and circumstances (see Chapter 14), school social work which could involve helping with school related resources, Individual education plans, and so on (see Chapter 11), or a mental health case manager to help individuals understand and cope with their mental illnesses (see Chapter 10).

The focus of micro level practice is to help individuals, families, and small groups by giving one on one support and provide skills to help manage challenges (Johnson & Yanca. 2010).

Mezzo level social work involves developing and implementing plans for communities such as neighborhoods, churches, and schools. Social workers on the mezzo level interact directly with people and agencies that share the same passion or interest. The big difference between micro and mezzo level social work is that instead of engaging in individual counseling and support, mezzo social workers administer help to groups of people. Examples of work and interest that mezzo social workers could be involved in include the establishment of a free food pantry within a local church to help with food resources for vulnerable populations, health clinics to provide services for the uninsured, or community budgeting/financial programs for low income families.

Many mezzo social work roles exist; however social workers generally engage in micro and mezzo practice simultaneously (Kirst-Ashman & Hull, 2015).

Macro level social work is very distinct from micro and mezzo level. The focus of macro level social work is to help vulnerable populations indirectly and on a larger scale. The responsibilities for social workers on a macro level typically are finding the root cause or the why and effects of citywide, state, and/or national social problems.

They are responsible for creation and implementation of human service programs to address large scale social problems. Macro level social workers often advocate to encourage state and federal governments to change policies to better serve vulnerable populations (Kirst-Ashman & Hull, 2015).

Social workers that work on the macro level are often employed at non-profit organizations, public defense law firms (working pro-bono cases), government departments, and human rights organizations.

While macro social workers typically do not provide therapy or other assistance (case management) to clients, they may interact directly with the individuals while conducting interviews during their research that pertains to the populations and social inequalities of their interest.

Although, social work is broad and allows practitioners to move within the micro, mezzo, and macro levels. All social workers begin at the micro level to understand the inequalities, disadvantages, and the needed advocacy for vulnerable populations.

Theories

Systems Theory

Systems Theory is an interdisciplinary study of complex systems. It focuses on the dynamics and interactions of people in their environments (Ashman, 2013). The Systems Theory is valuable to the social work profession because it assists social workers with identifying, defining, and addressing problems within social systems.

As social workers, we utilize the Systems Theory to help us understand the relationships between individuals, families, and organizations within our society. Systems theory allows social workers to identify how a system functions and how the negative impacts of a system can affect a person, family, organization, and society, by working together to cause a positive impact within that system (Flamand, 2017).

Ecological Systems Theory

The **Ecological Systems Theory** was created in the late 1970's by Urie Bronfenbrenner. According to Oswalt (2015), Bronfenbrenner developed the Ecological Systems Theory to explain how a child's environment affects their growth and development. The four levels that are described below are the different levels according to Bronfenbrenner that affect the different development stages of a child.

The main concept behind ecological approach is "person in environment" (P.I.E). The ecological approach implies that every person lives in an environment that can affect their outcome or circumstance. As social workers, our job is to improve a person's environment by helping them identify what is negatively impacting their environment.

When discussing this theory, it is important to understand the four systems that make up the ecological systems: microsystem, mesosystem, exosystem, and macrosystem.

The **microsystem** is the smallest system, focusing on the relationship between a person and their direct environment. The **mesosystem** is a step above the microsystem. This system focuses on the relationship between groups and the effects that one social group may have on another social group. The **exosystem** is a more generalized system as it shows the effect that a group has on interactions among other groups. Lastly, the **macrosystem** focuses on the bigger issues such as culture, politics, government, and society (Allen-Meares & Lane, 1987).

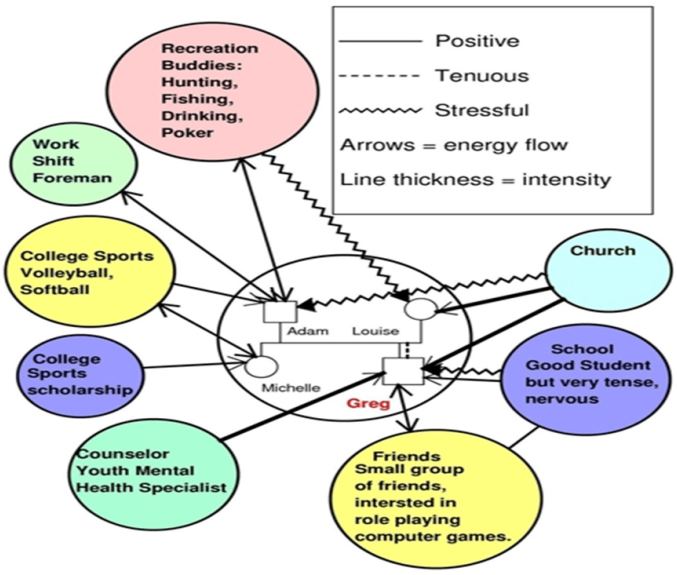
When focusing on a client by providing case management or support to an individual that is facing hardships, we often look at a person's microsystem. Looking at a person's environment allows us as social workers to help identify problem areas or what is negatively impacting their lives.

This is usually done by making an eco-map to give the client a visual aide during the identifying process. An **eco-map** is a diagram that shows the social and personal relationships of an individual with his or her environment. Eco-maps were developed in 1975 by Dr. Ann Hartman, a social worker who is also credited for developing the genogram (Genachte, 2009).

Below is an example of what an eco-map would look like once it is completed with your client.

Eco-maps will vary in what they look like as each map will cater to the specific client/family, and will highlight the stressors (negatives), positives, and relationships.

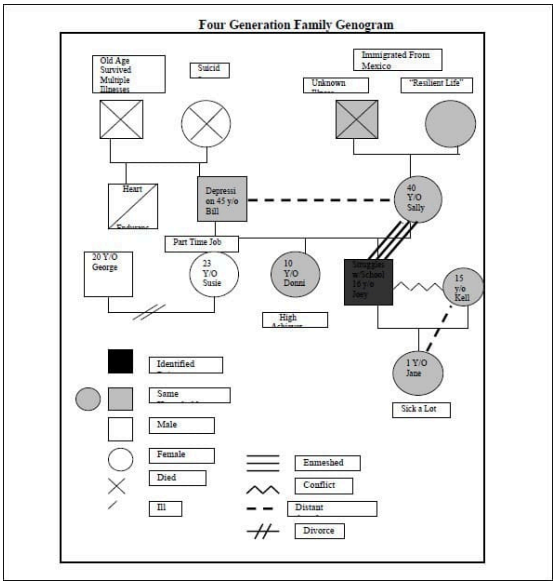
Greg's Eco-map



Example of an ecomap, http://www.genogramanalytics.com/

A **genogram** mimics a family tree. Normally when you look at a family tree you often find branches and each branch represent a family. A genogram digs deeper and identifies relationships, deaths, marriages, births, divorce, and adoptions just to name a few. When collecting information to complete a genogram it is useful to understand a family's dynamics (Johnson & Yanca, 2010.)

Here is an example of a genogram; this genogram along with other samples and variations can be found on www.sampletemplates.com. Genograms can help clients identify their roots and culture. While completing genograms also be aware that while unraveling a client's history, past trauma or closed wounds can be reopened. As a social worker you need to be prepared to discuss and address these issues to help your client address their past trauma.



Four Generation Family Genogram

Activity: In class or as homework complete and eco map and genogram of your own family. See how far you can go through family tree and connect your family, relationships, marriages, etc.

Strengths Approach

The development of the **StrengthsApproach** began and has been led by Dennis Saleeby and staff at the University of Kansas. The Strengths Approach is based off two very important principles:

- every person, group, family, and community has strengths
- every community or environment is full of resources (Johnson & Yanca, 2010)

In the Strengths Approach, it is the social worker's job to help the client identify their strengths. Often clients with whom we work with are only able to identify the negative impacts of their lives and have a difficult time identifying the positive aspects of their lives and situations. When using the Strengths Approach not only is the social worker helping the client to identify their personal strengths, but the worker is also helping the client identify local resources to help the client needs.

This approach focuses on the strengths and resources that the client already has rather than building on new strengths and resources. The reasoning behind the strength approach is to help clients with immediate needs, and to help with finding solutions to immediate problems.

Planned Change Model

The planned change process was introduced to the social work profession in 1957 by Helen Harris Perlman. The **Planned Change Model** is the development and implementation of a plan or strategy to improve or alter a pattern of behaviors, a condition, or circumstance to improve a client's well-being or situation (Kirst-Ashman, 2012).

The Planned Change Model consists of a seven-step process which includes:

- Engagement
- Assessment
- Planning
- Implementation
- Evaluation
- Termination
- Follow-up

The **Engagement phase** is the first interaction between the social worker and their client. The engagement stage does not have a predetermined time frame; it can last for a couple of minutes to a few hours depending on the client and the circumstances. It is very important during the engagement phase that the social worker displays active listening skills, eye contact, empathy and empathetic responses, can reflect to the client what has been said, and uses questioning skills (motivational interviewing). It is appropriate to take notes during the engagement phase for assessment purposes or for reflection. Remember, during the engagement phase, the social worker is building a level of rapport and trust with the client.

The **Assessment phase** is the process occurring between social worker and client in which information is gathered, analyzed and synthesized to provide a concise picture of the client and their needs and strengths. The assessment phase is very important as it is the foundation of the planning and action phases that follow.

During the assessment stages, there are five key points:

- identifying the need problem (concern)
- identify the nature of the problem
- identify strengths and resources
- collect information
- analyze the collected information

(Johnson & Yanca, 2010)

The **Planning phase** is when the client and social worker develop a plan with goals and objectives as to what needs to be done to address the problem. A plan is developed to help the client meet their need or address the problem (Johnson, & Yanca, 2010). The planning phase is a joint process where the worker and the client identify the strengths and resources gathered from the assessment phase. Once the strengths and resources are identified, the social worker and the client come up with a plan by

outlining goals, objectives, and tasks to help meets the clients goal to address the need or problem. During the planning phase, keep in mind that the goals should be what the client is comfortable with and finds feasible to obtain. The social worker's most important job during this phase is to help the client identify strengths and resources, not to come up with the client's goals for them.

The **Implementation/Actionphase** is when the client and social worker execute a plan to address the areas of concern by completing the objectives to meet the client's goals. The action phase is also considered a joint phase as the social worker and the client act! The worker and the client begin to work on the task that were identified in the planning phase (Johnson & Yanca, 2010). The worker and the client are responsible for taking on different parts of the identified task; for example, the social worker may find a local food pantry or help with food assistance program if the client needs food. The client may work on making a grocery list of foods that will make bigger portions for leftovers to make food last longer for the family. However, the worker and the client are jointly working together to obtain the goal of providing food for the client and their family.

The **Evaluation Phase/Termination phase** is a constant. The worker should always evaluate how the client is doing throughout the process of the working relationship (Johnson & Yanca, 2010). When the plan has been completed or the goals have been met, the client and social worker review the goals and objective and evaluate the change and/or the success. If change or progress has not been made the client and social worker will review the goals and objectives and make changes or modifications to meet the goal. Once the goals have been met, termination of services follows if there are no further need for services or other concerns to address. Sometimes termination happens before goal completion, due to hospitalizations, relocation, losing contact with a client, financial hardships , or the inability to engage the client.

The **Follow Up phase** is when the social worker reaches out to the client to make sure they are still following their goals, using their skills, and making sure the client is doing well. The follow up may not always be possible due to different situations such as death, relocation, and change in contact information, to name a few.

The diagram below shows the process of the Planned Change Model when working with clients.

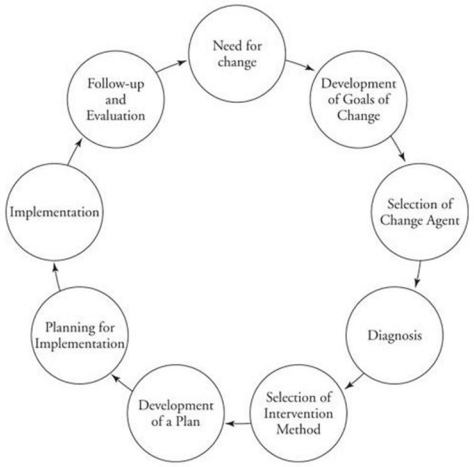


Figure 1 Stages of planned change.

Stages of Planned Change

Activity: Partner up with a classmate. Role play one person being the social worker and the other being the client. Come up with a problem or concern and try to go through the planned change process. I do not expect you to get through the whole process, but at least try to get through the first three stages. Remember to be creative and have fun while doing so!!

Evidence Based Practice (EBP)

According to David Sackett, evidence based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of a client. When working with clients it is important to combine research and clinical expertise. In the field of social work there is constant research being conducted to assess various assessment and treatment modalities. The

research that is conducted provides the evidence that we as social workers use to help our clients improve their living situations and concerns. Lastly, keep in mind that our clients are the experts on their own lives. We must keep in mind what their personal values are and what their preferences are for the outcome of their life situation. This is very important and often can become frustrating as a social worker as we think we know what is right for our client, but it may not be their personal preference.

When working with clients and evidence based practices it is important to know that research is constant surrounding evidence based practices, and as a practicing social worker it is very important to stay abreast of the constant change of new information and changes. It is important to do your own research, and most importantly always respect your clients' personal values and preferences.

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4.2: An Introduction to Theory and Practical Theorizing (Merlot)

https://www.merlot.org/merlot/viewMaterial.htm?id=1234926

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4.3: INTRODUCTION TO RESEARCH

How do social workers know the right thing to do? It's an important question. Incorrect social work actions may actively harm clients and communities. Timely and effective social work interventions further social justice and promote individual change. To do make the right choices, we must have a basis of knowledge, the skills to understand it, and the commitment to growing that knowledge. The source of social work knowledge is social science and this book is about how to understand and apply it to social work practice.

4.3.1: How do social workers know what to do?

4.3.2: Science and social work

4.3.3: Why should we care?

4.3.4: Understanding research

This chapter discusses or mentions the following topics: stereotypes of people on welfare, sexual harassment and sexist job discrimination, sexism, poverty, homelessness, mental illness, and substance abuse.

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4.3.1: How do social workers know what to do?

Learning Objectives

- Reflect on how we know what to do as social workers
- Differentiate between micro-, meso-, and macro-level analysis
- Describe intuition, its purpose in social work, and its limitations
- Identify specific types of cognitive biases and how the influence thought
- Define scientific inquiry

What would you do?

Imagine you are a clinical social worker at a children's mental health agency. Today, you receive a referral from your town's middle school about a client who often skips school, gets into fights, and is disruptive in class. The school has suspended him and met with the parents multiple times, who say they practice strict discipline at home. Yet, the client's behavior only gotten worse. When you arrive at the school to meet with the boy, you notice he has difficulty maintaining eye contact with you, appears distracted, and has a few bruises on his legs. At the same time, he is also a gifted artist, and you two spend the hour in which you assess him painting and drawing.

- *Given the strengths and challenges you notice, what interventions would you select for this client and how would you know your interventions worked?*

Imagine you are a social worker in an urban food desert, a geographic area in which there is no grocery store that sells fresh food. Many of your low-income clients rely on food from the dollar store or convenience stores in order to live or simply order takeout. You are becoming concerned about your clients' health, as many of them are obese and say they are unable to buy fresh food. Because convenience stores are more expensive and your clients mostly survive on minimum wage jobs or Supplemental Nutrition Assistance Program (SNAP) benefits, they often have to rely on food pantries towards the end of the month once their money runs out. You have spent the past month building a coalition composed of members from your community, including non-profit agencies, religious groups, and healthcare workers to lobby your city council.

- *How should your group address the issue of food deserts in your community? What intervention do you suggest? How would you know if your intervention worked?*

You are a social worker working at a public policy center focused on homelessness. Your city is seeking a large federal grant to address the growing problem of homelessness in your city and has hired you as a consultant to work on the grant proposal. After conducting a needs assessment in collaboration with local social service agencies and interviewing people who are homeless, you meet with city councilmembers to talk about your options to create a program. Local agencies want to spend the money to build additional capacity at existing shelters in the community. They also want to create a transitional housing program at an unused apartment complex where people can live after the shelter and learn independent living skills. On the other hand, the clients you interview want to receive housing vouchers so they can rent an apartment from a landlord in the community. They also fear the agencies running the shelter and transitional housing program would dictate how to live their lives and impose unnecessary rules, like restrictions on guests or quiet hours. When you ask the agencies about client feedback, they state that clients could not be trusted to manage in their own apartments and need the structure and supervision provided by agency support workers.

- *What kind of program should your city choose to implement? Which program is most likely to be effective?*

Assuming you've taken a social work course before, you will notice that the case studies cover different levels of analysis in the social ecosystem—micro, meso, and macro. At the **micro-level**, social workers examine the smallest levels of interaction; even in some cases, just "the self" alone. That is our misbehaving child in case 1. When social workers investigate groups and communities, such as our food desert in case 2, their inquiry is at the **meso-level**. At the **macro-level**, social workers examine social structures and institutions. Research at the macro-level examines large-scale patterns, including culture and government policy, as in case 3. These domains interact with each other, and it is common for a social work research project to address more than one level of analysis. Moreover, research that occurs on one level is likely to have implications at the other levels of analysis.

How do social workers know what to do?

Welcome to social work research. This chapter begins with three problems that social workers might face in practice and three questions about what a social worker should do next. If you haven't already, spend a minute or two thinking about how you would respond to each case and jot down some notes. How would you respond to each of these cases?



I assume it is unlikely you are an expert in the areas of children's mental health, community responses to food deserts, and homelessness policy. Don't worry, I'm not either. In fact, for many of you this textbook will likely come at an early point in your social work education, so it may seem unfair for me to ask you what the right answers are. And to disappoint you further, this course will not teach you the right answer to these questions. It will, however, teach you how to answer these questions for yourself. Social workers must learn how to examine the literature on a topic, come to a reasoned conclusion, and use that knowledge in their practice. Similarly, social workers engage in research to make sure their interventions are helping, not harming, clients and to contribute to social science as well as social justice.

Again, assuming you did not have advanced knowledge of the topics in the case studies, when you thought about what you might do in those practice situations, you were likely using **intuition** (Cheung, 2016). [1] Intuition is a way of knowing that is mostly unconscious. You simply have a gut feeling about what you should do. As you think about a problem such as those in the case studies, you notice certain details and ignore others. Using your past experiences, you apply knowledge that seems to be relevant and make predictions about what might be true.

In this way, intuition is based on **direct experience**. Many of us know things simply because we've experienced them directly. For example, you would know that electric fences can be pretty dangerous and painful if you touched one while standing in a puddle of water. We all probably have times we can recall when we learned something because we experienced it. If you grew up in Minnesota, you would observe plenty of kids learning each winter that it really is true that your tongue will stick to metal if it's very cold outside. Similarly, if you passed a police officer on a two-lane highway while driving 20 miles over the speed limit, you would probably learn that that's a good way to earn a traffic ticket.

Intuition and direct experience are powerful forces. Uniquely, social work is a discipline that values intuition, though it will take quite a while for you to develop what social workers refer to as **practice wisdom**. Practice wisdom is the "learning by doing" that develops as one practices social work over a period of time. Social workers also reflect on their practice, independently and with colleagues, which sharpens their intuitions and opens their mind to other viewpoints. While your direct experience in social work may be limited at this point, feel confident that through reflective practice you will attain practice wisdom.

However, it's important to note that intuitions are not always correct. Think back to the first case study. What might be your novice diagnosis for this child's behavior? Does he have attention deficit hyperactivity disorder (ADHD) because he is distractible and getting into trouble at school? Or are those symptoms of autism spectrum disorder or an attachment disorder? Are the bruises on his legs an indicator of ADHD, or do they indicate possible physical abuse at home? Even if you arrived at an accurate assessment of the situation, you would still need to figure out what kind of intervention to use with the client. If he has a mental health

issue, you might say, “give him therapy.” Well…what kind of therapy? Should we use cognitive-behavioral therapy, play therapy, art therapy, family therapy, or animal assisted therapy? Should we try a combination of therapy and medication prescribed by a psychiatrist?

We could guess which intervention would be best…but in practice, that would be highly unethical. If we guessed wrong, we could be wasting time, or worse, actively harming a client. We need to ground our social work interventions with clients and systems with something more secure than our intuition and experience.

Cognitive biases

Although the human mind is a marvel of observation and data analysis, there are universal flaws in thinking that must be overcome. We all rely on mental shortcuts to help us make sense of a continuous stream of new information. All people, including me and you, must train our minds to be aware of predictable flaws in thinking, termed **cognitive biases**. Here is a link to the Wikipedia entry on cognitive biases. As you can see, it is quite long. We will review some of the most important ones here, but take a minute and browse around to get a sense of how baked-in cognitive biases are to how humans think.



The most important cognitive bias for social scientists to be aware of is **confirmation bias**. Confirmation bias involves observing and analyzing information in a way that confirms what you already think is true. No person is a blank slate. We all arrive at each moment with a set of beliefs, experiences, and models of how the world works that we develop over time. Often, these are grounded in our own personal experiences. Confirmation bias assumes these intuitions are correct and ignores or manipulates new information order to avoid challenging what we already believe to be true.

Confirmation bias can be seen in many ways. Sometimes, people will only pay attention to the information that fits their preconceived ideas and ignore information that does not fit. This is called **selective observation**. Other times, people will make hasty conclusions about a broad pattern based on only a few observations. This is called **overgeneralization**. Let’s walk through an example and see how they each would function.

In our second case study, we are trying to figure out how to help people who receive SNAP (formerly Food Stamps) who live in a food desert. Let’s say that we have arrived at a solution and are now lobbying the city council to implement it. There are many people who have negative beliefs about people who are “on welfare.” These people believe individuals who receive social welfare benefits spend their money irresponsibly, are too lazy to get a job, and manipulate the system to maintain or increase their government payout. People expressing this belief may provide an example like Louis Cuff, who bought steak and lobster with his SNAP benefits and resold them for a profit.

City council members who hold these beliefs may ignore the truth about your client population—that people experiencing poverty usually spend their money responsibly and genuinely need help accessing fresh and healthy food. This would be an example of selective observation, only looking at the cases that confirm their biased beliefs about people in poverty and ignoring evidence that challenges that perspective. Likely, these are grounded in overgeneralization, in which one example, like Mr. Cuff, is applied

broadly to the population of people using social welfare programs. Social workers in this situation would have to hope that city council members are open to another perspective and can be swayed by evidence that challenges their beliefs. Otherwise, they will continue to rely on a biased view of people in poverty when they create policies.

But where do these beliefs and biases come from? Perhaps, someone who the person considers an authority told them that people in poverty are lazy and manipulative. Naively relying on **authority** can take many forms. We might rely on our parents, friends, or religious leaders as authorities on a topic. We might consult someone who identifies as an expert in the field and simply follow what they say. We might hop aboard a "bandwagon" and adopt the fashionable ideas and theories of our peers and friends.

Now, it is important to note that experts in the field should generally be trusted to provide well-informed answers on a topic, though that knowledge should be receptive to skeptical critique and will develop over time as more scholars study the topic. There are limits to skepticisim, however. Disagreeing with experts about global warming, the shape of the earth, or the efficacy and safety of vaccines does not make one free of cognitive biases. On the contrary, it is likely that the person is falling victim to the **Dunning-Kruger effect**, in which unskilled people overestimate their ability to find the truth. As this comic illustrates, they are at the top of Mount Stupid. Only through rigorous, scientific inquiry can they progress down the back slope and hope to increase their depth of knowledge about a topic.

Scientific Inquiry

Cognitive biases are most often expressed when people are using informal observation. Until I asked at the beginning of this chapter, you may have had little reason to formally observe and make sense of information about children's mental health, food deserts, or homelessness policy. Because you engaged in informal observation, it is more likely that you will express cognitive biases in your responses. The problem with informal observation is that sometimes it is right, and sometimes it is wrong. And without any systematic process for observing or assessing the accuracy of our observations, we can never really be sure that our informal observations are accurate. In order to minimize the effect of cognitive biases and come up with the truest understanding of a topic, we must apply a systematic framework for understanding what we observe.

The opposite of informal observation is scientific inquiry, used interchangeably with the term **research methods** in this text. These terms refer to an organized, logical way of knowing that involves both theory and observation. Science accounts for the limitations of cognitive biases—not perfectly, though—by ensuring observations are done rigorously, following a prescribed set of steps. Scientists clearly describe the methods they use to conduct observations and create theories about the social world. Theories are tested by observing the social world, and they can be shown to be false or incomplete. In short, scientists try to learn the truth. Social workers use scientific truths in their practice and conduct research to revise and extend our understanding of what is true in the social world. Social workers who ignore science and act based on biased or informal observation may actively harm clients.

Key Takeaways

- Social work research occurs on the micro-, meso-, and macro-level.
- Intuition is a powerful, though woefully incomplete, guide to action in social work.
- All human thought is subject to cognitive biases.
- Scientific inquiry accounts for cognitive biases by applying an organized, logical way of observing and theorizing about the world.

Glossary

- Authority- learning by listening to what people in authority say is true
- Cognitive biases- predictable flaws in thinking
- Confirmation bias- observing and analyzing information in a way that confirms what you already think is true
- Direct experience- learning through informal observation
- Dunning-Kruger effect- when unskilled people overestimate their ability and knowledge (and experts underestimate their ability and knowledge)
- Intuition- your "gut feeling" about what to do
- Macro-level- examining social structures and institutions
- Meso-level- examining interaction between groups

- Micro-level- examining the smallest levels of interaction, usually individuals
- Overgeneralization- using limited observations to make assumptions about broad patterns
- Practice wisdom- “learning by doing” that guides social work intervention and increases over time
- Research methods- an organized, logical way of knowing based on theory and observation

Image Attributions

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4.3.2: Science and social work

Learning Objectives

- Define science
- Describe the the difference between objective and subjective truth(s)
- Describe the role of ontology and epistemology in scientific inquiry

Science and social work

Science is a particular way of knowing that attempts to systematically collect and categorize facts or truths. A key word here is systematically–conducting science is a deliberate process. Scientists gather information about facts in a way that is organized and intentional, usually following a set of predetermined steps. More specifically, social work is informed by social science, the science of humanity, social interactions, and social structures. In other words, social work research uses organized and intentional procedures to uncover facts or truths about the social world. And social workers rely on social scientific research to promote individual and social change.



Philosophy of social science

This approach to finding truth probably sounds similar to something you heard in your middle school science classes. When you learned about the gravitational force or the mitochondria of a cell, you were learning about the theories and observations that make up our understanding of the physical world. These theories rely on an **ontology**, or a set of assumptions about what is real. We assume that gravity is real and that the mitochondria of a cell are real. Mitochondria are easy to spot with a powerful enough microscope and we can observe and theorize about their function in a cell. The gravitational force is invisible, but clearly apparent from observable facts, like watching an apple fall. The theories about gravity have changed over the years, but improvements in theory were made when observations could not be correctly interpreted using existing theories.

If we weren't able to perceive mitochondria or gravity, they would still be there, doing their thing because they exist independent of our observation of them. This is a philosophical idea called *realism,* and it simply means that the concepts we talk about in science really and truly exist. Ontology in physics and biology is focused on **objectivetruth**. Chances are you've heard of "being objective" before. It involves observing and thinking with an open mind, pushing aside anything that might bias your perspective. Objectivity also means we want to find what is true for everyone, not just what is true for one person. Certainly, gravity is true for everyone and everywhere. Let's consider a social work example, though. It is objectively true that children who are subjected

to severely traumatic experiences will experience negative mental health effects afterwards. A diagnosis of post-traumatic stress disorder (PTSD) is considered to be objective, referring to a real mental health issue that exists independent of the social worker observing it and that is highly similar in its presentation with our client as it would be with other clients.

So, an objective ontological perspective means that what we observe is true for everyone and true even when we aren't there to observe it. How do we come to know objective truths like these? This is the study of **epistemology**, or our assumptions about how we come to know what is real and true. The most relevant epistemological question in the social sciences is whether truth is better accessed using numbers or words. Generally, scientists approaching research with an objective ontology and epistemology will use **quantitative methods** to arrive at scientific truth. Quantitative methods examine numerical data to precisely describe and predict elements of the social world. This is due to the epistemological assumption that mathematics can represent the phenomena and relationships we observe in the social world.

Mathematical relationships are uniquely useful, in that they allow comparisons across individuals as well as across time and space. For example, while people can have different definitions for poverty, an objective measurement such as an annual income of less than $25,100 for a family of four provides (1) a precise measurement, (2) that can be compared to incomes from all other people in any society from any time period, (3) and refer to real quantities of money that exist in the world. In this book, we will review survey and experimental methods, which are the most common designs that use quantitative methods to answer research questions.

It may surprise you to learn that objective facts, such as income or mental health diagnosis, are not the only facts in the social sciences. Indeed, social science is not only concerned with objective truth. Social science also describes **subjective truth**, or the truths that are unique to individuals, groups, and contexts. Unlike objective truth, which is true for all people, subjective truths will vary based on who you are observing and the context in which you are observing them. The beliefs, opinions, and preferences of people are actually truths that social scientists measure and describe. Additionally, subjective truths do not exist independent of human observation because they are the product of the human mind. We negotiate what is true in the social world through language, arriving at a consensus and engaging in debate.

Epistemologically, a scientist seeking subjective truth assumes that truth lies in what people say, their words. A scientist uses **qualitative methods** to analyze words or other media to understand their meaning. Humans are social creatures, and we give meaning to our thoughts and feelings through language. Linguistic communication is unique. We share ideas with each other at a remarkable rate. In so doing, ideas come into and out of existence in a spontaneous and emergent fashion. Words are given a meaning by their creator. But anyone who receives that communication can absorb, amplify, and even change its original intent. Because social science studies human interaction, subjectivists argue that language is the best way to understand the world.

This epistemology is based on some interesting ontological assumptions. What happens when someone incorrectly interprets a situation? While their interpretation may be wrong, it is certainly true *to them* that they are right. Furthermore, they act on the assumption that they are right. In this sense, even incorrect interpretations are truths, even though they are only true to one person. This leads us to question whether the social concepts we think about really exist. They might only exist in our heads, unlike concepts from the natural sciences which exist independent of our thoughts. For example, if everyone ceased to believe in gravity, we wouldn't all float away. It has an existence independent of human thought.

Let's think through an example. In the Diagnositic and Statistical Manual (DSM) classification of mental health disorders, there is a list of culture-bound syndromes which only appear in certain cultures. For example, *susto* describes a unique cluster of symptoms experienced by people in Latin American cultures after a traumatic event that focus on the body. Indeed, many of these syndromes do not fit within a Western conceptualization of mental health because they differentiate less between the mind and body. To a Western scientist, *susto* may seem less real than PTSD. To someone from Latin America, their symptoms may not fit neatly into the PTSD framework developed within Western society. This conflict raises the question–do either *susto* or PTSD really exist at all? If your answer is "no," you are adopting the ontology of *anti-realism*, that social concepts do not have an existence apart from human thought. Unlike the realists who seek a single, universal truth, the anti-realists see a sea of truths, created and shared within a social and cultural environment.

Let's consider another example: *manels* or all-male panel discussions at conferences and conventions. Check out this National Public Radio article for some hilarious examples, ironically including panels about diversity and gender representation. Manels are a problem in academic gatherings, Comic-Cons, and other large group events. A holdover of sexist stereotypes and gender-based privilege, manels perpetuate the sexist idea that men are the experts who deserve to be listened to by other, less important and knowledgeable people. At least, that's what we've come to recognize over the past few decades thanks to feminist critique. However, let's take the perspective of a few different participants at a hypothetical conference and examine their individual, subjective truths.

When the conference schedule is announced, we see that of the ten panel discussions announced, there are only two that contain women. Pamela, an expert on the neurobiology of child abuse, thinks that this is unfair and as she was excluded from a panel on her specialty. Marco, an event organizer, feels that since the organizers simply went with who was most qualified to speak and did not consider gender, the results could not be sexist. Dionne, a professor who specializes in queer theory and indigenous social work, agrees with Pamela that manels are sexist but also feels that the focus on gender excludes and overlooks the problems with race, disability, sexual and gender identity, and social class among the conference panel members. Given these differing interpretations, how can we come to know what is true about this situation?

Honestly, there are a lot of truths here, not just one truth. Clearly, Pamela's truth is that manels are sexist. Marco's truth is that they are not necessarily sexist, as long as they were chosen in a sex-blind manner. While none of these statements is objectively true—a single truth for everyone, in all possible circumstances—they are subjectively true to the people who thought them up. Subjective truth consists of the the different meanings, understandings, and interpretations created by people and communicated throughout society. The communication of ideas is important, as it is how people come to a consensus on how to interpret a situation, negotiating the meaning of events, and informing how people act. Thus, as feminist critiques of society become more accepted, people will behave in less sexist ways. From a subjective perspective, there is no magical number of female panelists conferences much reach to be sufficiently non-sexist. Instead, we should investigate using language how people interpret the gender issues at the event, analyzing them within a historical and cultural context. But how do we find truth when everyone had their own unique interpretation? By finding patterns.



Science means finding patterns in data

Regardless of whether you are seeking objective truth or subjective truths, research and scientific inquiry aim to find and explain patterns. Most of the time, a pattern will not explain every single person's experience, a fact about social science that is both fascinating and frustrating. Even individuals who do not know each other and do not coordinate in any deliberate way can create patterns that persist over time. Those new to social science may find these patterns frustrating because they may believe that the patterns that describe their gender, age, or some other facet of their lives don't really represent their experience. It's true. A pattern can exist among your cohort without your individual participation in it. There is diversity within diversity.

Let's consider some specific examples. One area that social workers commonly investigate is the impact of a person's social class background on their experiences and lot in life. You probably wouldn't be surprised to learn that a person's social class background has an impact on their educational attainment and achievement. In fact, one group of researchers [1] in the early 1990s found that the percentage of children who did not receive any postsecondary schooling was four times greater among those in the lowest quartile (25%) income bracket than those in the upper quartile of income earners (i.e., children from high-income families were far more likely than low-income children to go on to college). Another recent study found that having more liquid wealth that can be easily converted into cash actually seems to predict children's math and reading achievement (Elliott, Jung, Kim, & Chowa, 2010). [2]

These findings—that wealth and income shape a child's educational experiences—are probably not that shocking to any of us. Yet, some of us may know someone who may be an exception to the rule. Sometimes the patterns that social scientists observe fit our commonly held beliefs about the way the world works. When this happens, we don't tend to take issue with the fact that patterns don't necessarily represent all people's experiences. But what happens when the patterns disrupt our assumptions?

For example, did you know that teachers are far more likely to encourage boys to think critically in school by asking them to expand on answers they give in class and by commenting on boys' remarks and observations? When girls speak up in class, teachers are more likely to simply nod and move on. The pattern of teachers engaging in more complex interactions with boys means that boys and girls do not receive the same educational experience in school (Sadker & Sadker, 1994). [3] You and your classmates, of all genders, may find this news upsetting.

People who object to these findings tend to cite evidence from their own personal experience, refuting that the pattern actually exists. However, the problem with this response is that objecting to a social pattern on the grounds that it doesn't match one's individual experience misses the point about patterns. Patterns don't perfectly predict what will happen to an individual person. Yet, they are a reasonable guide that, when systematically observed, can help guide social work thought and action.

A final note on qualitative and quantitative methods

There is no one superior way to find patterns that help us understand the world. As we will learn about in Chapter 6, there are multiple philosophical, theoretical, and methodological ways to approach uncovering scientific truths. Qualitative methods aim to provide an in-depth understanding of a relatively small number of cases. Quantitative methods offer less depth on each case but can say more about broad patterns in society because they typically focus on a much larger number of cases. A researcher should approach the process of scientific inquiry by formulating a clear research question and conducting research using the methodological tools best suited to that question.

Believe it or not, there are still significant methodological battles being waged in the academic literature on objective vs. subjective social science. Usually, quantitative methods are viewed as "more scientific" and qualitative methods are viewed as "less scientific." Part of this battle is historical. As the social sciences developed, they were compared with the natural sciences, especially physics, which rely on mathematics and statistics to find truth. It is a hotly debated topic whether social science should adopt the philosophical assumptions of the natural sciences—with its emphasis on prediction, mathematics, and objectivity—or use a different set of tools—understanding, language, and subjectivity—to find scientific truth.

You are fortunate to be in a profession that values multiple scientific ways of knowing. The qualitative/quantitative debate is fueled by researchers who may prefer one approach over another, either because their own research questions are better suited to one particular approach or because they happened to have been trained in one specific method. In this textbook, we'll operate from the perspective that qualitative and quantitative methods are complementary rather than competing. While these two methodological approaches certainly differ, the main point is that they simply have different goals, strengths, and weaknesses. A social work researcher should choose the methods that best match with the question they are asking.

Key Takeaways

- Social work is informed by science.
- Social science is concerns with both objective and subjective knowledge.
- Social science research aims to understand patterns in the social world.
- Social scientists use both qualitative and quantitative methods. While different, these methods are often complementary.

Glossary

- Epistemology- a set of assumptions about how we come to know what is real and true
- Objective truth- a single truth, observed without bias, that is universally applicable
- Ontology- a set of assumptions about what is real
- Qualitative methods- examine words or other media to understand their meaning
- Quantitative methods- examine numerical data to precisely describe and predict elements of the social world
- Science- a particular way of knowing that attempts to systematically collect and categorize facts or truth
- Subjective truth- one truth among many, bound within a social and cultural context

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Abstract art blur bright by Pixabay CC-0

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4.3.3: Why should we care?

Learning Objectives

- Describe and discuss four important reasons why students should care about social scientific research methods
- Identify how social workers use research as part of evidence-based practice

At this point, you may be wondering about the relevance of research methods to your life. Whether or not you choose to become a social worker, you should care about research methods for two basic reasons: (1) research methods are regularly applied to solve social problems and issues that shape how our society is organized, thus you have to live with the results of research methods every day of your life, and (2) understanding research methods will help you evaluate the effectiveness of social work interventions, an important skill for future employment.

Consuming research and living with its results

Another *New Yorker* cartoon depicts two men chatting with each other at a bar. One is saying to the other, "Are you just pissing and moaning, or can you verify what you're saying with data?" (https://condenaststore.com/featured/are-you-just-pissing-and-moaning-edward-koren.html). Which would you rather be, just a complainer or someone who can actually verify what you're saying? Understanding research methods and how they work can help position you to actually do more than just complain. Further, whether you know it or not, research probably has some impact on your life each and every day. Many of our laws, social policies, and court proceedings are grounded in some degree of empirical research and evidence (Jenkins & Kroll-Smith, 1996). [1] That's not to say that all laws and social policies are good or make sense. However, you can't have an informed opinion about any of them without understanding where they come from, how they were formed, and what their evidence base is. All social workers, from micro to macro, need to understand the root causes and policy solutions to social problems that their clients are experiencing.

A recent lawsuit against Walmart provides an example of social science research in action. A sociologist named Professor William Bielby was enlisted by plaintiffs in the suit to conduct an analysis of Walmart's personnel policies in order to support their claim that Walmart engages in gender discriminatory practices. Bielby's analysis shows that Walmart's compensation and promotion decisions may indeed have been vulnerable to gender bias. In June 2011, the United States Supreme Court decided against allowing the case to proceed as a class-action lawsuit (*Wal-Mart Stores, Inc. v. Dukes*, 2011). [2] While a class-action suit was not pursued in this case, consider the impact that such a suit against one of our nation's largest employers could have on companies and their employees around the country and perhaps even on your individual experience as a consumer. [3]

In addition to having to live with laws and policies that have been crafted based on social science research, you are also a consumer of all kinds of research, and understanding methods can help you be a smarter consumer. Ever notice the magazine headlines that peer out at you while you are waiting in line to pay for your groceries? They are geared toward piquing your interest and making you believe that you will learn a great deal if you follow the advice in a particular article. However, since you would have no way of knowing whether the magazine's editors had gathered their data from a representative sample of people like you and your friends, you would have no reason to believe that the advice would be worthwhile. By having some understanding of research methods, you can avoid wasting your money by buying the magazine and wasting your time by following inappropriate advice.

Pick up or log on to the website for just about any magazine or newspaper, or turn on just about any news broadcast, and chances are you'll hear something about some new and exciting research results. Understanding research methods will help you read past any hype and ask good questions about what you see and hear. In other words, research methods can help you become a more responsible consumer of public and popular information. And who wouldn't want to be more responsible?



Evidence-based practice

Probably the most asked questions, though seldom asked directly, are “Why am I in this class?” or “When will I ever use this information?“ While it may seem strange, the answer is “pretty often.” Social work supervisors and administrators at agency-based settings will likely have to demonstrate that their agency’s programs are effective at achieving their goals. Most private and public grants will require evidence of effectiveness in order to continue receiving money and keep the programs running. Social workers at community-based organization commonly use research methods to target their interventions to the needs of their service area. Clinical social workers must also make sure that the interventions they use in practice are effective and not harmful to clients. Social workers may also want to track client progress on goals, help clients gather data about their clinical issues, or use data to advocate for change. All social workers in all practice situations must also remain current on the scientific literature to ensure competent and ethical practice.

In all of these cases, a social worker needs to be able to understand and evaluate scientific information. **Evidence-based practice** (EBP) for social workers involves making decisions on how to help clients based on the best available evidence. A social worker must examine the literature, understanding both the theory and evidence relevant to the practice situation. According to Rubin and Babbie (2017), [4] EBP also involves understanding client characteristics, using practice wisdom and existing resources, and adapting to environmental context. It is not simply “doing what the literature says,” but rather a process by which practitioners examine the literature, client, self, and context to inform interventions with clients and systems. As we discussed in Section 1.2, the patterns discovered by scientific research are not perfectly applicable to all situations. Instead, we rely on the critical thinking of social workers to apply scientific knowledge to real-world situations.

Let’s consider an example of a social work administrator at a children’s mental health agency. The agency uses private grant funds to fund a program that provides low-income children with bicycles, teaches the children how to repair and care for their bicycles, and leads group bicycle outings after school. Physical activity has been shown to improve mental health outcomes in scientific studies, but is this social worker’s program improving mental health in their clients? Ethically, the social worker should make sure that the program is achieving its goals. If the program is not beneficial, the resources should be spent on more effective programs. Practically, the social worker will also need to demonstrate to the agency’s funders that bicycling truly helps children deal with their mental health concerns.

The example above demonstrates the need for social workers to engage in **evaluation research** or research that evaluates the outcomes of a policy or program. She will choose from many acceptable ways to investigate program effectiveness, and those choices are based on the principles of scientific inquiry you will learn in this textbook. As the example above mentions, evaluation research is baked into how nonprofit human service agencies are funded. Government and private grants need to make sure their money is being spent wisely. If your program does not work, then the money should go to a program that has been shown to be effective or a new program that may be effective. Just because a program has the right goal doesn’t mean it will actually accomplish that goal. Grant reporting is an important part of agency-based social work practice. Agencies, in a very important sense, help us discover what approaches actually help clients.



In addition to engaging in evaluation research to satisfy the requirements of a grant, your agency may engage in evaluation research for the purposes of validating a new approach to treatment. Innovation in social work is incredibly important. Sam Tsemberis relates an “aha” moment from his practice in this Ted talk on homelessness (https://youtu.be/HsFHV-McdPo).

YouTube Video

This interactive element is not available in this format. Visit the link or scan the QR code to access it online.

View this YouTube Video online

A faculty member at the New York University School of Medicine, he noticed a problem with people cycling in and out of the local psychiatric hospital wards. Clients would arrive in psychiatric crisis, stabilize under medical supervision in the hospital, and end up back at the hospital back in psychiatric crisis shortly after discharge. When he asked the clients what their issues were, they said they were unable to participate in homelessness programs because they were not always compliant with medication for their mental health diagnosis and they continued to use drugs and alcohol. Collaboratively, the problem facing these clients was defined as a homelessness service system that was unable to meet clients where they were. Clients who were unwilling to remain completely abstinent from drugs and alcohol or who did not want to take psychiatric medications were simply cycling in and out of psychiatric crisis, moving from the hospital to the street and back to the hospital.

The solution that Sam Tsemberis implemented and popularized was called Housing First, and it is an approach to homelessness prevention that starts by, you guessed it, providing people with housing first. Similar to an approach to child and family homelessness created by Tanya Tull, Tsemberis created a model of addressing chronic homelessness with people with co-occurring disorders (substance abuse and mental illness). The Housing First model holds that housing is a human right, one that should not be denied based on substance use or mental health diagnosis. Clients are given housing as soon as possible. The Housing First agency provides wraparound treatment from an interdisciplinary team, including social workers, nurses, psychiatrists, and former clients who are in recovery. Over the past few decades, this program has gone from one program in New York City to the program of choice for federal, state, and local governments seeking to address homelessness in their communities.

The main idea behind Housing First is that once clients have an apartment of their own, they are better able to engage in mental health and substance abuse treatment. While this approach may seem logical to you, it is backwards from the traditional homelessness treatment model. The traditional approach began with the client stopping drug and alcohol use and taking prescribed medication. Only after clients achieved these goals were they offered group housing. If the client remained sober and medication compliant, they could then graduate towards less restrictive individual housing.

Evaluation research helps practitioners establish that their innovation is better than the alternatives and should be implemented more broadly. By comparing clients who were served through Housing First and traditional treatment, Tsemberis could establish that Housing First was more effective at keeping people housed and progressing on mental health and substance abuse goals. Starting first with smaller studies and graduating to much larger ones, Housing First built a reputation as an effective approach to addressing homelessness. When President Bush created the Collaborative Initiative to Help End Chronic Homelessness in 2003, Housing First was used in a majority of the interventions and demonstrated its effectiveness on a national scale. In 2007, it was acknowledged as an evidence-based practice in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Policies (NREPP). [5]

I suggest browsing around the NREPP website (nrepp.samhsa.gov/landing.aspx) and looking for interventions on topics that interest you. Other sources of evidence-based practices include the Cochrane Reviews digital library (www.cochranelibrary.com/) and Campbell Collaboration (https://campbellcollaboration.org/). In the next few chapters, we will talk more about how to find literature about interventions in social work. The use of systematic reviews, meta-analyses, and randomized controlled trials are particularly important in this regard.

So why share the story of Housing First? Well, I want you think about what you hope to contribute to our knowledge on social work practice. What is your bright idea and how can it change the world? Practitioners innovate all the time, often incorporating those innovations into their agency's approach and mission. Through the use of research methods, agency-based social workers can demonstrate to policymakers and other social workers that their innovations should be more widely used. Without this wellspring of new ideas, social services would not be able to adapt to the changing needs of clients. Social workers in agency-based practice may also participate in research projects happening at their agency. Partnerships between schools of social work and agencies are a common way of testing and implementing innovations in social work. Clinicians receive specialized training, clients receive additional services, agencies gain prestige, and researchers can study how an intervention works in the real world.

While you may not become a scientist in the sense of wearing a lab coat and using a microscope, social workers must understand science in order to engage in ethical practice. In this section, we reviewed many ways in which research is a part of social work practice, including:

- Determining the best intervention for a client or system
- Ensuring existing services are accomplishing their goals
- Satisfying requirements to receive funding from private agencies and government grants
- Testing a new idea and demonstrating that it should be more widely implemented

Key Takeaways

- Whether we know it or not, our everyday lives are shaped by social scientific research.
- Understanding research methods is important for competent and ethical social work practice.
- Understanding social science and research methods can help us become more astute and more responsible consumers of information.
- Knowledge about social scientific research methods is important for ethical practice, as it ensures interventions are based on evidence.

Glossary

- Evaluation research- research that evaluates the outcomes of a policy or program
- Evidence-based practice- making decisions on how to help clients based on the best available evidence

Image Attributions

A peer counselor with mother by US Department of Agriculture CC-BY-2.0

Homeless man in New York 2008 by JMSuarez CC-BY-2.0

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4.3.4: Understanding research

Learning Objectives

- Describe common barriers to engaging with social work research
- Identify alternative ways to thinking about research methods

I've been teaching research methods for six years and have found many students struggle to see the connection between research and social work practice. Most students enjoy a social work theory class because they can better understand the world around them. Students also like practice because it shows them how to conduct clinical work with clients—i.e., what most social work students want to do. However, while I typically have a few students each year who are interested in becoming researchers, it's not very common. For this reason, I want to end this chapter on a more personal note. Most student barriers to research come from the following beliefs:

Research is useless!

Students who tell me that research methods is not a useful class to them are saying something important. As a scholar (or student), your most valuable asset is your time. You give your time to the subjects you consider important to you and your future practice. Because most social workers don't become researchers or practitioner-researchers, students feel like a research methods class is a waste of time.

Our discussion of evidence-based practice and the ways in which social workers use research methods in practice brought home the idea that social workers play an important role in creating new knowledge about social services. On a more immediate level, research methods will also help you become a stronger social work student. The next few chapters of this textbook will review how to search for literature on a topic and write a literature review. These skills are relevant in every classroom during your academic career. The rest of the textbook will help you understand the mechanics of research methods so you can better understand the content of those pesky journal articles your professors force you to cite in your papers.

Research is too hard!

Research methods involves a lot of terminology that is entirely new to social workers. Other domains of social work, such as practice, are easier to apply your intuition towards. You understand how to be an empathetic person, and your experiences in life can help guide you through a practice situation or even theoretical or conceptual question. Research may seem like a totally new area in which you have no previous experience. It can seem like a lot to learn. In addition to the normal memorization and application of terms, research methods also has wrong answers. There are certain combinations of methods that just don't work together.

The fear is entirely understandable. Research is not straightforward. As Figure 1.1 shows, it is a process that is non-linear, involving multiple revisions, wrong turns, and dead ends before you figure out the best question and research approach. You may have to go back to chapters after having read them or even peek ahead at chapters your class hasn't covered yet.



Figure 1.1 Research as a non-linear process [1]

Moreover, research is something you learn by doing...and stumbling a few times. It's an iterative process, or one that requires lots of tries to get right. There isn't a shortcut for learning research, but hopefully your research methods class is one in which your research project is broken down into smaller parts and you get consistent feedback throughout the process. No one just *knows* research. It's something you pick up by doing it, reflecting on the experiences and results, redoing your work, and revising it in consultation with your professor.

Research is boring!

We've talked already about the arcane research terminology, so I won't go into it again here. But research methods is sometimes seen as a boring topic by many students. Practice knowledge and even theory are fun to learn because they are easy to apply and give you insight into the world around you. Research just seems like its own weird, remote thing.

I completely understand where this perspective comes from and hope there are a few things you will take away from this course that aren't boring to you. In the first section of this textbook, you will learn how to take any topic and learn what is known about it. It may seem trivial, but it is actually a superpower. Your social work education will present some generalist material, which is applicable to nearly all social work practice situations, and some applied material, which is applicable to specific social work practice situations. However, no education will provide you with everything you need to know. And certainly, no education will tell you what will be discovered over the next few decades of your practice. Our work on literature reviews in the next few chapters will help you in becoming a strong social work student and practitioner. Following that, our exploration of research methods will help you further understand how the theories, practice models, and techniques you learn in your other classes are created and tested scientifically.

Get out of your own way

Together, the beliefs of "research is useless, boring, and hard" can create a self-fulfilling prophecy for students. If you believe research is boring, you won't find it interesting. If you believe research is hard, you will struggle more with assignments. If you believe research is useless, you won't see its utility. While I certainly acknowledge that students aren't going to love research as much as I do (it's a career for me, so I like it a lot!), I suggest reframing how you think about research using these touchstones:

- All social workers rely on social science research to engage in competent practice.
- No one *already* knows research. It's something I'll learn through practice. And it's challenging for everyone.
- Research is relevant to me because it allows me to figure out what is known about any topic I want to study.
- If the topic I choose to study is important to me, I will be more interested in research.

Structure of this textbook

While you may not have chosen this course, by reframing your approach to it, you increase the likelihood of getting a lot out of it. To that end, here is the structure of this book:

In Chapters 2-4, we'll review how to begin a research project. This involves searching for relevant literature, academic journal articles specifically, and synthesizing what they say about your topic into a literature review.

In Chapters 5-9, you'll learn about how research informs and tests theory. We'll discuss how to conduct research in an ethical manner, create research questions, and measure concepts in the social world.

Chapters 10-14 will describe how to conduct research, whether it's a quantitative survey or experiment, or alternately, a qualitative interview or focus group. We'll also review how to analyze data that someone else has already collected.

Finally, Chapters 15 and 16 will review the types of research most commonly used in social work practice, including evaluation research and action research, and how to report the results of your research to various audiences.

Key Takeaways

- Anxiety about research methods is a common experience for students.
- Research methods will help you become a better scholar and practitioner.

References

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4.4: THE PERSON IN ENVIRONMENT

4.4.1: How We Use Our Expectations

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4.4.1: How We Use Our Expectations

Learning Objectives

- Provide examples of how salience and accessibility influence information processing.
- Review, differentiate and give examples of the cognitive heuristics that influence social judgment.
- Summarize and give examples of the importance of social cognition in everyday life.

Once we have developed a set of schemas and attitudes, we naturally use that information to help us judge and respond to others. Our expectations help us think about, size up, and make sense of individuals, groups of people, and the relationships among people. If we have learned, for example, that someone is friendly and interested in us, we are likely to approach them; if we have learned that they are threatening or unlikable, we will be more likely to withdraw. And if we believe that a person has committed a crime, we may process new information in a manner that helps convince us that our judgment was correct. In this section, we will consider how we use our stored knowledge to come to accurate (and sometimes inaccurate) conclusions about our social worlds. Table 1 "How Expectations Influence Our Social Cognition" summarizes the concepts that we will discuss, some of the many ways that our existing schemas and attitudes influence how we respond to the information around us.

Table 1: How Expectations Influence Our Social Cognition

Cognitive Process	Description	Example
Cognitive accessibility	Some schemas and attitudes are more accessible than others.	We may think a lot about our new haircut because it is important for us.
Salience	Some stimuli, such as those that are unusual, colorful, or moving, grab our attention.	We may base our judgments on a single unusual event and ignore hundreds of other events that are more usual.
Representativeness heuristic	We tend to make judgments according to how well the event matches our expectations.	After a coin has come up heads many times in a row, we may erroneously think that the next flip is more likely to be tails.
Availability heuristic	Things that come to mind easily tend to be seen as more common.	We may overestimate the crime statistics in our own area because these crimes are so easy to recall.
Anchoring and adjustment	Although we try to adjust our judgments away from them, our decisions are overly based on the things that are most highly accessible in memory.	We may buy more of a product when it is advertised in bulk than when it is advertised as a single item.
Counterfactual thinking	We may "replay" events such that they turn out differently—especially when only minor changes in the events leading up to them make a difference.	We may feel particularly bad about events that might not have occurred if only a small change might have prevented them.
False consensus bias	We tend to see other people as similar to us.	We are surprised when other people have different political opinions or values.
Overconfidence	We tend to have more confidence in our skills, abilities, and judgments than is objectively warranted.	Eyewitnesses are often extremely confident that their identifications are accurate, even when they are not.

Automatic Versus Controlled Cognition

A good part of both cognition and social cognition is spontaneous or automatic. Automatic cognition refers to *thinking that occurs out of our awareness, quickly, and without taking much effort* (Ferguson & Bargh, 2003; Ferguson, Hassin, & Bargh, 2008). The things that we do most frequently tend to become more automatic each time we do them until they reach a level where they don't really require us to think about them very much. Most of us can ride a bike and operate a television remote control in an

automatic way. Even though it took some work to do these things when we were first learning them, it just doesn't take much effort anymore. And because we spend a lot of time making judgments about others, many of these judgments (and particularly those about people we don't know very well and who don't matter much to us) are made automatically (Willis & Todorov, 2006).

Because automatic thinking occurs outside of our conscious awareness, we frequently have no idea that it is occurring and influencing our judgments or behaviors. You might remember a time when you came back from your classes, opened the door to your dorm room, and 30 seconds later couldn't remember where you had put your keys! You know that you must have used the keys to get in, and you know you must have put them somewhere, but you simply don't remember a thing about it. Because many of our everyday judgments and behaviors are performed "on automatic," we may not always be aware that they are occurring or influencing us.

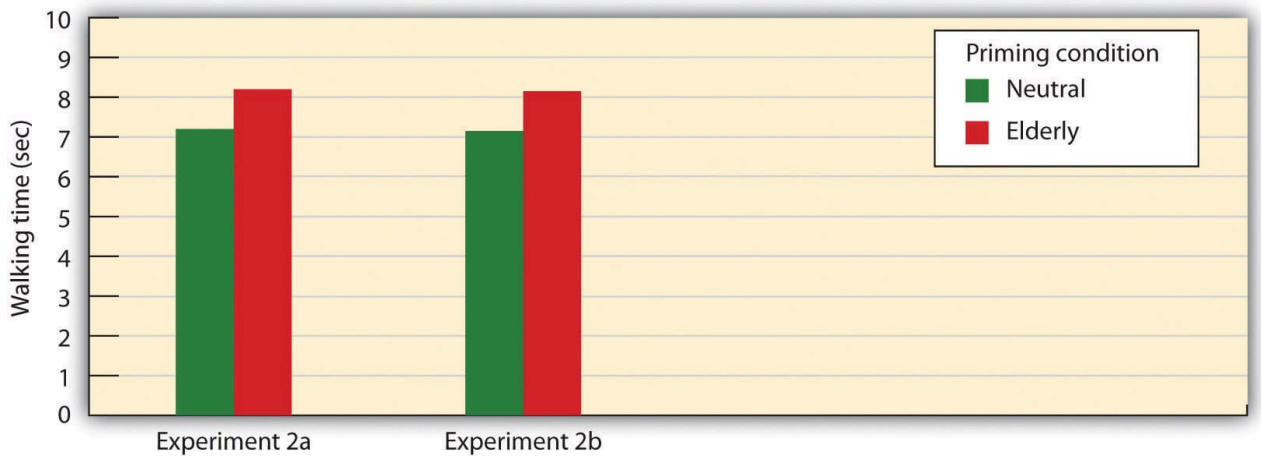
It is, of course, a good thing that many things operate automatically because it would be a real pain to have to think about them all the time. If you couldn't drive a car automatically, you wouldn't be able to talk to the other people riding with you or listen to the radio at the same time—you'd have to be putting most of your attention into driving. On the other hand, relying on our snap judgments about Bianca—that she's likely to be expressive, for instance—can be erroneous. Sometimes we need to—and should—go beyond automatic cognition and consider people more carefully. *When we deliberately size up and think about something—for instance another person*—we call it thoughtful cognition or controlled cognition.

Although you might think that controlled cognition would be more common and that automatic thinking would be less likely, that is not always the case. The problem is that thinking takes effort and time, and we often don't have too many of those things available. As a result, we frequently rely on automatic cognition, and these processes—acting outside of our awareness—have a big effect on our behaviors. In the following Research Focus, we will consider an example of a study that uses a common social cognitive procedure known as priming — *a technique in which information is temporarily brought into memory through exposure to situational events*—and that shows that priming can influence judgments entirely out of awareness.

Research Focus

Behavioral Effects of Priming

- >In one demonstration of how automatic cognition can influence our behaviors without us being aware of them, John Bargh and his colleagues (Bargh, Chen, & Burrows, 1996) conducted two studies, each with the exact same procedure. In the experiments, they showed college students sets of five scrambled words. The students were to unscramble the five words in each set to make a sentence. Furthermore, for half of the research participants, the words were related to the stereotype of the elderly. These participants saw words such as "in Florida retired live people" and "bingo man the forgetful plays."
- >The other half of the research participants also made sentences but did so out of words that had nothing to do with the elderly stereotype. The purpose of this task was to prime (activate) the schema of elderly people in memory for some of the participants but not for others.
- >The experimenters then assessed whether the priming of elderly stereotypes would have any effect on the students' behavior—and indeed it did. When each research participant had gathered all his or her belongings, thinking that the experiment was over, the experimenter thanked him or her for participating and gave directions to the closest elevator. Then, without the participant knowing it, the experimenters recorded the amount of time that the participant spent walking from the doorway of the experimental room toward the elevator. As you can see in the following figure, the same results were found in both experiments—the participants who had made sentences using words related to the elderly stereotype took on the behaviors of the elderly—they walked significantly more slowly (in fact, about 12% more slowly across the two studies) as they left the experimental room.



Automatic Priming and Behavior

In two separate experiments, Bargh, Chen, and Borroughs (1996) found that students who had been exposed to words related to the elderly stereotype walked more slowly than those who had been exposed to more neutral words.

- >To determine if these priming effects occurred out of the conscious awareness of the participants, Bargh and his colleagues asked the third group of students to complete the priming task and then to indicate whether they thought the words they had used to make the sentences had any relationship to each other or could possibly have influenced their behavior in any way. These students had no awareness of the possibility that the words might have been related to the elderly or could have influenced their behavior.
- >The point of these experiments, and many others like them, is clear—it is quite possible that our judgments and behaviors are influenced by our social situations, and this influence may be entirely outside of our conscious awareness. To return again to Bianca, it is even possible that we notice her nationality and that our beliefs about Italians influence our responses to her, even though we have no idea that they are doing so and really believe that they have not. It is in this way that our stereotypes may have their insidious effects, and it is exactly these processes that may have led to a mistaken eyewitness account in the case of Rickie Johnson.

Salience and Accessibility Determine Which Expectations We Use

We each have a large number of schemas that we might bring to bear on any type of judgment we might make. When thinking about Bianca, for instance, we might focus on her nationality, her gender, her physical attractiveness, her intelligence, or any of many other possible features. And we will react to Bianca differently depending on which schemas we use. Schema activation is determined both by characteristics of the person we are judging—the *salience* of the characteristics—and by the current activation of the schema in the individual—the *cognitive accessibility* of the schema.

Salience

- One determinant of which schemas are likely to be used in social justice is the extent to which we attend to particular features of the person or situation that we are responding to. We are more likely to judge people on the basis of characteristics that are salient, meaning that *they attract our attention when we see something or someone with them*. Things that are unusual, negative, colorful, bright and moving are more salient and thus more likely to be attended to than are things that do not have these characteristics (McArthur & Post, 1977; Taylor & Fiske, 1978).



Which of these people are more salient and therefore more likely to attract your attention? Erich Ferdinand – The Purger – CC BY 2.0; Hamad AL-Mohannna – Jump – CC BY-ND 2.0; LethaColleen – Session 5: Finished! – CC BY-NC-ND 2.0.

We are more likely to initially judge people on the basis of their sex, race, age, and physical attractiveness, rather than on, say, their religious orientation or their political beliefs, in part because these features are so salient when we see them (Brewer, 1988). Another thing that makes something particularly salient is its infrequency or unusualness. Because Bianca is from Italy and very few other people in our school are, that characteristic is something that we notice—it is salient, and we are therefore likely to attend to it. That she is also a woman is—at least in this context—less salient.

The salience of the stimuli in our social worlds may sometimes lead us to make judgments on the basis of information that is actually less informative than is other less salient information. Imagine, for instance, that you wanted to buy a new music player for yourself. You've been trying to decide whether to get the iPod or the Zune. You went online and checked out *Consumer Reports*, and you found that although the players differed on many dimensions, including price, battery life, ability to share music, and so forth, the Zune was nevertheless rated significantly higher by the owners than was the iPod. As a result, you decide to go purchase one the next day. That night, however, you go to a party, and a friend of yours shows you her iPod. You check it out, and it seems really great. You tell her that you were thinking of buying a Zune, and she tells you that you are crazy. She says she knows someone who had one and had a lot of problems—it didn't download music right, the battery went out right after it went out of warranty, and so forth—and that she would never buy one. Would you still buy the Zune, or would you switch your plans?

If you think about this question logically, the information that you just got from your friend isn't really all that important—you now know the opinions of one more person, but that can't really change the overall consumer ratings of the two machines very much. On the other hand, the information your friend gives you and the chance to use her iPod is highly salient. The information is right there in front of you, in your hand, whereas the statistical information from *Consumer Reports* is only in the form of a table that you saw on your computer. The outcome in cases such as this is that people frequently ignore the less salient, but more important, information, such as *the likelihood that events occur across a large population*—these statistics are known as base rates — in favor of the actually less important, but nevertheless more salient, information.

Another case in which we ignore base-rate information occurs when we use the representativeness heuristic (remember that *heuristic* refers to a simplifying strategy that we use to make judgments). The representativeness heuristic occurs when we *base our judgments on information that seems to represent, or match, what we expect will happen while ignoring more informative base-rate information*. Consider, for instance, the following puzzle. Let's say that you went to a hospital, and you checked the records of the babies that were born today (Table 2 "Using the Representativeness Heuristic"). Which pattern of births do you think that you are most likely to find?

Table 2: Using the Representativeness Heuristic

List A		List B	
6:31 a.m.	Girl	6:31 a.m.	Boy
8:15 a.m.	Girl	8:15 a.m.	Girl
9:42 a.m.	Girl	9:42 a.m.	Boy
1:13 p.m.	Girl	1:13 p.m.	Girl

List A		List B	
3:39 p.m.	Boy	3:39 p.m.	Girl
5:12 p.m.	Boy	5:12 p.m.	Boy
7:42 p.m.	Boy	7:42 p.m.	Girl
11:44 p.m.	Boy	11:44 p.m.	Boy

Most people think that list B is more likely, probably because list B looks more random and thus matches (is "representative of") our ideas about randomness. But statisticians know that any pattern of four girls and four boys is equally likely and thus that List B is no more likely than List A. The problem is that we have an image of what randomness should be, which doesn't always match what is rationally the case. Similarly, people who see a coin that comes up heads five times in a row will frequently predict (and perhaps even bet!) that tails will be next—it just seems like it has to be. But mathematically, this erroneous expectation (known as the gambler's fallacy) is simply not true: The base-rate likelihood of any single coin flip being tails is only 50%, regardless of how many times it has come up heads in the past.

To take one more example, consider the following information:

I have a friend who is short, shy and writes poetry. Which of the following is she? (Choose one.)

Can you see how you might be led, potentially incorrectly, into thinking that my friend is a professor of Chinese? Why? Because the description ("short, shy, and writes poetry") just seems so representative or stereotypical of our expectations about Chinese people. But the base rates tell us something completely different, which might make us wary. For one, because I am a psychology professor, it's much more likely that I know more psychology professors than Chinese professors. And at least on my campus, the number of professors in the psychology department is much bigger than the number of professors of Chinese. Although base rates suggest that "psychology" would be the right answer, the use of the representative heuristic might lead us (probably incorrectly) to guess "Chinese" instead.

Cognitive Accessibility

Although which characteristics we use to think about objects or people is determined in part by the salience of their characteristics (our perceptions are influenced by our social situation), individual differences in the person who is doing the judging are also important (our perceptions are influenced by person variables). People vary in the schemas that they find important to use when judging others and when thinking about themselves. One way to consider this importance is in terms of the *cognitive accessibility* of the schema. Cognitive accessibility refers to *the extent to which a schema is activated in memory and thus likely to be used in information processing*.

You probably know people who are golf nuts (or maybe tennis or some other sports nuts). All they can talk about is golf. For them, we would say that golf is a highly accessible construct. Because they love golf, it is important to their self-concept; they set many of their goals in terms of the sport, and they tend to think about things and people in terms of it ("if he plays golf, he must be a good person!"). Other people have highly accessible schemas about eating healthy food, exercising, environmental issues, or really good coffee, for instance. In short, when a schema is accessible, we are likely to use it to make judgments of ourselves and others.

Although accessibility can be considered a person variable (a given idea is more highly accessible for some people than for others), accessibility can also be influenced by situational factors. When we have recently or frequently thought about a given topic, that topic becomes more accessible and is likely to influence our judgments. This is, in fact, the explanation for the results of the priming study you read about earlier—people walked slower because the concept of the elderly had been primed and thus was currently highly accessible for them.

Because we rely so heavily on our schemas and attitudes—and particularly on those that are salient and accessible—we can sometimes be overly influenced by them. Imagine, for instance, that I asked you to close your eyes and determine whether there are more words in the English language that begin with the letter *R* or that have the letter *R* as the third letter. You would probably try to solve this problem by thinking of words that have each of the characteristics. It turns out that most people think there are more words that begin with *R*, even though there are in fact more words that have *R* as the third letter.

You can see that this error can occur as a result of cognitive accessibility. To answer the question, we naturally try to think of

all the words that we know that begin with *R* and that have *R* in the third position. The problem is that when we do that, it is much easier to retrieve the former than the latter because we store words by their first, not by their third, letter. We may also think that our friends are nice people because we see them primarily when they are around us (their friends). And the traffic might seem worse in our own neighborhood than we think it is in other places, in part because nearby traffic jams are more accessible for us than are traffic jams that occur somewhere else. And do you think it is more likely that you will be killed in a plane crash or in a car crash? Many people fear the former, even though the latter is much more likely: Your chances of being involved in an aircraft accident are about 1 in 11 million, whereas your chances of being killed in an automobile accident are 1 in 5,000—over 50,000 people are killed on U.S. highways every year. In this case, the problem is that plane crashes, which are highly salient, are more easily retrieved from our memory than are car crashes, which are less extreme.

The tendency to make judgments of the frequency of an event or the likelihood that an event will occur, on the basis of the ease with which the event can be retrieved from memory is known as the availability heuristic (Schwarz & Vaughn, 2002; Tversky & Kahneman, 1973). The idea is that things that are highly accessible (in this case, the term *availability* is used) come to mind easily and thus may overly influence our judgments. Thus, despite the clear facts, it may be easier to think of plane crashes than car crashes because the former are so highly salient. If so, the availability heuristic can lead to errors in judgments.

Still another way that the cognitive accessibility of constructs can influence information processing is through their effects on *processing fluency*. Processing fluency refers to *the ease with which we can process information in our environments*. When stimuli are highly accessible, they can be quickly attended to and processed, and they, therefore, have a large influence on our perceptions. This influence is due, in part, to the fact that our body reacts positively to information that we can process quickly, and we use this positive response as a basis of judgment (Reber, Winkielman, & Schwarz, 1998; Winkielman & Cacioppo, 2001).

In one study demonstrating this effect, Norbert Schwarz and his colleagues (Schwarz et al., 1991) asked one set of college students to list 6 occasions when they had acted either *assertively* or *unassertively* and asked another set of college students to list 12 such examples. Schwarz determined that for most students, it was pretty easy to list 6 examples but pretty hard to list 12.

The researchers then asked the participants to indicate how assertive or unassertive they actually were. You can see from Figure 2.4 “Processing Fluency” that the ease of processing influenced judgments. The participants who had an easy time listing examples of their behavior (because they only had to list 6 instances) judged that they did in fact have the characteristics they were asked about (either assertive or unassertive), in comparison with the participants who had a harder time doing the task (because they had to list 12 instances). Other research has found similar effects—people rate that they ride their bicycles more often after they have been asked to recall only a few rather than many instances of doing so (Aarts & Dijksterhuis, 1999), and they hold an attitude with more confidence after being asked to generate few rather than many arguments that support it (Haddock, Rothman, Reber, & Schwarz, 1999).

1. A professor of psychology
2. A professor of Chinese



When it was relatively easy to complete the questionnaire (only 6 examples were required), the student participants rated that they had more of the trait than when the task was more difficult (12 answers were required). Data are from Schwarz et al. (1991).

We are likely to use this type of quick and "intuitive" processing, based on our feelings about how easy it is to complete a task when we don't have much time or energy for more in-depth processing, such as when we are under time pressure, tired, or unwilling to process the stimulus in sufficient detail. Of course, it is very adaptive to respond to stimuli quickly (Sloman, 2002; Stanovich & West, 2002; Winkielman, Schwarz, & Nowak, 2002), and it is not impossible that in at least some cases, we are better off making decisions based on our initial responses than on a more thoughtful cognitive analysis (Loewenstein, Weber, Hsee, & Welch, 2001). For instance, Dijksterhuis, Bos, Nordgren, and van Baaren (2006) found that when participants were given tasks requiring decisions that were very difficult to make on the basis of cognitive analysis of the problem, they made better decisions when they didn't try to analyze the details carefully but simply relied on their unconscious intuition.

In sum, people are influenced not only by the information they get but by how they get it. We are more highly influenced by things that are salient and accessible and thus easily attended to, remembered, and processed. On the other hand, information that is harder to access from memory is less likely to be attended to, or takes more effort to consider is less likely to be used in our judgments, even if this information is statistically equally informative or even more informative.

The False Consensus Bias Makes Us Think That We Are More Like Others Than We Really Are

The tendency to base our judgments on the accessibility of social constructs can lead to still other errors in judgment. One such error is known as the false consensus bias: *the tendency to overestimate the extent to which other people are similar to us*. For instance, if you are in favor of abortion rights, opposed to gun control, and prefer rock music to jazz, then you are likely to think that other people share these beliefs (Ross, Greene, & House, 1977). In one demonstration of the false consensus bias, Joachim Krueger and his colleagues (Krueger & Clement, 1994) gave their research participants, who were college students, a personality test. Then they asked the same participants to estimate the percentage of other students in their school who would have answered the questions the same way that they did. The students who agreed with the items thought that others would agree with them too, whereas the students who disagreed thought that others would also disagree. You can see that the false consensus bias also occurs through the operation of cognitive accessibility: Once we have indicated our own belief, it becomes highly accessible, and it colors our estimates about other people.

Although it is commonly observed, the false consensus bias does not occur in all dimensions. Specifically, the false consensus bias is not usually observed on judgments of positive personal traits that we highly value as important. People (falsely, of course) report that they have better personalities (e.g., a better sense of humor), that they engage in better behaviors (e.g., they are more likely to wear seat belts), and that they have brighter futures than almost everyone else (Chambers, 2008). These results suggest that although in most cases we assume that we are similar to others, in cases of valued personal characteristics the goals of self-concern lead us to see ourselves more positively than we see the average person.

Perceptions of What "Might Have Been" Lead to Counterfactual Thinking

In addition to influencing our judgments about ourselves and others, the salience and accessibility of information can have an important effect on our own emotions—for instance, our self-esteem. Our emotional reactions to events are often colored not only by what did happen but also by what *might have* happened. If we can easily imagine an outcome that is better than what actually happened, then we may experience sadness and disappointment; on the other hand, if we can easily imagine that a result might have been worse than what actually happened, we may be more likely to experience happiness and satisfaction. *The tendency to think about events according to what might have been* known as counterfactual thinking (Roese, 1997).

Imagine, for instance, that you were participating in an important contest, and you won the silver medal. How would you feel? Certainly, you would be happy that you won, but wouldn't you probably also be thinking a lot about what might have happened if you had been just a little bit better—you might have won the gold medal! On the other hand, how might you feel if you won the bronze medal (third place)? If you were thinking about the counterfactual (the "what might have been"), perhaps the idea of not getting any medal at all would have been highly accessible—you'd be happy that you got the medal you did get.

Medvec, Madey, and Gilovich (1995) investigated exactly this idea by videotaping the responses of athletes who won medals in the 1992 summer Olympic Games. They videotaped the athletes both as they learned that they had won a silver or a bronze medal

and again as they were awarded the medal. Then they showed these videos, without any sound, to people who did not know which medal which athlete had won. The raters indicated how they thought the athlete was feeling, on a range from “agony” to “ecstasy.” The results showed that the bronze medalists did indeed seem to be, on average, happier than were the silver medalists. Then in a follow-up study, raters watched interviews with many of these same athletes as they talked about their performance. The raters indicated what we would expect on the basis of counterfactual thinking—the silver medalists talked about their disappointments in having finished second rather than first, whereas the bronze medalists focused on how happy they were to have finished third rather than fourth.



Does the bronze medalist look happier to you than the silver medalist? Medvec, Madey, and Gilovich (1995) found that, on average, bronze medalists were happier than silver medalists. Wikimedia Commons – CC BY-SA 2.0.

You might have experienced counterfactual thinking in other situations. I remember once that I was driving across the country and my car was having some engine trouble. I really, really wanted to make it home when I got near the end of my journey because I could tell that I was going to be very disappointed if the car broke down only a few miles before I got home (it would have been really easy to have imagined making it the whole way, making it even more painful if I did not). Counterfactual thinking has even been observed on juries—people who are asked to award monetary damages to others who had been in an accident offered them substantially more in compensation if they were almost not injured than they did if the accident did not seem close to not occurring (Miller, Turnbull, & McFarland, 1988).

Again, the moral of the story is clear—our thinking is frequently influenced by processes that we are not aware of and that may lead us to make judgments that seem reasonable but are objectively inaccurate. In the case of counterfactual thinking, the cognitive accessibility of the potential alternative outcome leads to some very paradoxical effects.

Anchoring and Adjustment Lead Us to Accept Ideas That We Should Revise

In some cases, we may be aware of the danger of acting on our expectations and attempt to adjust for them. Perhaps you have been in a situation where you are beginning a course with a new professor and you know that a good friend of yours does not like him. You may be thinking that you want to go beyond your negative expectations and prevent this knowledge from biasing your judgment. However, the accessibility of the initial information frequently prevents this adjustment from occurring—leading us to *anchor on the initial construct and not adjust sufficiently*. This is called the problem of anchoring and adjustment.

Tversky and Kahneman (1974) asked some of the student participants in one of their studies to solve this multiplication problem quickly and without using a calculator:

1 × 2 × 3 × 4 × 5 × 6 × 7 × 8

They asked other participants to solve this problem:

8 × 7 × 6 × 5 × 4 × 3 × 2 × 1

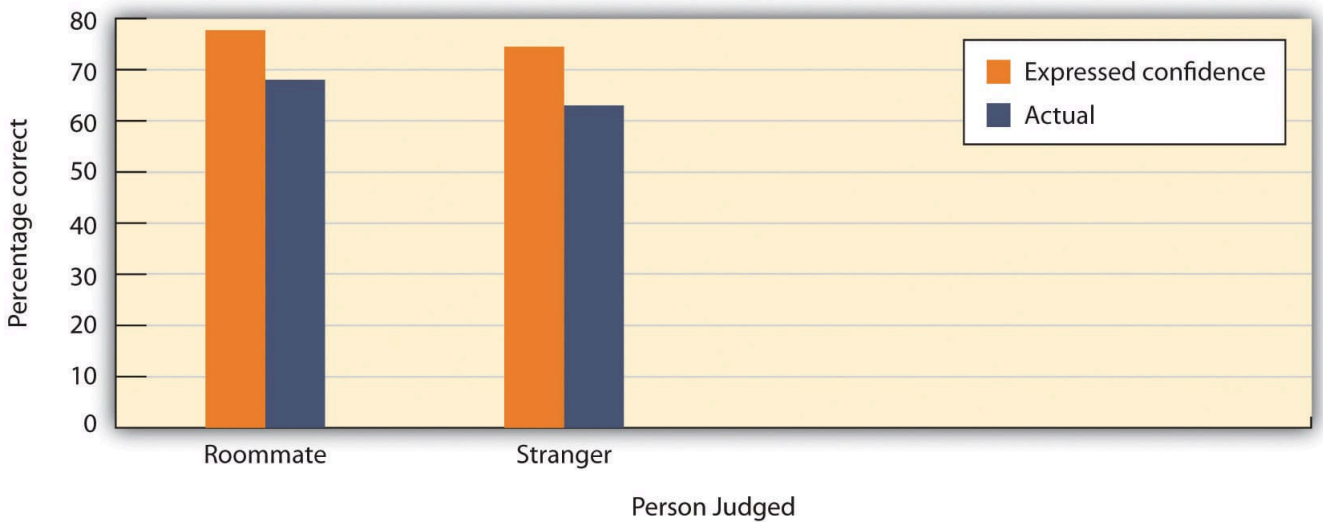
They found that students who saw the first problem gave an estimated answer of about 512, whereas the students who saw the second problem estimated about 2,250. Tversky and Kahneman argued that the students couldn't solve the whole problem in their head, so they did the first few multiplications and then used the outcome of this preliminary calculation as their starting point, or anchor. Then the participants used their starting estimate to find an answer that sounded plausible. In both cases, the estimates were too low relative to the true value of the product (which is 40,320)—but the first set of guesses was even lower because they started from a lower anchor.

Of course, savvy marketers have long used the anchoring phenomenon to help them. You might not be surprised to hear that people are more likely to buy more products when they are listed as four for $1.00 than when they are listed as $0.25 each (leading people to anchor on the four and perhaps adjust only a bit away) and when a sign says "buy a dozen" rather than "buy one."

And it is no accident that a car salesperson always starts negotiating with a high price and then works down. The salesperson is trying to get the consumer anchored on the high price with the hope that it will have a big influence on the final sale value.

Overconfidence

Still another potential judgmental bias, and one that has powerful and often negative effects on our judgments, is the tendency to be overconfident in our own skills, abilities, and judgments. We often have little awareness of our own limitations, leading us to act as if we are more certain about things than we should be, particularly on tasks that are difficult. Adams and Adams (1960) found that for words that were difficult to spell, people were correct in spelling them only about 80% of the time, even though they indicated that they were "100% certain" that they were correct. David Dunning and his colleagues (Dunning, Griffin, Milojkovic, & Ross, 1990) asked college students to predict how another student would react in various situations. Some participants made predictions about a fellow student whom they had just met and interviewed, and others made predictions about their roommates. In both cases, participants reported their confidence in each prediction, and accuracy was determined by the responses of the target persons themselves. The results were clear: Regardless of whether they judged a stranger or a roommate, the students consistently overestimated the accuracy of their own predictions.



Predictions

Dunning et al. (1990) found that, regardless of whether they were judging strangers or their roommates, students were overconfident. The percentage confidence that they assigned to their own predictions was significantly higher than the actual percentage of their predictions that were correct.

Making matters even worse, Kruger and Dunning (1999) found that people who scored low rather than high on tests of spelling, logic, grammar, and humor appreciation were also most likely to show overconfidence by overestimating how well they would do.

Apparently, poor performers are doubly cursed—they not only are unable to predict their own skills but also are the most unaware that they can't do so (Dunning, Johnson, Ehrlinger, & Kruger, 2003).

The tendency to be overconfident in our judgments can have some very negative effects. When eyewitnesses testify in courtrooms regarding their memories of a crime, they often are completely sure that they are identifying the right person. But their confidence doesn't correlate much with their actual accuracy. This is, in part, why so many people have been wrongfully convicted on the basis of inaccurate eyewitness testimony given by overconfident witnesses (Wells & Olson, 2003).

The Importance of Cognitive Biases in Everyday Life

Perhaps you are thinking that the use of heuristics and the tendency to be influenced by salience and accessibility don't seem that important—who really cares if we buy an iPod when the Zune is better, or if we think there are more words that begin with the letter *R* than there actually are? These aren't big problems in the overall scheme of things. But it turns out that what seems perhaps to be pretty small errors and biases on the surface can have profound consequences for people.

For one, if the errors occur for a lot of people, they can really add up. Why would so many people continue to buy lottery tickets or to gamble their money in casinos when the likelihood of them ever winning is so low? One possibility, of course, is the representative heuristic—people ignore the low base rates of winning and focus their attention on the salient likelihood of winning a huge prize. And the belief in astrology, which all scientific evidence suggests is not accurate, is probably driven in part by the salience of the occasions when the predictions do occur—when a horoscope is correct (which it will, of course, be sometimes), the correct prediction is highly salient and may allow people to maintain the (overall false) belief.

People may also take more care to prepare for unlikely events than for more likely ones because the unlikely ones are more salient or accessible. For instance, people may think that they are more likely to die from a terrorist attack or as a result of homicide than they are from diabetes, stroke, or tuberculosis. But the odds are much greater of dying from the health problems than from terrorism or homicide. Because people don't accurately calibrate their behaviors to match the true potential risks, the individual and societal costs are quite large (Slovic, 2000).

Salience and accessibility also color how we perceive our social worlds, which may have a big influence on our behavior. For instance, people who watch a lot of violent television shows also tend to view the world as more dangerous in comparison to those who watch less violent TV (Doob & Macdonald, 1979). This follows from the idea that our judgments are based on the accessibility of relevant constructs. We also overestimate our contribution to joint projects (Ross & Sicoly, 1979), perhaps in part because our own contributions are so obvious and salient, whereas the contributions of others are much less so. And the use of cognitive heuristics can even affect our views about global warming. Joireman, Barnes, Truelove, and Duell (2010) found that people were more likely to believe in the existence of global warming when they were asked about it on hotter rather than colder days and when they had first been primed with words relating to heat. Thus the principles of salience and accessibility, because they are such an important part of our social judgments, can create a series of biases that can make a difference.

Research has found that even people who should know better—and who need to know better—are subject to cognitive biases. Economists, stock traders, managers, lawyers, and even doctors have been found to make the same kinds of mistakes in their professional activities that people make in their everyday lives (Byrne & McEleney, 2000; Gilovich, Griffin, & Kahneman, 2002; Hilton, 2001). And the use of cognitive heuristics is increased when people are under time pressure (Kruglanski & Freund, 1983) or when they feel threatened (Kassam, Koslov, & Mendes, 2009), exactly the situations that may occur when professionals are required to make their decisions.

Although biases are common, they are not impossible to control, and psychologists and other scientists are working to help people make better decisions. One possibility is to provide people with better feedback. Weather forecasters, for instance, are quite accurate in their decisions, in part because they are able to learn from the clear feedback that they get about the accuracy of their predictions. Other research has found that accessibility biases can be reduced by leading people to consider multiple alternatives rather than focusing only on the most obvious ones, and particularly by leading people to think about exactly the opposite possible outcomes than the ones they are expecting (Hirt, Kardes, & Markman, 2004). And people can also be trained to make better decisions. For instance, Lehman, Lempert, and Nisbett (1988) found that graduate students in medicine, law, and chemistry, but particularly those in psychology, all showed significant improvement in their ability to reason correctly over the course of their graduate training.

Social Psychology in the Public Interest

The Validity of Eyewitness Testimony

- >As we have seen in the story of Rickie Johnson that opens this chapter, one social situation in which the accuracy of our person-perception skills is vitally important in the area of eyewitness testimony (Charman & Wells, 2007; Toglia, Read, Ross, & Lindsay, 2007; Wells, Memon, & Penrod, 2006). Every year, thousands of individuals such as Rickie Johnson are charged with and often convicted of crimes based largely on eyewitness evidence. In fact, more than 100 people who were convicted prior to the existence of forensic DNA have now been exonerated by DNA tests, and more than 75% of these people were victims of mistaken eyewitness identification (Wells, Memon, & Penrod, 2006; Fisher, 2011).
- >The judgments of eyewitnesses are often incorrect, and there is only a small correlation between how accurate and how confident an eyewitness is. Witnesses are frequently overconfident, and one who claims to be absolutely certain about his or her identification is not much more likely to be accurate than one who appears much less sure, making it almost impossible to determine whether a particular witness is accurate or not (Wells & Olson, 2003).
- >To accurately remember a person or an event at a later time, we must be able to accurately see and store the information in the first place, keep it in memory over time, and then accurately retrieve it later. But the social situation can influence any of these processes, causing errors and biases.
- >In terms of initial encoding of the memory, crimes normally occur quickly, often in situations that are accompanied by a lot of stress, distraction, and arousal. Typically, the eyewitness gets only a brief glimpse of the person committing the crime, and this may be under poor lighting conditions and from far away. And the eyewitness may not always focus on the most important aspects of the scene. Weapons are highly salient, and if a weapon is present during the crime, the eyewitness may focus on the weapon, which would draw his or her attention away from the individual committing the crime (Steblay, 1997). In one relevant study, Loftus, Loftus, and Messo (1987) showed people slides of a customer walking up to a bank teller and pulling out either a pistol or a checkbook. By tracking eye movements, the researchers determined that people were more likely to look at the gun than at the checkbook and that this reduced their ability to accurately identify the criminal in a lineup that was given later.
- >People may be particularly inaccurate when they are asked to identify members of a race other than their own (Brigham, Bennett, Meissner, & Mitchell, 2007). In one field study, for example, Meissner and Brigham (2001) sent White, Black, and Hispanic students into convenience stores in El Paso, Texas. Each of the students made a purchase, and the researchers came in later to ask the clerks to identify photos of the shoppers. Results showed that the White, Black, and Mexican American clerks demonstrated the own-race bias: They were all more accurate at identifying customers belonging to their own racial or ethnic group than they were at identifying people from other groups. There seems to be some truth to the adage that “They all look alike”—at least if an individual is looking at someone who is not of his or her race.

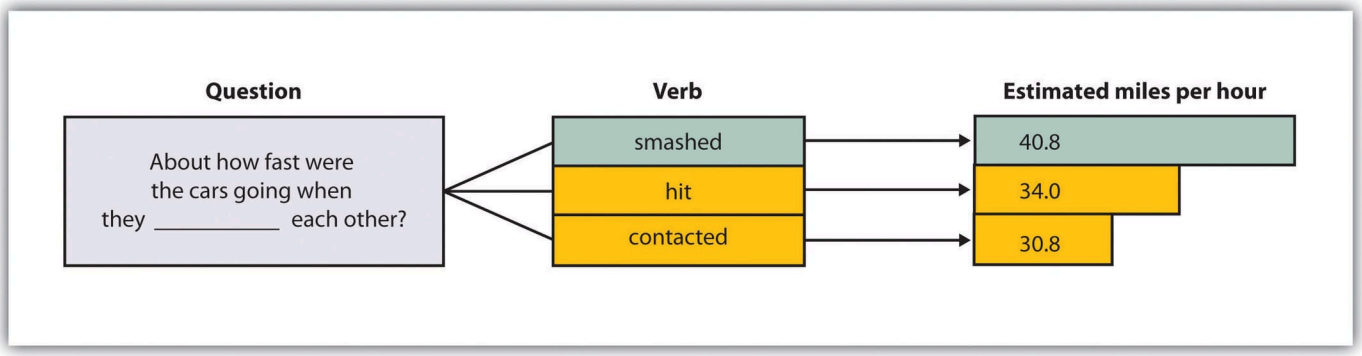


One source of error in eyewitness testimony is the relative difficulty of accurately identifying people who are not of one’s own race. Kira Westland – sisters – CC BY-NC-ND 2.0; Dillan K – Sisters – CC BY-NC-ND 2.0; Bill Lile – Robertos Brothers – CC BY-NC-ND 2.0.

- >Even if information gets encoded properly, memories may become distorted over time. For one thing, people might discuss what they saw with other people, or they might read the information relating to it from other bystanders or in the media. Such postevent information can distort the original memories such that the witnesses are no longer sure what the real information is and what was provided later. The problem is that the new, inaccurate information is highly cognitively accessible, whereas the older information is much less so. Even describing a face makes it more difficult to recognize the face later (Dodson,

Johnson, & Schooler, 1997).

- >In an experiment by Loftus and Palmer (1974), participants viewed a film of a traffic accident and then, according to random assignment to experimental conditions, answered one of three questions:
  1. "About how fast were the cars going when they hit each other?"
  2. "About how fast were the cars going when they smashed each other?"
  3. "About how fast were the cars going when they contacted each other?"
- >As you can see in the following figure, although all the participants saw the same accident, their estimates of the speed of the cars varied by condition. People who had seen the "smashed" question estimated the highest average speed, and those who had seen the "contacted" question estimated the lowest.



Reconstructive Memory

Participants viewed a film of a traffic accident and then answered a question about the accident. According to random assignment, the blank was filled by either "hit," "smashed," or "contacted" each other. The wording of the question influenced the participants' memory of the accident. Data are from Loftus and Palmer (1974).

- >The situation is particularly problematic when the eyewitnesses are children because research has found that children are more likely to make incorrect identifications than are adults (Pozzulo & Lindsay, 1998) and are also subject to the own-race identification bias (Pezdek, Blandon-Gitlin, & Moore, 2003). In many cases, when sex abuse charges have been filed against babysitters, teachers, religious officials, and family members, the children are the only source of evidence. The likelihood that children are not accurately remembering the events that have occurred to them creates substantial problems for the legal system.
- >Another setting in which eyewitnesses may be inaccurate is when they try to identify suspects from mug shots or lineups. A lineup generally includes the suspect and five to seven other innocent people (the fillers), and the eyewitness must pick out the true perpetrator. The problem is that eyewitnesses typically feel pressured to pick a suspect out of the lineup, which increases the likelihood that they will mistakenly pick someone (rather than no one) as the suspect.
- >Research has attempted to better understand how people remember and potentially misremember the scenes of and people involved in crimes and to attempt to improve how the legal system makes use of eyewitness testimony. In many states, efforts are being made to better inform judges, juries, and lawyers about how inaccurate eyewitness testimony can be. Guidelines have also been proposed to help ensure those child witnesses are questioned in a nonbiased way (Poole & Lamb, 1998). Steps can also be taken to ensure that lineups yield more accurate eyewitness identifications. Lineups are fairer when the fillers resemble the suspect when the interviewer makes it clear that the suspect might or might not be present (Steblay, Dysart, Fulero, & Lindsay, 2001), and when the eyewitness has not been shown the same pictures in a mug-shot book prior to the lineup decision. And several recent studies have found that witnesses who make accurate identifications from a lineup reach their decision faster than do witnesses who make mistaken identifications, suggesting that authorities must take into consideration not only the response but how fast it is given (Dunning & Perretta, 2002).
- >In addition to distorting our memories for events that have actually occurred, misinformation may lead us to falsely remember information that never occurred. Loftus and her colleagues asked parents to provide them with descriptions of events that did (e.g., moving to a new house) and did not (e.g., being lost in a shopping mall) happen to their children. Then (without telling the children which events were real or made-up) the researchers asked the children to imagine both types of events. The children were instructed to "think real hard" about whether the events had occurred (Ceci, Huffman, Smith, & Loftus, 1994). More than half of the children generated stories regarding at least one of the made-up events, and they remained insistent that the events did in fact occur even when told by the researcher that they could not possibly have occurred (Loftus & Pickrell, 1995). Even college students are susceptible to manipulations that make events that did not actually occur seem as if they did (Mazzoni, Loftus, & Kirsch, 2001).

- >The ease with which memories can be created or implanted is particularly problematic when the events to be recalled have important consequences. Therapists often argue that patients may repress memories of traumatic events they experienced as children, such as childhood sexual abuse, and then recover the events years later as the therapist leads them to recall the information—for instance, by using dream interpretation and hypnosis (Brown, Scheflin, & Hammond, 1998).
- >But other researchers argue that painful memories such as sexual abuse are usually very well remembered, that few memories are actually repressed and that even if they are, it is virtually impossible for patients to accurately retrieve them years later (McNally, Bryant, & Ehlers, 2003; Pope, Poliakoff, Parker, Boynes, & Hudson, 2007). These researchers have argued that the procedures used by the therapists to "retrieve" the memories are more likely to actually implant false memories, leading the patients to erroneously recall events that did not actually occur. Because hundreds of people have been accused, and even imprisoned, on the basis of claims about "recovered memory" of child sexual abuse, the accuracy of these memories has important societal implications. Many psychologists now believe that most of these claims of recovered memories are due to implanted, rather than real, memories (Loftus & Ketcham, 1994).
- >Taken together, then, the problems of eyewitness testimony represent another example of how social cognition—the processes that we use to size up and remember other people—may be influenced, sometimes in a way that creates inaccurate perceptions, by the operation of salience, cognitive accessibility, and other information-processing biases.

Key Takeaways

- We use our schemas and attitudes to help us judge and respond to others. In many cases, this is appropriate, but our expectations can also lead to biases in our judgments of ourselves and others.
- A good part of our social cognition is spontaneous or automatic, operating without much thought or effort. On the other hand, when we have the time and the motivation to think about things carefully, we may engage in thoughtful, controlled cognition.
- Which expectations we use to judge others are based on both the situational salience of the things we are judging and the cognitive accessibility of our own schemas and attitudes.
- Variations in the accessibility of schemas lead to biases such as the availability heuristic, the representativeness heuristic, the false consensus bias, and biases caused by counterfactual thinking.
- The potential biases that are the result of everyday social cognition can have important consequences, both for us in our everyday lives but even for people who make important decisions affecting many other people. Although biases are common, they are not impossible to control, and psychologists and other scientists are working to help people make better decisions.
- The operation of cognitive biases, including the potential for new information to distort information already in memory, can help explain the tendency for eyewitnesses to be overconfident and frequently inaccurate in their recollections of what occurred at crime scenes.

Exercises & Critical Thinking

1. Give an example of a time when you may have committed one of the cognitive errors listed in Table 2.1 "How Expectations Influence Our Social Cognition". What factors (e.g., availability? salience?) caused the error, and what was the outcome of your use of the shortcut or heuristic?
2. Go to the website http://thehothand.blogspot.com, which analyzes the extent to which people accurately perceive "streakiness" in sports. Consider how our sports perceptions are influenced by our expectations and the use of cognitive heuristics.

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4.5: Lifespan Theories

Learning Objectives

- Discuss Freud's Theory of psychosexual development.
- Describe the major tasks of child and adult psychosocial development according to Erikson.
- Discuss Piaget's view of cognitive development and apply the stages to understanding childhood cognition.
- Describe Kohlberg's theory of moral development.

Freud

Psychosexual Theory of Development

Freud (1856–1939) believed that personality develops during early childhood. For Freud, childhood experiences shape our personalities and behavior as adults. Freud viewed development as discontinuous; he believed that each of us must pass through a serious of stages during childhood and that if we lack proper nurturance and parenting during a stage, we may become stuck, or fixated, in that stage. Freud's stages are called the stages of psychosexual development. According to Freud, children's pleasure-seeking urges are focused on a different area of the body, called an erogenous zone, at each of the five stages of development: oral, anal, phallic, latency, and genital.

Erikson

Psychosocial Theory of Development

Erikson (1902–1994) (Figure 1), another stage theorist, took Freud's theory and modified it as psychosocial theory. Erikson's psychosocial development theory emphasizes the social nature of our development rather than its sexual nature. While Freud believed that personality is shaped only in childhood, Erikson proposed that personality development takes place all through the lifespan. Erikson suggested that how we interact with others is what affects our sense of self, or what he called the ego identity.



Figure 1: Erik Erikson proposed the psychosocial theory of development. In each stage of Erikson's theory, there is a psychosocial task that we must master in order to feel a sense of competence.

Table 1: Erikson's Psychosocial Stages of Development

Stage	Age (years)	Developmental Task	Description
1	0–1	Trust vs. mistrust	Trust (or mistrust) that basic needs, such as nourishment and affection, will be met
2	1–3	Autonomy vs. shame/ doubt	Develop a sense of independence in many tasks
3	3–6	Initiative vs. guilt	Take initiative on some activities—may develop guilt when unsuccessful or boundaries overstepped
4	7–11	Industry vs. inferiority	Develop self-confidence in abilities when competent or sense of inferiority when not
5	12–18	Identity vs. confusion	Experiment with and develop identity and roles
6	19–29	Intimacy vs. isolation	Establish intimacy and relationships with others
7	30–64	Generativity vs. stagnation	Contribute to society and be part of a family
8	65–	Integrity vs. despair	Assess and make sense of life and meaning of contributions

Piaget

Cognitive Theory of Development

Piaget (1896–1980) is another stage theorist who studied childhood development (Figure 2). Instead of approaching development from a psychoanalytical or psychosocial perspective, Piaget focused on children's cognitive growth. He believed that thinking is a central aspect of development and that children are naturally inquisitive. However, he said that children do not think and reason like adults (Piaget, 1930, 1932). His theory of cognitive development holds that our cognitive abilities develop through specific stages, which exemplifies the discontinuity approach to development. As we progress to a new stage, there is a distinct shift in how we think and reason.



Figure 2: Jean Piaget spent over 50 years studying children and how their minds develop.

Piaget said that children develop schemata to help them understand the world. **Schemata** are concepts (mental models) that are used to help us categorize and interpret information. By the time children have reached adulthood, they have created schemata for almost everything. When children learn new information, they adjust their schemata through two processes: assimilation and accommodation. First, they assimilate new information or experiences in terms of their current schemata: assimilation is

when they take in information that is comparable to what they already know. **Accommodation** describes when they change their schemata based on new information. This process continues as children interact with their environment.

For example, 2-year-old Blake learned the schema for dogs because his family has a Labrador retriever. When Blake sees other dogs in his picture books, he says, "Look mommy, dog!" Thus, he has assimilated them into his schema for dogs. One day, Blake sees a sheep for the first time and says, "Look mommy, dog!" Having a basic schema that a dog is an animal with four legs and fur, Blake thinks all furry, four-legged creatures are dogs. When Blake's mom tells him that the animal he sees is a sheep, not a dog, Blake must accommodate his schema for dogs to include more information based on his new experiences. Blake's schema for a dog was too broad since not all furry, four-legged creatures are dogs. He now modifies his schema for dogs and forms a new one for sheep.

Like Freud and Erikson, Piaget thought development unfolds in a series of stages approximately associated with age ranges. He proposed a theory of cognitive development that unfolds in four stages: sensorimotor, preoperational, concrete operational, and formal operational (Table 2).

Table 2: Piaget's Stages of Cognitive Development

Age (years)	Stage	Description	Developmental issues
0–2	Sensorimotor	The world experienced through senses and actions	Object permanence Stranger anxiety
2–6	Preoperational	Use words and images to represent things, but lack logical reasoning	Pretend play Egocentrism Language development
7–11	Concrete operational	Understand concrete events and analogies logically; perform arithmetical operations	Conservation Mathematical transformations
12–	Formal operational	Formal operations Utilize abstract reasoning	Abstract logic Moral reasoning

The first stage is the **sensorimotor** stage, which lasts from birth to about 2 years old. During this stage, children learn about the world through their senses and motor behavior. Young children put objects in their mouths to see if the items are edible, and once they can grasp objects, they may shake or bang them to see if they make sounds. Between 5 and 8 months old, the child develops object permanence, which is the understanding that even if something is out of sight, it still exists (Bogartz, Shinskey, & Schilling, 2000). According to Piaget, young infants do not remember an object after it has been removed from sight. Piaget studied infants' reactions when a toy was first shown to an infant and then hidden under a blanket. Infants who had already developed object permanence would reach for the hidden toy, indicating that they knew it still existed, whereas infants who had not developed object permanence would appear confused.

A brief video above demonstrating different children's ability to understand object permanence.

YouTube Video

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In Piaget's view, around the same time children develop object permanence, they also begin to exhibit stranger anxiety, which is a fear of unfamiliar people. Babies may demonstrate this by crying and turning away from a stranger, by clinging to a caregiver, or by attempting to reach their arms toward familiar faces such as parents. Stranger anxiety results when a child is unable to assimilate the stranger into an existing schema; therefore, she can't predict what her experience with that stranger will be like, which results in a fear response.

Piaget's second stage is the preoperational stage, which is from approximately 2 to 7 years old. In this stage, children can use symbols to represent words, images, and ideas, which is why children in this stage engage in pretend play. A child's arms might become airplane wings as he zooms around the room, or a child with a stick might become a brave knight with a sword. Children also begin to use language in the preoperational stage, but they cannot understand adult logic or mentally manipulate information (the term *operational* refers to logical manipulation of information, so children at this stage are considered to be *pre*-operational). Children's logic is based on their own personal knowledge of the world so far, rather than on conventional knowledge. For example, dad gave a slice of pizza to 10-year-old Keiko and another slice to her 3-year-old brother, Kenny. Kenny's pizza slice was cut into five pieces, so Kenny told his sister that he got more pizza than she did. Children in this stage cannot perform mental operations because they have not developed an understanding of conservation, which is the idea that even if you change the appearance of something, it is still equal in size as long as nothing has been removed or added.

During this stage, we also expect children to display egocentrism, which means that the child is not able to take the perspective of others. A child at this stage thinks that everyone sees, thinks, and feels just as they do. Let's look at Kenny and Keiko again. Keiko's birthday is coming up, so their mom takes Kenny to the toy store to choose a present for his sister. He selects an Iron Man action figure for her, thinking that if he likes the toy, his sister will too. An egocentric child is not able to infer the perspective of other people and instead attributes his own perspective.

Piaget's third stage is the concrete operational stage, which occurs from about 7 to 11 years old. In this stage, children can think logically about real (concrete) events; they have a firm grasp on the use of numbers and start to employ memory strategies. They can perform mathematical operations and understand transformations, such as addition is the opposite of subtraction, and multiplication is the opposite of division. In this stage, children also master the concept of conservation: Even if something changes shape, its mass, volume, and number stay the same. For example, if you pour water from a tall, thin glass to a short, fat glass, you still have the same amount of water. Remember Keiko and Kenny and the pizza? How did Keiko know that Kenny was wrong when he said that he had more pizza?

Children in the concrete operational stage also understand the principle of reversibility, which means that objects can be changed and then returned back to their original form or condition. Take, for example, water that you poured into the short, fat glass: You can pour water from the fat glass back to the thin glass and still have the same amount (minus a couple of drops).

The fourth, and last, stage in Piaget's theory is the formal operational stage, which is from about age 11 to adulthood. Whereas children in the concrete operational stage are able to think logically only about concrete events, children in the formal operational stage can also deal with abstract ideas and hypothetical situations. Children in this stage can use abstract thinking to problem solve, look at alternative solutions, and test these solutions. In adolescence, a renewed egocentrism occurs. For example, a 15-year-old with a very small pimple on her face might think it is huge and incredibly visible, under the mistaken impression that others must share her perceptions.

Beyond Formal Operational Thought

As with other major contributors to theories of development, several of Piaget's ideas have come under criticism based on the results of further research. For example, several contemporary studies support a model of development that is more continuous than Piaget's discrete stages (Courage & Howe, 2002; Siegler, 2005, 2006). Many others suggest that children reach cognitive milestones earlier than Piaget describes (Baillargeon, 2004; de Hevia & Spelke, 2010).

According to Piaget, the highest level of cognitive development is formal operational thought, which develops between 11 and 20 years old. However, many developmental psychologists disagree with Piaget, suggesting a fifth stage of cognitive development, known as the post formal stage (Basseches, 1984; Commons & Bresette, 2006; Sinnott, 1998). In post formal thinking, decisions are made based on situations and circumstances, and logic is integrated with emotion as adults develop principles that depend on contexts. One way that we can see the difference between an adult in post formal thought and an adolescent in formal operations is in terms of how they handle emotionally charged issues.

It seems that once we reach adulthood our problem-solving abilities change: As we attempt to solve problems, we tend to think more deeply about many areas of our lives, such as relationships, work, and politics (Labouvie-Vief & Diehl, 1999). Because of this, post formal thinkers are able to draw on past experiences to help them solve new problems. Problem-solving strategies using post formal thought vary, depending on the situation. What does this mean? Adults can recognize, for example, that what seems to be an ideal solution to a problem at work involving a disagreement with a colleague may not be the best solution to a disagreement with a significant other.

Kohlberg

Theory of Moral Development

A major task beginning in childhood and continuing into adolescence is discerning right from wrong. Psychologist Lawrence Kohlberg (1927–1987) extended upon the foundation that Piaget built regarding cognitive development. Kohlberg believed that moral development, like cognitive development, follows a series of stages. To develop this theory, Kohlberg posed moral dilemmas to people of all ages, and then he analyzed their answers to find evidence of their particular stage of moral development. Before reading about the stages, take a minute to consider how you would answer one of Kohlberg's best-known moral dilemmas, commonly known as the Heinz dilemma:

> In Europe, a woman was near death from a special kind of cancer. There was one drug that the doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost him to make. He paid $200 for the radium and charged $2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only get together about $1,000, which is half of what it cost. He told the druggist that his wife was dying and asked him to sell it cheaper or let him pay later. But the druggist said: "No, I discovered the drug and I'm going to make money from it." So Heinz got desperate and broke into the man's store to steal the drug for his wife. Should the husband have done that? (Kohlberg, 1969, p. 379)

How would you answer this dilemma? Kohlberg was not interested in whether you answer yes or no to the dilemma: Instead, he was interested in the reasoning behind your answer.

After presenting people with this and various other moral dilemmas, Kohlberg reviewed people's responses and placed them in different **stages of moral reasoning** (Figure 3). According to Kohlberg, an individual progresses from the capacity for pre-conventional mortality (before age 9) to the capacity for conventional morality (early adolescence), and toward attaining post-conventional morality (once formal operational thought is attained), which only a few fully achieve. Kohlberg placed in the highest stage responses that reflected the reasoning that Heinz should steal the drug because his wife's life is more important than the pharmacist making money. The value of human life overrides the pharmacist's greed.

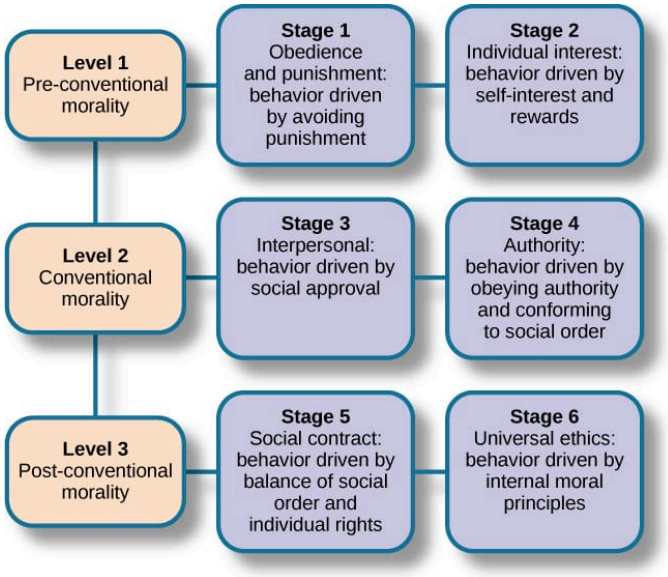


Figure 3: Kohlberg identified three levels of moral reasoning: pre-conventional, conventional, and post-conventional: Each level is associated with increasingly complex stages of moral development.

In a Different Voice: Psychological Theory and Women's Development, Gilligan (1982) criticized her former mentor's theory because it was based only on upper-class White men and boys. She argued that women are not deficient in their moral reasoning—she proposed that males and females reason differently. Girls and women focus more on staying connected and the importance of interpersonal relationships. Therefore, in the Heinz dilemma, many girls and women respond that Heinz should not steal the medicine. Their reasoning is that if he steals the medicine, is arrested, and is put in jail, then he and his wife will be

separated, and she could die while he is still in prison.

Additional Resources

This brief video demonstrates different children's ability to understand object permanence according to Jean Piaget's Stages of Cognitive Development in stage one: sensorimotor stage.

YouTube Video

This interactive element is not available in this format. Visit the link or scan the QR code to access it online.

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This video shows a 4.5-year-old boy in the preoperational stage as he responds to Piaget's conservation tasks in the Stages of Cognitive Development.

YouTube Video

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View this YouTube Video online

Piaget developed the Three-Mountain Task to determine the level of egocentrism displayed by children. Children view a 3-dimensional mountain scene from one viewpoint and are asked what another person at a different viewpoint would see in the same scene. Watch the Three-Mountain Task in action in this short video from the University of Minnesota and the Science Museum of Minnesota which represents Piaget's preoperational stage.

YouTube Video

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End-of-Chapter Summary

There are many theories regarding how babies and children grow and develop into happy, healthy adults. Sigmund Freud suggested that we pass through a series of psychosexual stages in which our energy is focused on certain erogenous zones on the body. Eric Erikson modified Freud's ideas and suggested a theory of psychosocial development. Erikson said that our social interactions and successful completion of social tasks shape our sense of self. Jean Piaget proposed a theory of cognitive development that explains how children think and reason as they move through various stages. Finally, Lawrence Kohlberg turned his attention to moral development. He said that we pass through three levels of moral thinking that build on our cognitive development.

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4.6: Carl Rogers and Humanistic Psychology

Carl Rogers is the psychologist many people associate first with humanistic psychology, but he did not establish the field in the way that Freud established psychoanalysis. A few years older than Abraham Maslow, and having moved into clinical practice more directly, Rogers felt a need to develop a new theoretical perspective that fit with his clinical observations and personal beliefs. Thus, he was proposing a humanistic approach to psychology and, more specifically, psychotherapy before Maslow. It was Maslow, however, who used the term humanistic psychology as a direct contrast to behaviorism and psychoanalysis. And it was Maslow who contacted some friends, in 1954, in order to begin meetings that led to the creation of the American Association for Humanistic Psychology. Rogers was included in that group, but so were Erich Fromm and Karen Horney, both of whom had distinctly humanistic elements in their own theories, elements that shared a common connection to Alfred Adler's Individual Psychology (Stagner, 1988). In addition, the spiritual aspects of humanistic psychology, such as peak experiences and transcendence, have roots in the work of Carl Jung and William James, and go even further back in time to ancient philosophies of Yoga and Buddhism.

In at least one important way, Rogers' career was similar to that of Sigmund Freud. As he began his clinical career, he found that the techniques he had been taught were not very effective. So, he began experimenting with his own ideas, and developing his own therapeutic approach. As that approach developed, so did a unique theory of personality that aimed at explaining the effectiveness of the therapy. Rogers found it difficult to explain what he had learned, but he felt quite passionately about it:

...the real meaning of a word can never be expressed in words, because the real meaning would be the thing itself. If one wishes to give such a real meaning he should put his hand over his mouth and *point*. This is what I should most like to do. I would willingly throw away all the words of this manuscript if I could, somehow, effectively *point* to the experience which is therapy. It is a process, a thing-in-itself, an experience, a relationship, a dynamic... (pp. ix; Rogers, 1951)

Brief Biography of Carl Rogers

Carl Ransom Rogers was born on January 8, 1902, in Chicago, Illinois. His parents were well-educated, and his father was a successful civil engineer. His parents loved their six children, of whom Rogers was the fourth, but they exerted a distinct control over them. They were fundamentalist Christians, who emphasized a close-knit family and constant, productive work, but approved of little else. The Rogers household expected standards of behavior appropriate for the 'elect' of God: there was no drinking of alcohol, no dancing, no visits to the theater, no card games, and little social life at all (DeCarvalho, 1991; Thorne, 2003).

Rogers was not the healthiest of children, and his family considered him to be overly sensitive. The more his family teased him, the more he retreated into a lonely world of fantasy. He sought consolation by reading books, and he was well above his grade level for reading when he began school. In 1914 the family moved to a large farm west of Chicago, a move motivated primarily by a desire to keep the children away from the temptations of suburban city life. The result was even more isolation for Rogers, who lamented that he'd only had two dates by the end of high school. He continued to learn, however, becoming something of an expert on the large moths that lived in the area. In addition, his father encouraged the children to develop their own ventures, and Rogers and his brothers raised a variety of livestock. Given these interests, and in keeping with family tradition, Rogers enrolled in the University of Wisconsin-Madison to study scientific agriculture (DeCarvalho, 1991; Thorne, 2003).

During his first year of college, Rogers attended a Sunday morning group of students led by Professor George Humphrey. Professor Humphrey was a facilitative leader, who refused to be conventional and who encouraged the students to make their own decisions. Rogers found the intellectual freedom very stimulating, and he also began to make close friends. This increased intellectual and emotional energy led Rogers to re-examine his commitment to Christianity. Given his strong religious faith, he decided to change his major to history, in anticipation of a career as a Christian minister. He was fortunate to be chosen as one of only twelve students from America to attend a World Student Christian Federation conference in Peking, China. He traveled throughout China (also visiting Korea, Hong Kong, Japan, the Philippines, and Hawaii) for 6 months, surrounded by other intelligent and creative young people. He kept a detailed journal, and wrote lengthy letters to his family and Helen Elliott, a childhood friend whom he considered to be his "sweetheart." His mind was stretched in all directions by this profound cross-cultural experience, and the intellectual and spiritual freedom he was embracing blinded him to the fact that his fundamentalist family was deeply disturbed by what he had to say. However, by the time Rogers was aware of his family's disapproval, he had been changed, and he believed that people of very different cultures and faiths can all be sincere and honest (Kirschenbaum, 1995; Thorne, 2003). As a curious side note, Rogers' roommate on the trip was a Black seminary professor. Rogers was vaguely aware that it was strange at that time for a Black man and a White man to room together, but he was particularly surprised at the stares

they received from the Chinese people they met, who had never seen a Black person before (Rogers & Russell, 2002). After his return from China, Rogers graduated from college, and 2 months later he married Helen. Again his family disapproved, believing that the young couple should be more established first. But Rogers had been accepted to the Union Theological Seminary in New York City, and both he and Helen wanted to be together. His family may have wanted them to wait because Union Theological Seminary was, perhaps, the most liberal seminary in America at the time (DeCarvalho, 1991; Rogers & Russell, 2002; Thorne, 2003).

Rogers spent 2 years at the seminary, including a summer assignment as the pastor of a small church in Vermont. However, his desire not to impose his own beliefs on others, made it difficult for him to preach. He began taking courses at nearby Teachers' College of Columbia University, where he learned about clinical and educational psychology, as well as working with disturbed children. He then transferred to Teachers' College, and after writing a dissertation in which he developed a test for measuring personality adjustment in children, he earned his Ph.D. in Clinical Psychology. Then, in 1928, he began working at the Rochester Society for the Prevention of Cruelty to Children (DeCarvalho, 1991; Thorne, 2003).

Rogers was immersed in his work in Rochester for 12 years. He found that even the most elaborate theories made little sense when dealing with children who had suffered severe psychological damage after traveling through the courts and the social work systems. So Rogers developed his own approach, and did his best to help them. Many of his colleagues, including the director, had no particular therapeutic orientation:

When I would try to see what I could do to alter their behavior, sometimes they would refuse to see me the next time. I'd have a hard time getting them to come from the detention home to my office, and that would cause me to think, "What is it that I did that offended the child?" Well, usually it was overinterpretation, or getting too smart in analyzing the causes of behavior...So we approached every situation with much more of a question of "What can we do to help?" rather than "What is the mysterious cause of this behavior?" or "What theory does the child fit into?" It was a very good place for learning in that it was easy to be open to experience, and there was certainly no pressure to fit into any particular pattern of thought. (pg. 108; Rogers & Russell, 2002)

Eventually Rogers wrote a book outlining his work with children, *The Clinical Treatment of the Problem Child* (Rogers, 1939), which received excellent reviews. He was offered a professorship at Ohio State University. Beginning as a full professor gave Rogers a great deal of freedom, and he was frequently invited to give talks. It has been suggested that one such talk, in December 1940, at the University of Minnesota, entitled "Newer Concepts in Psychotherapy," was the official birthday of client-centered therapy. Very popular with his students, Rogers was not so welcome amongst his colleagues. Rogers believed that his work was particularly threatening to those colleagues who believed that only their own expertise could make psychotherapy effective. After only 4 years, during which he published *Counseling and Psychotherapy* (Rogers, 1942), Rogers moved on to the University of Chicago, where he established the counseling center, wrote *Client-Centered Therapy* (Rogers, 1951) and contributed several chapters to *Psychotherapy and Personality Change* (Rogers & Dymond, 1954), and in 1956 received a *Distinguished Scientific Contribution Award* from the American Psychological Association. Then, in 1957, he accepted a joint appointment in psychiatry and psychology at the University of Wisconsin to study psychotic individuals. Rogers had serious doubts about leaving Chicago, but felt that the joint appointment would allow him to make a dramatic contribution to psychotherapy. It was a serious mistake. He did not get along with his colleagues in the psychology department, whom he considered to be antagonistic, outdated, "rat-oriented," and distrustful of clinical psychology, and so he resigned. He kept his appointment in the psychiatry department, however, and in 1961 published perhaps his most influential book, *On Becoming a Person* (Rogers, 1961).

In 1963, Rogers moved to California to join the Western Behavioral Sciences Institute, at the invitation of one of his former students, Richard Farson. This was a non-profit institute dedicated to the study of humanistically-oriented interpersonal relations. Rogers was leery of making another major move, but eventually agreed. He became very active in research on encounter groups and educational theory. Five years later, when Farson left the institute, there was a change in its direction. Rogers was unhappy with the changes, so he joined some colleagues in leaving and establishing the Center for Studies of the Person, where he remained until his death. In his later years, Rogers wrote books on topics such as personal power and marriage (Rogers, 1972, 1977). In 1980, he published *A Way of Being* (Rogers, 1980), in which he changed the terminology of his perspective from "client-centered" to "person-centered." With the assistance of his daughter Natalie, who had studied with Abraham Maslow, he held many group workshops on life, family, business, education, and world peace. He traveled to regions where tension and danger were high, including Poland, Russia, South Africa, and Northern Ireland. In 1985 he brought together influential leaders of seventeen Central American countries for a peace conference in Austria. The day he died, February 4, 1987, without knowing it, he had just been nominated for the Nobel Peace Prize (DeCarvalho, 1991; Kirschenbaum, 1995; Thorne, 2003).

Placing Rogers in Context: A Psychology 2,600 Years in the Making

Carl Rogers was an extraordinary individual whose approach to psychology emphasized individuality. Raised with a strong

Christian faith, exposed to Eastern culture and spirituality in college, and then employed as a therapist for children, he came to value and respect each person he met. Because of that respect for the ability of each person to grow, and the belief that we are innately driven toward actualization, Rogers began the distinctly humanistic approach to psychotherapy that became known as client-centered therapy.

Taken together, client-centered therapy and self-actualization offer a far more positive approach to fostering the growth of each person than most other disciplines in psychology. Unlike the existing approaches of psychoanalysis, which aimed to uncover problems from the past, or behavior therapies, which aimed to identify problem behaviors and control or "fix" them, client-centered therapy grew out of Rogers' simple desire to help his clients move forward in their lives. Indeed, he had been trained as a psychoanalyst, but Rogers found the techniques unsatisfying, both in their goals and their ability to help the children he was working with at the time. The seemingly hands-off approach of client-centered therapy fit well with a Taoist perspective, something Rogers had studied, discussed, and debated during his trip to China. In *A Way of Being*, Rogers (1980) quotes what he says is perhaps his favorite saying, one which sums up many of his deeper beliefs:

If I keep from meddling with people, they take care of themselves,

If I keep from commanding people, they behave themselves,

If I keep from preaching at people, they improve themselves,

If I keep from imposing on people, they become themselves.

Lao Tsu, c600 B.C.; Note: This translation differs somewhat from the one

cited in the References. I have included the translation Rogers quoted,

since the difference likely influenced his impression of this saying.

Rogers, like Maslow, wanted to see psychology contribute far more to society than merely helping individuals with psychological distress. He extended his sincere desire to help people learn to really communicate, with empathic understanding, to efforts aimed at bringing peace to the world. On the day he died, he had just been nominated for the Nobel Peace Prize. Since a Nobel Prize cannot be awarded to someone who has died, he was not eligible to be nominated again. If he had lived a few more years, he may well have received that award. His later years were certainly committed to peace in a way that deserved such recognition.

Basic Concepts

Rogers believed that each of us lives in a constantly changing private world, which he called the **experiential field**. Everyone exists at the center of their own experiential field, and that field can only be fully understood from the perspective of the individual. This concept has a number of important implications. The individual's behavior must be understood as a reaction to their experience and perception of the field. They react to it as an organized whole, and it is their reality. The problem this presents for the therapist is that only the individual can really understand their experiential field. This is quite different than the Freudian perspective, in which only the trained and objective psychoanalyst can break through the defense mechanisms and understand the basis of the patient's unconscious impulses. One's perception of the experiential field is limited, however. Rogers believed that certain impulses, or sensations, can only enter into the conscious field of experience under certain circumstances. Thus, the experiential field is not a true reality, but rather an individual's potential reality (Rogers, 1951).

The one basic tendency and striving of the individual is to actualize, maintain, and enhance the experiencing of the individual or, in other words, an **actualizing tendency**. Rogers borrowed the term **self-actualization**, a term first used by Kurt Goldstein, to describe this basic striving.

The tendency of normal life is toward activity and progress. For the sick, the only form of self-actualization that remains is the maintenance of the existent state. That, however, is not the tendency of the normal...Under adequate conditions the normal organism seeks further activity. (pp. 162-163; Goldstein, 1934/1995).

For Rogers, self-actualization was a tendency to move forward, toward greater maturity and independence, or self-responsibility. This development occurs throughout life, both biologically (the differentiation of a fertilized egg into the many organ systems of the body) and psychologically (self-government, self-regulation, socialization, even to the point of choosing life goals). A key factor in understanding self-actualization is the experiential field. A person's needs are defined, as well as limited, by their own potential for experience. Part of this experiential field is an individual's emotions, feelings, and attitudes. Therefore, who the individual

is, their actual **self**, is critical in determining the nature and course of their self-actualization (Rogers, 1951). We will examine Maslow's work on self-actualization in more detail below.

What then, is the self? In Rogers' (1951) initial description of his theory of personality, the experiential field is described in four points, the self-actualizing tendency in three points, and the remaining eleven points attempt to define the self. First and foremost, the self is a differentiated portion of the experiential field. In other words, the self is that part of our private world that we identify as "me," "myself," or "I." Beyond that, the self remains somewhat puzzling. Can the self exist in isolation, outside of relationships that provide some context for the self? Must the self be synonymous with the physical body? As Rogers' pointed out, when our foot "goes to sleep" from a lack of circulation, we view it as an object, not as a part of our self! Despite these challenging questions, Rogers tried to define and describe the self.

Rogers believed the self is formed in relation to others; it is an organized, fluid, yet consistent conceptual pattern of our experiential interactions with the environment and the values attached to those experiences. These experiences are symbolized and incorporated into the structure of the self, and our behavior is guided largely by how well new experiences fit within that structure. We may behave in ways inconsistent with the structure of our self, but when we do we will not "own" that behavior. When experiences are so inconsistent that we cannot symbolize them, or fit them into the structure of our self, the potential for psychological distress arises. On the other hand, when our concept of self is mature enough to incorporate all of our perceptions and experiences, and we can assimilate those experiences symbolically into our self, our psychological adjustment will be quite healthy. Individuals who find it difficult to assimilate new and different experiences, those experiences that threaten the structure of the self, will develop an increasingly rigid **self-structure**. Healthy individuals, in contrast, will assimilate new experiences, their self-structure will change and continue to grow, and they will become more capable of understanding and accepting others as individuals (Rogers, 1951).

The ability of individuals to make the choices necessary for actualizing their self-structure and to then fulfill those choices is what Rogers called **personal power** (Rogers, 1977). He believed there are many self-actualized individuals revolutionizing the world by trusting their own power, without feeling a need to have "power over" others. They are also willing to foster the latent actualizing tendency in others. We can easily see the influence of Alfred Adler here, both in terms of the creative power of the individual and seeking superiority within a healthy context of social interest. **Client-centered therapy** was based on making the context of personal power a clear strategy in the therapeutic relationship:

...the client-centered approach is a conscious renunciation and avoidance by the therapist of all control over, or decision-making for, the client. It is the facilitation of self-ownership by the client and the strategies by which this can be achieved...based on the premise that the human being is basically a trustworthy organism, capable of...making constructive choices as to the next steps in life, and acting on those choices. (pp. 14-15; Rogers, 1977)

Discussion Question: Rogers claimed that no one can really understand your experiential field. Would you agree, or do you sometimes find that close friends or family members seem to understand you better than you understand yourself? Are these relationships congruent?

Personality Development

Although Rogers described personality within the therapist-client relationship, the focus of his therapeutic approach was based on how he believed the person had arrived at a point in their life where they were suffering from psychological distress. Therefore, the same issues apply to personality development as in therapy. A very important aspect of personality development, according to Rogers, is the parent-child relationship. The nature of that relationship, and whether it fosters self-actualization or impedes personal growth, determines the nature of the individual's personality and, consequently, their self-structure and psychological adjustment.

A child begins life with an actualizing tendency. As they experience life, and perceive the world around them, they may be supported in all things by those who care for them, or they may only be supported under certain conditions (e.g., if their behavior complies with strict rules). As the child becomes self-aware, it develops a need for **positive regard**. When the parents offer the child **unconditional positive regard**, the child continues moving forward in concert with its actualizing tendency. So, when there is no discrepancy between the child's **self-regard** and its positive regard (from the parents), the child will grow up psychologically healthy and well-adjusted. However, if the parents offer only **conditional positive regard**, if they only support the child according the desires and rules of the parents, the child will develop **conditions of worth**. As a result of these conditions of worth, the child will begin to perceive their world selectively; they will avoid those experiences that do not fit with its goal of obtaining positive regard. The child will begin to live the life of those who set the conditions of worth, rather than living its own life.

As the child grows older, and more aware of its own condition in the world, their behavior will either fit within their own self-structure or not. If they have received unconditional positive regard, such that their self-regard and positive regard are closely matched, they will experience **congruence**. In other words, their sense of self and their experiences in life will fit together, and the child will be relatively happy and well-adjusted. But, if their sense of self and their ability to obtain positive regard do not match, the child will develop **incongruence**. Consider, for example, children playing sports. That alone tells us that parents have established guidelines within which the children are expected to "play." Then we have some children who are naturally athletic, and other children who are more awkward and/or clumsy. They may become quite athletic later in life, or not, but during childhood there are many different levels of ability as they grow. If a parent expects their child to be the best player on the team, but the child simply isn't athletic, how does the parent react? Do they support the child and encourage them to have fun, or do they pressure the child to perform better and belittle them when they can't? Children are very good at recognizing who the better athletes are, and they know their place in the hierarchy of athletics, i.e., their athletic self-structure. So if a parent demands dominance from a child who knows they just aren't that good, the child will develop incongruence. Rogers believed, quite understandably, that such conditions are threatening to a child, and will activate defense mechanisms. Over time, however, excessive or sudden and dramatic incongruence can lead to the breakdown and disorganization of the self-structure. As a result, the individual is likely to experience psychological distress that will continue throughout life (Rogers, 1959/1989).

Discussion Question: Conditions of worth are typically first established in childhood, based on the relationship between a child and his or her parents. Think about your relationship with your own parents and, if you have children, think about how you treat them. Are most of the examples that come to mind unconditional positive regard, or conditional positive regard? How has that affected your relationship with your parents and/or your own children?

Figure 1: Sometimes parents create conditions of worth by overemphasizing the importance of competition. Even a trip to the pumpkin patch can be a challenge to get the biggest, best pumpkin.

Another way in which Rogers approached the idea of congruence and incongruence was based on an individual's dual concept of self. There is, of course, the actual self-structure, or **real self**. In addition, there is also an **ideal self**, much like the fictional finalism described by Adler or the idealized self-image described by Horney. Incongruence develops when the real self falls far short of the accomplishment expected of the ideal self, when experience does not match the expectations of the self-structure (Rogers, 1951, 1959/1989). Once again, the relationship between parents and their children plays an important role in this development. If parents expect too much, such as all A's every marking period in school, but the child just isn't academically talented, or if the parents expect their child to be the football team's quarterback, but the child isn't a good athlete, then the ideal self will remain out of reach. Perhaps even worse, is when a child is physically or emotionally abused. Such a child's ideal self may remain at a relatively low standard, but the real self may be so utterly depressed that incongruence is still the result. An important aspect of therapy will be to provide a relationship in which a person in this unfortunate condition can experience the unconditional positive regard necessary to begin reintegrating the self-structure, such that the gap between the real self and the ideal self can begin to close, allowing the person to experience congruence in their life.

What about individuals who have developed congruence, having received unconditional positive regard throughout development or having experienced successful client-centered therapy? They become, according to Rogers (1961), a **fully functioning person**. He also said they lead a good life. The good life is a process, not a state of being, and a direction, not a destination. It requires psychological freedom, and is the natural consequence of being psychologically free to begin with. Whether or not it develops naturally, thanks to a healthy and supportive environment in the home, or comes about as a result of successful therapy, there are certain characteristics of this process. The fully functioning person is increasingly open to new experiences, they live fully in each moment, and they trust themselves more and more. They become more able and more willing to experience all of their feelings, they are creative, they trust human nature, and they experience the richness of life. The fully functioning person is not simply content, or happy, they are *alive*:

I believe it will become evident why, for me, adjectives such as happy, contented, blissful, enjoyable, do not seem quite appropriate to any general description of this process I have called the good life, even though the person in this process would experience each one of these feelings at appropriate times. But the adjectives which seem more generally fitting are adjectives such as enriching, exciting, rewarding, challenging, meaningful. This process...involves the courage to be. ...the deeply exciting thing about human beings is that when the individual is inwardly free, he chooses as the good life this process of becoming. (pp. 195-196; Rogers, 1961)

Discussion Question: Rogers described self-actualized people as fully functioning persons who are living a good life. Do you know anyone who seems to be a fully functioning person? Are there aspects of their personality that you aspire to for yourself? Does it seem difficult to be fully functioning, or does it seem to make life both easier and more enjoyable?

Connections Across Cultures

Self-Realization as the Path to Being a Fully Functioning Person

Rogers described an innate drive toward self-actualization, he talked about an ideal self, and he said that a fully functioning person lived a good life. But what does this actually mean? In the Western world we look for specific, tangible answers to such questions. We want to know what the self-actualization drive is, we want to know which ideals, or virtues, are best or right, and we want to define a "good life." All too often, we define a good life in terms of money, power, and possessions. The Eastern world has, for thousands of years, emphasized a very different perspective. They believe there is a natural order to life, and it is important that we let go of our need to explain the universe, and it is especially important that we let go of our need to own pieces of the universe. In the *Tao Te Ching*, Lao Tsu (c. 600 B.C./1989) writes:

Something mysteriously formed,

Born before heaven and earth.

In the silence and the void,

Standing alone and unchanging,

Ever present and in motion.

Perhaps it is the mother of ten thousand things.

I do not know its name,

Call it Tao.

For lack of a better word, I call it great...

The greatest Virtue is to follow Tao and Tao alone...

Tao follows what is natural.

At about the same time, some 2,600 years ago, the *Bhagavad Gita* was also written down (Mitchell, 2000). In the second chapter one finds:

When a man gives up all desires

That emerge from the mind, and rests

Contented in the Self by the Self,

He is called a man of firm wisdom...

In the night of all beings, the wise man

Sees only the radiance of the Self;

But the sense-world where all beings wake,

For him is as dark as night.

In each of these sacred books, we are taught that there is something deeper than ourselves that permeates the universe, but it is beyond our comprehension. It is only when we stop attempting to explain it, our way of trying to control it, and be content to just be ourselves, that we can actually attain that goal. To achieve this goal seems to require the absence of conditions of worth. If someone has been given unconditional positive regard throughout their life, they will be content to live that life

as it is. Rogers was well aware of this challenge, and he described the good life as a process, not something that you could actually get, but something that you had to "Be." Still, is it possible that a fully functioning person might have the insight necessary to understand the essence of the universe? Not according to Swami Sri Yukteswar:

Man possesses eternal faith and believes intuitively in the existence of a Substance, of which the objects of sense - sound, touch, sight, taste, and smell, the component parts of this visible world - are but properties. As man identifies himself with his material body, composed of the aforesaid properties, he is able to comprehend by these imperfect organs these properties only, and not the Substance to which these properties belong. The eternal Father, God, the only Substance in the universe, is therefore not comprehensible by man of this material world, unless he becomes divine by lifting his self above this creation of Darkness or *Maya*. See Hebrews 11:1 and John 8:28.

"Now faith is the substance of things hoped for, the evidence of things not seen."

"Then said Jesus unto them, When ye have lifted up the son of man, then shall ye know that I am he."

Jnanavatar Swami Sri Yukteswar Giri, 1894/1990

So whether we believe in God, Tao, an eternal Self, a mortal Self, or merely an actualizing tendency, for thousands of years there has been the belief, amongst many people, that our lives are about more than just being alive for a limited period of time. And it is in the recognition and acceptance, indeed the embracing, of that something more, even if we can't conceive it in our conscious mind, that we find and live a good life. When Paramahansa Yogananda, a direct disciple of Swami Yukteswar, came to the United States in 1920 to establish a permanent Yoga society, it was suggested that he name his society God-Realization. However, since he believed life is about realizing (or actualizing, in psychological terms) our selves, he established his organization as the Self-Realization Fellowship (Yogananda, 1946).

Self-realization, in the context of Yoga, refers to becoming aware of one's connection to the spark of divinity that exists within us, which may well be the source of our actualizing tendency. It is not the same as the sense of "I" or "me" that we normally think of. After all, are we our body or our mind? Consider the body. Is it the body we were born with, or the body we have now? Is our mind what we are thinking now, or what we were thinking 2 years ago? Both the body and the mind are transient, but the Self continues. It is that Self that Yogis, Buddhists, and Taoists seek to realize, and it may well be that Self which seeks its own actualization (separate from the consciousness created by the brain underlying our mind; see Feuerstein, 2003; Kabat-Zinn, 1994). This is also the Self of Being and transcendence, as described by Maslow.

Social Relationships and Marriage

Social and personal relationships were very important to Rogers, both in therapy and in everyday life. During each moment, we have our awareness (or consciousness), our experience (our perception of what is happening), and our communication (our relational behavior). For the fully functioning person, there is congruence between each of these phenomena. Unfortunately, we tend to be a poor judge of our own congruence. For example, if someone becomes angry with another person at a meeting or in a therapy group, they may remain unaware of their anger, even though it may be quite obvious to everyone else in the room. Thus, our relationship with others can reflect the true nature of our own personality, and the degree to which we are congruent. If others are congruent, and therefore are willing to talk to us openly and honestly, it will encourage us to become more congruent and, consequently, more psychologically healthy (Rogers, 1961, 1980). Curiously, the reason this became so important to Rogers was the lack of such meaningful relationships in his own life. Because his family followed strict, fundamentalist rules, they discouraged relationships with people outside their family. The consequences were rather disturbing for Rogers:

...the attitudes toward persons outside our large family can be summed up schematically in this way: "Other persons behave in dubious ways which we do not approve in our family. Many of them play cards, go to movies, smoke, dance, drink, and engage in other activities, some unmentionable. So the best thing to do is to be tolerant of them, since they may not know better, but to keep away from any close communication with them and to live your life within the family..."

I could sum up these boyhood years by saying that anything I would today regard as a close and communicative interpersonal relationship with another was completely lacking during that period...I was peculiar, a loner, with very little place or opportunity for a place in the world of persons. I was socially incompetent in any but superficial contacts. My fantasies during this period were definitely bizarre, and probably would be classed as schizoid by a diagnostician, but fortunately I never came in contact with a psychologist. (pp. 28-30; Rogers, 1980)

As noted above, the development of healthy relationships takes place whenever one person in the relationship is congruent. Their congruence encourages the other person to be more congruent, which supports the continued open communication on behalf of the first person. This interplay goes back and forth, encouraging continued and growing congruence in the relationship. As we will see below, this is basically the therapeutic situation, in which the therapist is expected to be congruent. However, it certainly does not require a trained therapist, since it occurs naturally in any situation in which one person is congruent from the beginning of the relationship.

One of the most important, and hopefully meaningful, relationships in anyone's life is marriage. Rogers was married for 55 years, and as the end of his wife's life approached he poured out his love to her with a depth that astonished him (Rogers, 1980). As relationships became more and more meaningful to him, he wanted to study the extraordinary relationships that become more than temporary. Although this is not necessarily synonymous with marriage, it most typically is. So he conducted a series of informal interviews with people who were, or had been, in lengthy relationships (at least 3 years). In comparing the relationships that seemed successful, as compared to those that were unhappy or had already come to an end, Rogers identified four factors that he believed were most important for long-term, healthy relationships: dedication or commitment, communication, the dissolution of roles, and becoming a separate self (Rogers, 1972).

Dedication, Commitment: Marriage is challenging: love seems to fade, vows are forgotten or set aside, religious rules are ignored (e.g., "What therefore God has joined together, let no man put asunder."; Matthew 19:6; Holy Bible, 1962). Rogers believed that in order for a relationship to last, each person must be dedicated to their partnership. They must commit themselves to working together throughout the changing process of their relationship, which is enriching their love and their life.

Communication: Communication encompasses much of human behavior, and it can be both subtle and complex. Communication itself is not a good thing, since many negative and hurtful things can be communicated. However, Rogers believed that we need to communicate persistent feeling, whether positive or negative, so that they don't overwhelm us and come out in inappropriate ways. It is always important to express such communication in terms of your own thoughts and feelings, rather than projecting those feelings onto others (especially in angry and/or accusatory ways). This process involves risk, but one must be willing to risk the end of a relationship in order to allow it to grow.

Dissolution of Roles: Culture provides many expectations for the nature of relationships, whether it be dating or something more permanent like marriage. According to Rogers, obeying the cultural rules seems to contradict the idea of a growing and maturing relationship, a relationship that is moving forward (toward actualization). However, when individuals make an intentional choice to fulfill cultural expectations, because they *want* to, then the relationship can certainly be actualizing for them.

Becoming a Separate Self: Rogers believed that "a *living* partnership is composed of two people, each of whom owns, respect, and develops his or her own selfhood" (pg. 206; Rogers, 1972). While it may seem contradictory that becoming an individual should enhance a relationship, as each person becomes more real and more open they can bring these qualities into the relationship. As a result, the relationship can contribute to the continued growth of each person.

Discussion Question: Consider Rogers' criteria for a successful marriage, which begins with commitment to the marriage. Given the divorce rate (which studies now place at over 60%), and ongoing political debates about what marriage is or is not, what is your opinion of the status of marriage in society today?

Client-Centered and Person-Centered Therapy

Central to Rogers' view of psychotherapy is the relationship between the therapist and the client, and we must again emphasize the distinction between a client and a patient. This involves shifting the emphasis in therapy from a psychologist/psychiatrist who can "fix" the patient to the client themselves, since only the client can truly understand their own experiential field. The therapist must provide a warm, safe environment in which the client feels free to express whatever attitude they experience in the same way that they perceive it. At the same time, the client experiences the therapist as someone temporarily divested of their own self, in their complete desire to understand the client. The therapist can then accurately and objectively reflect the thoughts, feelings, perceptions, confusions, ambivalences, etc., of the client back to the client. In this open, congruent, and supportive environment, the client is able to begin the process of reorganizing and reintegrating their self-structure, and living congruently within that self-structure (Rogers, 1951).

In 1957, Rogers published an article entitled *The Necessary and Sufficient Conditions of Therapeutic Personality Change* (Rogers, 1957/1989). The list is fairly short and straightforward:

1. The client and the therapist must be in psychological contact.

2. The client must be in a state of incongruence, being vulnerable or anxious.
3. The therapist must be congruent in the relationship.
4. The therapist must experience unconditional positive regard for the client.
5. The therapist must experience empathic understanding of the client's frame of reference and endeavor to communicate this experience to the client.
6. The client must perceive, at least to a minimal degree, the therapist's empathic understanding and unconditional positive regard.

According to Rogers, there is nothing else that is required; if these conditions are met over a period of time, there will be constructive personality change. What Rogers considered more remarkable are those factors that do *not* seem necessary for positive therapeutic change. For example, these conditions do not apply to one type of client, but to all clients, and they are not unique to client-centered therapy, but apply in all types of therapy. The relationship between the therapist and client is also not unique, these factors hold true in any interpersonal relationship. And most surprisingly, these conditions do not require any special training on the part of therapist, or even an accurate diagnosis of the client's psychological problems! Any program designed for the purpose of encouraging constructive change in the personality structure and behavior of individuals, whether educational, military, correctional, or industrial, can benefit from these conditions and use them as a measure of the effectiveness of the program (Rogers, 1957).

Can any one of these conditions be considered more important than the others? Although they are all necessary, Rogers came to believe that the critical factor may be the therapist's **empathic understanding** of the client (Rogers, 1980). The Dalai Lama (2001) has said that empathy is an essential first step toward a compassionate heart. It brings us closer to others, and allows us to recognize the depth of their pain. According to Rogers, empathy refers to entering the private world of the client, and moving about within it without making any judgments. It is essential to set aside one's own views and values, so that the other person's world may be entered without prejudice. Not just anyone can accomplish this successfully:

In some sense it means that you lay aside your self; this can only be done by persons who are secure enough in themselves that they know they will not get lost in what may turn out to be the strange or bizarre world of the other, and that they can comfortably return to their own world when they wish. (pg. 143; Rogers, 1980)

Finally, let us consider group therapy situations. Within a group, all of the factors described above hold true. Rogers, who late in his career was becoming more and more interested in the growth of all people, including those reasonably well-adjusted and mature to begin with, became particularly interested in **T-groups** and **encounter groups**. These groups were developed following the proposition by Kurt Lewin that modern society was overlooking the importance of training in human relations skills (the "T" in T-group stands for "training"). Encounter groups were quite similar to T-groups, except that there was a greater emphasis on personal growth and improved interpersonal communication through an experiential process. Each group has a leader, or facilitator, who fosters and encourages open communication. The group serves as a reflection of the congruence, or lack thereof, in the communication of whoever is currently expressing themselves. As a result, the group hopefully moves toward congruence, and the subsequent personal growth and actualization of the each individual (Rogers, 1970).

Given the usefulness of T-groups and encounter in a variety of settings, as well as the importance of continued personal growth and actualization for the well-adjusted as well as those suffering psychological distress, Rogers shifted his focus from simply client-centered therapy to a more universal **person-centered approach**, which encompasses client-centered therapy, student-centered teaching, and group-centered leadership (Rogers, 1980; see also Rogers & Roethlisberger, 1952/1993). Rogers believed that all people have within them vast resources for self-understanding and for changing their self-concepts, attitudes, and behaviors. In all relationships, whether therapist-client, parent-child, teacher-student, leader-group, employer-employee, etc., there are three elements that can foster personal growth: genuineness or congruence, acceptance or caring, and empathic understanding. When these elements are fostered in any setting, "there is greater freedom to be the true, whole person." The implications go far beyond individual relationships. We live in what seems to be an increasingly dangerous world. Globalism has brought with it global tension and conflict. However, Rogers argued that a person-centered approach would help to ease intercultural tension, by helping each of us to learn to appreciate and understand others. Whether the cultural differences are political, racial, ethnic, economic, whatever, as more leaders become person-centered there is the possibility for future growth of intercultural understanding and cooperation (Rogers, 1977).

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4.7: Abraham Maslow and Holistic-Dynamic Psychology

Maslow stands alongside Rogers as one of the founders of humanistic psychology. Although he began his career working with two of the most famous experimental psychologists in America, he was profoundly influenced by the events that led into World War II. He became devoted to studying the more virtuous aspects of personality, and he may be viewed as one of the founders of positive psychology. Well-known primarily for his work on self-actualization, Maslow also had a significant impact on the field of management. His fame in both psychology and business makes him a candidate for being, perhaps, the best-known psychologist of all time (Freud is certainly more famous, but remember that he was a psychiatrist). According to Maslow, his **holistic-dynamic theory** of personality was a blend of theories that had come before his:

This theory is, I think, in the functionalist tradition of James and Dewey, and is fused with the holism of Wertheimer, Goldstein, and Gestalt psychology, and with the dynamicism of Freud, Fromm, Horney, Reich, Jung, and Adler. This integration or synthesis may be called a holistic-dynamic theory. (pg. 35; Maslow, 1970)

Brief Biography of Abraham Maslow

Abraham H. Maslow was born on April 1, 1908 in Brooklyn, New York, the first of seven children. His father, Samuel, had left Kiev, Russia at just 14 years old. When Samuel Maslow arrived in America he had no money and did not speak English. Samuel Maslow spent a few years in Philadelphia, doing odd jobs and learning the language, before moving to New York City, where he married his first cousin Rose and began a cooperage business (a cooper builds and repairs barrels). Samuel and Rose Maslow did not have a happy marriage, and Abraham Maslow was particularly sensitive to this fact. Maslow resented his father's frequent absences, and apparently hated his mother. His mother was a superstitious woman, who severely punished Maslow for even minor misbehavior by threatening him with God's wrath. Maslow developed an intense distrust of religion, and was proud to consider himself an atheist (Gabor, 2000; Hoffman, 1988; Maddi & Costa, 1972).

Maslow's childhood was no better outside the home. Anti-Semitism was rampant in New York. Many teachers were cruel, and he overheard them say nasty things about him. He had no friends, and there were anti-Semitic gangs that would find and beat up Jewish children. At one point he decided to join a Jewish gang for protection, but he didn't have the "right" attitude:

I wanted to be a member of the gang, but I couldn't: they rejected me because I couldn't kill cats...We'd stake out a cat on a [clothesline] and stand back so many paces and throw rocks at it and kill it.

And the other thing was to throw rocks at the girls on the corner. Now I knew that the girls liked it, and yet I couldn't throw rocks at girls and I couldn't kill cats, so I was ruled out of the gang, and I could never be the gangster that I wanted to become. (pg. 4; Maslow, cited in Hoffman, 1988)

With six more children joining the family, one every couple of years, the family was constantly moving and, following the troubling death of one of his little sisters (Maslow blamed her illness, in part, on their mother's neglect), Maslow became a very unhappy and shy child. He also thought he was terribly ugly, something his father said openly at a large family gathering! Perhaps worst of all, he felt profoundly strange and different than other children, largely because he was so intellectual. Maslow reconciled with his father later in life. During the depression, Samuel Maslow lost his business. By that time he had divorced Maslow's mother, Rose, and he moved in with his son. The two became close, and after Samuel Maslow died, his son remembered him fondly. Maslow never forgave his mother, however. Some of the childhood stories he related were shockingly cruel. Once, he had searched through second-hand record shops for some special 78-RPM records. When he failed to put them away soon after returning home, his mother stomped them into pieces on the living room floor. Another time, Maslow brought home two abandoned kittens he had found. When his mother caught him feeding them a saucer of milk, she grabbed the kittens and smashed their heads against a wall until they were dead! Later in life, he refused to even attend her funeral.

What I had reacted to and totally hated and rejected was not only her physical appearance, but also her values and world view...I've always wondered where my utopianism, ethical stress, humanism, stress on kindness, love, friendship, and all the rest came from. I knew certainly of the direct consequences of having no mother-love. But the whole thrust of my life-philosophy and all my research and theorizing also has its roots in a hatred for and revulsion against everything she stood for. (pg. 9; Maslow cited in Hoffman, 1988)

Maslow spent much of his childhood reading, and despite the treatment he received from many of his prejudiced teachers,

he loved to learn. After high school Maslow won a scholarship to Cornell University, but encountered pervasive anti-Semitism throughout his first year. So he transferred to City College, where he first studied the work of behavioral scientists like John B. Watson. He was impressed by Watson's desire to use the newly created science of behaviorism to fight social problems, such as racial and ethnic discrimination. At the same time, however, Maslow had fallen in love with his first cousin Bertha Goodman, a relationship his parents strongly opposed. So Maslow left for the University of Wisconsin (Gabor, 2000; Hoffman, 1988; Maddi & Costa, 1972). Bertha Goodman followed, and they were soon married. Marriage boosted Maslow's self-esteem, and provided him with a sense of purpose in life. He later said that "life didn't really start for me until I got married and went to Wisconsin" (pg. 128; cited in Maddi & Costa, 1972).

In Wisconsin, Maslow studied the behavior of primates under the supervision of the renowned Harry Harlow (most famous for his studies on **contact comfort**). One day, while watching some monkeys seemingly enjoy munching on peanuts and other treats, Maslow recognized that appetite and hunger are two different things. Thus, motivation must be comprised of separate elements as well. In another study, Maslow tried to address the different aspects of Freud and Adler's psychodynamic perspectives by observing dominance behavior amongst the monkeys. His colleagues and professors, however, had little interest in the psychoanalytic science that they considered to be a European endeavor. Maslow completed his Ph.D. at Wisconsin in 1934, and then returned to New York. He earned a position at Columbia University with the renowned Edward Thorndike, and began studying the relative contributions of heredity and environment on social behavior, as part of a project to study factors involved in poverty, illiteracy, and crime. As a curious side note, Thorndike had also developed an IQ test; Maslow scored 195 on this test, one of the highest scores ever recorded. During this time at Columbia University, Maslow also began relationships with many of the psychologists, sociologists, and anthropologists who had fled Nazi Germany. He was very impressed with Max Wertheimer, one of the founders of Gestalt psychology, and who helped to lay the foundation for positive psychology:

"Are there not tendencies in men and in children to be kind, to deal sincerely [and] justly with the other fellow? Are these nothing but internalized rules on the basis of compulsion and fear?" he asked rhetorically. (pg. 159; Wertheimer, cited in Gabor, 2000)

Maslow was one of the first students to study with Alfred Adler in America, being particularly impressed with Adler's work helping academically-challenged children to succeed despite their low IQ scores. Maslow also studied with Erich Fromm, Karen Horney, and Ruth Benedict. Benedict was an anthropologist who encouraged Maslow to gain some field experience. She sponsored a grant application that Maslow received to study the Blackfoot Indians. During the summer of 1938, Maslow examined the dominance and emotional security of the Blackfoot Indians. He was impressed by their culture, and recognized what he believed was an innate need to experience a sense of purpose in life, a sense of meaning. A few years later, shortly after the beginning of World War II, Maslow had an epiphany regarding psychology's failure to understand the true nature of people. He devoted the rest of his life to the study of a hopeful psychology (Gabor, 2000; Hoffman, 1988; Maddi & Costa, 1972).

Maslow taught for a few years at Brooklyn College, and also served as the plant manager for the Maslow Cooperage Corporation (from 1947-1949). In 1951 he was appointed Professor and Chair of the Department of Psychology at Brandeis University, where he conducted the research and wrote the books for which he is most famous. By the late 1960s, Maslow had become disillusioned with academic life. He had suffered a heart attack in 1966, and seemed somewhat disconnected from the very department he had helped to form. In 1969, however, he accepted a four year grant from the Laughlin Foundation, primarily to study the philosophy of democracy, economics, and ethics as influenced by humanistic psychology. He had been troubled by what he viewed as a loss of faith in American values, and he was greatly enjoying his time working in California. He also attended management seminars at the Saga Corporation, urging the participants to commit themselves to humanistic management. One day in June, 1970, he was jogging slowly when he suffered a massive heart attack. He was already dead by the time his wife rushed over to him (Gabor, 2000; Hoffman, 1988; Maddi & Costa, 1972). He was only 62 years old. Shortly after his death, the *International Study Project* of Menlo Park, CA published a memorial volume in tribute to Abraham Maslow (International Study Project, 1972).

Placing Maslow in Context: Beyond Humanistic Psychology

Whereas Carl Rogers is often thought of as the founder of humanistic psychology, in large part because of his emphasis on psychotherapy, it was Maslow who studied in great detail the most significant theoretical aspect of it: self-actualization. In addition to studying self-actualization, he applied it both in psychology and beyond. His application of self-actualization to management continued the classic relationship between psychology and business (which began with John B. Watson and his application of psychological principles to advertising). Unfortunately, Maslow died just as he was beginning to study his proposed fourth force: transpersonal psychology. Transpersonal psychology offered a connection between psychology and many of the Eastern philosophies associated with Yoga and Buddhism, and also provided a foundation for the study of positive psychology.

Maslow's interest in business and management has quite possibly led to his being the most famous psychologist of all time, since he is well-known in both psychology and business. If he had continued being a vocal advocate for transpersonal psychology (if not

for his untimely death at an early age), given today's growing interest in Eastern philosophy and psychology and the establishment of positive psychology as a goal for the field of psychology by former APA President Martin Seligman, Maslow may well have become even more famous. It is interesting to note that someone so truly visionary seems to have become that way as a result of studying people whom he felt were themselves self-actualized. If positive psychology, the psychology of virtue and values, becomes the heir of Maslow's goal, it should become a significant force in the field of psychology. That will be Maslow's true legacy.

The Importance of Values in the Science of Psychology

A common criticism leveled against many personality theorists is that they have not confirmed their theories in a strict, scientific manner. When one goes so far as to consider **values**, which are typically associated with religious morality, there is even greater resistance on the part of those who would have psychology become "truly" scientific to consider such matters worthy of examination. However, Maslow felt that:

Both orthodox science and orthodox religion have been institutionalized and frozen into a mutually excluding dichotomy...One consequence is that they are both pathologized, split into sickness, ripped apart into a crippled half-science and a crippled half-religion...As a result...the student who becomes a scientist automatically gives up a great deal of life, especially its richest portions. (pg. 119; Maslow, 1966)

Consequently, Maslow urged that we need to be fully aware of our values at all times, and aware of how our values influence us in our study of psychology. Although people approach the world in common ways, they also pay selective attention to what is happening, and they reshuffle the events occurring around them according to their own interests, needs, desires, fears, etc. Consequently, Maslow believed that paying attention to human values, particularly to an individual's values, actually helps the psychological scientist achieve the goal of clearly understanding human behavior (Maslow, 1970). In a similar vein, when Maslow co-authored an abnormal psychology text early in his career, he included a chapter on normal psychology. His description of the characteristics of a healthy, normal personality provides an interesting foreshadowing of his research on self-actualization (Maslow & Mittelmann, 1941).

Maslow felt so strongly about the loss of values in our society that he helped to organize a conference and then served as editor for a book entitled *New Knowledge in Human Values* (Maslow, 1959). In the preface, Maslow laments that "...the ultimate disease of our time is valuelessness...this state is more crucially dangerous than ever before in history..." (pg. vii; Maslow, 1959). Maslow does suggest, however, that something can be done about this loss of values, if only people will try. In the book, he brought together an interesting variety of individuals, including: Kurt Goldstein, a well-known neurophysiologist who studied the holistic function of healthy vs. brain-damaged patients and who coined the term self-actualization; D. T. Suzuki, a renowned Zen Buddhist scholar; and Paul Tillich, a highly respected existential theologian (who had a direct and significant influence on the career of Rollo May). There are also chapters by Gordon Allport and Erich Fromm. In his own chapter, Maslow concludes:

If we wish to help humans to become more fully human, we must realize not only that they try to realize themselves but that they are also reluctant or afraid or unable to do so. Only by fully appreciating this dialectic between sickness and health can we help to tip the balance in favor of health. (pg. 135; Maslow, 1959)

Discussion Question: Maslow believed that values are very important, not only in the study of psychology, but in society as well. Do you agree? When politicians or religious leaders talk about values, do you think they represent meaningful, true values, or do they just support the values that are an advantage to their own goal or the goals of their political party or church?

The Hierarchy of Needs

Maslow's is undoubtedly best known for his **hierarchy of needs**. Developed within the context of a theory of human motivation, Maslow believed that human behavior is driven and guided by a set of **basic needs**: **physiological needs, safety needs, belongingness and love needs, esteem needs,** and the **need for self-actualization**. It is generally accepted that individuals must move through the hierarchy in order, satisfying the needs at each level before one can move on to a higher level. The reason for this is that lower needs tend to occupy the mind if they remain unsatisfied. How easy is it to work or study when you are really hungry or thirsty? But Maslow did not consider the hierarchy to be rigid. For example, he encountered some people for whom self-esteem was more important than love, individuals suffering from antisocial personality disorder seem to have a permanent loss of the need for love, or if a need has been satisfied for a long time it may become less important. As lower needs are becoming satisfied, though not yet fully satisfied, higher needs may begin to present themselves. And of course there are sometimes multiple determinants of behavior, making the relationship between a given behavior and a basic need difficult to

identify (Maslow, 1943/1973; Maslow, 1970).

The physiological needs are based, in part, on the concept of **homeostasis**, the natural tendency of the body to maintain critical biological levels of essential elements or conditions, such as water, salt, energy, and body temperature. Sexual activity, though not essential for the individual, is biologically necessary for the human species to survive. Maslow described the physiological needs as the most **prepotent**. In other words, if a person is lacking everything in life, having failed to satisfy physiological, safety, belongingness and love, and esteem needs, their consciousness will most like be consumed with their desire for food and water. As the lowest and most clearly biological of the needs, these are also the most animal-like of our behavior. In Western culture, however, it is rare to find someone who is actually starving. So when we talk about being hungry, we are really talking about an appetite, rather than real hunger (Maslow, 1943/1973; Maslow, 1970). Many Americans are fascinated by stories such as those of the ill-fated Donner party, trapped in the Sierra Nevada mountains during the winter of 1846-1847, and the Uruguayan soccer team whose plane crashed in the Andes mountains in 1972. In each case, either some or all of the survivors were forced to cannibalize those who had died. As shocking as such stories are, they demonstrate just how powerful our physiological needs can be.

The safety needs can easily be seen in young children. They are easily startled or frightened by loud noises, flashing lights, and rough handling. They can become quite upset when other family members are fighting, since it disrupts the feeling of safety usually associated with the home. According to Maslow, many adult neurotics are like children who do not feel safe. From another perspective, that of Erik Erikson, children and adults raised in such an environment do not trust the environment to provide for their needs. Although it can be argued that few people in America seriously suffer from a lack of satisfying physiological needs, there are many people who live unsafe lives. For example, inner city crime, abusive spouses and parents, incurable diseases like HIV/AIDS, all present life threatening dangers to many people on a daily basis.

One place where we expect our children to be safe is in school. However, as we saw in the last chapter (in the section on the martial arts), 160,000 children each day are too frightened to attend school (Nathan, 2005). Juvonen et al. (2006) looked at the effects of ethnic diversity on children's perception of safety in urban middle schools (Grade 6). They surveyed approximately 2,000 students in 99 classrooms in the greater Los Angeles area. The ethnicity of the students in this study was 46 percent Latino (primarily of Mexican origin), 29 percent African American, 9 percent Asian (primarily East Asian), 9 percent Caucasian, and 7 percent multiracial. When a given classroom, or a given school, is more ethnically diverse, both African American and Latino students felt safer, were harassed less by peers, felt less lonely, and they had higher levels of self-worth (even when the authors controlled for differences in academic engagement). Thus, it appears that ethnic diversity in schools leads toward satisfaction of the need for safety, at least in one important area of a child's life. Unfortunately, most minority students continue to be educated in schools that are largely ethnically segregated (Juvonen, et al., 2006).

Throughout the evolution of the human species we found safety primarily within our family, tribal group, or our community. It was within those groups that we shared the hunting and gathering that provided food. Once the physiological and safety needs have been fairly well satisfied, according to Maslow, "the person will feel keenly, as never before, the absence of friends, or a sweetheart, or a wife, or children" (Maslow, 1970). Although there is little scientific confirmation of the belongingness and love needs, many therapists attribute much of human suffering to society's thwarting of the need for love and affection. Most notable among personality theorists who addressed this issue was Wilhelm Reich. An important aspect of love and affection is sex. Although sex is often considered a physiological need, given its role in procreation, sex is what Maslow referred to as a multidetermined behavior. In other words, it serves both a physiological role (procreation) and a belongingness/love role (the tenderness and/or passion of the physical side of love). Maslow was also careful to point out that love needs involve both giving and receiving love in order for them to be fully satisfied (Maslow, 1943/1973; Maslow, 1970).

Maslow believed that all people desire a stable and firmly based high evaluation of themselves and others (at least the others who comprise their close relationships). This need for self-esteem, or self-respect, involves two components. First is the desire to feel competent, strong, and successful (similar to Bandura's self-efficacy). Second is the need for prestige or status, which can range from simple recognition to fame and glory. Maslow credited Adler for addressing this human need, but felt that Freud had neglected it. Maslow also believed that the need for self-esteem was becoming a central issue in therapy for many psychotherapists. However, as we saw in Chapter 12, Albert Ellis considers self-esteem to be a sickness. Ellis' concern is that self-esteem, including efforts to boost self-esteem in therapy, requires that people rate themselves, something that Ellis felt will eventually lead to a negative evaluation (no one is perfect!). Maslow did acknowledge that the healthiest self-esteem is based on well-earned and deserved respect from others, rather than fleeting fame or celebrity status (Maslow, 1943/1973; Maslow, 1970).

When all of these lower needs (physiological, safety, belongingness and love, and esteem) have been largely satisfied, we may still feel restless and discontented unless we are doing what is right for ourselves. "What a man *can* be, he *must* be" (pg. 46; Maslow, 1970). Thus, the need for self-actualization, which Maslow described as the highest of the basic needs, can also be referred to as a **Being-need**, as opposed to the lower **deficiency-needs** (Maslow, 1968). We will examine self-actualization in more detail in the following section.

Maslow's hierarchy of needs is based on a theory of motivation. Individuals must essentially satisfy the lower deficiency needs before they become focused on satisfying the higher Being needs. Beyond even the Being needs there is something more, a state of transcendence that ties all people and the whole of creation together.

Although Maslow recognized that humans no longer have instincts in the technical sense, we nonetheless share basic drives with other animals. We get hungry, even though how and what we eat is determined culturally. We need to be safe, like any other animal, but again we seek and maintain our safety in different ways (such as having a police force to provide safety for us). Given our fundamental similarity to other animals, therefore, Maslow referred to the basic needs as **instinctoid**. The lower the need the more animal-like it is, the higher the need, the more human it is, and self-actualization was, in Maslow's opinion, uniquely human (Maslow, 1970).

In addition to the basic needs, Maslow referred to **cognitive needs** and **aesthetic needs**. Little is known about cognitive needs, since they are seldom an important focus in clinic settings. However, he felt there were ample grounds for proposing that there are positive impulses to know, to satisfy curiosity, to understand, and to explain. The eight-fold path described by the Buddha, some 2,600 years ago, begins with right knowledge. The importance of mental stimulation for some people is described quite vividly by Maslow:

I have seen a few cases in which it seemed clear to me that the pathology (boredom, loss of zest in life, self-dislike, general depression of the bodily functions, steady deterioration of the intellectual life, of tastes, etc.) were produced in intelligent people leading stupid lives in stupid jobs. I have at least one case in which the appropriate cognitive therapy (resuming part-time studies, getting a position that was more intellectually demanding, insight) removed the symptoms.

I have seen many women, intelligent, prosperous, and unoccupied, slowly develop these same symptoms of intellectual inanition. Those who followed my recommendation to immerse themselves in something worthy of them showed improvement or cure often enough to impress me with the reality of the cognitive needs. (pg. 49; Maslow, 1970)

There are also classic studies on the importance of environmental enrichment on the structural development of the brain itself (Diamond et al., 1975; Globus, et al., 1973; Greenough & Volkmar, 1973; Rosenzweig, 1984; Spinelli & Jensen, 1979; Spinelli, Jensen, & DiPrisco, 1980). Even less is known about the aesthetic needs, but Maslow was convinced that some people need to experience, indeed they crave, beauty in their world. Ancient cave drawings have been found that seem to serve no other purpose than being art. The cognitive and aesthetic needs may very well have been fundamental to our evolution as modern humans.

Self-Actualization

Maslow began his studies on self-actualization in order to satisfy his own curiosity about people who seemed to be fulfilling their unique potential as individuals. He did not intend to undertake a formal research project, but he was so impressed by his results that he felt compelled to report his findings. Amongst people he knew personally and public and historical figures, he looked for individuals who appeared to have made full use of their talents, capacities, and potentialities. In other words, "people who have developed or are developing to the full stature of which they are capable" (Maslow, 1970). His list of those who clearly seemed self-actualized included Abraham Lincoln, Thomas Jefferson, Albert Einstein, Eleanor Roosevelt, Jane Addams, William James, Albert Schweitzer, Aldous Huxley, and Baruch Spinoza. His list of individuals who were most-likely self-actualized included Goethe (possibly the great-grandfather of Carl Jung), George Washington, Benjamin Franklin, Harriet Tubman (born into slavery, she became a conductor on the Underground Railroad prior to the Civil War), and George Washington Carver (born into slavery at the end of the Civil War, he became an agricultural chemist and prolific inventor). In addition to the positive attributes listed above, Maslow also considered it very important that there be no evidence of psychopathology in those he chose to study. After comparing the seemingly self-actualized individuals to people who did not seem to have fulfilled their lives, Maslow identified fourteen characteristics of self-actualizing people (Maslow, 1950/1973, 1970), as follows:

More Efficient Perception of Reality and More Comfortable Relations with It: Self-actualizing people have an ability to recognize fakers, those who present a false persona. More than that, however, Maslow believed they could recognize hidden or confused realities in all aspects of life: science, politics, values and ethics, etc. They are not afraid of the unknown or people who are different, they find such differences to be a pleasant challenge. Although a high IQ may be associated with this characteristic, it is not uncommon to find those who are seemingly intelligent yet unable to be creative in their efforts to discover new phenomena. Thus, the perception of reality is not simply the same as being smart.

Acceptance (Self, Others, Nature): Similar to the approach Albert Ellis took with REBT (and his hypothesized dangers inherent

in self-esteem), Maslow believed that self-actualizing people accept themselves as they are, including their faults and the differences between their personal reality and their ideal image of themselves. This is not to say that they are without guilt. They are concerned about personal faults that can be improved, any remaining habits or psychological issues that are unhealthy (e.g., prejudice, jealousy, etc.), and the shortcomings of their community and/or culture.

Spontaneity: The lives of self-actualizing people are marked by simplicity and a natural ease as they pursue their goals. Their outward behavior is relatively spontaneous, and their inner life (thoughts, drives, etc.) is particularly so. In spite of this spontaneity, they are not always unconventional, because they can easily accept the constraints of society and find their own way to fit in without being untrue to their own sense of self.

Problem-Centering: Self-actualizing individuals are highly problem-centered, not ego-centered. The problems they focus on are typically not their own, however. They focus on problems outside themselves, on important causes they would describe as necessary. Solving such problems is taken as their duty or responsibility, rather than as something they want to do for themselves.

The Quality of Detachment; the Need for Privacy: Whereas social withdrawal is often seen as psychologically unhealthy, self-actualizing people enjoy their privacy. They can remain calm as they separate themselves from problematic situations, remaining above the fray. In accordance with this healthy form of detachment, they are active, responsible, self-disciplined individuals in charge of their own lives. Maslow believed that they have more free will than the average person.

Self-actualized individuals need their privacy. This may help them put life in perspective and prepare for each day.

Autonomy, Independence of Culture and Environment: As an extension of the preceding characteristics, self-actualizing individuals are growth-motivated as opposed to being deficiency-motivated. They do not need the presence, companionship, or approval of others. Indeed, they may be hampered by others. The love, honor, esteem, etc., that can be bestowed by others has become less important to someone who is self-actualizing than self-development and inner growth.

Continued Freshness of Appreciation: Self-actualizing people are able to appreciate the wonders, as well as the common aspects, of life again and again. Such feelings may not occur all the time, but they can occur in the most unexpected ways and at unexpected times. Maslow offered a surprising evaluation of the importance of this characteristic of self-actualization:

I have also become convinced that getting used to our blessings is one of the most important nonevil generators of human evil, tragedy, and suffering. What we take for granted we undervalue, and we are therefore too apt to sell a valuable birthright for a mess of pottage, leaving behind regret, remorse, and a lowering of self-esteem. Wives, husbands, children, friends are unfortunately more apt to be loved and appreciated after they have died than while they are still available. Something similar is true for physical health, for political freedoms, for economic well-being; we learn their true value after we have lost them. (pp. 163-164; Maslow, 1970)

The "Mystic Experience" or "Oceanic Feeling;" Peak Experiences: The difference between a **mystic experience** (also known as an **oceanic feeling**) and a **peak experience** is a matter of definition. Mystic experiences are viewed as gifts from God, something reserved for special or deserving (i.e., faithful) servants. Maslow, however, believed that this was a natural occurrence that could happen for anyone, and to some extent probably did. He assigned the psychological term of peak experiences. Such experiences tend to be sudden feelings of limitless horizons opening up to one's vision, simultaneous feelings of great power and great vulnerability, feelings of ecstasy, wonder and awe, a loss of the sense of time and place, and the feeling that something extraordinary and transformative has happened. Self-actualizers who do not typically experience these peaks, the so-called "**non-peakers**," are more likely to become direct agents of social change, the reformers, politicians, crusaders, and so on. The more transcendent "**peakers**," in contrast, become the poets, musicians, philosophers, and theologians.

Maslow devoted a great deal of attention to peak experiences, including their relationship to religion. At the core of religion, according to Maslow, is the private illumination or revelation of spiritual leaders. Such experiences seem to be very similar to peak experiences, and Maslow suggests that throughout history these peak experiences may have been mistaken for revelations from God. In his own studies, Maslow found that people who were spiritual, but not religious (i.e., not hindered by the doctrine of a specific faith or church), actually had more peak experiences than other people. Part of the explanation for this, according to Maslow, is that such people need to be more serious about their ethics, values, and philosophy of life, since their guidance and motivation must come from within. Individuals who seek such an appreciation of life may help themselves to experience an extended form of peak experience that Maslow called the **plateau experience**. Plateau experiences always have both noetic and cognitive elements, whereas peak experiences can be entirely emotional (Maslow, 1964). Put another way, plateau experiences involve serene and contemplative **Being-cognition**, as opposed to the more climactic peak experiences (Maslow, 1971).

Gemeinschaftsgefuhl: A word invented by Alfred Adler, **gemeinschatfsgefuhl** refers to the profound feelings of identification, sympathy, and affection for other people that are common in self-actualization individuals. Although self-actualizers may often feel apart from others, like a stranger in a strange land, becoming upset by the shortcomings of the average person, they nonetheless feel a sense of kinship with others. These feelings lead to a sincere desire to help the human race.

Interpersonal Relations: Maslow believed that self-actualizers have deeper and more profound personal relationships than other people. They tend to be kind to everyone, and are especially fond of children. Maslow described this characteristic as "compassion for all mankind," a perspective that would fit well with Buddhist and Christian philosophies.

The Democratic Character Structure: Self-actualizing people are typically friendly with anyone, regardless of class, race, political beliefs, or education. They can learn from anyone who has something to teach them. They respect all people, simply because they are people. They are not, however, undiscriminating:

The careful distinction must be made between this democratic feeling and a lack of discrimination in taste, of an undiscriminating equalizing of any one human being with any other. These individuals, themselves elite, select for their friends elite, but this is an elite of character, capacity, and talent, rather than of birth, race, blood, name, family, age, youth, fame, or power. (pg. 168; Maslow, 1970)

Discrimination Between Means and Ends, Between Good and Evil: Self-actualizers know the difference between right and wrong. They are ethical, have high moral standards, and they do good things while avoiding doing bad things. They do not experience the average person's confusion or inconsistency in making ethical choices. They tend to focus on ends, rather than means, although they sometimes become absorbed in the means themselves, viewing the process itself as a series of ends.

Philosophical, Unhostile Sense of Humor: The sense of humor shared by self-actualizers is not typical. They do not laugh at hostile, superior, or rebellious humor. They do not tell jokes that make fun of other people. Instead, they poke fun at people in general for being foolish, or trying to claim a place in the universe that is beyond us. Such humor often takes the form of poking fun at oneself, but not in a clown-like way. Although such humor can be found in nearly every aspect of life, to non-self-actualizing people the self-actualizers seem to be somewhat sober and serious.

Creativeness: According to Maslow, self-actualizing people are universally creative. This is not the creativity associated with genius, such as that of Mozart or Thomas Edison, but rather the fresh and naive creativity of an unspoiled child. Maslow believed that this creativity was a natural potential given to all humans at their birth, but that the constraints on behavior inherent in most cultures lead to its suppression.

As desirable as self-actualization may seem, self-actualizing individuals still face problems in their lives. According to Maslow, they are typically not well adjusted. This is because they resist being enculturated. They do not stand out in grossly abnormal ways, but there is a certain inner detachment from the culture in which they live. They are not viewed as rebels in the adolescent sense, though they may be rebels while growing up, but rather they work steadily toward social change and/or the accomplishment of their goals. As a result of their immersion in some personal goal, they may lose interest in or patience with common people and common social practices. Thus, they may seem detached, insulting, absent-minded, or humorless. They can seem boring, stubborn, or irritating, particularly because they are often superficially vain and proud only of their own accomplishments and their own family, friends, and work. According to Maslow, outbursts of temper are not rare. Maslow argued that there are, in fact, people who become saints, movers and shakers, creators, and sages. However, these same people can be irritating, selfish, angry, or depressed. No one is perfect, not even those who are self-actualizing (Maslow, 1950/1973, 1970).

Discussion Question: Consider Maslow's characteristics of self-actualizing people. Which of those characteristics do you think are part of your personality? Are there any characteristics that you think may be particularly difficult for you to achieve?

Obstacles to Self-Actualization

In *The Farther Reaches of Human Nature* (Maslow, 1971), which was completed by Maslow's wife and one of his colleagues shortly after Maslow's death, Maslow described self-actualization as something that one does not obtain or fulfill at a specific point in time. Rather, it is an ongoing process of self-actualizing, characterized for some by brief periods of self-actualization (the peak experiences, for example). Maslow also described two major obstacles to achieving self-actualization: **desacralizing** and the **Jonah complex**. The Jonah complex, a name suggested by Maslow's friend Professor Frank Manuel, refers to being afraid of one's own greatness, or evading one's destiny or calling in life. Maslow specifically described this as a non-Freudian defense mechanism in which a person is as afraid of the best aspects of their psyche as they are afraid of the worst aspects of their psyche (i.e., the socially unacceptable id impulses). He described the process of this fear as a recognition, despite how much we enjoy

the godlike possibilities revealed by our finest accomplishments, of the weakness, awe, and fear we experience when we achieve those accomplishments. According to Maslow, “great emotions after all can in *fact* overwhelm us” (Maslow, 1971). Nonetheless, he encouraged people to strive for greatness, within a reasonable sense of their own limitations.

A very important defense mechanism, which affects young people in particular, is what Maslow called desacralizing. The source of this problem is usually found within the family:

These youngsters mistrust the possibility of values and virtues. They feel themselves swindled or thwarted in their lives. Most of them have, in fact, dopey parents whom they don’t respect very much, parents who are quite confused themselves about values and who, frequently, are simply terrified of their children and never punish them or stop them from doing things that are wrong. So you have a situation where the youngsters simply despise their elders - often for good and sufficient reason. (pg. 49; Maslow, 1971)

As a result, children grow up without respect for their elders, or for anything their elders consider important. The values of the culture itself can be called into question. While such a situation may sometimes be important for changing social conventions that unfairly discriminate against some people, can we really afford to live in a society in which *nothing* is sacred? Indeed, can such a society or culture continue to exist? Thus, Maslow emphasized a need for **resacralizing**. Maslow noted that he had to make up the words desacralizing and resacralizing “because the English language is rotten for good people. It has no decent vocabulary for the virtues” (Maslow, 1971). Resacralizing means being willing to see the sacred, the eternal, the symbolic. As an example, Maslow suggested considering a medical student dissecting a human brain. Would such a student see the brain simply as a biological organ, or would they be awed by it, also seeing the brain as a sacred object, including even its poetic aspects? This concept is particularly important for counselors working with the aged, people approaching the end of their lives, and may be critical for helping them move toward self-actualization. According to Maslow, when someone asks a counselor for help with the self-actualizing process, the counselor had better have an answer for them, “or we’re not doing what it is our job to do” (Maslow, 1971).

Discussion Question: Maslow believed that desacralizing was particularly challenging for young people. Do you think our society has lost its way, have we lost sight of meaningful values? Is nothing sacred anymore? Is there anything that you do in your life to recognize something as sacred in a way that has real meaning for your community?

Maslow had something else interesting to say about self-actualization in *The Farther Reaches of Human Nature*: "What does self-actualization mean in moment-to-moment terms? What does it mean on Tuesday at four o'clock?" (pg. 41). Consequently, he offered a preliminary suggestion for an operational definition of the process by which self-actualization occurs. In other words, what are the behaviors exhibited by people on the path toward fulfilling or achieving the fourteen characteristics of self-actualized people described above? Sadly, this could only remain a preliminary description, i.e., they are "ideas that are in midstream rather than ready for formulation into a final version," because this book was published after Maslow's death (having been put together before his sudden and unexpected heart attack).

What does one do when he self-actualizes? Does he grit his teeth and squeeze? What does self-actualization mean in terms of actual behavior, actual procedure? I shall describe eight ways in which one self-actualizes. (pg. 45; Maslow, 1971)

- They experience full, vivid, and selfless *concentration* and total absorption.
- Within the ongoing process of self-actualization, they make *growth choices* (rather than fear choices; progressive choices rather than regressive choices).
- They are aware that there is a *self* to be actualized.
- When in doubt, they choose to be *honest* rather than dishonest.
- They trust their own *judgment* even if it means being different or unpopular (being courageous is another version of this behavior).
- They put in the effort necessary to improve themselves, working regularly toward *self-development* no matter how arduous or demanding .
- They embrace the occurrence of *peak experiences*, doing what they can to facilitate and enjoy more of them (as opposed to denying these experiences as many people do).
- They identify and *set aside their ego defenses* (they have "the courage to give them up"). Although this requires that they face up to painful experiences, it is more beneficial than the consequences of defenses such as repression.

Being and Transcendence

Maslow had great hope and optimism for the human race. Although self-actualization might seem to be the pinnacle of personal

human achievement, he viewed Humanistic Psychology, or **Third Force Psychology**, as just another step in our progression:

I should say also that I consider Humanistic, Third Force Psychology to be transitional, a preparation for a still "higher" Fourth Psychology, transpersonal, transhuman, centered in the cosmos rather than in human needs and interest, going beyond humanness, identity, self-actualization, and the like...These new developments may very well offer a tangible, usable, effective satisfaction of the "frustrated idealism" of many quietly desperate people, especially young people. These psychologies give promise of developing into the life-philosophy, the religion-surrogate, the value-system, the life-program that these people have been missing. Without the transcendent and the transpersonal, we get sick, violent, and nihilistic, or else hopeless and apathetic. We need something "bigger than we are" to be awed by and to commit ourselves to in a new, naturalistic, empirical, non-churchly sense, perhaps as Thoreau and Whitman, William James and John Dewey did. (pp. iii-iv; Maslow, 1968)

Although Maslow wrote about this need for a **Fourth Force Psychology** in 1968, it was not until the year 1998 that APA President Martin Seligman issued his call for the pursuit of positive psychology as an active force in the field of psychology. Maslow believed that all self-actualizing people were involved in some calling or vocation, a cause outside of themselves, something that fate has called them to and that they love doing. In so doing, they devote themselves to the search for **Being-values** (or B-values; Maslow, 1964, 1967/2008, 1968). The desire to attain self-actualization results in the B-values acting like needs. Since they are higher than the basic needs, Maslow called them **metaneeds**. When individuals are unable to attain these goals, the result can be **metapathology**, a sickness of the soul. Whereas counselors may be able to help the average person with their average problems, metapathologies may require the help of a **metacounselor**, a counselor trained in philosophical and spiritual matters that go far beyond the more instinctoid training of the traditional psychoanalyst (Maslow, 1967/2008). The B-values identified by Maslow (1964) are an interesting blend of the characteristics of self-actualizing individuals and the human needs described by Henry Murray: truth, goodness, beauty, wholeness, dichotomy-transcendence, aliveness, uniqueness, perfection, necessity, completion, justice, order, simplicity, richness, effortlessness, playfulness, self-sufficiency.

Transcendence is typically associated with people who are religious, spiritual, or artistic, but Maslow said that he found transcendent individuals amongst creative people in a wide variety of vocations (including business, managers, educators, and politicians), though there are not many of them in any field. Transcendence, according to Maslow, is the very highest and most holistic level of human consciousness, which involves relating to oneself, to all others, to all species, to nature, and to the cosmos as an end rather than as a means (Maslow, 1971). It is essential that individuals not be reduced to the role they play in relation to others, transcendence can only be found within oneself (Maslow, 1964, 1968). Maslow's idea is certainly not new. Ancient teachings in Yoga tell us that there is a single universal spirit that connects us all, and Buddhists describe this connection as **interbeing**. The Abrahamic religions teach us that the entire universe was created by, and therefore is connected through, one god. It was Maslow's hope that a transcendent Fourth Force in psychology would help all people to become self-actualizing. In Buddhist terms, Maslow was advocating the intentional creation of psychological Bodhisattvas. Perhaps this is what Maslow meant by the term metacounselor.

Connections Across Cultures:

Is Nothing Sacred?

Maslow described some lofty ambitions for humanity in *Toward a Psychology of Being* (1968) and *The Farther Reaches of Human Nature* (1971), as well as some challenges we face along the way. Transcendence, according to Maslow, is a loss of our sense of Self, as we begin to feel an intimate connection with the world around us and all other people. But transcendence is exceedingly difficult when we are hindered by the defense mechanism of desacralization. What exactly does the word "sacred" mean? It is not easily found in psychological works. William James often wrote about spiritual matters, but not about what is or is not sacred. Sigmund Freud mentioned sacred prohibitions in his final book, *Moses and Monotheism* (Freud, 1939/1967), but he felt that anything sacred was simply a cultural adaptation of all children's fear of challenging their father's will (and God was created as a symbol of the mythological father). A dictionary definition of sacred says that it is "connected with God (or the gods) or dedicated to a religious purpose and so deserving veneration." However, there is another definition that does not require a religious context: "regarded with great respect and reverence by a particular religion, group, or

individual" (The Oxford American College Dictionary, 2002). Maslow described desacralization as a rejection of the values and virtues of one's parents. As a result, people grow up without the ability to see anything as sacred, eternal, or symbolic. In other words, they grow up without meaning in their lives.

The process of resacralization, which Maslow considered an essential task of therapists working with clients who seek help in this critical area of their life, requires that we have some concept of what is sacred. So, what is sacred? Many answers can be found, but there does seem to be at least one common thread.

Christians have long believed that forgiveness lies at the heart of faith. Psychologists have recently found that forgiveness may also lie at the heart of emotional and physical well-being.

David Myers & Malcolm Jeeves (2003)

...Compassion is the wish that others be free of suffering. It is by means of compassion that we aspire to attain enlightenment. It is compassion that inspires us to engage in the virtuous practices that lead to Buddhahood. We must therefore devote ourselves to developing compassion.

The Dalai Lama (2001)

I have been engaged in peace work for more than thirty years: combating poverty, ignorance, and disease; going to sea to help rescue boat people; evacuating the wounded from combat zones; resettling refugees; helping hungry children and orphans; opposing wars; producing and disseminating peace literature; training peace and social workers; and rebuilding villages destroyed by bombs. It is because of the practice of meditation - stopping, calming, and looking deeply - that I have been able to nourish and protect the sources of my spiritual energy and continue this work.

Thich Nhat Hanh (1995)

...Our progress is the penetrating of the present moment, living life with our feet on the ground, living in compassionate, active relationship with others, and yet living in the awareness that life has been penetrated by the eternal moment of God and unfolds in the power of that moment.

Fr. Laurence Freeman (1986)

Keep your hands busy with your duties in this world, and your heart busy with God.

Sheikh Muzaffer (cited in Essential Sufism by Fadiman & Frager, 1997)

Forgiveness is a letting go of past suffering and betrayal, a release of the burden of pain and hate that we carry.

Forgiveness honors the heart's greatest dignity. Whenever we are lost, it brings us back to the ground of love.

Jack Kornfield (2002)

And he said to him, "You shall love the Lord your God with all your heart, and with all your soul, and with all your mind. This is the great and first commandment. And a second is like it, You shall love your neighbor as yourself..."

Jesus Christ (The Holy Bible, 1962)

In examining self-actualizing people directly, I find that in all cases, at least in our culture, they are dedicated people, devoted to some task "outside themselves," some vocation, or duty, or beloved job. Generally the devotion and dedication is so marked that one can fairly use the old words vocation, calling, or mission to describe their passionate, selfless, and profound feeling for their "work."

The spiritual life is then part of the human essence. It is a defining-characteristic of human nature, without which human nature is not full human nature. It is part of the Real Self, of one's identity, of one's inner core, of one's specieshood, of full humanness.

Abraham Maslow (1971)

Christians, Buddhists, Muslims, as well as members of other religions and humanists, all have some variation of what has been called *The Golden Rule*: treating others as you would like to be treated. If that is sacred, then even amongst atheists, young people can evaluate the values and virtues of their parents, community, and culture, and then decide whether those values are right or wrong, whether they want to perpetuate an aspect of that society based on their own thoughts and feelings about how they, themselves, may be treated someday by others. This resacralization need not be religious or spiritual, but it commonly is, and some psychologists are comfortable embracing spirituality as such.

Kenneth Pargament and Annette Mahoney (2005) wrote a chapter entitled *Spirituality: Discovering and Conserving the Sacred*, which was included in the *Handbook of Positive Psychology* (Snyder & Lopez, 2005). First, they point out that religion is an undeniable fact in American society. Some 95 percent of Americans believe in God, and 86 percent believe that He can be reached through prayer and that He is important or very important to them. Spirituality, according to Pargament and Mahoney, is the process in which individuals seek both to discover and to conserve that which is sacred. It is interesting to note that Maslow and Rogers consider self-actualization and transcendence to be a process as well, not something that one can get and keep permanently. An important aspect of defining what is sacred is that it is imbued with divinity. God may be seen as manifest in marriage, work can be seen as a vocation to which the person is called, the environment can been seen as God's creation. In each of these situations, and in others, what is viewed as sacred has been sanctified by those who consider it sacred. Unfortunately, this can have negative results as well, such as when the Heaven's Gate cult followed their sanctified leader to their deaths. Thus, spirituality is not necessarily synonymous with a good and healthy lifestyle.

Still, there is research that has shown that couples who sanctify their marriage experience greater marital satisfaction, less marital conflict, and more effective marital problem-solving strategies. Likewise, mothers and fathers who sanctify the role of parenting report less aggression and more consistent discipline in raising their children. For college students, spiritual striving was more highly correlated with well-being than any other form of goal-setting (see Pargament & Mahoney, 2005). So there appear to be real psychological advantages to spiritual pursuits. This may be particularly true during challenging times in our lives:

...there are aspects of our lives that are beyond our control. Birth, developmental transitions, accidents, illnesses, and death are immutable elements of existence. Try as we might to affect these elements, a significant portion of our lives remains beyond our immediate control. In spirituality, however, we can find ways to understand and deal with our fundamental human insufficiency, the fact that there are limits to our control... (pg. 655; Pargament & Mahoney, 2005)

Eupsychian Management and Theory Z

It is not merely a coincidence that Maslow is well-known in the field of business. He spent 3 years as the plant manager for the Maslow Cooperage Corporation, and later he spent a summer studying at an electronics firm in California (Non-Linear Systems, Inc.) at the invitation of the company's president. He became very interested in industrial and managerial psychology, and the journal he kept in California was published as *Eupsychian Management* (Maslow, 1965). **Eupsychia** refers to real possibility and improvability, and a movement toward psychological health, as opposed to the vague fantasies of proposed Utopian societies. More precisely, though this is something of a fantasy itself, Maslow described Eupsychia as the culture that would arise if 1,000 self-actualizing people were allowed to live their own lives on a sheltered island somewhere. Maslow applied his psychological theories, including both the hierarchy of needs and self-actualization, to a management style that takes advantage of this knowledge to maximize the potential of the employees in a company (also see the collection of Maslow's unpublished papers by Hoffman, 1996).

Maslow introduced a variety of terms related to his theories on management, one of the most interesting being **synergy**. Having borrowed the term from Ruth Benedict, synergy refers to a situation in which a person pursuing their own, selfish goals is automatically helping others, and a person unselfishly helping others is, at the same time, helping themselves. According to Maslow, when selfishness and unselfishness are mutually exclusive, it is a sign of mild psychopathology. Self-actualizing individuals are above the distinction between selfishness and unselfishness; they enjoy seeing others experience pleasure. Maslow offered the personal example of feeding strawberries to his little daughter. As the child smacked her lips and thoroughly loved the strawberries, an experience that thrilled Maslow, what was he actually giving up by letting her eat the strawberries instead of eating them himself? In his experience with the Blackfoot tribe, a member named Teddy was able to buy a car. He was the only one who had one, but tradition allowed anyone in the tribe to borrow it. Teddy used his car no more often than anyone else, but he had to pay the bills, including the gas bill. And yet, everyone in the tribe was so proud of him that he was greatly admired and they elected him chief. So, he benefited in other ways by following tradition and letting everyone use his car (Maslow, 1965). In the business field, when managers encourage cooperation and communication, everyone benefits from the healthy growth and continuous improvement of the company. And this leads us to **Theory Z** (which is Eupsychian management).

Douglas McGregor, a professor of industrial relations at the Massachusetts Institute of Technology, was greatly impressed with Maslow's work, and McGregor had used *Motivation and Personality* as a textbook in his business classes. Based on Maslow's theories, McGregor published a book in 1960 in which he outlined two managerial models, **Theory X** and **Theory Y** (Gabor, 2000; Hoffman, 1996). Maslow described the two theories as follows:

...To put it succinctly, *Theory Y* assumes that if you give people responsibilities and freedom, then they will like to work and will do a better job. Theory Y also assumes that workers basically like excellence, efficiency, perfection, and the like.

Theory X, which still dominates most of the world's workplace, has a contrasting view. It assumes that people are basically stupid, lazy, hurtful, and untrustworthy and, therefore, that you have got to check everything constantly because workers will steal you blind if you don't. (pg. 187; Maslow, 1996a)

The Theory X/Theory Y strategy was intentionally put into practice at Non-Linear Systems, hence Maslow's invitation to study there. Maslow concluded, however, that even Theory Y did not go far enough in maximizing people's potential. People have metaneeds(the need for B-values), needs that go beyond simply offering higher salaries. When employees have their basic needs met, but recognize inefficiency and mismanagement in the company, they will still complain, but these higher level complaints can now be described as **metagrumbles** (as opposed to the lower level grumbles about lower level needs). Theory Z attempts to transcend Theory Y and actively facilitate the growth of a company's employees toward self-actualization (Hoffman, 1996; Maslow, 1971; Maslow 1996b).

Discussion Question: How's your job (or any job you have had)? Would you describe your supervisor or boss as someone who uses Eupsychian or Theory Z management? Does the workplace foster synergy amongst the employees? If not, can you imagine how the job would be different if they did?

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5: CHAPTER 5

5.1: Social Work Practice Settings
5.2: Prevention and Promotion

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5.1: Social Work Practice Settings

Social Work practice begins with the purpose of the social worker. Understanding of the social work profession starts with an intense appreciation of the person in which the social worker serves (Sheafor & Horejsi, 2008). The social worker understands that humans are social beings, these social creature's growth and development need the guidance of nurturing and protection provided by others around them. It's this inter-connectedness and interdependence of people in the social environment that is the foundation of practice in social work as a profession. The environment a person lives in has a lot to do with how a social worker may apply knowledge and guidance. There are two distinct types of social work practice that are used according to the type of setting.



Social work practice setting

Direct Practice

Direct practice is when the social worker works directly with an individual, family, or group of people. The first direct meeting can occur in a variety of ways such as a crisis, voluntary, or involuntary. The first meeting is a critical point in establishing a good helping relationship. A social worker should prepare for any type of first contact, so that they may set up the best relationship possible with the client (Sheafor & Horejsi, 2008).



Advocacy day

At the BSW level, direct practice is primarily done as a case worker. The case worker may met with the individual daily, weekly, or monthly depending on the type of work. For example, in short term crisis work, the person may have daily meetings. For adults with intellectual disabilities, a monthly check in may be more appropriate and required by the supervising agency. Direct practice is typically done as a worker at an agency, non- profit, or government setting. A direct case worker may be involved in many different areas of practice, including but not limited to working in adoption, Child Protective Services, in a group home for individuals with brain injuries, a shelter for abuse survivors, or with Community Mental Health. The caseworker may be involved in finding resources or providing support for the client. Meetings may take place at an agency or in the client's home.

At the MSW level, direct practice is usually done in the role of the therapist or counselor. Therapists generally see their clients on a weekly basis, although this time frame may vary. Therapists often work at the same agencies as BSW level caseworkers, but in a different role. While the BSW worker is involved with taking care of the many logistical issues a client may have (housing, food, etc.), the MSW worker is usually assisting the client with skill building, learning coping strategies, and focusing on their overall mental health treatment. Sessions may take place at an agency or in the client's home.

Indirect Practice

Indirect practice is generally when the social worker is involved in activities that consist with facilitating change through programs and policies. This type of practice is more of behind the scenes and is aimed to help prevent problems from developing. Also, the social worker may participate in this type of practice by advocating through agency administrators, legislators, or other powerful people to effect a change (Sheafor & Horejsi, 2008). You may also hear the term *Macrosystem practice,* which means systems larger than a small group or single person (Zastrow & Kirst-Ashman, 2010). Micro systems are continuously affected by the Macro systems. The two major Macro systems that impact individuals the most are communities and organizations.

Community is defined by Merriam-Webster a unified body of individuals: such as a state or common wealth; the people with common interests living in an area geographically. Community can also me the individuals are connected in other ways, such as an activity, job or an identifying ethnic trait (Zastrow & Kirst-Ashman, 2010). *Community Theory,* is a theoretical frame work adopted when working within a community. Community Theory consists of two components; the nature of the community such as perspectives which may include how it is defined. The second component is how social workers practice in the community (Zastrow & Kirst-Ashman, 2010).

An organization is defined by Merriam-Webster as an administrative and functional structure; this is a group of individuals that come together to work towards a common goal (as cited in Zastrow & Kirst-Ashman, 2010). Each of the individuals involved in the organization preform specific duties.

Collaboration with agencies are a vital part of indirect practice. The social (Zastrow & Kirst-Ashman, 2010) worker can help facilitate change by reaching out to other agencies that can assist in meeting other needs of the client.

According to an article written by Johnson (1999), Indirect social practice has often referred to environmental intervention in the client's networks or social aspect. The belief was to help alleviate challenges in the client's surroundings. There are two elements associated with indirect practice. The first one is called concrete assistance, this is resources available to the client to help with basic needs. For example, food assistance programs are the most common resource needed for clients. The second element to indirect social work practice is sociopsychological intervention. Which is the adjustment of attitude or behavior of significant people with in the client's social environment (Johnson, 1999).

Human behavior occurs within a community, it is ever present and continuous. Individuals develop through the interactions with others. Behavior is ever dependent on others in the environment, as well as the individual client's behavior affecting those they interact making behavior interdependent (Zastrow & Kirst-Ashman, 2010). The term community can mean so many various things. As a social worker, one must figure out in what context the clients community affects them. What makes up that person's community? Do all the community members suffer the same common problems? Due to the broad nature of the meaning Community, we can break it down in three categories; A designated group of people; this group has something in common; and we know that because of a commonality the individuals in the community, they interact in some way or possibly will in the future (Zastrow & Kirst-Ashman, 2010).



Rural environment

Rural Communities

Agreement among scholars have lead the social work profession to use a more generalist approach in small towns. The generalist approach allows the social worker to gain skills for working with individuals, families, small groups, organizations and communities. The rationale for this type of practice is solely based on the structural normality's in the majority of rural areas. These areas are usually characterized by a lack of formal resources which includes the services of private social entities. The Social workers that serve in these areas often work in the public service. They are asked to perform in a range of problems that are presented by those they serve.

There is no set-definition of what defines a rural community, but as such can be understood as those non-metropolitan areas, including surrounding towns with a reduced population that have limited to no access to social services (Lohmann, 2012). It is important to note that despite the stereotype that all rural areas are the same, the reality is that all rural areas differ from one to the next based on socioeconomics, climate, surrounding culture, present ethnicities, and religious structures to name just a few. With this in mind, the rural social worker must be able to work positively within this communities, and take into consideration the differences that exist within them. These areas are usually characterized by a lack of formal resources which includes the services of private social entities. The Social workers that serve in these areas often work in the public service.

Such limited resources in consideration include available locations, trained and licensed individuals, and monetary founds. Thus, as Lohmann (2011) describes, social workers must play multiple roles, from community organizers to caseworkers. As such, these roles are valued for their creativity in how treatment occurs, and how flexible the social worker is with switching between the

individual and the community. Limited resources also mean that rural social workers often practice in isolation, without direct supervision and with difficulty accessing continuing educational materials. As such, it is important that these workers seek additional opportunities to expand their professional development and continue advocating for best practices.

Agreement among scholars have lead the social work profession to use a more generalist approach in small towns (Lohmann, 2012; Waltman, 2013). The generalist approach allows the social worker to gain skills for working with individuals, families, small groups, organizations, and communities. The rationale for generalist practice refers to the limited social resources available for rural communities that must be substituted by Social Workers. As such, the generalist approach is best used in rural settings, as it allows the social worker to take on multiple roles that the community needs.

One notable complication with rural communities is the potential of dual relationships between the Social Worker and their clientele. These relationships refer to the proximity of Social Workers living and working in the same environment, where clients may be neighbors or members of similar social groups. Pugh (2007) discusses that these situations present ethical problems, such as maintaining a professional appearance by avoiding invitations for conversations, but ultimately that the social workers role is defined by how they conduct themselves in the community. Additionally, Humble, Lewis, Scott, and Herzog (2013) describe the potential for professional fatigue when the social work is always “on duty”. Despite the additional transparency, rural social workers must balance their professional and private lives in order to work effectively in these areas.



Urban environment

Urban Communities

In contrast to rural communities, urban communities are those settings involving metropolitan areas with an increase in population density, a decrease in general size, and an increase in access to social services for its population. The rise of industrialization has led to a migration from rural communities to urban ones, resulting in a population shift between the two areas where urban areas hold the majority of the population. This, in term, leads to an increase in problems, such as differences in socioeconomic status, an increase in migrant and immigrant populations, higher crime rates, and differences in health outcomes of residents.

Social workers in urban environments will find considerable job opportunities in both the public and the private sectors. Publicly, Social Workers may find jobs with Community Mental Health programs, alliances that work with veteran or homeless populations, and with educational settings to name a few. Privately, Social Workers may find opportunities for clinical care roles and job specialties, such as working with victims of sexual assault. What urban environments offer is the ability for the social work individual to focus on what area, while allowing referrals to other qualified individuals.

Unlike rural environments, urban environments allow for a range of continual educational options, including seminars at meeting halls or college campuses, specialized opportunities for trainings in issues such as a trauma, and the ability for social workers to gather in conferences. This, in turn, allows social workers to have outside supervision, as well as an increase in communication

across the profession.

Despite the advantages urban environments offer in terms of networking and job opportunities, it is important to remember that there are setbacks. As mentioned, with an increase in population comes a rise in disparities between socioeconomic status. One of the larger issues faced by clients is the level of healthcare coverage that they can afford. This often entails poor healthcare outcomes, and a decrease in mental health care. Social Workers in these environments will often work with the economically disadvantaged, and must understand the cultural variations that exist in the area they work. Additionally, it is imperative that Social Workers understand the local resources available to their clients, such as transportation and food services, and be able to help their clients with these issues.

Social Work Job Opportunities

BSW- Bachelors of Social Work: this is considered an Undergraduate degree and is an employable degree once you gain your Limited License. If you choose not to move on to a Graduate degree you will need to take the state licensing exam to practice a career in what you have learned. Your employment at the BSW level will generally be related to casework. Many individuals work with just their BSW for their entire lives. If you enjoy casework, it is not necessary to obtain your MSW degree. There are many positions available for BSW level workers.

MSW- Masters of Social Work: this is considered a graduate degree and is employable with a Limited License. If you choose to stay with your MSW you can take the licensing exam in the state you are choosing to practice in and follow your state's guidelines for licensure and procure a clinical or macro licensure. After two years of practicing with your Limited License, you will be eligible for a full license. With this license you can practice independently without the supervision of a another fully licensed social worker.

Upon completion of your set professional education track, it is time to search for career opportunities. The search can be very overwhelming, even the thought of starting the process can be quite intimidating. Do not fear the search, with today's technology there are many ways one can look for career starting jobs. One of the most common is to strike out on the internet. There are many sites to type in key words for the type of job you are looking for. For example, www.indeed.com and www.monster.com are amongst the most popular when aiming to post a resume for a position. Another great way to find an opportunity is to search the webpages of agencies around the community in which you are searching. Agencies typically have a section for employment opportunities they have available. If you are searching for a position in your home states public sector, you can go to the state website and find out how to apply for those. Volunteering at an agency where you may be interested in employment is also another opportunity to learn about future job possibilities.

When you locate a position, it is time to apply. The application usually has two parts: the cover letter and the professional resume. The **cover letter** is a letter that pertains to the reason why you are interested in that position. In the letter, you explain why you are qualified for the position. It should be no more than a page in length, and carefully written with no spelling, grammar or punctuation errors. The cover letter along with the resume should indicate the application for a position. The letter is not the place to discuss salary, or reasons for leaving a past job. The cover letter should be written in a positive and cheerful fashion.

Sample Cover Letter

John Doe , MSW Graduate

Street address city, State zip Phone and email address

Date Written

Agency Name

Agency address

To Whom It May Concern:

I am extremely excited and interested in the Prevention Coordinator position for CMH. My experience working with clients as well as extended education has equipped me with a multitude of professional skills.

> Throughout my career I have demonstrated excellent interpersonal skills such as compassion and understanding. When I saw that CMH was accepting resumes for a Prevention Coordinator, I immediately knew it would be a good fit for me. I am highly interested in helping individuals succeed. I am socially perceptive and able to demonstrate a caring and compassionate approach to people's needs. I am also proficient at communicating with staff and clients, organizing and filing paper work as well as using multiple databases that will go along with the cases presented in this field. Not only do I have a great attitude, I am very detail orientated and I am also very motivated to do anything that is necessary to improve the clients' well-being. I would prove to be an exceptional asset to your staff, and most importantly to the Team.
>
> My interest has recently been in developing my knowledge in Mental Health and Trauma, in which I can assist those in need. I have a yearning to empower people so that they can lead better lives. Due to my knowledge and experience with serving clients, I know that I have the talent and knowledge necessary to succeed and enhance the staff in your agency. Thank you for considering me; I welcome the opportunity to introduce myself to your agency in person to discuss this collaboration.
>
> Sincerely,
>
> John Doe

The second aspect to the application process is the **professional resume.** The resume is more nonspecific than the cover letter and can be applied to several positions with minor updates. The organization consists of a summary of your professional credentials. The purpose is to showcase the applicant's abilities to the employer, in hope that he/she may consider the applicant for an interview. When creating a resume` there is no standard format, rather use a creative approach to gain the attention of the screening committee. Although you should avoid being adorable or cunning.

A resume should at least include the following information; other credentials may be added at the applicant's discretion:

- **Personal data**. Include your name, street address, email address and phone number where you can be easily reached so you can discuss interview details.
- **Education**. List the name of your degree(s), your major, the name of the colleges or universities you have attended and the graduation dates. Also list all the schools that you have attended (list in reverse order). Also denote any special classes or projects you were included in such as honors or special training you may have had.
- **Experience**. List employment starting with your most current employer and jobs previous. Give the job title, name of agency, dates of employment and job duties. It is also helpful to employers for you to add any volunteer experience that has contributed to your skill base.
- **Activities and interests**. Denote your professional interests as well as those that go beyond social work. This may include memberships in professional organizations, your participation in clubs, offices or special interests.
- **References**. If the job opening is asking specifically for references they should be listed on the cover letter or on a page after the resume`. The references you select to use, should be able to speak on your skills as they pertain to the position. Make sure to include the phone and email address of the people you have selected for references so that the employer can contact them.
- **Other information**. You may want to add other information such as publications, travel experiences, and unique experiences that have impacted your skill level.

For examples of social work resumes, check out websites like resumezpras.tk/social-work-resume.html# or Google "social work resume example".

Upon a successful application process, you may hear back from the agency by receiving an invitation to interview. The interview typically will consist of a panel or committee of employees. The panel will ask you varied questions based on the type of position you are applying for, this may include scenarios of real possibilities on the field. To prepare for this interview, you will want to research the agency's mission and vision statements, the type of population they serve. You can achieve this knowledge by going to the agency's webpage, talking to employees, or stopping by the agency to pick up brochures on services. Finally, be prepared for inquiries about your personal and professional interests as well as your skills for specific job duties.

Licensure

Now that you are more familiar with the job processes let's move on to a vital part of working in the field, licensure. It is important to keep in mind that all states and countries are different with regulations regarding licensure for practice. The same goes for BSW and MSW criteria for licensure. The examples I am going to use is for the state of Michigan; these are the regulations that I am more familiar with, please make sure to review the laws in your area for licensure to practice.

The Michigan Board of Social Workers was created under Article 16 of Public Act 299 of 1980, as amended, the Occupational Code, to register social workers in Michigan. Public Act 11 of 2000 transferred the Board of Social Work, and its authority, to the Public Health Code, Public Act 368 of 1978, as amended.

Social Work is defined as the professional application of social work values, principles, and techniques to counseling or to helping an individual, family, group, or community to enhance or restore the capacity for social functioning and/or provide, obtain, or improve tangible social and health services.

The Public Health Code mandates certain responsibilities and duties for a health professional licensing board. Underlying all duties is the responsibility of the board to promote and protect the public's health, safety, and welfare. The Board implements this responsibility by ascertaining minimal entry level competency of health practitioners. The Board also has the obligation to take disciplinary action against licensees and registrants who have adversely affected the public's health, safety, and welfare. Chapter One also includes information on obtaining your license for social work practice.

What is it like to be a social worker?

Life as a social worker is never boring. One of the wonderful things about social work is that there is such a wide variety of employment possibilities. If you do not enjoy one area of social work, there is probably another area that you will enjoy. There are jobs in casework, therapy, administration, supervision, advocacy, community work, education, and other areas. Over time, many social workers move between these positions as their interests and skills levels change.

To read more about what it may be like to be a social worker, read the interview with Professor Gladden below.

Interview

Interviewer: How lead you to become a social worker?

Dr. Gladden: When I was in my undergraduate program, I worked at Degage Ministries in Grand Rapids with homeless individuals. I didn't expect to love the work as much as I did! I decided social work wa the field I should be in and went straight into my MSW degree when I finished my BA.

I: What kinds of social work have you done?

Dr. G: I have done so many different kinds of work in the last 15 years! I started as a therapist for teens and adults who were survivors of domestic violence and sexual abuse. After that I worked with kids with autism, in therapeutic foster care, doing crisis work with adults and kids, and running a group home for adults with mental illness. One of my favorite positions was running and working on an Assertive Community Treatment (ACT) team. The ACT program works in depth with adults with severe mental illness diagnoses such as schizophrenia and Bipolar I disorders. There are therapists, caseworkers, nurses, and psychiatrists all working as a team to keep the adult safely in the community instead of in the hospital or an institution. I founded and ran a non- profit organization to support refugees in the Grand Rapids community. I have also been a social work professor for 10 years now, working to train new social workers!

I: What is a typical day for you as a social worker?

Dr. G: There is no such thing as a typical day, which is one of the things I love about social work! I've had positions where clients came to me in the office, so that was somewhat consistent, although there were always surprises such as a crisis client coming in. When running the crisis lines and working with the refugees, I would often spend part of the day in the office and part of the day driving out to see clients. Now I spend some days teaching classes, others seeing clients, and some doing paperwork for part of the day while doing all the other activities.

I: What is your favorite thing about social work?

Dr. G: I love the feeling of making a difference in someone's life. There are many clients and students that you will work with that you have no idea what happened to them. Maybe they stopped coming in for therapy sessions without warning, or maybe the student graduates and you never even know if they are working in the social work field. But there are some that you do know about. I had a client who was a survivor of sexual abuse and sexual assault that I worked with for about a year and a

half. At the end of our sessions, she wrote me a letter. In that letter, she said that I had saved her life. That may be overly dramatic, as I literally did not save her life, but that meant that to her, I made a difference. Those are the clients that keep you going.

I: What do you think makes social work unique?

Dr. G: I think social work's perspective of the person in the environment is key. Many professions look at one part of the individual, but social work looks at everything. We look at the client's mental status, where they live, where they work, what supports they have, what skills or strengths they have, and so much more! As social workers we need to know about more than just the person. We need to know community resources. We need to know about fields as varied as economics and neuroscience. And we need to have the ability to relate to the individual. Research has shown that it is not the method that we use that makes a difference, but the relationship. We need to be able to have those helping, supportive relationships with our clients. That is also what makes social work fun!

I: What advice would you give to new social workers or social work students?

Dr. G: Take care of yourself first. You need to know yourself, your beliefs, and what makes you feel safe and fuels your passions. Have outside interests and people to give you support. You can't be there for your clients unless you take care of yourself first.

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5.2: Prevention and Promotion

Learning Objectives

- Understand historical perspectives on prevention and promotion
- Define the different types of prevention
- Identify examples of risk and protective factors
- Describe various aspects of prevention programs and evaluation



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Community Psychology is the focus on **prevention** of problems and wellness promotion, as discussed in Chapter 1 (Jason, Glantsman, O'Brien, & Ramian, 2019). This occurs through addressing individual-level competencies within a community and also through working to change systems and contexts. As highlighted in Chapter 1, prevention serves as an exemplary framework for Community Psychology research and also an innovative way to approach real-world problems. The core belief is that taking action early on can prevent more serious problems from developing in the future. Case Study 12.1 profiles Head Start, an early childhood prevention program for kids aimed to reduce the negative effects of poverty. The case study highlights the way the political and social forces of the time shaped the development of Head Start. This program represents a pivotal tale in the history of prevention, serving as an example of many of the key concepts detailed throughout this chapter.

Case Study 12.1
The Head Start Model



"kindergarten is fun" by woodleywonderworks is licensed under CC BY 2.0

Head Start, an early childhood education program for children experiencing poverty and related stressors, was first established in 1965. Head Start was created in response to President Lyndon B. Johnson's famous State of the Union address in 1964 where he called for an "unconditional war on poverty" (Watch the speech here). Programs from this era reflected efforts to improve social conditions and prevent the negative outcomes associated with poverty.

The Head Start Advantage for a closer look). Head Start involvement has resulted in improved language development, learning/pre-academics, and social-emotional skills of children by the time of kindergarten entry (U.S. Department of Health and Human Services Administration for Children and Families, 2010).

Interactive and detailed timeline. Head Start (and Early Head Start) programs currently serve children from birth to 5 years of age. According to the Office of Head Start, there are Head Start programs across all 50 states and several US territories.

Historical Perspectives



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The concept of prevention comes from the field of public health. This is very different from the **medical model**, which refers to the framework of treating social problems in the same manner that we treat illness. Community psychologists have long been critical of the medical model, given its shortcomings in locating social problems in the individual, which are often rooted in systematic inequalities. This talk describes key distinctions between the medical model and community-based **advocacy** to address female juvenile delinquency.

Incidence refers to the number of new cases during a specified period of time (e.g., the annual rate of new cases of depression among women, the annual rate of new individuals who experience homelessness). **Prevalence** is the total number of cases in a population (e.g., the total number of women in the population with depression, the total number of people in the population who are homeless in a particular country). Understanding the incidence and prevalence of a social problem is a critical first step to developing a prevention focus.



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prevention, rather than *treatment,* of individual disease (medical model). As seen in President Johnson's speech, a focus on prevention was in the spirit of the times. During this point in history, there was a concentrated focus on social inequality and civil rights, the prevention of mental health disorders, and the establishment of innovative prevention programming in the community (e.g., Head Start). This time was not without debates about where to focus resources and how to define social problems. For example, Albee (1983) argued forcefully against the medical model for treating mental illness. That is, no mass disorder that affects large amounts of individuals (e.g., poverty, mental illness, homelessness) has ever been eradicated by providing treatment to each person affected by the problem. Nor is it feasible to train enough professionals (e.g., clinical psychologists) to end a problem (e.g., mental illness) that has roots in deeper social problems such as poverty and **oppression**. Prevention efforts require an ideology aligned with social change, education, and primary prevention (Albee, 1983).



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Preventive Psychology: Theory, Research and Practice.

Types of Prevention



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In the wake of these debates, an abundance of programming and **empirical research** surfaced. This included research on preventive interventions to reduce mental illness and social problems such as crime and homelessness. The findings from these studies demonstrated that taking a prevention focus is effective (e.g., see Durlak & Wells' 1997 meta-analysis on this topic).

Primary Prevention

Interventions designed to prevent the onset or future incidence of a specific problem

Secondary Prevention

An early intervention that decreases the prevalence of a specific problem

Tertiary Prevention

Treatment designed to improve quality of life and reduce the symptoms after a disease or disorder has developed
Does not reduce incidence or prevalence

"Types of Prevention" by Valerie Anderson, Samanta Boddapati, and Symone Pate.

Primary prevention includes efforts to stop the problem from beginning in the first place. For example, Durlak and Wells (1997), in a **meta-analysis**, analyzed mental health treatment studies and outcomes from prevention interventions with another area of focus: drug use, physical health, academic achievement. They identified that specific high-quality programs can prevent multiple problems across different areas. This research specified how important it is for collaboration to occur among prevention scientists across disciplines. Collaboration and **interdisciplinary** work are other key focus areas of Community Psychology. Collaboration can maximize prevention efficiency and help researchers and practitioners understand the short-term and long-term effects of preventive interventions. The other important finding from this study was that positive mental health outcomes could be achieved through interventions targeting other aspects of human development and functioning. For example, (1) successful education

programming can reduce future drug use and (2) programs promoting positive physical health can boost academic achievement.

Secondary prevention includes interventions that detect a disease early and prevent it from getting worse. In another meta-analysis, Durlak and Wells (1998) evaluated outcomes of 130 secondary prevention mental health programs for children and adolescents. They found that secondary prevention produces positive effects on young people receiving treatment for mental health through significantly reducing problem behavior, increasing youth competencies, and improving social and emotional adjustment. This work was groundbreaking in that it highlighted how preventive interventions can be *just as effective* as providing individualized psychotherapy for children and adolescents and *more effective* than reactive approaches to preventing problem behavior such as smoking, alcohol use, and delinquency. One case study example of secondary prevention is sexual assault prevention on college campuses. The Rape, Abuse, and Incest National Network states that college-age women have a high likelihood of experiencing sexual assault. Secondary prevention efforts to reduce sexual assault on college campuses may include self-defense, bystander intervention training, sex education regarding consent, resource education, and increasing sexual assault survivor visibility. The Centers for Disease Control and the American Psychological Association have both published recommendations to reduce sexual violence and make college campuses safer. A life transition can be stressful, such as entering school, graduating from school or getting married, and these are excellent times for implementing secondary preventive interventions. The following Case Study 12. 2 illustrates one such program from youth transferring into a new school when some children are at high risk for developing academic and social problems.

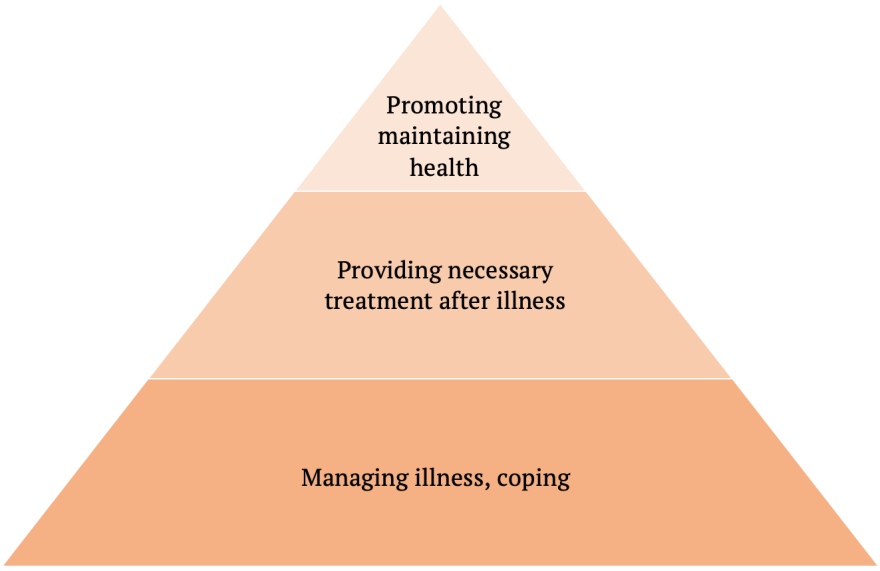
Case Study 12.2
At-Risk Youth Transferring Into a New School



"centennial elementary school 41" by Pasco County Schools is licensed under CC BY-NC 2.0

Tertiary prevention treats disease or social problems with the goal to improve quality of life and reduce symptoms of the problem after it has developed. Tertiary prevention differs from primary and secondary prevention in that it does not focus on reducing the incidence or prevalence of a disease or social problems, but rather on treating the problem once it arises. For example, as depicted in the video "An Ounce of Prevention," parenting programs that increase key parenting characteristics, such as parental warmth, and support parents' abilities to manage disruptive behaviors during early childhood, can prevent child maltreatment and future behavioral concerns in children. The video specifically describes the impact of such a tertiary prevention effort for a Mexican immigrant family facing several risks that may place children at greater risk for maltreatment and future behavioral distress, including underlying medical factors and poverty. These programs can be delivered to families on an individual or group basis (e.g., Incredible Years®, Triple P – Positive Parenting Program®) in the community.

The Ounce of Prevention video further depicts four prevention and promotion programs for young children, middle school adolescents, unemployed adults, and elderly people. These programs highlight each of the different types of prevention discussed above and why these programs are advantageous for their respective populations. The video includes interviews of the **participants** and program developers, footage of program activities, and a discussion of program outcomes. Indeed, an ounce of prevention can reduce a host of problematic behaviors and outcomes later in life.



The Institute of Medicine's Prevention Efforts by Valerie Anderson, Samanta Boddapati, and Symone Pate

Indicated prevention refers to programming that targets people who have detectable early signs of maladjustment that foreshadow social, physical, or mental health problems. For example, the field of pediatrics has increased attention to decreasing the prevalence of childhood obesity in order to prevent adult obesity. Goldschmidt et al. (2013) specifically describe an indicated prevention approach that employed an intensive family-based treatment that included a combination of dieting, exercise, and behavioral (e.g., self-monitoring, parent skill training) strategies that targeted 669 obese and overweight youth across three cities in the US. Researchers measured the change in weight that was necessary to alter the status of overweight or obese youth to non-overweight. Results showed that despite some differences by age and initial weight classification, even a small decrease in weight was enough to move children into the non-overweight status after one year. Specifically, this underscores that preventive efforts during childhood may need only a small investment of resources to produce important changes. Another example of indicated prevention programs targeting substance use among youth can be found here.

Selective prevention involves programming that targets individuals who do not show any indication of the problem, but are at high risk for the development of the problem. For example, Head Start can be considered a type of selective prevention because many programs aim to provide comprehensive supports (e.g., schooling, family-based interventions) to children experiencing specific risk factors that place children at risk for later academic and social-emotional difficulties, such as poverty or developmental delays.

Universal prevention, which is similar to primary prevention, targets all of the people in a given population. School-based universal prevention programs that target behavioral and social-emotional functioning at the school or class-wide level are an example of a universal prevention approach to increasing access to services. These programs are a direct response to literature which indicated that the unmet behavioral and mental health needs of school-aged children increase the risk for longer-term declines in mental health, academic, and social functioning (Costello, Egger, & Angold, 2005; Nastasi, 2004). One such prevention approach to population health that has demonstrated immediate and long-term behavioral, academic, and societal benefits, the PAX Good Behavior Game, is described in Case Study 12.3.

Case Study 12.3
The PAX Good Behavior Game®



PAX Good Behavior Game Image by PAXIS Institute

The PAX Good Behavior Game® is a set of universal prevention strategies, rooted in decades of behavioral science that are implemented by classroom teachers in schools. PAX GBG aims to create a positive, safe, and nurturing classroom environment for learning and pro-social interactions. This nurturing environment enhances children's behavioral skills, such as self-regulation and co-regulation with other classmates, and can improve learning outcomes in children. PAX is an example of universal prevention because it targets and benefits *all* students in a classroom or school, including the students who are exhibiting signs of behavioral and/or learning concerns as well as those who are not exhibiting these concerns. Click here to learn more about the good behavior game and watch Dr. Dennis Embry, president and senior scientist at PAXIS Institute talk about PAX.

In addition to immediate changes in the classroom, such as fewer instances of discipline referrals, studies have shown that children who were in PAX GBG classrooms during elementary school were less likely to use tobacco and other substances and more likely to experience better behavior and mental health in high school and young adulthood (e.g., Storr et al., 2002; Wilcox et al., 2008). Learn more about some of the short and long-term benefits of PAX GBG here.

** PAX Good Behavior Game images reproduced with permission from PAXIS Institute*

Which Classrooms Do You Want Your Kids or Grandkids?

Benefits of PAX GBG compared to control classrooms in the same schools when the students were in their early 20's after 1-2 years of expsure to PAX GBG in 1st or 1st and 2nd grade.

Relative Difference = (GBG/Control)-1

Increased Outcomes	Student Groups	Control Classrooms	PAX GBG Classrooms	Relative Benefit	PAX GBG Benefits
High school graduation	All girls	58.6%	73.6%	+125.5%	Increase
	All boys	44.8%	53.3%	+118.9%	Increase
College attendance	All girls	26.4%	40.3%	+152.6%	Increase
	All boys	12.8%	26.6%	+207.8%	Increase
Decreased Outcomes	**Student Groups**	**Control Classrooms**	**PAX GBG Classrooms**	**Relative Benefit**	**PAX GBG Benefits**
Any special education services	All girls	26.2%	19.5%	-25.5%	Reduction
	All boys	43.2%	24.6%	-56.9%	Reduction
Regular smoking	All boys	19%	6%	-68.4%	Reduction
	Aggressive boys	83%	29%	-65.0%	Reduction
Alcohol abuse	All boys & girls	20%	13%	-35%	Reduction
Heroin, crack cocaine use	All boys & girls	7.3%	2.6%	-64%	Reduction
Any drug abuse disorder	All boys	38%	19%	-50%	Reduction
Anti-social personality disorder	Hi-aggressive boys	100%	40%	-60%	Reduction
Violent & criminal behavior & ASPD	Hi-aggressive boys	50%	34%	-32%	Reduction
Any services for behavioral, emotional, drug or alcohol problems	All boys	42%	25%	-40.4%	Reduction
Suicidal thoughts	Boys & Girls	12%	7.1%	-51.3%	Reduction

Promotion



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Related to the key concept of primary prevention is **promotion**. Promotion involves empowering individuals to increase control of their health and well-being through literacy and programming. Community psychologists identified that the goal of preventing problems can be done through promoting well-being. Generally, there are two approaches to promotion. The first is through reducing the chances that the problem will arise. The second is through increasing skills, strengths, and competencies of individuals and settings to reduce the risk for problems arising. Cost-benefit analyses of promotion have shown that efforts that focus on health promotion are very cost-effective compared to reactive or treatment-oriented approaches (Durlak & Wells, 1997). Community psychologists argue that promotion must also take into consideration *ecological approaches* to improving the human condition. That is, those who are interested in preventing social problems and promoting human competencies and well-being must call attention to the relationship between broader social forces and rates of disease and social distress seen in communities (Albee, 1983). For example, Case Study 12.4 describes a community-based advocacy program developed by community psychologists to promote well-being among girls in the juvenile justice system.

Case Study 12.4
Resilience, Opportunity, Safety, Education, Strength (ROSES)



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ROSES.

Risk and Protective Factors



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Another key concept is the role of risk and protective factors. **Risk factors** are variables that are related to an increased risk for developing a disease or problem. While the term comes from a public health perspective, community psychologists use risk factors to understand factors associated with increased risk for various social problems such as homelessness, juvenile delinquency, or gender-based violence. For example, Figure 3 below depicts some of the most common risk factors, especially among children and adolescents, which prevention programs need to consider in reducing the development of social problems. Case Study 12.5 provides a specific example of risk factors for human trafficking, a pervasive problem around the globe. In contrast to risk factors, **protective factors** include variables that are related to a decreased risk for developing a disease or a social problem. Protective factors can include variables such as positive relationships, academic achievement, parental support, and strong economic conditions.

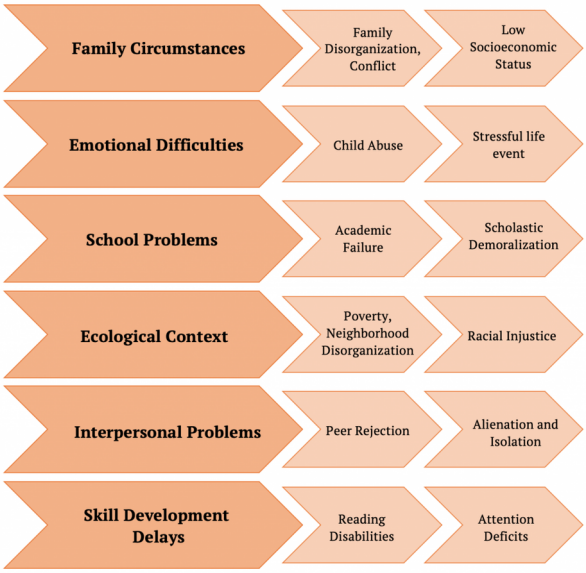


Figure 3. “Risk Factors” by Valerie Anderson, Samanta Boddapati, and Symone Pate

Case Study 12.5
The Most Vulnerable, The Risk Factors, and The Most Effective Programming



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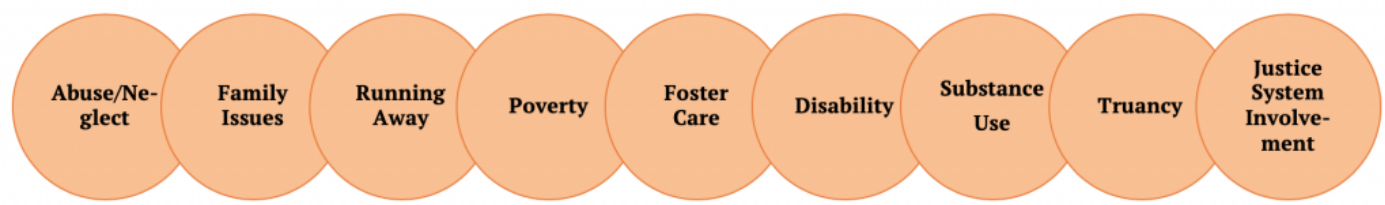


Figure 4. “Risk Factors for Human Trafficking” by Valerie Anderson, Samanta Boddapati, and Symone Pate

Prevention Research and Programming



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The Institute of Medicine developed a model for problem assessment, intervention, and **dissemination** strategies. For example,

this research cycle includes assessing the prevalence of risk and protective factors of a problem area, developing prevention **innovations**, researching the **effectiveness** of those innovations, and disseminating innovations into the community. Figure 5 below outlines each aspect of the preventive intervention research cycle.

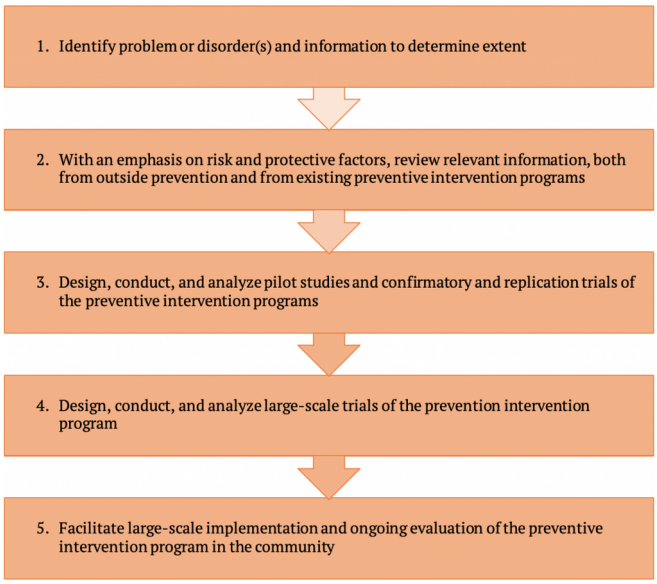


Figure 5. "The Preventive Intervention Research Cycle" by Valerie Anderson, Samanta Boddapati, and Symone Pate

There are a number of challenges to conducting prevention research and using these models since they identify *what* needs to be done but provide very little detail on *how* these things will happen. Most models, such as the Institute of Medicine framework, focus on the functions that are part of the innovation, **implementation**, and dissemination process, but not on the systems that support these functions. To address this gap, Wandersman and colleagues (2008) proposed a framework that describes relevant systems to help bridge the gap. The Interactive Systems Framework works to connect step four (conducting trials of the program) and step five (implementing the program in the community) of the Institute of Medicine model. Figure 6 below details the critical components of the Interactive Systems Framework to bridge this gap. For example, Halgunseth and colleagues (2012) used the Interactive Systems Framework to understand the relationship between program capacity and implementation in after-school settings. They examined eight after-school sites that received the Good Behavior Game (described in Case Study 12.2). Aligned with the Prevention Support System element of the Interactive Systems Framework, the after-school staff was trained and received weekly on-site support in implementing the intervention. It was found that after-school settings that were more organized and maintained strong links to individuals or community-based organizations scored higher in program fidelity and quality. Funders can utilize the Interactive Systems Framework to identify what kinds of support they should provide for the Prevention Synthesis and Translation System element; similarly, practitioners can gather information from that same component for what they need as well as from the Prevention Support System element. Additionally, practitioners can see what they need to do to build capacity from the perspective of the Prevention Delivery System component.

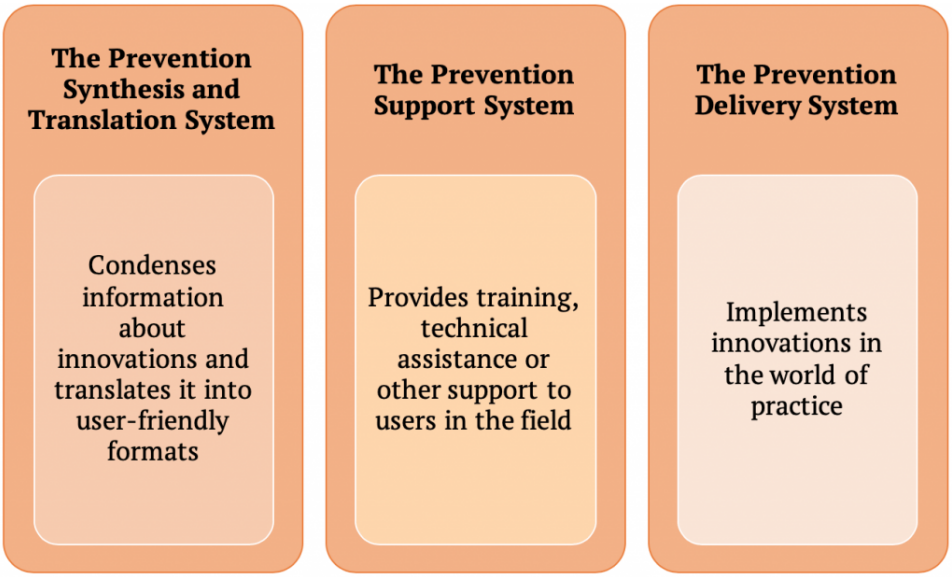


Figure 6. Critical Components of the Interactive Systems Framework by Valerie Anderson, Samanta Boddapati, and Symone Pate

Program evaluation is a cornerstone of Community Psychology research and action. Broadly, program evaluation involves measuring the effectiveness of interventions and policies. This can include both processes (e.g., how were intervention activities implemented) and outcomes (e.g., did the intervention achieve the outcome objectives). Community psychologists engaged in prevention and promotion research and action use **logic models** to guide these efforts. To read more about program evaluation, check out these resources from the Centers for Disease Control and the Community Tool Box. Conducting program evaluations is a key way that community psychologists can measure whether or not our prevention and promotion efforts are having the intended effect.

Critiques of the Prevention Paradigm



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Even though prevention and promotion are seminal concepts in Community Psychology, they are not without drawbacks. Community psychologists have outlined two key critiques. First, prevention and promotion is limited in its focus on **empowerment** (Rappaport, 1981). Rappaport argued that prevention is "one-sided" in part because it is derived from a needs model, rather than a rights model. Further, Rappaport argued prevention programs may not be enough to change social institutions, but rather

just add on to what is already in place. Rappaport made the case that empowerment is a better model because it prioritizes rights and offers a more transformative perspective to change social problems. Second, Miller and Shinn (2005) outlined another critique of prevention and promotion: the failure to adopt prevention programming is rooted in difficulties in implementation and dissemination.

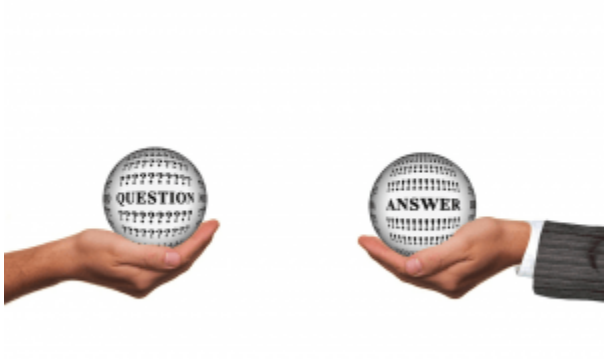


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Miller and Shinn (2005) described potential problems with the Institute of Medicine model of dissemination and potential ways community psychologists can directly counteract these problems in their dissemination efforts. They identified four distinct problems in disseminating prevention and promotion innovations. First, many communities have limited capacity (as shown in the video link) to implement a program causing dissemination failure. The context in which community-based organizations function shapes that capacity, so folks interested in disseminating programs must take into account ecological factors. Second, often times there is an incongruence of values—a lack of compatibility and/or consistency between the setting and the prevention program. Third, Miller and Shinn argued that there is a presumption that innovations that "prove their worth" in a controlled, experimental setting are better than what they might replace when implemented. They referred to this as "innovation bias" that wrongly characterizes communities as passively waiting to adopt a prevention program rather than problem-solving themselves. Finally, they argued that the Institute of Medicine prevention and promotion model proposes an overly simplistic model of decision-making. It assumes that the evidence of the success of an innovation in a controlled, experimental setting is sufficient to promote decisions about adopting the innovation in practice. We know that many other considerations are also relevant in the decision-making of community agencies.

Miller and Shinn (2005) proposed two potential solutions to these pitfalls of the Institute of Medicine framework. Rather than curating innovations in the context of a university and then translating them to a different environment in the community, community psychologists should identify promising prevention and promotion interventions already functioning in communities and study those to understand their effectiveness. Finally, they proposed that researchers should focus less on specific programs and more on powerful ideas that can improve the quality of life. This focus on powerful ideas may actually come from the process of understanding how prevention and promotion programs work in communities by specifying the core elements of a program that could be applied in other community contexts. Thus, we should be "learning from communities" and disseminating their prevention and promotion efforts that work.

Despite these critiques, prevention is still an important framework in Community Psychology and has the potential to create sustainable change in communities. Looking at precipitating factors, an attempt is made to make meaningful changes in environmental or personal factors to eliminate the barriers to success and wellness. Disease and community disorder will always require reactive responses and treatment; however, one goal of Community Psychology is to prevent some of it. Prevention lowers the demand for treatment and allows for increased access to resources that individuals may otherwise not have access to. As noted in this chapter, prevention also has the potential to reduce societal costs in the long run, which means resources can continue being spread for a greater amount of time.

Summing Up



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Critical Thought Questions

1. What role do risk factors play in promotion? Why is that important?
2. How have historical debates on prevention and promotion shaped the way we view their usefulness currently?
3. How does each type of prevention impact problems experienced in society or by members of society?
4. What aspects must we consider regarding prevention research and programming?

Take the Chapter 12 Quiz

View the Chapter 12 Lecture Slides

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UNIT 3: SOCIAL WELFARE POLICIES AND PROGRAMS

6: Chapter 6

6.1: Poverty

6.2: What Is Public Policy?

6.3: Poverty (Social Problems - Continuity and Change)

6.3.1: The Measurement and Extent of Poverty

6.3.2: Who the Poor Are- Social Patterns of Poverty

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6.3.6: Reducing Poverty

6.3.7: End-of-Chapter Material

6.4: Video- The myth of “us” and “them” – Why we all need the Welfare State

6.5: Video- Senator Stabenow Encourage Social Workers to Get Political

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6.1: Poverty

“Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time.

Poverty has many faces, changing from place to place and across time, and has been described in many ways . Most often, poverty is a situation people want to escape. So poverty is a call to action — for the poor and the wealthy alike — a call to change the world so that many more may have enough to eat, adequate shelter, access to education and health, protection from violence, and a voice in what happens in their communities.” – The World Bank Organization

Introduction to Poverty

Although poverty is one of the most familiar and enduring conditions known to humanity, it is a highly complicated concept to understand fully. Above is a definition of poverty given by The World Bank Organization. To date there is no one standard definition of poverty, but numerous definitions and descriptions. All current definitions and descriptions agree that poverty is a complex societal problem.

Regardless as to how poverty is defined, it can be agreed that it is a problem requiring everyone’s attention. It is important that all members of our society work together to provide opportunities for all members to reach their full potential. It helps all of us to help one another.



Povery wordart

Poverty looks different across the world. Commonly when we think of poverty, we relate it to the images we see on television of malnourished children living in developing countries. However, poverty is all around us. Even in the wealthiest of countries poverty still exists. Individuals who are living in poverty are made up of all races, ethnicities, ages, backgrounds, and geographic locations (Rodgers, 2015). For many individuals living in poverty, their lives are characterized by low wages, unemployment, underemployment, little property ownership, no savings, and lack of food reserves. The ability to meet even the most basic needs is in constant jeopardy. Feelings of helplessness, dependence, and inferiority develop easily under these circumstances (Sue, Rasheed, & Rasheed, 2012).

Absolute and Relative Poverty

When discussing poverty the terms absolute poverty and relative poverty are often used (Iceland, 2013). Absolute and relative are

the two most common forms of poverty delineated in our society and around the world (Pierson & Thomas, 2010).

Absolute poverty

Absolute poverty refers to the amount of money necessary to meet basic needs such as food, clothing, and shelter. The concept of absolute poverty is not concerned with the broader quality of life issues or with the overall level of inequality in society but is based strictly on whether or not basic needs are being met (UNESCO, 2017). Examples of absolute poverty would include not knowing when or where your next meal will come from, not having access to clean drinking water, and not having an adequate place to sleep each night.

Relative poverty

Relative poverty refers to the lack of resources to obtain the types of diet, participate in the activities, and have the living conditions and amenities that are customary to maintain the average standard of living in society (Pierson, & Thomas, 2010; Poverty eradication, 2012). Relative poverty defines poverty in relation to the economic status of other members of the society, therefore determining if people are poor by gauging if they fall below normal standards of living in a given society (UNESCO, 2017). Examples of relative poverty would include not being able to have your children participate in after school activities, not being able to afford to dine out, or not being able to take vacations.

Three degrees of poverty

Evaluating poverty can be broken down into three different levels; the first and most severe is extreme poverty, the second is moderate poverty, and the third is relative poverty.

Extreme poverty

Extreme poverty is the most extensively discussed and researched degree of poverty due to its widespread effect around the world. Those living in extreme poverty are considered the poorest in the world (Harack, 2010). Individuals and families who live in extreme poverty cannot meet their basic needs for survival. These individuals frequently may not have access to food, safe drinking water, shelter, medical care, clothing, and educational opportunities, making everyday life a challenge (Poverty eradication, 2012, The World Bank, 2015).

Moderate poverty

Moderate poverty can be characterized when individuals and families can usually meet their basic needs but commonly face struggles in doing so (Poverty eradication, 2012). Individuals living in moderate poverty are in less danger than those living in extreme poverty. These individuals usually lack much, if any disposable income, but the majority, if not all of their basic needs are being met. Those living in moderate poverty may not be struggling to survive, but this type of poverty does make it difficult for individuals to progress in society and escape poverty completely (Harack, 2010).

Relative poverty: refer to the section above.

Measuring poverty in the United States

In the United States, there are two official poverty measures. Poverty thresholds are the primary version of the federal poverty measure and the second measure being poverty guidelines.

Poverty thresholds

Poverty thresholds were developed in the mid-1960s by Mollie Orshansky, a staff economist at the Social Security Administration. Orshansky created the poverty threshold by determining the cost of a minimum food diet and then multiplied the cost by three to account for other family expenses (United States Census Bureau, 2016). The U.S Census Bureau updates the threshold annually to account for inflation using the Consumer Price Index (Institute for Research on Poverty, 2016).

The U.S. Census Bureau determines poverty status by comparing pre-tax cash income against the threshold that has been set for that year (Institute for Research on Poverty, 2016). If the family's total income is less than the family's threshold, then that family and every individual in it is considered to be living in poverty (United States Census Bureau, 2016). According to the U.S Census Bureau in 2015, the most recent year for which data is available, the poverty threshold for a family of four was $24,257,

and the official poverty rate was 13.5 percent (Institute for Research on Poverty, 2016). Based on the poverty threshold data it was concluded there were 43.1 million people in the United States living in poverty in 2015 (Institute for Research on Poverty, 2016; Proctor, Semega, & Kollar, 2016).

Money Income: Income Used to Compute Poverty Status

The income used to compute poverty status includes (before taxes):

- Earnings
- Unemployment compensation
- Workers' compensation
- Social Security
- Supplemental Security Income
- Public assistance
- Veterans' payments
- Survivor benefits
- Pension or retirement income
- Interest
- Dividends
- Rents
- Royalties
- Income from estates
- Trusts
- Educational assistance
- Alimony
- Child support
- Assistance from outside the household
- Other miscellaneous sources

Money income does not include:

- Capital gains or losses
- Noncash benefits (e.g. food stamps and housing subsidies)
- Tax credits

(United States census bureau, 2016)

Money income: Income used to compute poverty status

The poverty thresholds are primarily used for statistical purposes which include tracking poverty over time, poverty rates, and comparing poverty across different demographic groups. Furthermore, the data obtained from the poverty thresholds is used to create and develop annual poverty guidelines. (United States Census Bureau, 2016; Institute for Research on Poverty, 2016)

U.S. Census Bureau Poverty Thresholds, 2015

Size of Family Unit	Poverty Threshold
One person (unrelated individual)	$12,082
Under age 65	12,331
Age 65 or older	11,367
Two people	15,391
Householder under age 65	15,952
Householder age 65 or older	14,342
Three people	18,871
Three people with two related children	19,096
Four people	24,257
Four people with two related children	24,036
Five people	28,741
Five people with two related children	28,995
Six people	32,542
Six people with two related children	33,342
Seven people	36,998
Seven people with two related children	38,421
Eight people	41,029
Eight people with two related children	43,230
Nine people or more	49,177

Source: U.S. Census Bureau, Poverty Thresholds for 2015 by Size of Family and Number of Related Children Under 18 Years, released in September 2016.

(United States census bureau, 2016)

U.S. Census Bureau Poverty Thresholds, 2015, released September 2016

Poverty guidelines are the other official federal poverty measure used in the United States. The poverty guidelines are a simplification of the poverty thresholds utilized by the federal government to determine an individual's eligibility for select federal programs (DHHS, 2017).

Updated poverty guidelines are issued every year by the U.S. Department of Health and Human Services (DHHS) (Institute for Research on Poverty, 2016). The 2017 poverty guidelines were determined using data taken from the 2015 poverty thresholds; the updated guidelines take economic changes taken into account.

Examples of federal programs that use poverty guidelines to determine eligibility include the following:

- Department of Health and Human Services: Community Services Block Grant, Head Start, Low-Income Home Energy Assistance
- Department of Agriculture: Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamp Program), National School Lunch Program, Child and Adult Care Food Program
- Department of Energy: Weatherization Assistance for Low-Income Persons
- Department of Labor: Job Corps, National Farmworker Jobs Program, Workforce Investment Act Youth Activities

(Institute for Research on Poverty, 2016)

2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,180 for each additional person.	
1	$12,060
2	$16,240
3	$20,420
4	$24,600
5	$28,780
6	$32,960
7	$37,140
8	$41,320

(United States census bureau, 2016)

2017 Povery Guidelines for the 48 Contiguous States and the District of Columbia

Even though the current official poverty measures have been used consistently since the 1960s, there are widespread concerns that the federal poverty measure is flawed. There is an overarching agreement that the Census Bureau does not identify all individuals living in poverty. The Census Bureau is unable to obtain exact numbers because many low-income individuals live with others or are frequently moving, and are in many cases homeless; furthermore, those residing in psychiatric hospitals, college dorms, nursing homes, serving in the military, and/or in jails or prisons are not counted. It is estimated that several million individuals who likely would fall below the poverty threshold and poverty guidelines are not counted each year (Rodgers, 2015).

For annual updates on poverty thresholds and poverty guidelines and further information on measuring poverty, please visit:

- United States Census Bureau at https://www.census.gov/topics/income-poverty.html
- The U.S Department of Health and Human Services at https://aspe.hhs.gov/poverty-guidelines

Measuring Global Poverty

International poverty line

Currently, global poverty is measured by the international poverty line. The international poverty line is a monetary threshold under which an individual is considered to be living in extreme poverty. It is calculated by taking the poverty threshold from each country, given the value of the goods needed to sustain one adult, and converting it to dollars (The World Bank, 2015).

The international poverty line was developed by The World Bank Organization and a team of independent researchers in order to gauge the number of individuals living in poverty around the world. The researchers examined national poverty lines from most impoverished countries around the world and converted the lines into a common currency by using purchasing power parity (PPP) exchange rates. The PPP exchange rates warrant that the same amount of goods or services are priced equivalently across the nation. Once converted into common currency, it was determined that the value of the national poverty line was $1 per day per

person in the 1990s (The World Bank, 2015).

Since the first national poverty line was developed, it has been revised twice, first in the mid-2000s when the line rose to $1.25 per person per day after the collection of additional countries' poverty lines and further data on internationally comparable prices were collected. The second and most recent revision was released in 2015 when the international poverty line rose again to $1.90 per person per day (The World Bank, 2015). Unlike the United States, official poverty measures for the international poverty line does not have a set schedule as to when or how often the line is revised.

For further information on global poverty and how it is measured please visit: The World Bank http://www.worldbank.org/

Poverty in America

Poverty in America is much different than the poverty in third world countries. The standard of what constitutes poverty in the United States is much different than the global standard of poverty (Iceland, 2013). Even though the United States is one of the wealthiest countries in the world, the effects of poverty are crippling.

An example of what living in poverty looks like in America is a single parent who works full time, but still can't afford to pay for food, rent, child care, medical bills, and the costs of transportation to work (Results, 2017).

Each year millions of Americans live in poverty. The United Sates Census Bureau reports that in 2015, there were 43.1 million people in poverty (Proctor, Semega, & Kollar, 2016). A wide array of Americans from all races, ethnicities, ages, backgrounds, and geographic locations make up the 43.1 million people currently living in poverty. Some groups are more vulnerable to poverty. The most vulnerable groups make up most of the impoverished population (Rodgers, 2015). The groups that are more susceptible to suffer poverty include single parent families (especially those headed by women), minorities, unemployed or under-employed adults, individuals with mental illness or disabilities, and the elderly (Rodgers, 2015).

Poverty is said to be America's most serious and costly social problem (Rodgers, 2015). High levels of poverty result in many serious social and political consequences. Individuals living in poverty frequently feel alienated from a conventional society which can provoke social disorder. Individuals living in poverty also often feel overlooked in the political realm, further reducing the individual's confidence in democratic institutions (Iceland, 2013).

Each year hundreds of billions of public and private dollars are spent on efforts to prevent poverty and assist those living in poverty (Rodgers, 2015). To many, it may seem that the efforts put forth to end poverty have not made an impact. However, the most up to date data attainable from the United States Census Bureau shows that there have been improvements. In 2015, for the first time in five years, the number of individuals living in poverty had decreased. The official poverty rate was down to 13.5%, 1.2% lower than in 2014, equaling 3.5 million fewer people living in poverty (Proctor, Semega, & Kollar, 2016). Although we may never see poverty completely eradicated in our lifetime, it is hopeful that poverty will continue to decrease in the coming years.



Find a Place to Live Simulation

Online poverty simulation game; click link to play: http://playspent.org/html/

Homelessness

Similar to the term poverty, there are numerous definitions for the term homeless or homelessness. We have chosen to use the definition of homeless used by the Department of Health and Human Services (DHHS) that was created by, and in conjunction with, the Health Resource and Service Administration (HRSA). It is as follows:

"A homeless individual is defined in section 330(h)(5)(A) as 'an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation' (National Health Care for Homeless Council, 2017, para. 2).

Who is experiencing homelessness?

The current 2016 statistics on homelessness in the United States are derived from *The 2016 Annual Homeless Assessment Report (AHAR)* to Congress.

- According to the AHAR the number of individuals experiencing homelessness on any given night in 2016 was 549,928.
- Among the 549,928 individuals who experience homelessness each night in the United States vary by age, race, sex, and other classifiable characteristics.
- According to AHAR, 69% of homeless individuals were over the age of 24, 22% were children and adolescents under the age of 18, and 9% were between the ages of 18 and 24.
- The AHAR reports that 60% of the individuals experiencing homelessness were men, 40% were women, and less than 1% were transgender.
- As for race, the AHAR reports that nearly half of all people experiencing homelessness were white totaling 48%, African Americans 39%, multiracial individuals 7%, and Native Americans, Asians, and Pacific Islanders made up the remaining 6%.

The data collected from the 2016 *AHAR* to Congress further concluded that homelessness and poverty affects all individuals regardless of age, sex, or race.



Picture of homelessness

Sheltering the Homeless

All information below is from *The 2016 Annual Homeless Assessment Report (AHAR).*

There are various resources for homeless individuals within the United States to gain safe shelter overnight or for temporary amounts of time. The following are some of the well-known homeless resources in the United States:

> *Emergency Shelter* is a facility with the primary purpose of providing temporary shelter for homeless people
>
> *Rapid Rehousing* is a housing model designed to provide temporary housing assistance to people experiencing homelessness, moving them quickly out of homelessness and into permanent housing.
>
> S*afe Havens* are projects that provide private or semi-private long-term housing for people with severe mental illness and are limited to serving no more than 25 people within a facility.
>
> *Transitional Housing Program*s provide people experiencing homelessness a place to stay combined with supportive services for up to 24 months.

Even with the implementation of the programs listed above, many homeless individuals remain unsheltered on any given night within the United States. Statistics show that 68% (373,571 people) were staying in emergency shelters, transitional housing programs, or safe havens, while 32% (176,357 people) were staying in unsheltered locations.

Rural vs Urban Homelessness

In our society, homelessness is often depicted as an urban problem. Urban areas are known to have a higher population of homeless individuals than in rural areas of the county. However, there is an increasing number of homeless individuals in rural America (National Alliance to End Homelessness, 2010). Geographical location makes a difference to the resources available for those experiencing homelessness, and sadly those living in rural America are often overlooked.

Rural areas face different barriers than urban areas when it comes to serving individuals experiencing homelessness. These barriers include lack of available, affordable housing, limited transportation methods and limited employment opportunities; federal grants and programs also tend to be dispersed in more urban areas (National Alliance to End Homelessness, 2010). The lack of federal funding in rural areas causes a problem when trying to house the homeless. Due to this lack of funding there typically are not homeless shelters in rural areas, causing individuals experiencing homelessness in these areas to sleep in cars, campers, tents because shelter is not available.

Affordable Housing:

There are countless reasons as to why or how an individual becomes homeless, but research shows the key reason as to why he or she cannot escape homelessness is because the individual cannot afford housing. The United States is currently experiencing an extreme shortage of affordable housing (National Alliance to End Homelessness, 2017). The two main types of affordable housing are Public Housing and the Housing Choice Voucher Program (HCVP) which was formerly known as Section 8. It is not uncommon for Public Housing programs and the HCVP to have wait lists that are several years out.

Housing Voucher Program: This program provides vouchers to low-income households to help them pay for housing in the private market and has been found to sharply reduce homelessness (National Alliance to End Homelessness, 2017).

Public Housing: Federally-funded housing that is rented at subsidized rates to eligible low-income families, the elderly, and persons with disabilities.

Federal Government Response to Poverty: Welfare

The United States laid its foundation for a national welfare system in response to the Great Depression that started in 1929 and went through most of the 1930s. The Social Security Act of 1935 was the first of many government policies and welfare programs created to combat poverty and economic hardships (Rodgers, 2015).

The welfare system in the United States consists of government programs which provide financial assistance to individuals and families who cannot support themselves. Welfare programs are funded by taxpayers and allow people to cope with financial stress during challenging periods of their lives. The goals of welfare include the attainment of work, education, and an overall better standard of living and decrease in economic hardship and poverty.

Welfare programs

Since the establishment of Social Security Act of 1935, the federal government has continued to develop numerous welfare programs to attempts to eradicate poverty and the economic hardships faced by millions of Americans.

Key programs to combat poverty include but are not limited to the following:

All information below is from the Center for Poverty Research

1935: The Social Security Act

Part of President Franklin Roosevelt's New Deal legislation, the original act included grants to states for unemployment compensation, aid to dependent children and public health. Today, Social Security is the largest safety net program in the U.S.

1935: Unemployment Insurance

Unemployment insurance was a part of President Franklin Roosevelt's 1935 Social Security Act. Today's U.S. Department of Labor Unemployment Insurance (UI) programs provides benefits to eligible workers who become unemployed through no fault of their own and who meet certain requirements.

1964: Head Start

This pre-school education program was a part of the 1964 Economic Opportunity Act that was designed to reduce disparities among young children. The 1994 Head Start Act Amendments established the Early Head Start program, which expanded the benefits of early childhood development to low-income families with children under three years old.

1964: Supplemental Nutrition Assistance Program (SNAP)

The first Food Stamp program ran from 1939-43, but the program we know today was established with the 1964 Food Stamp Act. The program is now known as the Supplemental Nutrition Assistance Program.

1965: Medicare/Medicaid

These health programs were established with amendments to the Social Security Act in 1965. Today, Medicare provides health insurance for people over 65 years of age and some younger than that but who have certain disabilities or diseases. Medicaid is a Federal and state partnership that provides health coverage for people with low income.

1972: Supplemental Security Income Program (SSI)

SSI is a Federal program that provides income people 65 or older as well as to blind or disabled adults and children.

1972: Women, Infants, and Children (WIC)

WIC is a nutrition program that benefits pregnant women, new mothers and young children who live near poverty and who are at nutritional risk. WIC is not an entitlement program, so the number of people who receive the benefits depends on the amount Congress allots for the program from year to year.

1972: Federal Pell Grant Program

Pell Grants help pay for tuition and other expenses for low-income college students.

1975: The Earned Income Tax Credit (EITC)

The EITC is a tax credit that benefits working people who have low to moderate income, especially families.

1996: Temporary Assistance for Needy Families (TANF)

TANF issues federal grants to states for programs that provide temporary benefits to families with children when the income does not provide for the family's basic needs. Programs include job preparation, family planning, and other benefits as well as cash assistance.

1997: Children's Health Insurance Program (CHIP)

CHIP provides health coverage to nearly eight million children in families who cannot afford private health insurance but who have incomes that are too high to qualify for Medicaid.

According to the United States Census Bureau in 2012, there were approximately 52.2 million (or 21.3 %) people in the United States receiving some sort of assistance through government funded welfare programs (United States Census Bureau, 2016). To receive assistance from government funded programs individuals must meet a certain criteria to be eligible; each program has their own distinct criteria. To apply to these programs individuals must go through state Departments of Health and Human Services (DHHS).

For further information on government funded assistance programs please visit:

- The U.S. Department of Health and Human Services, at https://www.hhs.gov/programs/social-services/index.html
- Benefits. Gov Your Path to Government Benefits, at https://www.benefits.gov/

Poverty Stigmas and Stereotypes

Stigmas

In the United States individuals living in poverty are not only faced with their day to day hardships but also with the harsh stigmas that society has surrounding poverty. When evaluating stigmas surrounding poverty, they typically fall into three categories: institutional, social, and personal stigmas (Bell, 2012; Inglis, 2016):

Institutional Stigmas: institutional level stigma can be seen in laws, policies and institutional practices that discriminate against, or shame individuals living in poverty (Inglis, 2016). Institutional stigma is that which arises from the process of claiming benefits (Bell, 2012)

Social Stigmas: Social stigma includes public attitudes toward poverty and welfare, and are typically measured through national surveys (Inglis, 2016). Social stigma is the feeling that other people judge claiming benefits to be shameful (Bell, 2012)

Personal Stigmas: Personal stigma occurs when individuals internalize the various forms of stigma and discrimination that they experience or perceive from others (Inglis, 2016). Personal stigma is a person's own feeling that claiming benefits is shameful (Bell, 2012).

Stereotypes

Furthermore, society holds many stereotypes about individuals living in poverty. A stereotype can be defined as an often unfair and untrue belief that many people have about all people with a specific characteristic (Stereotype, 2017). The stereotypes that society has labeled individuals living in poverty are usually false. Some of the most common stereotypes and misconceptions of individuals living in poverty include:

- Individuals living in poverty are lazy and have weak work ethics

    In reality, there is no suggestion that individuals living in poverty are lazier or have weaker work ethics than individuals from other/higher socioeconomic groups. In fact, poor working adults work, on average, 2,500 hours per year, the rough equivalent of 1.2 full-time jobs often patching together several part-time jobs in order to support their families (Gorski, 2013)

- Individuals living in poverty have problems with substance use

    In reality, research has shown that low-income individuals are less likely to use or abuse substances than their wealthier counterparts (Gorski, 2013).

Stigmatizing and stereotyping individuals living in poverty only further creates a divide between low-income people who are living in poverty and those who are not (Inglis, 2016). Society's harsh views on poverty cause impoverished individuals to further feel socially excluded and ashamed of the situation they are in. Research has shown negative effects on an individual's self-esteem, self-concept, and mental and physical health due to being stigmatized and stereotyped so severely by society (Inglis, 2016).

Theories and Explanations of Poverty

There are many theories that attempt to explain poverty and why it exists. A theory in simple terms can be defined as idea or a structure of ideas intended to explain something (Theory, 2017). You will learn more about theories in-depth in higher level social work courses.

The following are some of the most commonly used theories to explain the existence of poverty.

The Culture of Poverty

The culture of poverty theory was created by the anthropologist Oscar Lewis in 1959. The culture of poverty is the theory that certain groups and individuals persist in a state of poverty because they have distinct beliefs, values, behavior, and attitudes that are incompatible with economic success (Pierson, & Thomas, 2010). Therefore, the individuals are unable to get out of poverty.

The Cycle of Poverty

The cycle of poverty is also commonly known as the cycle of deprivation. The cycle of deprivation is a theoretical explanation for the persistence of poverty. The theory focuses on how attitudes, values, and behaviors are passed on from one generation to the next, further explaining the ongoing cycle of low educational attainment, unemployment, poor housing and so on within families and communities (Pierson & Thomas, 2010).

As discussed in the explanation of the cycle, poverty is passed down generationally, meaning that children and adolescents are targeted victims falling into the cycle of poverty and not getting out of it. There is much research that indicates that children and adolescents who grow up in poverty suffer significant disadvantages, not just as children but throughout their lifespan. Alarming statistics report that children who grow up in poverty are twice as likely to drop out of school and are one and half times more likely to be unemployed (Rodgers, 2015), further contributing to the ongoing cycle of poverty.

Structural/ Environmental Explanation:

Structural explanations propose that poverty is based on the social structure of society (Kirst-Ashman, 2013). To put it simply, the structural explanation suggests that poverty and its ongoing existence results from problems in society that lead to a lack of opportunity and a lack of jobs (University of Minnesota, 2010). Structural and environmental factors that play a role in this explanation include fluctuations in the economy, not having enough jobs in the job market, low paying jobs or jobs with no benefits, lack of affordable housing, and discrimination (Ritter, 2014). An example of this would be: poverty occurs when wages are too low and that there are not enough adequate paying jobs (Kirst-Ashman, 2013).

Individualistic Explanation:

Similar to the culture of poverty theory, the individualistic explanation of poverty suggests that poverty results from the fact that poor people lack the motivation to work and have certain beliefs and values that contribute to their poverty (University of Minnesota, 2010). Individual factors that contribute to a person living in poverty may include lack of job skills, educational deficits, mental illness, declining health or disabilities, substance use, single parenting, lack of childcare, and lack of reliable transportation (Ritter, 2014). An example of this would be: a person who lost their job due to being late so many days in a row and now he or she cannot afford rent and may be at risk of becoming homeless.

Poverty and Social Work

National Association of Social Work

As discussed in chapter two, social workers abide by the National Association of Social Work (NASW) Code of Ethics. One of the six values in the NASW code of ethics is social justice. The definition of the ethical principle from the NASW states, “Social workers’ social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice,” (NASW, 2008). With the NASW Code of Ethics acting as the professions guiding light it is highly important for social workers to have knowledge and understanding of poverty and its severity within our society and around the world.

Social work’s role

The social work profession has an extensive history of working to assist poverty at the micro, mezzo, and macro levels (National Association of Social Workers, 2017). The following are examples of social work roles on each of the three levels.

Micro

Case Study: Micro Level Social Work

"A social worker has an intervention with a young woman living in a poor urban community. When she first appeared for social services, the young woman was pregnant, depressed and unable to pay her rent. However, she was determined to improve her life circumstances and those for her unborn child. She couldn't save money because she had another child to support. Although he was emotionally supportive, her partner was unable to financially contribute to her support. During their work together, the social worker was able to develop a plan of action with her client. By following up on leads, the young woman was connected with several sources of tangible help in her community. Over the next few months, she was able to identify subsidized housing, obtain prenatal care, and receive treatment for her depression and to enroll in a part-time job training program. Her partner was also able to find employment through a community job bank. By the time her baby was born, the young woman's outlook on life was brighter." *(NASW, 2017)*

Micro level practice works with an individual or a family on a one-on-one basis (Giffords, & Garber, 2014). Micro level social workers are the clinicians who often work most hands- on with individuals who are living in poverty. Micro practice, as it relates to poverty, may include linking a client to unemployment resources, housing resources, assisting individuals in applying for welfare programs, and helping the individual cope with the hardships of living in poverty.

Mezzo

Intervening at the group level constitutes mezzo practice (Giffords, & Garber, 2014). Some focuses on mezzo level social work practice in regards to poverty include facilitating groups that focus on employment skills, working in schools to help low-income children learn to read and write better, and working with community organizations and agencies that assist with poverty and homelessness.

Macro

At the Macro level social workers focus on effecting systematic change that can benefit individuals at a societal level (MSW careers, 2017). In regards to poverty some of the ways macro level social workers can assist include advocating for laws that affect those living in poverty, developing programs to assist individuals and families living in poverty, and educating the community on the need for social change.

For further information on micro, mezzo, and macro social work please refer back to Chapter 4.

Summary

After reading this chapter it is my hope that you have expanded your knowledge and understanding of poverty and how it closely relates to the social work profession. As previously stated social works focus on poverty stems back the NASW Code of Ethics which acts as the professions guiding light.

Regardless as to what career path you take in the field of social work it is anticipated that you will serve individuals and families who fall below the poverty line and face financial hardships. Therefore, as future social workers it is important that you have an adequate understanding of what poverty is and the effects it has on individuals and society as a whole.

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6.2: What Is Public Policy?

Learning Objectives

By the end of this section, you will be able to:

- Explain the concept of public policy
- Discuss examples of public policy in action

It is easy to imagine that when designers engineer a product, like a car, they do so with the intent of satisfying the consumer. But the design of any complicated product must take into account the needs of regulators, transporters, assembly line workers, parts suppliers, and myriad other participants in the manufacture and shipment process. And manufacturers must also be aware that consumer tastes are fickle: A gas-guzzling sports car may appeal to an unmarried twenty-something with no children; but what happens to product satisfaction when gas prices fluctuate, or the individual gets married and has children?

In many ways, the process of designing domestic policy isn't that much different. The government, just like auto companies, needs to ensure that its citizen-consumers have access to an array of goods and services. And just as in auto companies, a wide range of actors is engaged in figuring out how to do it. Sometimes, this process effectively provides policies that benefit citizens. But just as often, the process of policymaking is muddied by the demands of competing interests with different opinions about society's needs or the role that government should play in meeting them. To understand why, we begin by thinking about what we mean by the term "public policy."

Public Policy Defined

One approach to thinking about **public policy** is to see it as the broad strategy government uses to do its job. More formally, it is the relatively stable set of purposive governmental actions that address matters of concern to some part of society.

James E. Anderson. 2000. *Public Policymaking: An Introduction*, 4th ed. Boston: Houghton Mifflin.

This description is useful in that it helps to explain both what public policy is and what it isn't. First, public policy is a guide to legislative action that is more or less fixed for long periods of time, not just short-term fixes or single legislative acts. Policy also doesn't happen by accident, and it is rarely formed simply as the result of the campaign promises of a single elected official, even the president. While elected officials are often important in shaping policy, most policy outcomes are the result of considerable debate, compromise, and refinement that happen over years and are finalized only after input from multiple institutions within government as well as from interest groups and the public.

Consider the example of health care expansion. A follower of politics in the news media may come away thinking the reforms implemented in 2010 were as sudden as they were sweeping, having been developed in the final weeks before they were enacted. The reality is that expanding health care access had actually been a priority of the Democratic Party for several decades. What may have seemed like a policy developed over a period of months was in fact formed after years of analysis, reflection upon existing policy, and even trial implementation of similar types of programs at the state level. Even before passage of the ACA (2010), which expanded health care coverage to millions, and of the HCERA (2010), more than 50 percent of all health care expenditures in the United States already came from federal government programs such as Medicare and Medicaid. Several House and Senate members from both parties along with First Lady Hillary Clinton had proposed significant expansions in federal health care policy during the Democratic administration of Bill Clinton, providing a number of different options for any eventual health care overhaul.

"National Health Insurance—A Brief History of Reform Efforts in the U.S.," March 2009, kaiserfamilyfoundation.files...13/01/7871.pdf (March 1, 2016).

Much of what became the ACA was drawn from proposals originally developed at the state level, by none other than Obama's 2012 Republican presidential opponent Mitt Romney when he was governor of Massachusetts.

"Romneycare vs. Obamacare: Key Similarities & Differences," 13 November 2013. boston.cbslocal.com/2013/11/1...s-differences/ (March 1, 2016).

In addition to being thoughtful and generally stable, public policy deals with issues of concern to some large segment of society, as opposed to matters of interest only to individuals or a small group of people. Governments frequently interact with individual actors like citizens, corporations, or other countries. They may even pass highly specialized pieces of legislation, known as private bills, which confer specific privileges on individual entities. But public policy covers only those issues that are of interest to larger segments of society or that directly or indirectly affect society as a whole. Paying off the loans of a specific individual would not be public policy, but creating a process for loan forgiveness available to certain types of borrowers (such as those who provide a public service by becoming teachers) would certainly rise to the level of public policy.

A final important characteristic of public policy is that it is more than just the actions of government; it also includes the behaviors or outcomes that government action creates. Policy can even be made when government refuses to act in ways that would change the status quo when circumstances or public opinion begin to shift.

E. E. Schattschneider. 1960. *The Semi-Sovereign People*. New York: Holt, Rinehart & Winston.

For example, much of the debate over gun safety policy in the United States has centered on the unwillingness of Congress to act, even in the face of public opinion that supports some changes to gun policy. In fact, one of the last major changes occurred in 2004, when lawmakers' inaction resulted in the expiration of a piece of legislation known as the **Federal Assault Weapons Ban**(1994).

Brad Plumer, "Everything you need to know about the assault weapons ban, in one post," *The Washington Post*, 17 December 2012. www.washingtonpost.com/news/...s-in-one-post/ (March 1, 2016).

Public Policy as Outcomes

Governments rarely want to keep their policies a secret. Elected officials want to be able to take credit for the things they have done to help their constituents, and their opponents are all too willing to cast blame when policy initiatives fail. We can therefore think of policy as the formal expression of what elected or appointed officials are trying to accomplish. In passing the HCERA (2010), Congress declared its policy through an act that directed how it would appropriate money. The president can also implement or change policy through an executive order, which offers instructions about how to implement law under his or her discretion (Figure). Finally, policy changes can come as a result of court actions or opinions, such as ***Brown v. Board of Education of Topeka*** (1954), which formally ended school segregation in the United States.

Brown v. Board of Education of Topeka, 347 U.S. 483 (1954).

An image of a group of 12 people standing around Barack Obama, who is seated at a desk and signing a piece of paper.

President Obama signs a 2009 executive order to accelerate the federal government's recruitment and hiring of returning veterans. Executive orders are an expression of public policy undertaken at the discretion of the president.

Typically, elected and even high-ranking appointed officials lack either the specific expertise or tools needed to successfully create and implement public policy on their own. They turn instead to the vast government bureaucracy to provide policy guidance. For example, when Congress passed the **Clean Water Act** (1972), it dictated that steps should be taken to improve water quality throughout the country. But it ultimately left it to the bureaucracy to figure out exactly how 'clean' water needed to be. In doing so, Congress provided the Environmental Protection Agency (EPA) with discretion to determine how much pollution is allowed in U.S. waterways.

There is one more way of thinking about policy outcomes: in terms of winners and losers. Almost by definition, public policy promotes certain types of behavior while punishing others. So, the individuals or corporations that a policy favors are most likely to benefit, or win, whereas those the policy ignores or punishes are likely to lose. Even the best-intended policies can have unintended consequences and may even ultimately harm someone, if only those who must pay for the policy through higher taxes. A policy designed to encourage students to go to liberal arts colleges may cause trade school enrollment to decline. Strategies to promote diversity in higher education may make it more difficult for qualified white or male applicants to get accepted into competitive programs. Efforts to clean up drinking water supplies may make companies less competitive and cost employees their livelihood. Even something that seems to help everyone, such as promoting charitable giving through tax incentives, runs

the risk of lowering tax revenues from the rich (who contribute a greater share of their income to charity) and shifting tax burdens to the poor (who must spend a higher share of their income to achieve a desired standard of living). And while policy pronouncements and bureaucratic actions are certainly meant to rationalize policy, it is whether a given policy helps or hurts constituents (or is perceived to do so) that ultimately determines how voters will react toward the government in future elections.

The Social Safety Net

During the **Great Depression** of the 1930s, the United States created a set of policies and programs that constituted a social safety net for the millions who had lost their jobs, their homes, and their savings (Figure). Under President Franklin Delano **Roosevelt**, the federal government began programs like the Work Progress Administration and Civilian Conservation Corps to combat unemployment and the Home Owners' Loan Corporation to refinance Depression-related mortgage debts. As the effects of the Depression eased, the government phased out many of these programs. Other programs, like Social Security or the minimum wage, remain an important part of the way the government takes care of the vulnerable members of its population. The federal government has also added further social support programs, like Medicaid, Medicare, and the Special Supplemental Nutrition Program for Women, Infants, and Children, to ensure a baseline or minimal standard of living for all, even in the direst of times.

An image of people standing in long lines.

In 1937, during the Great Depression, families in Calipatria, California, waited in line for relief checks, part of the federal government's newly introduced social safety net. (credit: modification of work by the Library of Congress)

In recent decades, however, some have criticized these safety net programs for inefficiency and for incentivizing welfare dependence. They deride "government leeches" who use food stamps to buy lobster or other seemingly inappropriate items. Critics deeply resent the use of taxpayer money to relieve social problems like unemployment and poverty; workers who may themselves be struggling to put food on the table or pay the mortgage feel their hard-earned money should not support other families. "If I can get by without government support," the reasoning goes, "those welfare families can do the same. Their poverty is not my problem."

So where should the government draw the line? While there have been some instances of welfare fraud, the welfare reforms of the 1990s have made long-term dependence on the federal government less likely as the welfare safety net was pushed to the states. And with the income gap between the richest and the poorest at its highest level in history, this topic is likely to continue to receive much discussion in the coming years.

Where is the middle ground in the public policy argument over the social safety net? How can the government protect its most vulnerable citizens without placing an undue burden on others?

Explore historical data on United States budgets and spending from 1940 to the present from the Office of Management and Budget.

Summary

Public policy is the broad strategy government uses to do its job, the relatively stable set of purposive governmental behaviors that address matters of concern to some part of society. Most policy outcomes are the result of considerable debate, compromise, and refinement that happen over years and are finalized only after input from multiple institutions within government. Health care reform, for instance, was developed after years of analysis, reflection on existing policy, and even trial implementation at the state level.

People evaluate public policies based on their outcomes, that is, who benefits and who loses. Even the best-intended policies can have unintended consequences and may even ultimately harm someone, if only those who must pay for the policy through higher taxes.

Which of the following is *not* an example of a public policy outcome?

a. the creation of a program to combat drug trafficking

b. the passage of the Affordable Care Act (Obamacare)
c. the passage of tax cuts during the George W. Bush administration
d. none of the above; all are public policy outcomes

Public policy _____.

a. is more of a theory than a reality
b. is typically made by one branch of government acting alone
c. requires multiple actors and branches to carry out
d. focuses on only a few special individuals

What are some of the challenges to getting a new public policy considered and passed as law?

Glossary

public policy
: the broad strategy government uses to do its job; the relatively stable set of purposive governmental behaviors that address matters of concern to some part of society

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6.3: POVERTY (SOCIAL PROBLEMS - CONTINUITY AND CHANGE)

6.3.1: The Measurement and Extent of Poverty

6.3.2: Who the Poor Are- Social Patterns of Poverty

6.3.3: Explaining Poverty

6.3.4: The Consequences of Poverty

6.3.5: Global Poverty

6.3.6: Reducing Poverty

6.3.7: End-of-Chapter Material

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6.3.1: The Measurement and Extent of Poverty

Learning Objectives

1. Understand how official poverty in the United States is measured.
2. Describe problems in the measurement of official poverty.
3. Describe the extent of official poverty.

When US officials became concerned about poverty during the 1960s, they quickly realized they needed to find out how much poverty we had. To do so, a measure of official poverty, or a poverty line, was needed. A government economist, Mollie Orshanky, first calculated this line in 1963 by multiplying the cost of a very minimal diet by three, as a 1955 government study had determined that the typical American family spent one-third of its income on food. Thus a family whose cash income is lower than three times the cost of a very minimal diet is considered officially poor.

This way of calculating the official poverty line has not changed since 1963. It is thus out of date for many reasons. For example, many expenses, such as heat and electricity, child care, transportation, and health care, now occupy a greater percentage of the typical family's budget than was true in 1963. In addition, this official measure ignores a family's noncash income from benefits such as food stamps and tax credits. As a national measure, the poverty line also fails to take into account regional differences in the cost of living. All these problems make the official measurement of poverty highly suspect. As one poverty expert observes, "The official measure no longer corresponds to reality. It doesn't get either side of the equation right—how much the poor have or how much they need. No one really trusts the data" (DeParle, et. al., 2011). We'll return to this issue shortly.



The measure of official poverty began in 1963 and stipulates that a family whose income is lower than three times the cost of a minimal diet is considered officially poor. This measure has not changed since 1963 even though family expenses have risen greatly in many areas. Wikimedia Commons – public domain.

The poverty line is adjusted annually for inflation and takes into account the number of people in a family: The larger the family size, the higher the poverty line. In 2010, the poverty line for a nonfarm family of four (two adults, two children) was $22,213. A four-person family earning even one more dollar than $22,213 in 2010 was *not* officially poor, even though its "extra" income hardly lifted it out of dire economic straits. Poverty experts have calculated a no-frills budget that enables a family to meet its basic needs in food, clothing, shelter, and so forth; this budget is about twice the poverty line. Families with incomes between the poverty line and twice the poverty line (or *twice poverty*) are barely making ends meet, but they are not considered officially poor. When we talk here about the poverty level, then, keep in mind that we are talking only about *official* poverty and that there are many families and individuals living in near poverty who have trouble meeting their basic needs, especially when they face

unusually high medical expenses, motor vehicle expenses, or the like. For this reason, many analysts think families need incomes twice as high as the federal poverty level just to get by (Wright, et. al., 2011). They thus use *twice-poverty* data (i.e., family incomes below twice the poverty line) to provide a more accurate understanding of how many Americans face serious financial difficulties, even if they are not living in official poverty.

The Extent of Poverty

With this caveat in mind, how many Americans are poor? The US Census Bureau gives us some answers that use the traditional, official measure of poverty developed in 1963. In 2010, 15.1 percent of the US population, or 46.2 million Americans, lived in official poverty (DeNavas-Walt, et. al., 2011). This percentage represented a decline from the early 1990s but was higher than 2000 and even higher than the rate in the late 1960s (see Figure 2.1 "US Poverty, 1959–2010"). If we were winning the war on poverty in the 1960s (notice the sharp drop in the 1960s in Figure 2.1 "US Poverty, 1959–2010"), since then poverty has fought us to a standstill.



Figure 2.1 US Poverty, 1959–2010 Source: Data from US Census Bureau. (2011). Historical poverty tables: People. Retrieved from www.census.gov/hhes/www/pover...al/people.html.

Another way of understanding the extent of poverty is to consider episodic poverty, defined by the Census Bureau as being poor for at least two consecutive months in some time period. From 2004 to 2007, the last years for which data are available, almost one-third of the US public, equal to about 95 million people, were poor for at least two consecutive months, although only 2.2 percent were poor for all three years (DeNavas-Walt, et al., 2010). As these figures indicate, people go into and out of poverty, but even those who go out of it do not usually move very far from it. And as we have seen, the majority of Americans can expect to experience poverty or near poverty at some point in their lives.

The problems in the official poverty measure that were noted earlier have led the Census Bureau to develop a *Supplemental Poverty Measure*. This measure takes into account the many family expenses in addition to food; it also takes into account geographic differences in the cost of living, taxes paid and tax credits received, and the provision of food stamps, Medicaid, and certain other kinds of government aid. This new measure yields an estimate of poverty that is higher than the rather simplistic official poverty measure that, as noted earlier, is based solely on the size of a family and the cost of food and the amount of a family's cash income. According to this new measure, the 2010 poverty rate was 16.0 percent, equal to 49.1 million Americans (Short, 2011). Because the official poverty measure identified 46.2 million people as poor, the new, more accurate measure increased the number of poor people in the United States by almost 3 million. Without the help of Social Security, food stamps, and other federal programs, at least 25 million additional people would be classified as poor (Sherman, 2011). These programs thus are essential in keeping many people above the poverty level, even if they still have trouble making ends meet and even though the poverty rate remains unacceptably high.

A final figure is worth noting. Recall that many poverty experts think that twice-poverty data—the percentage and number of people living in families with incomes below twice the official poverty level—are a better gauge than the official poverty level of

the actual extent of poverty, broadly defined, in the United States. Using the twice-poverty threshold, about one-third of the US population, or more than 100 million Americans, live in poverty or near poverty (Pereyra, 2011). Those in near poverty are just one crisis—losing a job or sustaining a serious illness or injury—away from poverty. Twice-poverty data paint a very discouraging picture.

Key Takeaways

- The official poverty rate is based on the size of a family and a minimal food budget; this measure underestimates the true extent of poverty.
- The official poverty rate in 2010 was 15.1 percent, equal to more than 46 million Americans.
- About one-third of the US population, or more than 100 million Americans, have incomes no higher than twice the poverty line.

For Your Review

1. Write a short essay that summarizes the problems by which the official poverty rate is determined.
2. Sit down with some classmates and estimate what a family of four (two parents, two young children) in your area would have to pay annually for food, clothing, shelter, energy, and other necessities of life. What figure do you end up with? How does this sum of money compare with the official poverty line of $22,213 in 2010 for a family of four?

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6.3.2: Who the Poor Are- Social Patterns of Poverty

Learning Objectives

1. Describe racial/ethnic differences in the poverty rate.
2. Discuss how family structure is related to the poverty rate.
3. Explain what poverty and labor force participation data imply about the belief that many poor people lack the motivation to work.

Who are the poor? Although the official poverty rate in 2010 was 15.1 percent, this rate differs by the important sociodemographic characteristics of race/ethnicity, gender, and age, and it also differs by region of the nation and by family structure. The poverty rate differences based on these variables are critical to understanding the nature and social patterning of poverty in the United States. We look at each of these variables in turn with 2010 census data (DeNavas-Walt, et, al., 2011).

Race/Ethnicity

- Here is a quick quiz; please circle the correct answer.
    - Most poor people in the United States are

        1. Black/African American
        2. Latino
        3. Native American
        4. Asian
        5. White

- What did you circle? If you are like the majority of people who answer a similar question in public opinion surveys, you would have circled *a. Black/African American*. When Americans think about poor people, they tend to picture African Americans (White, 2007). This popular image is thought to reduce the public's sympathy for poor people and to lead them to oppose increased government aid for the poor. The public's views on these matters are, in turn, thought to play a key role in government poverty policy. It is thus essential for the public to have an accurate understanding of the racial/ethnic patterning of poverty.



The most typical poor people in the United States are non-Latino whites. These individuals comprise 42.4 percent of all poor

Americans.Franco Folini – Homeless guys with dogs – CC BY-SA 2.0.

Unfortunately, the public's racial image of poor people is mistaken, as census data reveal that *the most typical poor person is white (non-Latino)*. To be more precise, 42.4 percent of poor people are white (non-Latino), 28.7 percent are Latino, 23.1 percent are black, and 3.7 percent are Asian (see Figure 2.2 "Racial and Ethnic Composition of the Poor, 2010 (Percentage of Poor Persons Who Belong to Each Group)"). As these figures show, non-Latino whites certainly comprise the greatest number of the American poor. Turning these percentages into numbers, they account for 19.6 million of the 46.2 million poor Americans.

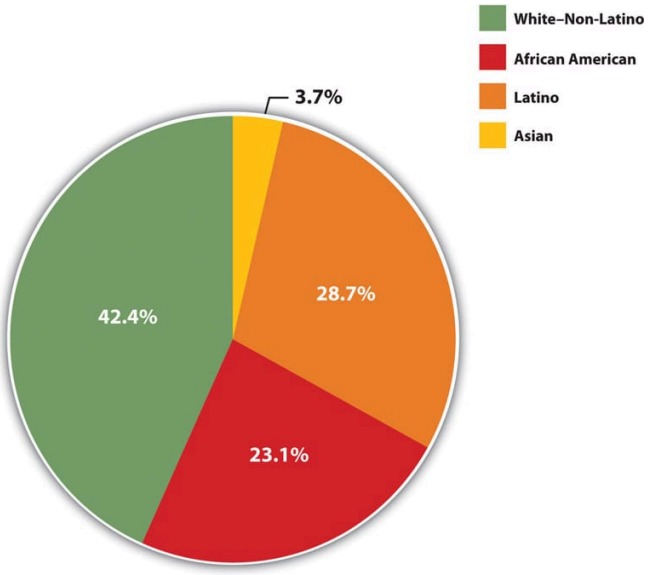


Figure 2.2 Racial and Ethnic Composition of the Poor, 2010 (Percentage of Poor Persons Who Belong to Each Group). Source: Data from DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2011). *Income, poverty, and health insurance coverage in the United States: 2010* (Current Population Report P60-239). Washington, DC: US Census Bureau.

It is also true, though, that race and ethnicity affect the chances of being poor. While only 9.9 percent of non-Latino whites are poor, 27.4 percent of African Americans, 12.1 percent of Asians, and 26.6 percent of Latinos (who may be of any race) are poor (see Figure 2.3 "Race, Ethnicity, and Poverty, 2010 (Percentage of Each Group That Is Poor)"). Thus African Americans and Latinos are almost three times as likely as non-Latino whites to be poor. (Because there are so many non-Latino whites in the United States, the greatest number of poor people are non-Latino white, even if the percentage of whites who are poor is relatively low.) The higher poverty rates of people of color are so striking and important that they have been termed the "colors of poverty" (Lin & Harris, 2008).

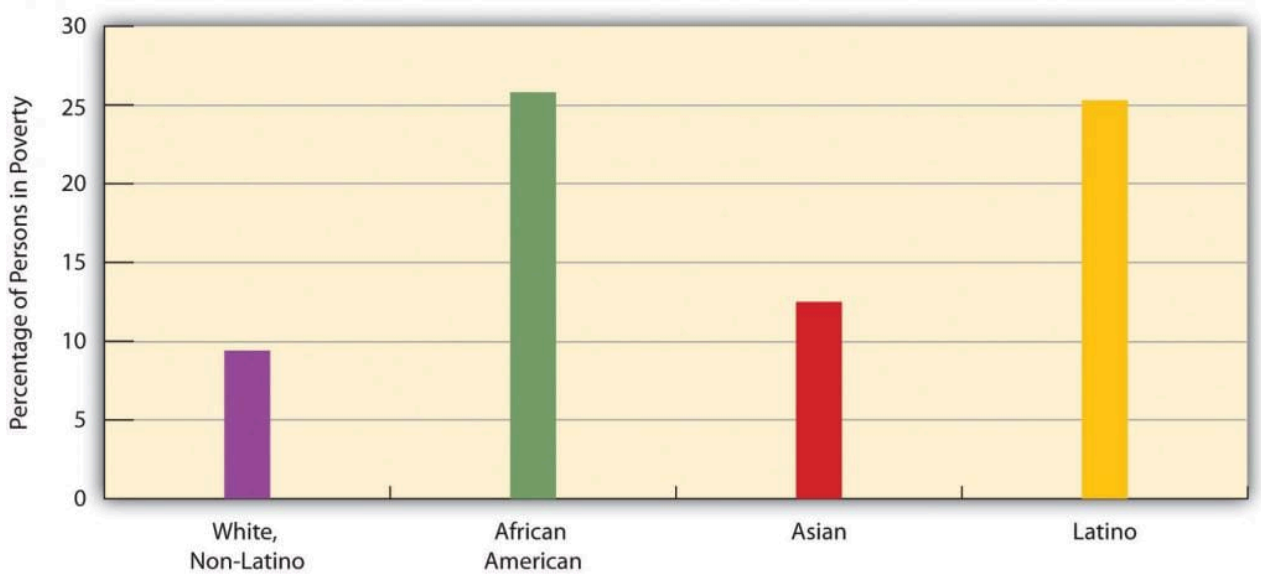


Figure 2.3 Race, Ethnicity, and Poverty, 2010 (Percentage of Each Group That Is Poor) Source: Data from DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2011). *Income, poverty, and health insurance coverage in the United States: 2010* (Current Population Report P60-239). Washington, DC: US Census Bureau.

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6: CHAPTER 6

6.1: Poverty

6.2: What Is Public Policy?

6.3: Poverty (Social Problems - Continuity and Change)

6.3.1: The Measurement and Extent of Poverty

6.3.2: Who the Poor Are- Social Patterns of Poverty

6.3.3: Explaining Poverty

6.3.4: The Consequences of Poverty

6.3.5: Global Poverty

6.3.6: Reducing Poverty

6.3.7: End-of-Chapter Material

6.4: Video- The myth of “us” and “them” – Why we all need the Welfare State

6.5: Video- Senator Stabenow Encourage Social Workers to Get Political

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6.3.3: Explaining Poverty

Learning Objectives

1. Describe the assumptions of the functionalist and conflict views of stratification and of poverty.
2. Explain the focus of symbolic interactionist work on poverty.
3. Understand the difference between the individualist and structural explanations of poverty.

Why does poverty exist, and why and how do poor people end up being poor? The sociological perspectives introduced in Chapter 1 “Understanding Social Problems” provide some possible answers to these questions through their attempt to explain why American society is *stratified*—that is, why it has a range of wealth ranging from the extremely wealthy to the extremely poor. We review what these perspectives say generally about social stratification (rankings of people based on wealth and other resources a society values) before turning to explanations focusing specifically on poverty.

In general, the functionalist perspective and conflict perspective both try to explain why social stratification exists and endures, while the symbolic interactionist perspective discusses the differences that stratification produces for everyday interaction. Table 2.2 “Theory Snapshot” summarizes these three approaches.

Table 2.2 Theory Snapshot

Theoretical perspective	Major assumptions
Functionalism	Stratification is necessary to induce people with special intelligence, knowledge, and skills to enter the most important occupations. For this reason, stratification is necessary and inevitable.
Conflict theory	Stratification results from lack of opportunity and from discrimination and prejudice against the poor, women, and people of color. It is neither necessary nor inevitable.
Symbolic interactionism	Stratification affects people’s beliefs, lifestyles, daily interaction, and conceptions of themselves.

The Functionalist View

As discussed in Chapter 1 “Understanding Social Problems”, functionalist theory assumes that society’s structures and processes exist because they serve important functions for society’s stability and continuity. In line with this view, functionalist theorists in sociology assume that stratification exists because it also serves important functions for society. This explanation was developed more than sixty years ago by Kingsley Davis and Wilbert Moore (Davis & Moore, 1945) in the form of several logical assumptions that imply stratification is both necessary and inevitable. When applied to American society, their assumptions would be as follows:

To illustrate their assumptions, say we have a society where shining shoes and doing brain surgery both give us incomes of $150,000 per year. (This example is *very* hypothetical, but please keep reading.) If you decide to shine shoes, you can begin making this money at age 16, but if you decide to become a brain surgeon, you will not start making this same amount until about age 35, as you must first go to college and medical school and then acquire several more years of medical training. While you have spent nineteen additional years beyond age 16 getting this education and training and taking out tens of thousands of dollars in student loans, you could have spent those years shining shoes and making $150,000 a year, or $2.85 million overall. Which job would you choose?



Functional theory argues that the promise of very high incomes is necessary to encourage talented people to pursue important careers such as surgery. If physicians and shoe shiners made the same high income, would enough people decide to become physicians? Public Domain Images – CC0 public domain.

As this example suggests, many people might not choose to become brain surgeons unless considerable financial and other rewards awaited them. By extension, we might not have enough people filling society's important jobs unless they know they will be similarly rewarded. If this is true, we must have stratification. And if we must have stratification, then that means some people will have much less money than other people. If stratification is inevitable, then, poverty is also inevitable. The functionalist view further implies that if people are poor, it is because they do not have the ability to acquire the skills and knowledge necessary for the important, high-paying jobs.

The functionalist view sounds very logical, but a few years after Davis and Moore published their theory, other sociologists pointed out some serious problems in their argument (Tumin, 1953; Wrong, 1959).

First, it is difficult to compare the importance of many types of jobs. For example, which is more important, doing brain surgery or mining coal? Although you might be tempted to answer with brain surgery, if no coal were mined then much of our society could not function. In another example, which job is more important, attorney or professor? (Be careful how you answer this one!)

Second, the functionalist explanation implies that the most important jobs have the highest incomes and the least important jobs the lowest incomes, but many examples, including the ones just mentioned, counter this view. Coal miners make much less money than physicians, and professors, for better or worse, earn much less on the average than lawyers. A professional athlete making millions of dollars a year earns many times the income of the president of the United States, but who is more important to the nation? Elementary school teachers do a very important job in our society, but their salaries are much lower than those of sports agents, advertising executives, and many other people whose jobs are far less essential.

Third, the functionalist view assumes that people move up the economic ladder based on their abilities, skills, knowledge, and, more generally, their merit. This implies that if they do not move up the ladder, they lack the necessary merit. However, this view ignores the fact that much of our stratification stems from lack of equal opportunity. As later chapters in this book discuss, because of their race, ethnicity, gender, and class standing at birth, some people have less opportunity than others to acquire the skills and training they need to fill the types of jobs addressed by the functionalist approach.

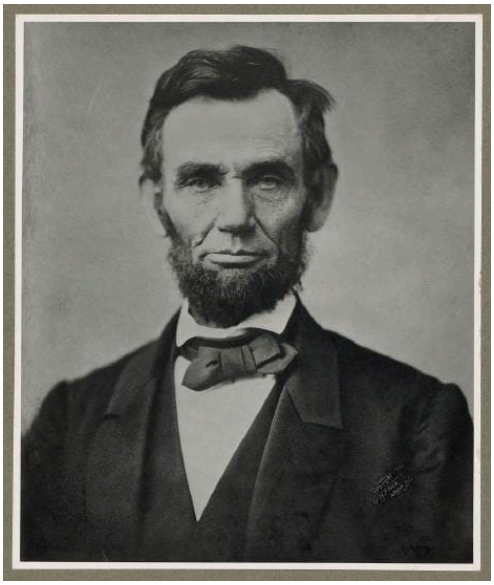
Finally, the functionalist explanation might make sense up to a point, but it does not justify the extremes of wealth and poverty found in the United States and other nations. Even if we do have to promise higher incomes to get enough people to become physicians, does that mean we also need the amount of poverty we have? Do CEOs of corporations really need to make millions of dollars per year to get enough qualified people to become CEOs? Do people take on a position as CEO or other high-paying job at least partly because of the challenge, working conditions, and other positive aspects they offer? The functionalist view does not answer these questions adequately.

One other line of functionalist thinking focuses more directly on poverty than generally on stratification. This particular

functionalist view provocatively argues that poverty exists because it serves certain positive functions for our society. These functions include the following: (1) poor people do the work that other people do not want to do; (2) the programs that help poor people provide a lot of jobs for the people employed by the programs; (3) the poor purchase goods, such as day-old bread and used clothing, that other people do not wish to purchase, and thus extend the economic value of these goods; and (4) the poor provide jobs for doctors, lawyers, teachers, and other professionals who may not be competent enough to be employed in positions catering to wealthier patients, clients, students, and so forth (Gans, 1972). Because poverty serves all these functions and more, according to this argument, the middle and upper classes have a vested interested in neglecting poverty to help ensure its continued existence.

1. **Some jobs are more important than other jobs.** For example, the job of a brain surgeon is more important than the job of shoe shining.
2. **Some jobs require more skills and knowledge than other jobs.** To stay with our example, it takes more skills and knowledge to perform brain surgery than to shine shoes.
3. **Relatively few people have the ability to acquire the skills and knowledge that are needed to do these important, highly skilled jobs.** Most of us would be able to do a decent job of shining shoes, but very few of us would be able to become brain surgeons.
4. **To encourage the people with the skills and knowledge to do the important, highly skilled jobs, society must promise them higher incomes or other rewards.** If this is true, some people automatically end up higher in society's ranking system than others, and stratification is thus necessary and inevitable.

The Conflict View



Because he was born in a log cabin and later became president, Abraham Lincoln's life epitomizes the American Dream, which is the belief that people born into poverty can become successful through hard work. The popularity of this belief leads many Americans to blame poor people for their poverty. US Library of Congress – public domain.

Conflict theory's explanation of stratification draws on Karl Marx's view of class societies and incorporates the critique of the functionalist view just discussed. Many different explanations grounded in conflict theory exist, but they all assume that stratification stems from a fundamental conflict between the needs and interests of the powerful, or "haves," in society and those of the weak, or "have-nots" (Kerbo, 2012). The former take advantage of their position at the top of society to stay at the top, even if it means oppressing those at the bottom. At a minimum, they can heavily influence the law, the media, and other institutions in a way that maintains society's class structure.

In general, conflict theory attributes stratification and thus poverty to lack of opportunity from discrimination and prejudice against the poor, women, and people of color. In this regard, it reflects one of the early critiques of the functionalist view that the previous section outlined. To reiterate an earlier point, several of the remaining chapters of this book discuss the various obstacles that make it difficult for the poor, women, and people of color in the United States to move up the socioeconomic ladder and to otherwise enjoy healthy and productive lives.

Symbolic Interactionism

Consistent with its micro orientation, symbolic interactionism tries to understand stratification and thus poverty by looking at people's interaction and understandings in their daily lives. Unlike the functionalist and conflict views, it does not try to explain why we have stratification in the first place. Rather, it examines the differences that stratification makes for people's lifestyles and their interaction with other people.

Many detailed, insightful sociological books on the lives of the urban and rural poor reflect the symbolic interactionist perspective (Anderson, 1999; C. M. Duncan, 2000; Liebow, 1993; Rank, 1994). These books focus on different people in different places, but they all make very clear that the poor often lead lives of quiet desperation and must find ways of coping with the fact of being poor. In these books, the consequences of poverty discussed later in this chapter acquire a human face, and readers learn in great detail what it is like to live in poverty on a daily basis.

Some classic journalistic accounts by authors not trained in the social sciences also present eloquent descriptions of poor people's lives (Bagdikian, 1964; Harrington, 1962). Writing in this tradition, a newspaper columnist who grew up in poverty recently recalled, "I know the feel of thick calluses on the bottom of shoeless feet. I know the bite of the cold breeze that slithers through a drafty house. I know the weight of constant worry over not having enough to fill a belly or fight an illness...Poverty is brutal, consuming and unforgiving. It strikes at the soul" (Blow, 2011).



Sociological accounts of the poor provide a vivid portrait of what it is like to live in poverty on a daily basis. Pixabay – CC0 public domain.

On a more lighthearted note, examples of the symbolic interactionist framework are also seen in the many literary works and films that portray the difficulties that the rich and poor have in interacting on the relatively few occasions when they do interact. For example, in the film *Pretty Woman*, Richard Gere plays a rich businessman who hires a prostitute, played by Julia Roberts, to accompany him to swank parties and other affairs. Roberts has to buy a new wardrobe and learn how to dine and behave in these social settings, and much of the film's humor and poignancy come from her awkwardness in learning the lifestyle of the rich.

Specific Explanations of Poverty

The functionalist and conflict views focus broadly on social stratification but only indirectly on poverty. When poverty finally attracted national attention during the 1960s, scholars began to try specifically to understand why poor people become poor and remain poor. Two competing explanations developed, with the basic debate turning on whether poverty arises from problems either within the poor themselves or in the society in which they live (Rank, 2011). The first type of explanation follows logically from the functional theory of stratification and may be considered an individualistic explanation. The second type of explanation follows from conflict theory and is a structural explanation that focuses on problems in American society that produce poverty. Table 2.3 "Explanations of Poverty" summarizes these explanations.

Table 2.3 Explanations of Poverty

Explanation	Major assumptions
Individualistic	Poverty results from the fact that poor people lack the motivation to work and have certain beliefs and values that contribute to their poverty.
Structural	Poverty results from problems in society that lead to a lack of opportunity and a lack of jobs.

It is critical to determine which explanation makes more sense because, as sociologist Theresa C. Davidson (Davidson, 2009) observes, "beliefs about the causes of poverty shape attitudes toward the poor." To be more precise, the particular explanation that people favor affects their view of government efforts to help the poor. Those who attribute poverty to problems in the larger society are much more likely than those who attribute it to deficiencies among the poor to believe that the government should do more to help the poor (Bradley & Cole, 2002). The explanation for poverty we favor presumably affects the amount of sympathy we have for the poor, and our sympathy, or lack of sympathy, in turn affects our views about the government's role in helping the poor. With this backdrop in mind, what do the individualistic and structural explanations of poverty say?

Individualistic Explanation

According to the individualistic explanation, the poor have personal problems and deficiencies that are responsible for their poverty. In the past, the poor were thought to be biologically inferior, a view that has not entirely faded, but today the much more common belief is that they lack the ambition and motivation to work hard and to achieve success. According to survey evidence, the majority of Americans share this belief (Davidson, 2009). A more sophisticated version of this type of explanation is called the *culture of poverty* theory (Banfield, 1974; Lewis, 1966; Murray, 2012). According to this theory, the poor generally have beliefs and values that differ from those of the nonpoor and that doom them to continued poverty. For example, they are said to be impulsive and to live for the present rather than the future.

Regardless of which version one might hold, the individualistic explanation is a blaming-the-victim approach (see Chapter 1 "Understanding Social Problems"). Critics say this explanation ignores discrimination and other problems in American society and exaggerates the degree to which the poor and nonpoor do in fact hold different values (Ehrenreich, 2012; Holland, 2011; Schmidt, 2012). Regarding the latter point, they note that poor employed adults work more hours per week than wealthier adults and that poor parents interviewed in surveys value education for their children at least as much as wealthier parents. These and other similarities in values and beliefs lead critics of the individualistic explanation to conclude that poor people's poverty cannot reasonably be said to result from a culture of poverty.

Structural Explanation

According to the second, structural explanation, which is a blaming-the-system approach, US poverty stems from problems in American society that lead to a lack of equal opportunity and a lack of jobs. These problems include (a) racial, ethnic, gender, and age discrimination; (b) lack of good schooling and adequate health care; and (c) structural changes in the American economic system, such as the departure of manufacturing companies from American cities in the 1980s and 1990s that led to the loss of thousands of jobs. These problems help create a vicious cycle of poverty in which children of the poor are often fated to end up in poverty or near poverty themselves as adults.

As Rank (Rank, 2011) summarizes this view, "American poverty is largely the result of failings at the economic and political levels, rather than at the individual level…In contrast to [the individualistic] perspective, the basic problem lies in a shortage of viable opportunities for all Americans." Rank points out that the US economy during the past few decades has created more low-paying and part-time jobs and jobs without benefits, meaning that Americans increasingly find themselves in jobs that barely lift them out of poverty, if at all. Sociologist Fred Block and colleagues share this critique of the individualistic perspective: "Most of our policies incorrectly assume that people can avoid or overcome poverty through hard work alone. Yet this assumption ignores the realities of our failing urban schools, increasing employment insecurities, and the lack of affordable housing, health care, and child care. It ignores the fact that the American Dream is rapidly becoming unattainable for an increasing number of Americans, whether employed or not" (Block, et. al., 2006).

Most sociologists favor the structural explanation. As later chapters in this book document, racial and ethnic discrimination, lack of adequate schooling and health care, and other problems make it difficult to rise out of poverty. On the other hand, some ethnographic research supports the individualistic explanation by showing that the poor do have certain values and follow certain practices that augment their plight (Small, et. al., 2010). For example, the poor have higher rates of cigarette smoking (34 percent

of people with annual incomes between $6,000 and $11,999 smoke, compared to only 13 percent of those with incomes $90,000 or greater [Goszkowski, 2008]), which helps cause them to have more serious health problems.

Adopting an integrated perspective, some researchers say these values and practices are ultimately the result of poverty itself (Small et, al., 2010). These scholars concede a culture of poverty does exist, but they also say it exists because it helps the poor cope daily with the structural effects of being poor. If these effects lead to a culture of poverty, they add, poverty then becomes self-perpetuating. If poverty is both cultural and structural in origin, these scholars say, efforts to improve the lives of people in the "other America" must involve increased structural opportunities for the poor and changes in some of their values and practices.

Key Takeaways

For Your Review

- According to the functionalist view, stratification is a necessary and inevitable consequence of the need to use the promise of financial reward to encourage talented people to pursue important jobs and careers.
- According to conflict theory, stratification results from lack of opportunity and discrimination against the poor and people of color.
- According to symbolic interactionism, social class affects how people interact in everyday life and how *they view certain aspects of the social world*.
- The individualistic view attributes poverty to individual failings of poor people themselves, while the structural view attributes poverty to problems in the larger society.

1. In explaining poverty in the United States, which view, individualist or structural, makes more sense to you? Why?
2. Suppose you could wave a magic wand and invent a society where everyone had about the same income no matter which job he or she performed. Do you think it would be difficult to persuade enough people to become physicians or to pursue other important careers? Explain your answer.

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6.3.4: The Consequences of Poverty

Learning Objectives

1. Describe the family and housing problems associated with poverty.
2. Explain how poverty affects health and educational attainment.

Regardless of its causes, poverty has devastating consequences for the people who live in it. Much research conducted and/or analyzed by scholars, government agencies, and nonprofit organizations has documented the effects of poverty (and near poverty) on the lives of the poor (Lindsey, 2009; Moore, et. al., 2009; Ratcliffe & McKernan, 2010; Sanders, 2011). Many of these studies focus on childhood poverty, and these studies make it very clear that childhood poverty has lifelong consequences. In general, poor children are more likely to be poor as adults, more likely to drop out of high school, more likely to become a teenaged parent, and more likely to have employment problems. Although only 1 percent of children who are never poor end up being poor as young adults, 32 percent of poor children become poor as young adults (Ratcliffe & McKernan, 2010).



Poor children are more likely to have inadequate nutrition and to experience health, behavioral, and cognitive problems. Kelly Short – Poverty: “Damaged Child,” Oklahoma City, OK, USA, 1936. (Colorized). – CC BY-SA 2.0.

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6.3.5: Global Poverty

Learning Objectives

1. Describe where poor nations tend to be located.
2. Explain the difference between the modernization and dependency theories of poverty.
3. List some of the consequences of global poverty.

As serious as poverty is in the United States, poverty in much of the rest of the world is beyond comprehension to the average American. Many of the world's poor live in such desperate circumstances that they would envy the lives of poor Americans. Without at all meaning to minimize the plight of the American poor, this section provides a brief look at the world's poor and at the dimensions of global poverty

Global Inequality

The world has a few very rich nations and many very poor nations, and there is an enormous gulf between these two extremes. If the world were one nation, its median annual income (at which half of the world's population is below this income and half is above it) would be only $1,700 (Dikhanov, 2005). The richest fifth of the world's population would have three-fourths of the world's entire income, while the poorest fifth of the world's population would have only 1.5 percent of the world's income, and the poorest two-fifths would have only 5.0 percent of the world's income (Dikhanov, 2005). Reflecting this latter fact, these poorest two-fifths, or about 2 billion people, live on less than $2 per day (United Nations Development Programme, 2009). As Figure 2.5 "Global Income Distribution (Percentage of World Income Held by Each Fifth of World Population)" illustrates, this distribution of income resembles a champagne glass.

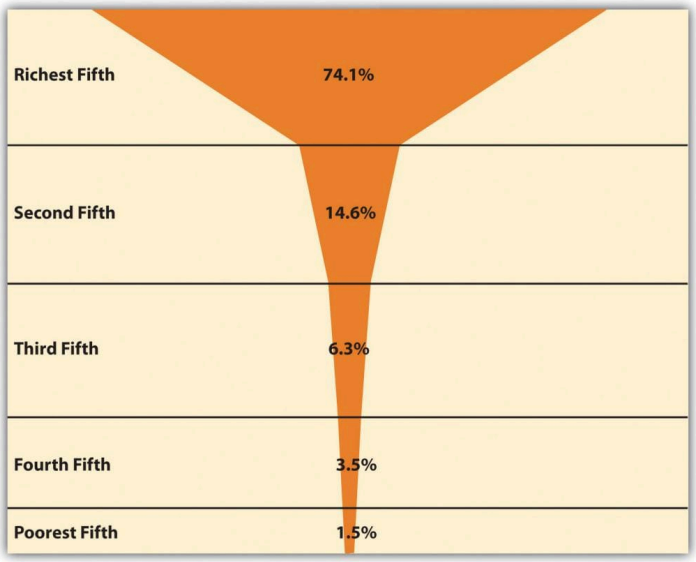


Figure 2.5 Global Income Distribution (Percentage of World Income Held by Each Fifth of World Population)

Source: Data from Dikhanov, Y. (2005). Trends in global income distribution, 1970–2000, and scenarios for 2015. New York, NY: United Nations Development Programme.

To understand global inequality, it is helpful to classify nations into a small number of categories based on their degree of wealth or poverty, their level of industrialization and economic development, and related factors. Over the decades, scholars and international organizations such as the United Nations and the World Bank have used various classification systems, or typologies. A popular typology today simply ranks nations into groups called *wealthy* (or high-income) nations, *middle-income* nations, and *poor* (or low-income) nations, based on measures such as gross domestic product (**GDP**) per capita (the total value of a nation's

goods and services divided by its population). This typology has the advantage of emphasizing the most important variable in global stratification: how much wealth a nation has. At the risk of being somewhat simplistic, the other important differences among the world's nations all stem from their degree of wealth or poverty. Figure 2.6 "Global Stratification Map" depicts these three categories of nations (with the middle category divided into upper-middle and lower-middle). As should be clear, whether a nation is wealthy, middle income, or poor is heavily related to the continent on which it is found.

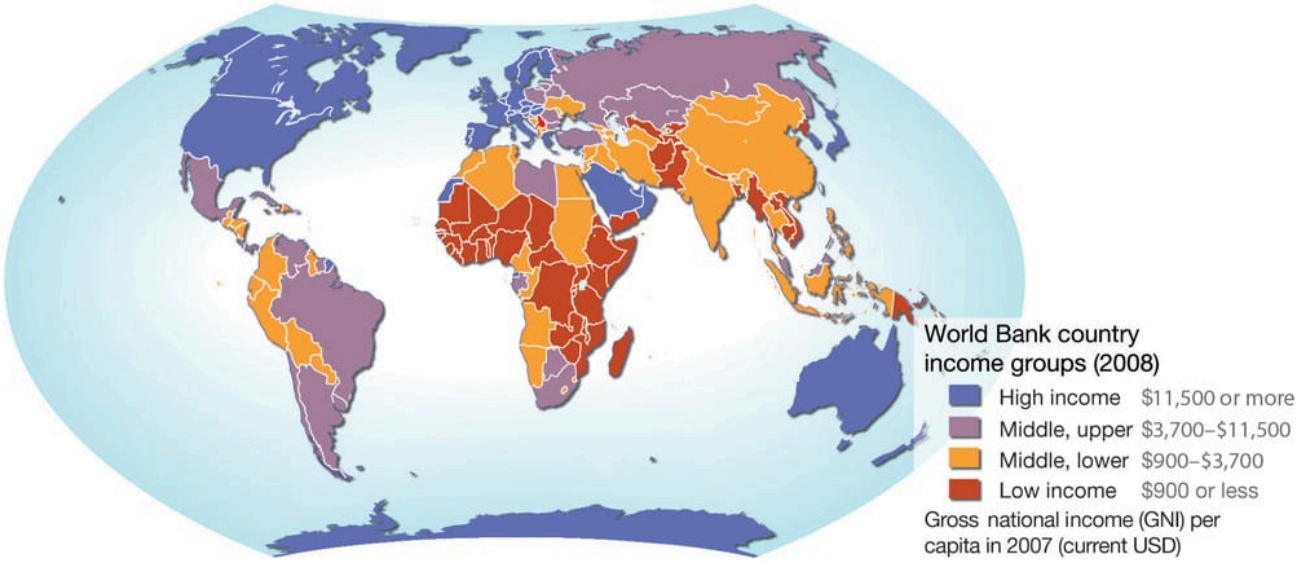


Figure 2.6 Global Stratification Map

Source: Adapted from UNEP/GRID-Arendal Maps and Graphics Library. (2009).Country income groups (World Bank classification). Retrieved from http://maps.grida.no/go/graphic/coun...classification.

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6.3.6: Reducing Poverty

Learning Objectives

1. Explain why the United States neglects its poor.
2. List any three potentially promising strategies to reduce US poverty.
3. Describe how to reduce global poverty from a sociological perspective.

As this chapter noted at the outset, the United States greatly reduced poverty during the 1960s through a series of programs and policies that composed the so-called war on poverty. You saw evidence of the success of the war on poverty in Figure 2.1 "US Poverty, 1959–2010", which showed that the poverty rate declined from 22.2 percent in 1960 to a low of 11.1 percent in 1973 before fluctuating from year to year and then rising since 2000. The Note 2.19 "Lessons from Other Societies" box showed that other democracies have much lower poverty rates than the United States because, as many scholars believe, they have better funded and more extensive programs to help their poor (Brady, 2009; Russell, 2011).

The lessons from the 1960s' war on poverty and the experience of other democracies are clear: It is very possible to reduce poverty if, and only if, a nation is willing to fund and implement appropriate programs and policies that address the causes of poverty and that help the poor deal with the immediate and ongoing difficulties they experience.

A major reason that the US poverty rate reached its low in 1973 and never went lower during the past four decades is that the United States retreated from its war on poverty by cutting back on the programs and services it had provided during that good war (Soss, et. al., 2007). Another major reason is that changes in the national economy during the past few decades have meant that well-paying manufacturing jobs have been replaced by low-paying service jobs with fewer benefits (Wilson, 2010). Yet this has also happened in other democracies, and their poverty rates remain lower than the US rate because, unlike the United States, they have continued to try to help their poor rather than neglect them.

Why does the United States neglect its poor? Many scholars attribute this neglect to the fact that many citizens and politicians think the poor are poor because of their own failings. As summarized by sociologist Mark R. Rank (Rank, 2011), these failings include "not working hard enough, failure to acquire sufficient skills, or just making bad decisions." By thus blaming the poor for their fate, citizens and politicians think the poor do not deserve to have the US government help them, and so the government does not help, or at least not nearly as much as other democracies do. We have seen that the facts do not support the myth that the poor lack motivation to work, but that does not lessen the blame given the poor for being poor.

To renew the US effort to help the poor, it is essential that the actual facts about poverty become better known so that a fundamental shift in thinking about poverty and the poor can occur. Rank (Rank, 2011) says that one aspect of this shift must include the recognition, as noted at the beginning of this chapter, that "poverty affects us all" because it costs so many tax dollars to help the poor and because a majority of the public can expect to be poor or near poor at some point in their lives. A second aspect of this shift in thinking, adds Rank, is the recognition (following a blaming-the-system approach) that poverty stems much more from the lack of opportunity, lack of jobs, declining government help for the poor, and other structural failings of American society than from individual failings of the poor themselves. A third aspect of this shift in thinking, he concludes, is that poverty must become seen as a "moral problem" and as "an injustice of a substantial magnitude" (Rank, 2011). As he forcefully argues, "Something is seriously wrong when we find that, in a country with the most abundant resources in the world, there are children without enough to eat, families who cannot afford health care, and people sleeping on the streets for lack of shelter" (Rank, 2011). This situation, he says, must become seen as a "moral outrage" (Rank, 2011).

Sociologist Joe Soss (Soss, 2011) argues that a change in thinking is not enough for a renewed antipoverty effort to occur. What is needed, he says, is political protest and other political activity by the poor and on behalf of the poor. Soss notes that "political conflict and mass mobilization played key roles" in providing the impetus for social-welfare programs in the 1930s and 1960s in the United States, and he adds that the lower poverty rates of Western European democracies "are products of labor movements, unions, and parties that mobilized workers to demand more adequate social supports." These twin histories lead Soss to conclude that the United States will not increase its antipoverty efforts unless a new wave of political activity by and on behalf of the poor arises. As he argues, "History suggests that major antipoverty victories can be achieved. But they won't be achieved by good will and smart ideas alone. They'll be won politically, when people—in poor communities, in advocacy groups, in government, in the academy, and elsewhere—mobilize to advance antipoverty agendas in ways that make politics as usual untenable."

Antipoverty Programs and Policies



To help reduce poverty, it is essential to help poor parents pay for child care. Herald Post – Family Child Care – CC BY-NC 2.0.

If a renewed antipoverty effort does occur for whatever reason, what types of programs and policies show promise for effectively reducing poverty? Here a sociological vision is essential. It is easy to understand why the hungry schoolchildren described in the news story that began this chapter might be going without food during a very faltering national economy. Yet a sociological understanding of poverty emphasizes its structural basis in bad times and good times alike. Poverty is rooted in social and economic problems of the larger society rather than in the lack of willpower, laziness, or other moral failings of poor individuals themselves. Individuals born into poverty suffer from a lack of opportunity from their first months up through adulthood, and poverty becomes a self-perpetuating, vicious cycle. To the extent a culture of poverty might exist, it is best seen as a logical and perhaps even inevitable outcome of, and adaptation to, the problem of being poor and not the primary force driving poverty itself.

This sort of understanding suggests that efforts to reduce poverty must address first and foremost the structural basis for poverty while not ignoring certain beliefs and practices of the poor that also make a difference. An extensive literature on poverty policy outlines many types of policies and programs that follow this dual approach (Cancian & Danziger, 2009; Greenberg, et. al., 2007; Iceland, 2006; Lindsey, 2009; Moore et al., 2009; Rank, 2004). If these were fully adopted, funded, and implemented, as they are in many other democracies, they would offer great promise for reducing poverty. As two poverty experts recently wrote, “We are optimistic that poverty can be reduced significantly in the long term if the public and policymakers can muster the political will to pursue a range of promising antipoverty policies” (M. Cancian & S. Danziger, 2009, p. 32).Cancian, M., & Danziger, S. H. (2009). *Changing poverty, changing policies*. New York, NY: Russell Sage Foundation. Although a full discussion of these policies is beyond the scope of this chapter, the following measures are commonly cited as holding strong potential for reducing poverty, and they are found in varying degrees in other Western democracies:

1. Adopt a national “full employment” policy for the poor, involving federally funded job training and public works programs, and increase the minimum wage so that individuals working full-time will earn enough to lift their families out of poverty.
2. Increase federal aid for the working poor, including higher earned income credits and child-care subsidies for those with children.
3. Establish well-funded early childhood intervention programs, including home visitations by trained professionals, for poor families.
4. Provide poor families with enough income to enable them to pay for food and housing.
5. Increase the supply of affordable housing.
6. Improve the schools that poor children attend and the schooling they receive and expand early childhood education programs for poor children.
7. Provide better nutrition and health services for poor families with young children.
8. Establish universal health insurance.
9. Increase Pell Grants and other financial aid for higher education. Global Poverty
    1. Write a brief essay summarizing the changes in thinking that some sociologists argue must occur before a renewed

effort to reduce poverty can take place.
2. Write a brief essay summarizing any four policies or programs that could potentially lower US poverty.

Global Poverty

Years of international aid to poor nations have helped them somewhat, but, as this chapter has shown, their situation remains dire. International aid experts acknowledge that efforts to achieve economic growth in poor nations have largely failed, but they disagree why this is so and what alternative strategies may prove more successful (Cohen & Easterly, 2009).Cohen, J., & Easterly, W. (Eds.). (2009). *What works in development? Thinking big and thinking small*. Washington, DC: Brookings Institution Press. One very promising trend has been a switch from macro efforts focusing on infrastructure problems and on social institutions, such as the schools, to micro efforts, such as providing cash payments or small loans directly to poor people in poor nations (a practice called *microfinancing*) and giving them bed nets to prevent mosquito bites (Banerjee & Duflo, 2011; Hanlon, Barrientos, & Hulme, 2010; Karlan & Appel, 2011).Banerjee, A. V., & Duflo, E. (2011). *Poor economics: A radical rethinking of the way to fight global poverty*. New York, NY: PublicAffairs; Hanlon, J., Barrientos, A., & Hulme, D. (2010). *Just give money to the poor: The development revolution from the global south*. Sterling, VA: Kumarian Press; Karlan, D., & Appel, J. (2011). *More than good intentions: How a new economics is helping to solve global poverty*. New York, NY: Dutton. However, the evidence on the success of these efforts is mixed (Bennett, 2009; The Economist, 2010).Bennett, D. (2009, September 20). Small change. *The Boston Globe*. Retrieved from http://www.boston.com/bostonglobe/id...fight_poverty/; The Economist. (2010). A better mattress. *The Economist, 394*(8673), 75–76. Much more to help the world's poor certainly needs to be done.

In this regard, sociology's structural approach is in line with dependency theory and suggests that global stratification results from the history of colonialism and from continuing exploitation today of poor nations' resources by wealthy nations and multinational corporations. To the extent such exploitation exists, global poverty will lessen if and only if this exploitation lessens. A sociological approach also emphasizes the role that class, gender, and ethnic inequality play in perpetuating global poverty. For global poverty to be reduced, gender and ethnic inequality must be reduced.

Writers Nicholas D. Kristof and Sheryl WuDunn (2010)Kristoff, N. D., & WuDunn, S. (2010). *Half the sky: Turning oppression into opportunity for women worldwide*. New York, NY: Vintage Books. emphasize the need to focus efforts to reduce global poverty of women. We have already seen one reason this emphasis makes sense: women are much worse off than men in poor nations in many ways, so helping them is crucial for both economic and humanitarian reasons. An additional reason is especially illuminating: When women in poor nations acquire extra money, they typically spend it on food, clothing, and medicine, essentials for their families. However, when men in poor nations acquire extra money, they often spend it on alcohol, tobacco, and gambling. This gender difference might sound like a stereotype, but it does indicate that aid to women will help in many ways, while aid to men might be less effective and often even wasted.

Key Takeaways

For Your Review

- According to some sociologists, a change in thinking about poverty and the poor and political action by and on behalf of the poor are necessary for a renewed effort to help poor Americans.
- Potentially successful antipoverty programs and policies to help the US poor include expanding their employment opportunities and providing them much greater amounts of financial and other aid.
- To help people in poor nations, gender and ethnic inequality must be addressed.

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6.3.7: End-of-Chapter Material

Summary

1. Poverty statistics are misleading in at least two ways. First, the way that poverty is measured is inadequate for several reasons, and more accurate measures of poverty that have recently been developed suggest that poverty is higher than the official poverty measure indicates. Second, even if people live slightly above the poverty line, they are still living in very difficult circumstances and are having trouble making ends meet.
2. Children, people of color, the South, and single-parent families headed by women have especially high poverty rates. Despite what many Americans think, the most typical poor person is white, and most poor people who are able to work outside the home in fact do work.
3. To explain social stratification and thus poverty, functionalist theory says that stratification is necessary and inevitable because of the need to encourage people with the needed knowledge and skills to decide to pursue the careers that are most important to society. Conflict theory says stratification exists because of discrimination against, and blocked opportunities for, the have-nots of society. Symbolic interactionist theory does not try to explain why stratification and poverty exist, but it does attempt to understand the experience of being poor.
4. The individualistic explanation attributes poverty to individual failings of poor people themselves, while the structuralist explanation attributes poverty to lack of jobs and lack of opportunity in the larger society.
5. Poverty has serious consequences in many respects. Among other problems, poor children are more likely to grow up to be poor, to have health problems, to commit street crime, and to have lower levels of formal education.
6. The nations of the world differ dramatically in wealth and other resources, with the poorest nations being found in Africa and parts of Asia.
7. Global poverty has a devastating impact on the lives of hundreds of millions of people throughout the world. Poor nations have much higher rates of mortality and disease and lower rates of literacy.
8. Modernization theory attributes global poverty to the failure of poor nations to develop the necessary beliefs, values, and practices to achieve economic growth, while dependency theory attributes global poverty to the colonization and exploitation by European nations of nations in other parts of the world.
9. A sociological perspective suggests that poverty reduction in the United States and around the world can occur if the structural causes of poverty are successfully addressed.

Using What You Know

It is December 20, and you have just finished final exams. In two days, you will go home for winter break and are looking forward to a couple weeks of eating, sleeping, and seeing your high school friends. Your smartphone signals that someone has texted you. When you read the message, you see that a friend is asking you to join her in serving a holiday supper on December 23 at a food pantry just a few miles from your campus. If you do that, you will not be able to get home until two days after you had been planning to arrive, and you will miss a big high school “reunion” party set for the night of the twenty-third. What do you decide to do? Why?

What You Can Do

To help fight poverty and the effects of poverty, you may wish to do any of the following:

1. Contribute money to a local, state, or national organization that provides various kinds of aid to the poor.
2. Volunteer at a local food pantry or homeless shelter.
3. Start a canned food or used clothing drive on your campus.
4. Write letters or send e-mails to local, state, and federal officials that encourage them to expand antipoverty programs.

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6.4: Video- The myth of “us” and “them” – Why we all need the Welfare State

YouTube Video

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6.5: Video- Senator Stabenow Encourage Social Workers to Get Political

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UNIT 4: CLIENT POPULATIONS AND SETTINGS

7: Chapter 7

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7: CHAPTER 7

7.1: Child Welfare and Foster Care
7.2: Video- How Childhood Trauma affects Health across a Lifetime

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7.1: Child Welfare and Foster Care

One hundred years from now it won't matter what car I drove, what kind of house I lived in, how much I had in my bank account, nor what my clothes looked like. But, the world may be a little better because I was important in the life of a child. – *Unknown*

In this chapter, you will learn many of the basics of child welfare and foster care. In addition, you will learn about family, what the basic definition of family is, the various family functions, and how these play a role in the child welfare system. Family is the foundation of the child welfare system. The child welfare system is necessary to help keep children safe, including providing safe places to live through other family members or even foster care. Before the welfare system existed, the safety of children was left up to the parents. They were able to punish and raise their children however they felt was necessary.

You will learn through this chapter that the necessity of the child welfare system is important to help families keep children safe. Also, some myths about the child welfare system may be refuted as well to hopefully give you as the reader a better understanding of what the child welfare system is and what it is not.

To get a good overview/understanding of what a child may experience with their family, abuse, and in the Child Welfare System (CPS and Foster Care), please follow this link and watch the two videos provided. Warning, this video may evoke some heavy emotions of sadness, so prepare yourself to watch this video: Removed Film (https://www.removedfilm.com/pages/watch)

Family

Family Structure

Families are the foundation of society. Family is where children learn the basic skills necessary to succeed. Children learn how to interact with others, learn what love is, and more. There are numerous types of family structures, and each culture has its own family practice. A basic definition of family, according to the United States Census Bureau, is a group of people (two or more) that are related in various ways including birth, marriage, or adoption, and share residence with one another. This section will outline various family structures along with highlighting some families within different cultures.

The family structure is ever changing and can have various effects on the family as they move forward. A traditional family, also known as nuclear family, is defined by Edwards (2007) as a married couple and their biological children. This is one of the more reinforced family structures in the dominant society. It should be noted that a child starts out with their traditional family, and as they grow, becomes more involved in outside activities, or even move out to live with others. Thus, the family grows to beyond relatives and includes friends. Another thing to keep in mind is the idea that a child may start out in one type of family structure and then the structure or dynamic of that family may change due to divorce, death, parents marrying again, or even just an addition to the family through adoption, foster care and more.

Single-parent families are families with one parent and their child/children. The parent has sole responsibility for caring for their child. Though most think of it being single mothers, this includes fathers as well, and can happen in various other ways. The parents could separate and/or divorce/break-up and do what is known as co-parenting. Edwards (2009), coins the term as co-custody family. This is shared responsibility, in which both parents take care of the child at different points (i.e one parent may have them for a week and the other would have them on weekends or every other weekend). The co-parenting can be set up in various ways either through Friend of the Court, or just by mutual agreement. Single parent families can also occur by a spouse passing away. Grief counseling would then be a great tool for these families to utilize.

Key Term

Friend of the Court or FOC, is a section of the circuit court that investigates custody, parenting time, or even child support. They are directed by the judge, and is in a sense a third party to a lawsuit who is not the defendant or the plaintiff (the person who places the complaint in a lawsuit).

To learn more about what a FOC is and what their duties are, look at this FOC handbook provided by the Michigan Government. courts.mi.gov/administration/scao/resources/documents/publications/manuals/focb/focb_hbk.pdf

Often parents who are divorced or become a single parent by other means potentially remarry to others who may or may not

have children of their own. This in turn creates what is known as step-family. Step-family refers to the dynamics of a re-married couple who have children but do not all share DNA. This means that the mother may have a child, but the child is only the fathers' responsibility through marriage and not by any other means (same with the father having a child who does not share DNA with the mother). Another aspect to consider when step-families are created is that when they then have children together it creates a blended-family. Though the children may not be biologically related to both parents, they can still have a secure and strong bond/attachment with said parent. Some children may refer to their step-parent as their mother or father, and some may refer to them by first name. When working with the children within this family structure, validate them by addressing their caregivers the same way they do. This in turn will help build the rapport with the child needed to be able to help them to the best of our ability.

An extended family is a family that includes members outside of the nuclear family. This term encompasses the grandparents, aunts, uncles, cousins and more. In some cultures, the extended family members, more specifically grandparents, live with the nuclear family. Now, especially in American society, we see a lot of the elderly being placed in nursing homes. Even if they do stay home, usually they rely on home health practitioners for support. To learn more about the area of gerontology and the social workers role within that population refer to Chapter 8.

Keep in mind that these are only a handful of the various types of family. Other types may include transnational, LGBTQ (this population is especially vulnerable due to difficulty with civil rights), and more.

Family Function

One of the foundational functions of a family is to care for their children. Clinical Psychologist Diana Baumrind founded three models of parenting styles. These include **authoritarian**, **permissive**, and **authoritative** parents. Enrique et al. (2007) added **uninvolved** parenting as a style in child rearing.

Authoritarian parenting is defined by Baumrind (1966) as a parenting style that attempts to shape or control a child's behavior with a set of absolute standards. They are typically the type of parents that lay out the rules with "no questions asked" mentality. Therefore, they expect their rules to be followed with no explanation at all.

Permissive parenting is known more as the responsive type rather than the demanding type. Characteristically, they are very "lenient, do not require mature behavior, and avoid confrontation" (Enrique et al., 2007). Baumrind (1966) describes permissive parenting as a style that does not expect or demand help around the house, orderly behavior and so on. However, she also describes them as parents who are more accepting of the child's behavior.

Authoritative parenting is described by Baumrind (1966) as the parent attempting to "direct the child's activities in a rational, issue oriented manner. Encourages verbal give and take," and more (p. 891). Authoritative parenting is seen as more ideal and valued as this parenting style tends to encourage structure, and firmness with rules, but it does not restrict the child in any way.

Uninvolved parenting can take on many forms, but in every form the parents do not involve themselves in their child's lives. Enrique et. al (2007), discuss that with uninvolved parenting parents are either too involved in other activities (work, friends, etc.) that they do not have the time or energy for their child(ren), or they may have even rejected their child.

It is important to consider that the parenting styles listed above only describe normative behaviors; meaning, they are not taking into consideration homes with abusive parents or other variations that could occur. A "crucial role for parents is to influence, teach, and control their children" (Enrique et. al, 2007). In other words, caregivers have a tremendous amount of impact on a child's life. For example, a child who grew up in a household where the parents are accepting of everyone, non-judgmental, and respectful, may then portray the same behaviors in other environments. Thus, the four primary parenting styles simply describe some of the various ways in which parents attempt to interact and influence their children.



One of the foundational functions of a family is to care for their children.

Key Term

Antisocial Behavior: Antisocial Behavior is termed as Antisocial Personality Disorder in the DSM 5. This means that a person typically has no regard for others in the form of violence, and others, lack of remorse, no regard for safety, lack of empathy, and more.

To get more information refer to the DSM 5.

You can also follow the link provided to read more about it online: www.ncbi.nlm.nih.gov/books/NBK55333/ You can also learn more in Chapter 9: Mental Health and Substance Use.

Each parenting style has positive and negative aspects and having a balance is key. Baumrind (1966) discusses the various effects of different parenting styles and found that authoritative parenting tends to have a positive effect on children. She mentioned that having firm control was associated with conscious development and being too rigid could lead to hostility in children. Authoritative parenting, as mentioned above, is a mixture of give and take, and firm control. This typically allows the parents to have their children obey rules, and to discuss many variables as well to help the child understand the punishment.

Baumrind (1966) states that the key to avoiding negative outcomes when parenting children is to offer firmness and structure, but to not be repressive, hostile or restrictive. She goes on to mention that partaking in a more rigid and restrictive parenting style can lead to antisocial behavior, rebelliousness, and hostility. Authoritarian parenting, where the parents are more rigid – almost as if a drill sergeant – can have many negative effects, like hostility in children. Being more restrictive can lead to decreasing self-assertiveness in children, as well, according to Baumrind (1966).

Family Culture/Values

In the field of social work, it is highly important to remember that we are to validate the families we work with and not judge them. We must acknowledge the family's culture by respecting their belief systems and values. For example, if a family comes to you and you notice that the female is looking down and not making eye contact, consider the fact that in their culture that may be how the female shows respect to her husband, and possibly other authoritative figures. Thus, interacting with the family in the way they feel comfortable (i.e talking to the husband first etc.) will help one build a solid rapport (close relationship) with the family group.

Enrique et al. (2007), provides the following ideas for working with families:

Working with Families

1. Avoid stereotyping

2. When introducing new ideas, materials, and more respect the family's need for control
3. Recognize the parenting styles being utilized, and their boundaries
4. Recognize that everything may be a family affair with some families
5. Help families notice their strengths within each other
6. Ask for family's input when coming up with solutions to conflict
7. Encourage families to plan ways to increase stability and security (i.e. bedtime rituals etc.)
8. Observe and engage with the family to learn the different dynamics (i.e. male head of the household, or is it the female?)
9. Provide opportunities for the family to discuss what their beliefs are about children (should they be seen not heard etc.)
10. Maintain an objective viewpoint when working with conflict within the family system



Child welfare wordcloud

Child Welfare

Brief History

Child welfare is necessary in our society to help maintain child safety and keep families working cohesively. The Child Welfare Information Gateway (CWIG) (www.childwelfare.gov) defines child welfare as a field of services that aims to protect children and ensure family have the tools to care for their children successfully. Many people see this happen through an agency like the Department of Health and Human Services (DHHS) which is present in every state. To ensure the safety of children, DHHS is responsible for performing various tasks. These tasks include things like coordinating services to help prevent abuse or neglect, and providing services to families who need help protecting and caring for children. They are also responsible for investigating reports of potential abuse and/or neglect, and then determining if alternative placement of children is necessary. They are also in charge of various other aspects including support services to children, achieving reunification, and more. Child protective service workers and foster care workers are the more specific workers in which these work functions are performed.

According to Myers (2008), the first organization that was solely focused on protection was known as the New York Society for the Prevention of Cruelty to Children. This agency was established in 1875, and prior to that many children in our society went without protection, although many people were still prosecuted by the criminal justice system. Organized protection services came about after the rescue of 11-year-old Mary Ellen Wilson who was continuously beaten and neglected in her home.

If you want to learn more about how her story inspired the creation of the New York Society for the Prevention of Cruelty to Children follow this link: http://www.facesofchildabuse.org/mary-ellen-wilson.html

The federal government did not become more involved in child welfare until approximately 1935 when they became more involved with the funding of the agencies. Thus, it was the Great Depression that sparked the start of the Child Welfare System. In 1975, Michigan passed the Child Protection Law available to view at the link provided below. This act defines various abuses, central registry and various other aspects that involve the child welfare system. The act provides guidelines for people to follow in regard

to when to report (and what is grounds for a report, the court processes, and more).

https://www.michigan.gov/documents/DHS-PUB-0003_167609_7.pdf

Indian Child Welfare Act (ICWA)

ICWA is another segment of child welfare specifically for Native American families. “In 1958 until 1967 the Child Welfare League of America has contracted with the Bureau of Indian Affairs with the purpose of placing Native American children with white families in hopes of assimilating the children to mainstream culture.” (ICWA Law Center). This practice often left the children in boarding schools severing the relationship with the families. In response, the Indian Child Welfare Act was put into place in 1978. This act highlights the recognition of tribal sovereignty, preservation of Indian families, and tribal and family connectedness. To learn more about the ICWA visit the link provided.

http://www.icwlc.org/education-hub/understanding-the-icwa/

Child Protection Services

Child Protection Services, or CPS, is a segment within the Department of Health and Human Services. The role of CPS is filled by a variety of disciplines including but not limited to Social Work, Criminal Justice, and Psychology. According to the Michigan Department of Health and Human Services website CPS is “responsible investigating allegations of child abuse and neglect” (MDHHS, 2017c). There are many rules and regulations when it comes to the process of a CPS investigation and the removal of a child from the home. Keep in mind that though many think of CPS workers as being “kid snatchers” the intent of CPS is not to remove children just because they feel like it. Instead, their goal is to keep the family together if possible. They remove children if their safety is being threatened. The link provided outlines in more detail the grounds for a removal. If services alone cannot help provide protection and safety to children then a removal is necessary. dhhs.michigan.gov/OLMWEB/EX/PS/Public/PSM/715-2.pdf

The process of a CPS investigation starts out with a report called in of a suspected child abuse/neglect case. Chapter 2: Social Work Values and Ethics provides a definition of mandated reporting as well as the people who are mandated reporters. After a report has been made, CPS has 24 hours to begin the investigation, unless there are mitigating circumstances in which the investigation needs to be started sooner. There are different priority levels in which an investigation takes place. This is explained in the Child Protective Services Manual.

Priority one is when the child is in immediate danger, and thus CPS has 12 hours to begin the investigation and 24 hours to interview the victim. Priority two is when it is determined that the child is not in immediate danger/risk. The CPS worker then has 24 hours to begin the investigation, and 72 hours to initiate an interview with the child. After the investigation has begun, CPS then has 30 days to complete the investigation (unless there are circumstances that cause a need for an extension) and to determine whether or not the child needs to be removed, if further support services are needed, or if there is no need for an intervention.

According to the Michigan Government, the investigation typically includes face to face interviews with the alleged victims, caregivers, and the person who supposedly committed the act of abuse. They do a thorough search of the home making sure that there is food, running water, electricity, a bed to sleep in and that the house is well kept and clear of any safety hazards. The investigator then digs into previous reports, potential criminal history, and school and medical reports as well. They do a safety risk assessment, and analyze the child’s behavior and risk of future abuse/neglect, and then complete an assessment of the family’s needs and strengths as well.

The purpose of the assessments and interviews is to get a well-rounded understanding of what is going on. They are searching for things like alternative explanations of what was reported, if the child has any injuries, the condition of the home, adequate supervision, and do the best they can in finding out if the caretakers are abusing or neglecting the child in any way and more.

The next step is determination for removal (follow this link, Removal, to learn more about what the state finds as grounds for removal). There must be enough evidence to prove that the child was abused or neglected in some way.

MDHHS identifies five categories in which a case is placed depending on the evidence that was found during the investigation. They range from Category I to Category V.

- **Category I:** Department determines that there is enough evidence of abuse or neglect and court petition is needed and required.
- **Category II:** Department determines that there is enough evidence of abuse or neglect, and the risk assessments show high

risks
- **Category III:** Department determines that there enough evidence of abuse and neglect, and the risk assessments show a low or moderate risk
- **Category IV:** Department did not find enough evidence of abuse and or neglect and the department must then assist the child's family in participating in community based services.
- **Category V:** In this instance CPS was unable to locate the family, or there was no evidence of abuse or neglect. It is also possible that the courts may have declined to issue an order in which the family would be required to cooperate in the investigation.

These categories were listed at the Michigan government website (link below). In Category I and Category II cases, the person who committed the act of violence will be placed on the Child Abuse and Neglect Central Registry.

http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_7194-159484--,00.html

Though removals may be necessary, they are still traumatic for the child. The child has a bond with the caregiver, and that caregiver is all they know. If there is more than one child involved, CPS will try and keep the children together. A child who has been through any type of abuse in their home still has a strong emotional bond between all members of the family. That is why many people are confused as to why the victim may want to return to their families who harmed them. That is where their bond is, and it will take time for them to understand that what has happened is wrong and they deserve better.

CPS workers work in a high stress position. They often are entering into environments in which the safety of a child, and even their own safety, is of great concern. Vicarious Trauma (often known as secondary trauma) is another type of trauma in which CPS workers will need to be aware of. Vicarious trauma is defined by the National Children's Traumatic Institute as the "experience of professionals who are exposed to others' traumatic experiences and in turn develop their own traumatic systems and reactions" (NCTSN, 2012, p. 1).

Due to the high stress, and the emotional toll that this job can have on a person, self-care is highly important. Self-Care is in a sense something that a person does to help them cope with stress. This can be through meditation, doing an activity that they enjoy, going for a walk and more. YouTube, is a great resource to look up guided meditation videos. NCTSN (2012) discusses that without coping mechanisms, or even seeking out help for it, the reaction from one person can impact other workers until it spreads. The spreading is then as if the whole agency is one person who has experienced secondary trauma, thus burnout rates increase.

Key Term

Burnout: "prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by three dimensions of exhaustion, cynicism, and inefficacy" (Maslach, Schaufeli, Leiter, 2001, p. 397). In a sense, a person no longer has the passion or empathy they once had. The link below is an article that describes the signs of burnout, and what to do for prevention.

Prevention is the key to fighting against burnout. http://www.naswassurance.org/pdf/PP_Burnout_Final.pdf



Abused children often suffer from trauma throughout their adult lives. Patients that were exposed to trauma in early childhood can express their anxieties through drawings.

Types of Abuse/Trauma

Children involved in the Child Welfare System have often experienced trauma. Trauma is defined by the National Child Traumatic Stress Network as frightening events that are overwhelming to anyone who experiences them (NTCSN, 2017). Often a person feels that their safety is a concern and are on high alert to anticipate what may or may not happen next. There are three different types of trauma: acute, chronic and complex.

Before defining the different types of trauma, one must understand that all types of trauma impact the brain. The stress hormone cortisol is released, then creating the fight or flight mentality. These reactions can occur any time after a traumatic experience. The link provided is a video that explains the effects of trauma on the brain and provides many explanations of how one can help others' who have experienced trauma: www.changingmindsnow.org.

Acute Trauma / Chronic Trauma

Acute Trauma is a single traumatic incident. An example would be a car accident or even a natural disaster. It may only be a single incident, but it can have lasting effects such as fear of being in a vehicle. Chronic Trauma is a traumatic experience that is repeated over a period of time. This type of trauma would include domestic violence, and war. Both have lasting effects on many people and the consequences can be hard to overcome.

Complex Trauma

Complex Trauma is a repeated traumatic experience that has been inflicted by a caregiver. This includes, but is not limited to, physical abuse, sexual abuse, and verbal/emotional abuse (also known as psychological abuse). Complex trauma leaves a child confused and conflicted. The person who inflicted harm was supposed to be the one protecting them and keeping them safe. When that does not happen the child is then in a predicament where they do not know who to trust. A main type of trauma that will be highlighted in this chapter is complex trauma. This type of trauma occurs in various forms of abuse which are defined below.

Abuse comes in many forms including physical, emotional/verbal, and sexual abuse. According to the National Child Traumatic Stress Network (NCTSN, 2017) physical abuse is defined as any act, completed or attempted, that physically hurts or injures a child. NCTSN also describes that acts of physical abuse include hitting, kicking, scratching, pulling hair, and more. Child Protection Services typically get reports of bruises, and other noticeable marks when investigating a report of physical abuse.

Emotional abuse is a nonphysical maltreatment of a child through verbal language. NSPCC (National Society for the Prevention of Cruelty to Children) states that emotional abuse includes "humiliation, threatening, ignoring, manipulating, and more." (www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/emotional-abuse/what-is-emotional-abuse/) Emotional abuse can

be combined with other forms of abuse like physical and sexual abuse. Most reports emotional abuse is harder to prove and thus physical or sexual abuse tends to be the main cause of removal in a home.

Statistics about Sexual Abuse

- In 2012 26% of sexually abused victims were ages of 12-14 years. 34% were ages 9 or younger. (U.S Department of Justice, NSOPW).
- Center for Disease Control found that 1 in 6 boys and 1 in 4 girls are sexually abused before they reach the age of 18.

The link provided is where these statistics were found, and more statistics are available: https://www.nsopw.gov/(X(1)S(0otvrpqvguoplfo5wbafq5ag))/en-US/Education/FactsStatistics?AspxAutoDetectCookieSupport=1

Sexual abuse has many facets when it comes to a specific definition. Overall, sexual abuse is a "type of maltreatment, violation, and exploitation that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator. It includes contact for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities." (American Society for the Positive Care of Children, 2017). The person who inflicted harm will typically use force, threats, or coercion to those who cannot/do not give consent.

A grooming process typically takes place when it comes to sexual abuse. According to the National Center for Victims of Crime, there are seven grooming steps that tend to take place when sexual abuse may or already has occurred. They are good steps to watch for to potentially help prevent a potentially abusive situation from occurring. Most, if not all, sexual abuse is inflicted by someone the victim knows and usually trust. Thus, the grooming process can be very easy for the potential abuser to enact on the victim. However, this is not intending to say that all sexual abuse is inflicted by someone the victim knows; it can be inflicted by those the victim does not know, as well.

Grooming Steps

- **Identify/Target Victim**: anyone can be a victim pending the type of person the offender may be attracted to
- **Gaining Trust/Access**: the person intending to inflict harm may look for vulnerabilities
- **Play a Role in Child's Life**: could be a mentor, may manipulate the relationship to make themselves appear to be the only one that knows the victim
- **Isolating the Child**: Offering rides away from current surroundings is an example.
- **Creating Secrecy Around Relationship**: reinforce the relationship through private communication. Coercion may be used like threatening harm to themselves, or others and more.
- **Initiating Sexual Contact:** At this point the offender has control of the relationship, may start as 'friendly' touching, but can lead to penetration or worse over time
- **Controlling the Relationship**: Secrecy is needed in order to keep the process going. Fear is usually the key factor as to why abuse is often not reported. Victim blaming (it's your fault I am doing this, no one will believe you,) often happens at this point along with continued threat of potential harm to them or their families

Abuse does not always have to be physical, sexual, or verbal assault. It can also be neglect. According to the National Society for the Prevention of Cruelty to Children (NSPCC), neglect is the failure to meet the basic needs of a child. The NSPCC website states that neglect is the most common form of abuse. According to Crossen-Tower (2010) there are three categories of neglect: physical, medical, and emotional. NSPCC adds educational neglect to the list.

Things to Remember When Working with Trauma Victims

When working with children who have been abused, or a family who has experienced trauma, remember that building resiliency is a key factor. Resilience is defined by the American Psychological Association (APA) as having the ability to adapt when facing adversity including trauma (APA, 2017) This, in a sense, means that one is able to bounce back after facing trauma. However, this does not mean that there will not be any kind of consequences or negative impact as a result of trauma. A resilient individual will have the tools needed to move past the traumatic experience and potential future traumas.

To help children build resiliency, the APA suggests a variety of different techniques (APA, 2017). One is to help the client build connections. Finding a support person they can be close to and trust will help them have the ability to attach and bond appropriately. This, in turn, will also help them be able to work through the events that they have experienced. Another factor is to help them find a positive view of themselves. Trauma can often have a negative effect on the victims view of themselves. Building up their confidence will not only help them bounce back from present traumatic experiences, but give them the confidence to be able to move past future experiences as well.

Everyone deals with traumatic experiences differently. One child may be able to bounce back quickly after being abused or neglected, while another may be portraying heavy side effects such as resentment, anger, aggression, withdrawal and more. Here is a case example of how an adolescent has responded to a traumatic experience.

Case Study

** Disclaimer names have been changed to ensure confidentiality remained intact.

Jane Doe is a 16 -year- old white female living with her mother , Amy Doe. Jane has been exposed to sexual abuse. The abuse that she has been exp osed to has occurred since she was born. Jane Doe has negative behaviors as a result of the abuse that have taken place since the age of twelve. These behaviors include self-harm, and multiple suicide attempts. Other behaviors that can be linked to the trauma include hyperactivity, eating problems, excessive mood swings, chronic sadness, and presen ts herself with a flat affect. Jane Doe was referred to mental health services to receive counseling.

In the case of Jane Doe, what would you as a social worker do when working with this client? Why?

Childhood trauma is discussed heavily in this chapter as being some form of abuse or neglect, but that is not the only trauma to be aware of. The death of a loved one, car accidents, divorce, domestic violence, and negative experiences are equally as traumatic and age does not matter. There can also be medical trauma. Maybe you or someone you know has been diagnosed with an illness, or maybe you went in for a simple surgery and things did not go as planned so now there may be something else wrong. It is all trauma, and it is ALL IMPORTANT.

The intent of this chapter is to simply define the trauma that specifically relates to child welfare, not to minimize other traumatic events. Do not discredit yourself or others who may have been through a traumatic event that is not necessarily defined in this chapter. Go to www.nctsn.org to you will learn more about trauma, resiliency and more.

The National Child Traumatic Stress Network (NCTSN) uses a trauma screening checklist that lists various events that can be considered a traumatic event. This being said, we must take note that everyone has experienced some sort of trauma in their lives, and work in an empathetic way to help build resilience, and even just to educate them that what they have experienced was traumatic. The links provided below are checklists for different age groups – one is for ages 0-5 and the other for ages 6-18 – which provide the lists of traumas, and the emotional, and behavioral responses that may have occurred in response to the trauma. http://www.nctsn.org/sites/default/files/assets/pdfs/trauma_screening_checklist_0-18_final.pdf

Thus, when working with victims of trauma, regardless of the type, age, sex, and more, empathy (which is defined in Chapter 1) is an important tool to utilize. When working with a client avoid assuming that they are making anything up, or that their behavior that are being portrayed are intentional. As mentioned above, trauma has a huge impact on the brain. The primary areas of the brain in which are more heavily impacted is the hippocampus, medial prefrontal cortex, and the amygdala which is our alarm system (Bremmer, 2006). Work with the client and understand that they are protecting themselves the only way they know how.

Watch the video to gain more understanding of trauma on the brain, and what to do and what not to do when working with a victim of trauma.

Working with Trauma Victims

YouTube Video

This interactive element is not available in this format. Visit the link or scan the QR code to access it online.

View this YouTube Video online



Circle of friends

Foster Care, Guardianships, and Adoption

Foster Care

The foster care system has been around for years. According to The National Foster Parent Association, the United States foster care system developed from the English Poor Law of 1562. This law stated that children from poor homes would enter into indentured services until they were at an age in which they could care for themselves. The first child in the US to enter into the foster care system was in 1636, and he went by the name Benjamin Eaton. Charles Loring Brace was the first to initiate a free foster home movement in 1853, more information about the history of foster care can be found at this link: nfpaonline.org/page-1105741.

Today foster care is known as a temporary placement in which children who have been removed from their families take up residence either with other family members (first choice, or non-relatives (alternative if no family is able or available to step in). Children who are in foster care were usually abused or neglected in some way and the risk of them being abused again is very high. Referring back to the categories of the different case levels in CPS, category I or II would typically encompass cases where the children were placed into foster care. Foster care can be done through the state at DHHS, and other agencies like the Big Rapids branch of Bethany Christian Services. To learn more about Bethany Christian Services refer to the link provided: https://www.bethany.org/

Foster care is usually the last result, and is also considered to be a short-term intervention. Thus, immediately after removal reunification is sought after to bring the child back to their family. Reunification, according to DHHS, is simply stated as returning to their homes. At this point, when reunification is mentioned many people are shocked and ask, “How is that possible? They hurt their kids!” Remember, as stated above, that the children still have a strong bond with their caregivers even though they have been abused. DHHS will NOT let a child back into their family’s home if it is deemed unsafe. For a parent to get their child back they have to prove to the courts through petitions that they are fit and can adequately care for their child. During this whole process foster care workers are looking out for the best interest of the child. If it is deemed that the parents have followed through with all of the recommendations made by CPS, foster care, and the courts, and that they have completed them successfully they have a chance to get their child back.

When a child is removed it does not necessarily mean that the parental rights are terminated. Foster care is intended to be short term, not a permanent solution. However, there are situations in which parental rights are terminated. Termination of parental rights ultimately means that they no longer have guardianship of their child. The Probate Code of 1939: Act 288 (legislature.mi.gov/doc.aspx?mcl-act-288-of-1939) outlines the protocols and reasons in which termination is permitted. An example that the act gives includes if the parent caused, or could have prevented, physical or sexual abuse and the courts deem that the abuse will most likely continue if they remain or return to their parents’ home. Once a parents’ rights are terminated they no longer have the ability to legally care for their child and may not have the opportunity to regain custody of their child.

Thus, termination happens after sufficient evidence has been provided to the courts showing that the child would indeed be in imminent danger if returned to the parents.

Working with foster care is another high stress position as a child's response to trauma varies and is uncertain. Having people willing to be foster parents is highly necessary and there are many websites and associations to go to in order to seek out help including the National Foster Parent Association: nfpaonline.org/

Steps to Become a Foster Parents

On the other end there are many steps to take to become a foster parent. The Michigan DHHS website lists five steps that have to be completed in order for anyone to become official foster parents. These steps are listed below:

- **Call a Navigator**: Foster Care Navigators are experienced foster parents who can answer questions and find an agency.
- **Attend an Orientation**: Review guidelines, illustrate what to expect, and has representatives to help answer questions.
- **Complete Application**: agency chosen provides a licensing application packet (one must be licensed in order to officially become a foster parent). Refer to link to learn more about the application process.
- **Participate in a Home Evaluation**: Have to pass an on-site home evaluation performed by licensing agent. Interviews and home visits will be done multiple times.
- **Attend Free Training**: Agency will schedule a PRIDE (Parent Resources for Information Development and Education) training with the prospective foster parent. Must complete 12 hours and once they are licensed they have 18 months to go through it again.

http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7117—,00.html

Guardianships

With permanency being the goal, guardianship is one way to help provide permanency to children who may or may not be able to return home. This is an alternative to potentially avoid bouncing from one foster home to another. Guardianships, however, do not necessarily mean that the parental rights are terminated. This option provides permanency yet allows the parents to still have access to the child through visitation. For this process, there is a court hearing and the court decides if the potential guardians are deemed appropriate. They have to pass home visits and more, just like a foster parent. Anyone can be a guardian, but it is common for other family members to apply for guardianships to help avoid the child having to go to people who are not within the family system.

Key Terms

Permanency: is essentially finding or creating a permanent place for home, and care.

Guardianship: In lieu of terminating parental rights, a guardianship allows caregivers to legally make decisions on behalf of a child who has been removed from their home.

(MDHHS, 2014)

Adoption

If a child cannot be returned to the family, and the parental rights have been terminated, adoption is sought after. At this point, parental rights had already been terminated and thus can no longer go home to their birth family. The goal is to find permanency as quick as possible. According to MDHHS, nearly 3,000 foster children are up for adoption at any point in time, and of those 3,000 children, about 300 do not find homes for adoption (MDHHS, 2017).

Many youth in the foster care system age out. Aging out simply means that the youth turned 18 before finding a permanent home. According to the organization, Children's Rights (www.childrensrights.org), more than 20,000 foster children aged out of the system in 2015. To top that off, they state that those who age out of the system are less likely to achieve a high school diploma. By the ages of about 26, 80% of youth who aged out of the foster care system were able to get a diploma or a GED in comparison with 94% of the general population. Michigan uses many private agencies in which their focus is finding parents to adopt children who cannot go back to their parents.

Social Work Roles in Foster Care and Adoption

Just like a CPS worker, a Foster Care worker can come from a variety of backgrounds including social work, criminal justice, and even psychology. Within the role of a Foster Care worker, their ultimate priority is to identify and place children who cannot remain with their parents due to safety concerns. MDHHS has protocols in place which outline the duties of a foster care worker. These include home visits and various other tasks such as interviews with biological parents and schools.

Before a child is placed with a foster family, or if the child is relocating to another foster home, there are protocols that a foster care worker follows. These protocols include providing Medicaid card/records, enrolling or insuring the children are attending school, and providing education records to the caregiver within five days of placement. If the child is attending the same school they previously attended then a transportation plan is to be discussed. One last example of what a Foster Care worker does is discussing any revision or plans for parents or siblings to be able to visit the child. Foster Care workers are responsible for visiting a child in the foster home. In a sense, they are searching for the same things a CPS worker would, mainly a safe place to live, ensuring that medical needs are taken care of and safe sleeping requirements are met, and then gathering information of how the child feels about being placed in that home. They meet with the caregivers as well to discuss various aspect of the child including medical (i.e doctor visits, dental visits etc.), education, and behaviors portrayed in the home.

There are also protocols set in place for human trafficking victims. Refer to Chapter 9 to learn more about human trafficking and what the definition of it is. In regard to foster care, there are seven behaviors or characteristics that a foster care worker must look for to determine whether or not the child indeed was a victim. The responses they gather will determine if further assessment and care is needed.

Foster Care and Human Trafficking Behaviors/Characteristics

- History of running away
- Withdrawal or lack of interest in previous activities
- Signs of current physical abuse, and/or sexually transmitted diseases
- Inexplicable appearance of expensive gifts, clothing, cell phones, tattoos, or other costly items
- Presence of an older boyfriend/girlfriend
- Drug addiction
- Gang Involvement

These behaviors may or may not indicate trafficking. However, more investigation should take place. If you, or anyone you know suspects that two or more of these items are happening call Centralized Intake at 1-855-444-3911. Foster Care workers are expected to call this number if the victim meets two or more of these assessment points. (MDHHS, 2015)

Summary

In this chapter, we have discussed family and what family is. We discussed various parenting styles and how they have an effect on children. There are many aspects that influence the family dynamics and how they function. We went on to discuss the history of child welfare, and discussed child protective services, trauma, and foster care, adoption, and guardianships. There is always more to learn about the child welfare system as it encompasses a wide range of services in our communities. Even the history of the system is a huge topic.

Key factors to remember are that a child has a right to be safe and cared for, and when the parents of the child fail to do just that, it is the duty of the state to step in and ensure that they are safe and can be kept safe. Regardless of rumors that people have heard (CPS workers being kid snatchers one of them), the state looks for the best interest of the child and that is the ultimate factor within this system.

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7.2: Video- How Childhood Trauma affects Health across a Lifetime

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8.1: Gerontology and People with Disabilities

Gerontology

One of the fastest growing populations that social workers provide services to is the elderly. For social workers, the elderly offer unique challenges that are not present in other populations. This section will discuss the various aspects and challenges that social workers will encounter when working with the aging population.

Key Terms

Gerontology: the scientific study of old age, the process of aging, and the particular problems of old people.

Dementia: a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning.

Geriatric: relating to old people, especially regarding their health care.(Merriam-Webster's collegiate dictionary, 1999)

The Aging Population

The biggest contributing factor to the fast-paced growth of the aging population, is the Baby Boomers. The Baby Boomers are the generation of individuals born in the years following WWII. What once was a large population of babies and children has now aged into a large population of aging and elderly individuals. With the advancement of modern medicine, people are now able to live longer than any other period in history. This aging population has posed many benefits and challenges to our society. Western culture has moved away from Eastern ideals of providing and caring for our elderly. Shifting cultural ideals has led to the rise of assisted living and nursing facilities in the United States and other parts of the world, which will be discussed later in this chapter. Social workers must be prepared to work with the ever-changing landscape of gerontology.



An aging population

Challenges of Aging

There are many challenges that the elderly face in our society which range from medical and mental health to financial concerns. Below are some common challenges that the elderly face in this country that social workers will have to be familiar with.

Dementia and Alzheimer's Disease

Among the most common of challenges facing the elderly are medical conditions that attack cognition. Dementia and Alzheimer's Disease are the most common medical conditions that the elderly suffer from; both directly impair cognition to various levels. Dementia is a general term for loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by physical changes in the brain (Alzheimer's Association, 2017). The rates of dementia are so high in the elderly that special facilities and whole units of nursing facilities are dedicated to working with those who suffer from it.

There are various forms of dementia ranging from Lewy Body Dementia to Frontotemporal Lobe Dementia. The most common form of Dementia is Alzheimer's disease. It is estimated that 60-80% of dementia cases are Alzheimer's disease (Alzheimer's Association, 2017). Each form of dementia has different symptoms and physical impact on the brain. Social workers will need to be versed on the various types of dementia and the interventions available to best address their elderly clients need.

Health Complications

Along with medical conditions that impact cognition, there are also many illnesses and diseases that impact physical health. As we age, our body begins to break down over time. Our immune systems are no longer able to fight off infections and illnesses that it could earlier in the lifespan. There are multitude of illnesses and diseases that the elderly population are more susceptible to. These health complications range from simple infections such as urinary tract infections to major diseases such as Parkinson's disease. The elderly are at a disadvantage when it comes to such diseases, as the older we get the less capable we are able to maintain health. All too often, physical health deterioration leads to elderly individuals to be placed in nursing facilities, as they can no longer care for themselves without medical professionals available around the clock.

Did You Know...

Urinary tract infections (UTIs) can cause unique symptoms in the elderly. With symptoms ranging from confusion, agitation, hallucinations, fallings, and delirium. It is due to these symptoms that some UTIs in elderly individuals are mistaken for earlier stages of dementia. (Solitto, 2016)

Mental Health

Not only are the elderly more prone to diseases that impact physical health and cognition, but the population has their own unique set of mental health concerns. There are many elderly individuals that have suffered from mental illness much of their lives. As we age, there are also mental health concerns that are a direct result of growing older. One of the most prevalent mental illnesses that the elderly face is depression. Depression is common among the elderly population due to a variety of reasons. Grief and loss are two contributing factors to elder depression. As we get older, we are subjected to a number of losses. There is the loss of loved ones through death, the loss of our physical capabilities and health, even the loss of financial independence. These series of losses can impact the mental health of the elderly.

Isolation is also a contributing factor for depression in the elderly. It does not matter if an elderly individual is living in the community, assisted living, or a nursing facility. Isolation rates for the elderly are high due to physical immobility and lack of transportation. Too often, our elderly are secluded from the rest of society, leading to feelings of loneliness and depression. Social workers working with this population must address grief, loss, and isolation with their clients to provide better mental health care.

The Cost of Aging

Another major challenge of aging is the simple cost to age. Most elderly are unemployed due to advanced age and physical health. Many live off Social Security and retirement benefits and many utilize Medicare and Medicaid for insurance. Those who live in assisted living communities or nursing facilities have a clear majority of their income allocated for their care. The cost of medications, general living expenses, and food often monopolize the fixed income of our elderly. With the constant political turmoil regarding nationwide health care, the elderly are not guaranteed health insurance in this country. These factors contribute to the rising cost of aging.

Remaining in the Community

One way to ease the growing cost of aging would be to implement support for elders so that they can stay in the community for as long as possible. Assisted living and nursing facilities are costly, even with health insurance and retirement benefits. The cost of being placed in a facility can absorb all an individual's resources. Remaining in the community for as long as possible can save both the elderly and the taxpayers' money in the long run.

However, there are potential dangers to the elderly who remain in the community. The risk of falls which can lead to life threatening complications is increased for those living in the community. According to the National Council on Aging, there are approximately 2.8 million falls a year. One fourth of elderly Americans over the age of 65 fall each year (2017). Isolation and depression rates can also increase for the elderly in the community, as lack of mobility and transportation can impede social interaction. While living in the community may seem like the most economically suited option, it can pose a risk to the elderly who need more medical assistance than the home can provide.

Caregivers

One way that the elderly can stay in the community longer is by having caregivers present in the home. Caregivers can be medical professionals, family members, or everyday individuals that provide care for the elderly in the home. Caregivers often come in the form of family such as adult children taking care of their elderly parents. Caregivers are a key role in enabling the elderly to remain in the community for as long as possible.

Caregiving is a demanding and strenuous role. Caregivers are often faced with the challenges of working outside the home while still trying to provide care. Caregivers also have to provide medical care that they may not be fully trained or competent in. Some caregivers are not suited to provide care and can pose a risk to the elderly individual. Unqualified caregivers can also be potentially dangerous, abusing their elderly charge in a variety of ways. Many caregivers do not have the proper physical, emotional, or mental support to deal with the stress that comes with the role. Lack of support can lead to feelings of burnout, resentment, and physical ailments for many providing care for the elderly.

Elder Abuse

For elders both inside facilities and outside facilities, there is a potential for abuse. While some abuse is unintentional, unfortunately there are multiple cases of elder abuse every year. Elder abuse can be committed by family members, medical staff, and anyone associating with the elderly on a regular basis.

Forms of elder abuse:

- Physical abuse. Use of physical force that may result in bodily injury, physical pain, or impairment.
- Sexual abuse. Non-consensual sexual contact of any kind with an elderly person.
- Emotional abuse. Infliction of anguish, pain, or distress through verbal or non-verbal acts.
- Financial/material exploitation. Illegal or improper use of an elder's funds, property, or assets.
- Neglect. Refusal, or failure, to fulfill any part of a person's obligations or duties to an elderly person.
- Abandonment. Desertion of an elderly person by an individual who has physical custody of the elder or by a person who has assumed responsibility for providing care to the elder.
- Self-neglect. Behaviors of an elderly person that threaten the elder's health or safety.

(National Center on Elder Abuse, 2005)

Case Study: Gloria Fielding

Adult Protective Services (APS) received a report that Gloria Fielding, a very frail 88-year-old woman, needed care for all activities of daily living. Ms. Fielding was legally blind, extremely hard of hearing, unable to walk and suffered from dementia. She was confined to a hospital bed placed in the basement of her home by her caregiver. Ms. Fielding owned two houses. Her primary residence was so severely neglected as to be uninhabitable. The caregiver stated that the dilapidated condition of the house was the reason Ms. Fielding was moved into the basement, while the caregiver resided in Ms. Fielding's other home.

When the APS worker investigated the report of abuse, she heard yelling coming from Ms. Fielding's garage but could not gain access to the house. A neighbor offered to help the APS worker by calling the caregiver. The caregiver drove to Ms. Fielding's house and upon arriving, opened the garage door and drove her car right into Ms. Fielding's bed, knocking it with her bumper.

The basement had no furniture beside the hospital bed. The floor was littered with used hypodermic syringes. The caregiver stated that Ms. Fielding's medical doctor pre-filled the syringes and instructed her to inject Ms. Fielding whenever she requested.

> Upstairs, numerous photographs of Ms. Fielding's physician were found throughout residence. The APS investigation discovered that the M.D. had received large monetary gifts from Ms. Fielding, had engaged in sexual relations with her and had recommended the caregiver to Ms. Fielding.
>
> Despite Ms. Fielding's frailties, when the APS worker interviewed Ms. Fielding, she reported that she was being abused by her doctor and caregiver.
>
> (National Adult Protective Services Association, 2017)

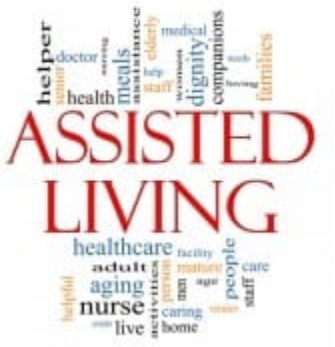
What to do in the event of elder abuse.

- Contact your local Adult Protective Services
- For Michigan call **855-444-3911**
- Contact your local police department
- Call 911
- Contact the local Long-Term Care Ombudsman for residents of assisted living, nursing homes, and adult foster care (AFC) care.

Assisted Living

As mentioned previously, one form of care for the elderly is assisted living facilities. Assisted living facilities are generally small communities or facilities that provide limited assistance for elderly individuals. Most often, elderly couples and individuals who are still in relative good health will reside in these forms of care. To the outside, assisted living facilities will often look like small apartment buildings with special features such as ramps and rails throughout the units. This forms of care often provides limited medical assistance such as having nurse aids employed to provide basic health care. Often, cleaning services and landscaping services will be provided as part of the fee.

Assisted living options offer more independence for those who reside in them, however there are other components to be considered. Some health insurance policies do not cover this form of assistance and even with health insurance, living in this form of community can be costly. Assisted living facilities are also not monitored by the State (which heavily monitor nursing facilities), thus leaving room for lack of quality and proper procedure. Assisted living facilities normally do not employ social services, for the elders who need these services they must be sought outside of assisted living services. Larger assisted living communities may contract with outside social service agencies to provide services, but rarely employ them on site.



Assisted living wordcloud

Nursing Facilities (Nursing Homes)

Nursing facilities have become a norm in our country for providing care for the elderly. They provide 24-hour medical care for those who can no longer remain in the community and need extra support than what assisted living facilities provide. Those who reside in these facilities are referred to as "residents" as most will remain in the facilities for the remainder of their lives. Many nursing facilities also provide rehabilitation services such as physical therapy, generally for those recovering from surgery or serious illness. These services are short-term and most of those who utilize them discharge back to the community.

Nursing facilities provide a wide range of services for residents. All meals and domestic services are covered by staff. There are a variety of medical professionals that are employed by these facilities such as certified nursing aids (CNAs), licensed practicing nurses (LPNs), and registered nurses (RNs). These professional provide medical care for the residents. For medical needs that are outside the scope of practice in nursing facilities, outside services are utilized. Most elderly living in nursing facilities have their expenses covered by health insurances such as Medicare and Medicaid. There are some who pay for their stay privately, but this is costly. U.S. News reported in 2013 that the general cost of living in a nursing facility $222 dollars a day for a semi- private room, which is about $81,000 per year (Mullin, 2013). The price of nursing home stays are on the rise and many cannot afford to stay in these facilities without health insurance.

Along with nursing staff, nursing facilities generally employ a large range of professions to best provide services. Social workers, dietitians, physical therapists, maintenance staff, and environmental services are just some professions outside of nursing that are employed in these types of facilities. Those professions that provide medical and mental health services work together as an Interdisciplinary Team (IDT). IDTs work collaboratively to provide the best care for each resident. The size and number of IDTs is determined by the size of the facility. One facility can have as many as five IDTs. Social workers in nursing facilities are tasked with the residents' mental health and emotional well-being. The day to day tasks of social workers in these facilities can range depending on employment, but generally have common themes. Social workers in these facilities most commonly work with residents who are experiencing depression, anxiety, grief and loss, and dementia. MSWs will also oversee psychotropic monitoring (not prescribing) and will make medication recommendations. Social workers often play a major role in nursing facilities as they help with admissions, day-to-day activities, mental health and emotional well-being, and discharge planning.

Many residents, due to cognitive impairments and health complications, are no longer able to make decisions for themselves. Those who have been declared incompetent by two medical doctors, have in place a guardians' or durable power of attorney (DPOAs). These individuals can be family, friends, or public guardian services. When one has a guardian or DPOA in place, they can no longer make medical or financial decisions for themselves. This process aims to protect residents from poor decision making.

Many interpret having a guardian or DPOA in place as having no rights of their own. This is not true. In the United States, every individual is guaranteed rights. Residents have a special Bill of Rights in place to insure they are being treated with respect and dignity. Residents who feel that their rights are being impeded upon can contact their local Ombudsman (information provided above).

Did You Know...

Nursing facilities that accept Medicaid and Medicare as funding must be certified and go through an annual State Survey as a requirement of federal law. Each state's Health Department is in charge of the process. (Nursing Home Alert, 2017)

Summary

The aging face many unique challenges. Finances, health, mental health, and political considerations must all be considered when social workers provide services to the aging population. Growing older is inevitable, however social workers can make the process smoother from those who have entered the later stages of life.

Now let's take a look at social work and people with disabilities.

People with Disabilities

There are many populations that social workers provide services for daily. One such population is People with Disabilities. Disabilities can take many forms, such as physical, cognitive, or mental illness (Centers for Disease Control and Prevention, 2016). The broad range of potential disabilities can pose many unique challenges for social workers. It is also important to note that while disabilities can be a singular occurrence for some individuals, often disabilities span across many population segments. It is common for people with disabilities to suffer from victimization, stigmatization, and segregation in our society. Therefore, all social workers no matter what area of social work they are in should knowledgeable on the types of disabilities and those who live their lives with them.



Forms of disabilities

Forms of Disabilities

There are various forms of disabilities that people can suffer from. The three major forms of disabilities are physical, cognitive, and mental illness, with most disabilities falling within these three categories. To better understand disabilities, let's consider the three categories.

Key Terms

Physical Disability: a limitation on a person's physical functioning, mobility, dexterity or stamina.

Cognitive Disability: a generalized disorder characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors that appears before adulthood.

Mental Illness: a wide range of mental health conditions — disorders that affect mood, thinking and behavior.(Merriam-Webster's collegiate dictionary, 1999)

Physical Disabilities

Physical disabilities can take many forms and can occur at any time in an individual's life. Many physical abnormalities can occur before a person is born, developing in utero. Known as congenital disorders and most commonly referred to as birth defects, these impairments can take many forms. Some can be a minor as a birth mark or as severe as a missing limb or internal abnormalities (Nemours, 2017). When a birth defect proves to be severe and long lasting, it has the potential to develop into a disability. Infants born with missing limbs or improperly developed physical traits will often grow to have a physical disability. Some physical birth defects can be corrected or improved with medical technology, such as surgeries to correct cleft palates; however there are many physical birth defects that cannot be corrected potentially leading to a physical disability.

There are also physical disabilities that occur after birth at any time in an individual's life. Major accidents are the most common cause of physical disabilities after birth. Car accidents are a common accident that can cause physical disabilities at any time in life. Car accidents can lead to minor injuries, but in severe cases can cause lifelong physical disabilities such as severed limbs and brain injuries (Disabled World, 2015). Military personnel are also at high risk of procuring physical disabilities through outside means. War can lead to various physical disabilities due to military engagements. The most recent military conflicts have led to high numbers of physical disabilities resulting from IEDs (Intermittent Explosive Devices) which have caused loss of limbs and traumatic brain injuries.

Physical disabilities can impact individuals in a variety of ways. Depending on the nature of the physical impairment individuals

may be limited on where they can travel, the type of employment they can procure, and even their personal relationships. Social workers must be prepared to not only address the physical limitations that a physical disability can pose, but also the emotional impact that one may have on a client. Working with clients who have a physical disability can be a unique and rewarding experience. Each client will require an individualized approach, as not everyone who has a physical disability will cope in a uniformed way.

Cognitive Disabilities

Cognitive disabilities, also known as intellectual disabilities, are other forms of disabilities that social workers will encounter in the field. There are many types of cognitive disabilities that can vary in severity.

Some common types of cognitive disabilities are:

- Autism
- Down Syndrome
- Traumatic Brain Injury (TBI)
- Dementia
- Dyslexia
- ADHD
- Learning Disabilities

Cognitive disabilities, like physical disabilities, can be present at birth. Cognitive disabilities at birth can be almost impossible to distinguish and usually begin to present in early childhood. Some indicators of cognitive disabilities can be present in infancy, such as the infant failing to meet certain milestones or presenting with unusual symptoms such as lack of sleep and inconsolable crying. While these indicators can be present, it is often difficult for medical professionals to diagnose cognitive disabilities in infants and toddlers.

Most cognitive disabilities are diagnosed in childhood and early adolescence. There are several assessments that can be conducted to determine the presence of a cognitive disability. While many medical professionals may suspect a cognitive disability, most often patients are referred out to have the appropriate assessments completed. Once a diagnosis is made there are several forms of therapy that can be performed depending on the type of cognitive disability.

Even with the advancements in medical technology, unfortunately there are no “cures” for cognitive disabilities. While various therapies and some medications can help improve cognition and stall deterioration in some, there is no way to fully heal the cognitive disability. Cognitive disabilities can impact individuals on many levels, from employment to personal relationships. Depending on the severity of the cognitive impairment, some individuals may never be able to live independently or function in mainstream society. Social workers working with this population must be prepared for the diversity within and the individual challenges faced by those with cognitive disabilities.

Mental Illness

While many may not consider mental illness to be a category of disability, there are several mental illnesses that impact an individual’s life in such a way that it can be classified as a disability. Mental illnesses such as Schizophrenia, Borderline Personality Disorder, and Bipolar Disorder can be so severe that an individual’s everyday life is impacted. When a mental illness impairs an individual’s ability to function, it can be considered a disability.

For some mental illnesses, medication can help alleviate symptoms. This is especially true regarding disorders such as Schizophrenia and Bipolar disorder. While there is no cure for these disorders, medication in combination with behavioral therapies can reduce the symptoms. However, there are some mental illnesses that even with medication and therapy can still make coping difficult. Agoraphobia is one disorder that can severely impact everyday functions, to the point where the individual may not even be able to leave their home due to anxiety.

Mental illnesses in themselves can be considered disabilities when they impact an individual’s life to the point of impairing functioning. Mental illnesses can also contribute to other health concerns and behavioral symptoms that greatly impact lives. For more information on mental illness please see Chapter 10: Mental Health and Substance Use.

Did You Know...

Agoraphobia consists of an individual experiencing marked anxiety in at least two of the following: using public transportation,

being in open spaces, being in enclosed spaces, standing in line or being in a crowd, being outside of the home alone. (DSM-5, 2013, p. 217)

The Americans with Disability Act (ADA)

The Americans with Disability Act (ADA) was put into place in 1990. It guarantees equal rights for those with disabilities in the United States. It prohibits discrimination against those with disabilities "in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public" (ADA National Network, 2017). While this policy has created great advancements for those with disabilities, especially in education and employment, discrimination still takes place on a daily basis in our country.



ADA Compliance sign

Youth with Disabilities

As mentioned previously in this chapter, the age of diagnosis of disabilities can vary depending on the type of disability and potential origin. Most cognitive disabilities such as learning disabilities and autism are diagnosed in early childhood. Symptoms can vary in type and severity, the less severe generally being observed later. Children who are diagnosed with any type of disability face many challenges. Physical disabilities are often able to physically seen, therefore being diagnosed much sooner. Cognitive disabilities and mental illnesses do not manifest in a physical manner, therefore leading to later diagnosis. Parents, caregivers, and teachers are often the first to notice symptoms of a cognitive disability and/or mental illness. While cognitive disabilities have standard procedures for diagnosing, mental illnesses in children can often be difficult to diagnose. Many mental health professionals may be hesitant to make a mental illness diagnosis for a young child, as the brain is just beginning to develop and symptoms can vary.

The K-12 Education System

For cognitive disabilities and mental illnesses, the K-12 education system can pose particular challenges and resources for children. Depending on the geographic area, children with disabilities may find either a helpful system with resources or an overtaxed system with an inability to adequately help.

Higher Education System

The higher education system can also pose some unique challenges for people with disabilities. While many universities and community colleges have disability accommodations, the quality of these accommodations can vary depending on the institution. For many with physical disabilities, colleges and universities can be difficult places to maneuver – literally. There have been instances of universities failing in snow removal so that those who require mobility assistance such as wheelchairs are not able to traverse the campus. There have also been accounts of buildings being poorly designed so that doorways are not easily accessible

for those who are not able to walk.

Accommodations for those with cognitive disabilities can also vary depending on the institution. Many higher education institutions have made efforts to be inclusive for those with cognitive disabilities, per ADA requirements. Most offer accommodations for those who qualify such as tutoring, alternate exam areas to allow for more time and individuals who are dedicated to helping those with cognitive disabilities succeed. People with cognitive disabilities in the higher education system most often have resources available to them provided by the institution, which is a change from the past, where even fifty years ago they would not have been accepted into the system.

The Workplace

For people with disabilities, the workplace can present certain difficulties. Discrimination in the work place for people with disabilities is unfortunately all too common. No matter what form of disability, employers can be quick to judge an individual's abilities based solely on their disability. This is most common with physical and cognitive disabilities as they are more visible. Those with mental illness will also face discrimination in the work place as employers may see them as "too challenging" to employ. Some discrimination can be unintentional as well. Employers may make unnecessary accommodations for their employees with disabilities or may conduct themselves in a manner that is unintentionally condescending. Discrimination in the workplace can be both intentional and unintentional (Workplace Fairness, 2017).

While some employers can be hesitant or outright refuse to hire people with disabilities, others do not share such reservations. For employers who hire people with disabilities, accommodations must be made at times. The ADA requires that all public buildings be wheelchair accessible and many businesses have made great strides towards that goals. For those with cognitive disabilities and mental illnesses, accommodations can be made to make employment more inclusive such as training for other employees and trying to be educated on the topic.

Health insurance is a major factor for employers when hiring people with disabilities. Many employers may be hesitant to hire people with disabilities due to their health insurance provider. Some health insurance companies offer less coverage, some do not even offer mental health services in their packages. This could influence whether people with disabilities will be hired at certain workplaces, as the health insurance coverage may not be adequate to cover specialized medical care.

Aging with a Disability

As stated in the Gerontology portion of this chapter, aging with a disability can pose particular challenges. Often as those with disabilities begin to age, the familial caregivers become unable to provide care or pass away. This leads many with more severe disabilities to being placed in assisted living facilities, adult foster care, or nursing facilities. Nursing facilities provide around the clock medical care; however assisted living facilities and adult foster care homes do not.

Health insurance is also a major issue for those aging with a disability. For some, health insurance can be easily obtained. Medicaid and Medicare are the two main health insurances utilized by the aging. With the current political climate, it is unsure how available these resources will be for those with disabilities or what services they will provide. Social workers must be ready to contend with an ever changing political landscape of the country.



Elderly man sitting in a wheelchair

Abuse and Neglect

People with disabilities, like any other section of the population, are at risk for abuse and neglect. For children with disabilities, any suspected neglect or abuse should be reported to your local Child Protective Services. For adults with disabilities, any suspected abuse or neglect should be reported to your local Adult Protective Services.

> **Case Study: Carolyn Grant**
>
> Carolyn is 21-years-old, and autistic with moderate intellectual disabilities. She attends a special school program to assist with her disabilities. On a recent field trip, Carolyn's teacher left her and two male students unsupervised in the school van for a brief period of time. While the teacher was gone, one of the young men took Carolyn's shirt off, fondled her bare breasts, and took a picture of them. When the students returned to school, he showed the pictures to other students. Carolyn told her mother about what happened and her mother contacted APS for help.
>
> (National Adult Protective Services Association, 2017)

What to do in the event of abuse/neglect for children with disabilities

- Contact your local Child Protective Services
- Contact your local police department
- Call 911

What to do in the event of abuse/neglect for adults with disabilities

- Contact your local Adult Protective Services
- For Michigan call **855-444-3911**
- Contact your local police department
- Call 911

Summary

People with disabilities face challenges in modern society that other population segments do not experience. With the various and sometimes limited resources offered, social workers must know how to navigate a system to better provide for their clients. With the rising cost of health care and an ever changing political environment, social workers are tasked with advocating and serving those in the population who may not be able to do so themselves. Both people of advanced age and people with disabilities are valuable contributing members of our world and as social workers we must stand to make a better future for all.

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8.2: Aging Population

Key Term	Definition	Source
Abuse	Harm or threatened harm to an adult's health or welfare caused by another person. Abuse may be physical, sexual or emotional.	(State of Michigan, 2019)
Aging Shock	The uncovered cost of prescriptions drugs, medical care not paid by Medicare or their private insurance and the actual cost of the private that is expected to pay the gaps that Medicare does not pay and the uncovered costs of long-term care.	(Knickman & Snell, 2002)
Bereavement	A form of depression with anxiety symptoms that is a common reaction to the loss of a loved one. It may be accompanied by insomnia, hyperactivity, and other effects. Although bereavement does not necessarily lead to depressive illness, it may be a triggering factor in a person who is otherwise vulnerable to depression.	Bereavement (2001)
Burnout	A process involving gradually increasing emotional exhaustion in workers, along with a negative attitude toward clients and reduced commitment to the profession (Maslach, 1993)	(State of Michigan, 2019)
Compassion Fatigue	Is the residue of emotional energy from the empathetic response to the client and is the on-going demand for action to relieve the suffering of a client.	(State of Michigan, 2019)
Elderly	Any person that is 65 years of age or older.	(Niles-Yokum & Wagner,2015)
Empathetic Response	Is the extent to which the psychotherapist makes an effort to reduce the suffering of the sufferer through empathetic understanding.	(State of Michigan, 2019)
Exploitation	Misuse of an adult's funds, property, or personal dignity by another person.	(State of Michigan, 2019)
Exposure to the Client	Is experiencing the emotional energy of the suffering of clients through direct exposure.	(State of Michigan, 2019)
Grief	A nearly universal pattern of physical and emotional responses to bereavement, separation, or loss. It is time linked and must be differentiated from depression. The physical components are similar to those of fear, hunger, rage, and pain. The emotional components proceed in stages from alarm to disbelief and denial, to anger and guilt, to a search for a source of comfort, and, finally, to adjustment to the loss.	Grief (2001)
Life Disruption	Is the unexpected changes in schedule, routine, and managing life responsibilities that demand attention (e.g., illness, changes in life style, social status, or professional or personal responsibilities).	(State of Michigan, 2019)
Material abuse	Including theft, fraud, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.	(O'Connor & Rowe, 2005, p. 48)
Neglect	Including the failure of a designated care to meet the needs of a dependent old person, forced isolation from services or supportive networks, or failure to provide access to appropriate health or social care.	(O'Connor & Rowe, 2005, p. 48)

Key Term	Definition	Source
Physical abuse	Including physical harm or injury, physical coercion and physical restraint	(O'Connor & Rowe, 2005, p. 48)
Prolonged Exposure	Is the ongoing sense of responsibility for the care of the suffering, over a protracted period of time.	(State of Michigan, 2019)
Psychological abuse	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation and verbal abuse.	(O'Connor & Rowe, 2005, p. 48)
Sexual Abuse	Including rape, sexual assault or sexual acts to which the vulnerable older adult has not consented, could not consent, or was pressured into consenting.	(O'Connor & Rowe, 2005, p. 48)
Stigma	A mark of shame or disgrace. A strain.	(Merriam-Webster, 2019)
Self-care	Promote specific outcomes such as a "sense of subjective well-being".	(Lee & Miller, 2013, p. 97)
Senescence	Refers to the aging process, including biological, emotional, intellectual, social, and spiritual changes.	(Lee & Miller, 2013, p. 97)
Vulnerable	A condition in which an adult is unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or advanced age.	(State of Michigan, 2019)

Statistics of Elderly Population: Prior to the 17th century, statistics show the elderly made up less than 2% of the population in the United States. A male's life expectancy estimated 30 to 38 years of age due to lack of proper health care, farming accidents', unhealthy working conditions, war fatalities and lack of proper nutrition. A women's life expectancy was significantly decreased due to bearing many children and suffering poor medical services during childbirth (Egendorf, 2002). Following World War II, we experienced the fastest growth in population, this generation is known as the baby boomers. This population has now become our highest elderly population and with this significant increase, the influx poses both benefits and challenges to our society (Tice & Perkins, 1996).



Seventy-six million people were born between 1946 and 1964 making this the largest and longest-lived generation in the history of the United States. (Torres-Gil, 1992). This is identified as the baby boomer generation. As a result of the baby boomer

generation, the number of Americans aged 65 or older is projected to more than double from 46 million today to over 98 million by 2060, increasing from 15% to 24% (Mather, 2016). As a result of improved healthcare, better working conditions and families choosing to have less children, the life expectancy for a man is now 74 years of age and women's life expectancy is now 80 years of age (Merck Manual, 2004). This produces many new challenges to our current social structure. Social security and medical costs have increased, including the cost of uncovered expenses of medications and long term care.

Baby boomers have introduced a new lifestyle, building careers, having fewer children and waiting till later in life to have children. It is estimated since this population is not reproducing at a rate much less than historically, the population in the United States will decrease as a result (Colby, S., & Ortman, J., 2014 p.2). The decrease in population will help to stabilize the social structure and medical costs.

Diversity of Population



Populations representing about 16% of the elder population: 8% African American, 5.5% Hispanic, 2.1% Asian-Pacific Islander and less than 1% American Indian and native Alaskan. The majority elder population is comprised of whites, at a rate of 74%. (Older Americans, 2000, p.1). In order to understand the needs and circumstances of the diverse population in the United States, it is important to know the demographics of the clients we are serving. One plan does not fit all solutions. Some fail miserably. The various demographics we must know of the population we attempt to serve include: health, age, work, marital status, sex, sexual orientation, race and culture. Whether they have family support, access to transportation and disposable income. We must establish wants and needs before determining what services and products will be put into place. If we do not understand the needs of the population we are serving, we will likely fail when creating services to help. (ODPHD, 2013).

Stages of Development

"Growing older and dealing with long-term care includes help from many people, family members, friends, medical professionals and practitioners in the community. Sometimes aging is gradual and sometimes it's abrupt with many bumps and emergencies. As people age, the majority develop at least one health problem resulting in functional decline" (Marak, C. 2016, p 1). Many seniors live healthy, independent lives, without experiencing the stages of decline.

Stage 1: Self Sufficiency. Seniors are more independent and able to manage their own health issues. They may begin to acknowledge what the community has to offer for seniors and determine if their homes may need safety features in the future. But for the present time, the elderly enjoys the sense of accomplishments their independence offers. Programs established to help seniors remain in their own homes are Area Agency on Aging, Senior SAFE Program and Life Alert, to name just a few.

Stage 2: Interdependence. Seniors may begin relying on others such as a partner, older children or friends for assistance. Many seniors view this stage as a time of decline because they are no longer able to accomplish the tasks they once could. This is the stage where help may be brought in to assist with minor tasks on a regular basis. It is also a time when safety and security should be addressed by installing safety bars in the bathtub and hallways, ramps for wheelchairs and walkers and obtaining life alert pendants in the case of a fall or emergency.

Stage 3: Dependency. As the aging process continues, the need for more assistance with activities of daily living (ADL's) may increase. These activities include bathing, toileting, cooking, and shopping. There may also be a decline in memory or psychological functions. At this stage, the senior may experience more physical ailments and chronic pain. As these conditions advance, it may be necessary to move to a senior facility with the level of care necessary for the senior. More often, the needs can be provided by a caregiver for more advanced care and needs Other medical issues, including increased pain can be managed by the primary care physician. This option can become very costly and as additional care is needed, for the safety and care of the elderly, a move to a facility may be the best option.

Stage 4: Crisis Management. In the event of continued decline, the family may recognize they are unable to continue providing the level of care necessary to keep their loved one safe or manage their needs. In this case, family will make decisions regarding the best options for appropriate care such as seeking constant in-home care by a professional or moving the senior to a facility where the care needs can be met.

Stage 5: End of Life. If the senior is able to remain in the home with sufficient care and pain management, many are able to remain in the home until their demise. If hospice is involved, they assist to manage pain and help the family to deal with complex end-of-life decisions. Many professions such as home health aides, nursing home personnel, hospice providers and care physicians are involved at this stage. If the senior is in a facility or needs to be moved for care during the end of life stage, they will be cared for by professionals in a skilled nursing facility (Marak, C., 2016, p 1).

Elderly will progress through the stages of development differently. Some will live life without pain and suffering and pass easily, while others may suffer Alzheimer's disease or symptoms of dementia and require the care offered by a memory care facility. As we are all very different and have been exposed to different lifestyles, we will move through these stages, each at our own pace and tolerances (Marak, C. 2016).

Physical Changes



According to Busse, (1989), there may be several meanings to the word "aging". "As a biologic term, it is used to describe those inherent biologic changes that take place through time and ultimately end with death." (Busse, 1989 pg. 3-4). This definition is at odds with the process of growth and development. Aging begins the moment a person is born. A baby develops into a child, teen and then an adult. But at some point, the aging process changes. The body begins to decline in function, ultimately leading to death. The term used to describe the beginning decline is called senescence. As aging occurs, the body's cells age and the organs functioning declines.

- Change in vision is one of the most undeniable signs of aging.
- A seniors hearing may also decline, resulting in the need for hearing aids.
- The skin becomes thinner, less elastic, drier and finely wrinkled.
- A elder's ability to taste and smell may also diminish as they age.
- Bones and joints become less dense and weaker due to the decrease in the body's ability to absorb calcium. This causes high risk of falls and broken bones.

- The elder loses muscle tissue over time and muscle strength tends to decrease.
- The heart and blood vessels change. The walls of the heart become stiffer and the heart fills with blood more slowly.
- The artery walls become thicker and the blood flow changes.
- The aged lungs may weaken, and the kidneys and urinary tract are often affected by age.
- The most common reported chronic conditions among the elderly are arthritis, high blood pressure, heart disease, hearing loss, problems of bones and tendons, cataracts, chronic sinusitis, diabetes and vision loss. This is a condensed list (Merck Manual of Health and Aging, 2004, pp 7-16).

Mental/Emotional Changes

As with the body, the mind is also susceptible to illness. Among the most common challenges facing the elderly are medical conditions that attack the brain, specifically the memory. Alzheimer's disease and dementia are the most common and both directly affect cognition at various levels. Dementia is a general term for loss of memory as well as other mental and physical abilities severe enough to interfere with daily activities. Dementia is not a disease, rather a multitude of symptoms that do not lead to a known disease and is caused by physical changes in the brain. Dementia is common among stroke victims (Mayo Clinic, 1998). There are 9 types of dementia. Alzheimer's Disease comes in three known forms. Early onset which occurs in those under age 65, usually age 40 to 45, experiencing memory loss and difficulty with daily activities. Late onset occurs in those over 65 years of age and is the most common form of Alzheimer's disease. The third and most rare form is called Familial Alzheimer's Disease. It occurs in less than 1% of all cases of Alzheimer's and is a gene known to exist in at least two generations of the family. (Alzheimer's and Dementia, 2017). For those suffering Alzheimer's Disease or dementia, it is not uncommon for them to experience a multitude of behaviors and symptoms. Along with memory loss, a senior suffering Alzheimer's or dementia may incur loss of communication skills, loss of attention, perceptual problems, depression, agitation, suspiciousness, angry outburst, delusions and hallucinations.

Although depression is a common for those with Alzheimer's disease and dementia, it is also very common among the elderly in general. Charles M. Schulz, Peanuts author and illustrator provided a scenario that perfectly depicts the emotional pain many feel as indicated by Charlie Brown.

"Charlie Brown was sitting at Lucy's psychiatric booth. He asked, "Can you cure loneliness?" She replied, "For a nickel I can cure anything." Charlie Brown then asked, "Can you cure deep down, black, bottom of the well, no hope end of the world, what's the use loneliness?" Lucy protested, "For the same nickel?!" (Blazer, 1990, p.62-63).

Depression among elderly is a serious condition. Many become depressed due to the decline in their ability to function as they did in early years. Others are fearful of thoughts of end of life, while many suffer severe loneliness as the traditional family unit has changed so drastically over the years. Many lose their spouses and find it difficult to continue on while the severe loneliness and depression sets in. Many elderly men served in wars and suffer Post Traumatic Stress Syndrome.

Suicide is the 8th leading cause of death in the U.S. Persons 65 and older make up 12.5 of the total U.S. population and account for 20.9% of suicides annually. Suicide rates among the elderly increased significantly following the Great Depression, then declined until 1981 through 1987, again increasing from 17 to 20 per 100,000 persons. Among older men, suicide rates increase with age. Among women, the rates are lower at 6.6 per 100,000. Women are more likely to commit suicide at midlife. Although many factors can account for the reasons a senior may consider suicide, such as failing health, lack of independence, loss of spouse, it has been found a relationship between major depressive condition and death by suicide has been identified (Blazer, 1990)

Paranoia, suspiciousness and agitation are common behaviors among elderly. As the memory begins to fail, many elderly people become paranoid and suspicious about things they do not understand or cannot remember. The feeling of not knowing where they are or who the people are around them brings on much anxiety. If the anxiety increases, sudden outbursts often are the outcome of the paranoia or suspiciousness and agitation. When working with people who suffer these behaviors, it is necessary to make them feel safe and validate their thoughts but to also help them understand they do not need to feel fearful or frustrated. It is essential to help the senior feel safe when experiencing these episodes of paranoia, suspiciousness and agitation.

Additional emotional issues are often a result of alcohol abuse by elderly. Alcohol is a depressant and if used long term or abused can lead to more severe depression and many physical issues such as memory loss called alcohol amnesiac disorder which causes difficulty with both short- and long-term memory and an inability to learn new information. This is also identified as one of the 9 types of dementia. (Blazer, 2004).

Often seniors want to feel valued and listened to, especially as they evaluate their life. Oftentimes we deny them the privilege to share with us the knowledge and invaluable presence that we too could offer future generations. The history and knowledge of

the elderly is priceless.

Social



The elderly struggle with a multitude of social issues. Some have been identified in other sections of this chapter but apply to their involvement in society as well. The most pertinent issues identified by both social workers and the elderly who were questioned provided the following list from (Aging Care, 2019):

- ◦ Loneliness from losing a spouse and friends
  ◦ Inability to independently manage regular activities of living
  ◦ Difficulty coping and accepting physical changes of aging
  ◦ Frustration with ongoing medical problems and increasing number of medications
  ◦ Social isolation as adult children are engaged in their own lives
  ◦ Feeling inadequate from the inability to continue to work
  ◦ Boredom from retirement and lack of routine activities
  ◦ Financial stresses from the loss of regular income
  ◦ STD's are currently on the rise with the senior population
  ◦ Younger generation taking advantage of elderly's vulnerability (Aging Care, 2019)

Spiritual

For most elderly, religion plays a major role in their life, with approximately half attending religious services weekly. "Older adults' level of religious participation is greater than that in any other age group. For older people, the religious community is the largest source of social support outside of the family and involvement in religious organizations is the most comon type of voluntary social activity" (Kaplin & Berkman, 2019, p.1).

When caring for the elderly, religion and spiritual beliefs often play a significant part in the care provided for the seniors. As the elderly ages and necessary increased care is provided, the elderly may have special wishes in accordance with their religious beliefs or spiritual beliefs. It is essential to know if spirituality or religion are important to the elderly as the beliefs may offer assistance with the elderly coping skills acceptance of their declining health and decreased fear of their final demise (Erichsen & Bussing, 2013, p. 1).

Myths/Stigmas



There are many myths and stigmas that have been associated with elderly population. A myth as defined is, “a usually traditional story of ostensibly historical events that serves to unfold part of the world view of a people or explain a practice, belief, or natural phenomenon” (Merriam-Webster, 2019, p.1). Stigma is defined as, “a mark of shame or discredit” (Merriam-Webster, 2019 p. 1). The term stigmatization is evident in the prevailing of “if I can buy enough pills, cream, and hair, I can avoid becoming old” (Esposito, 1987). Seniors efforts to avoid the uncontrollable outcomes of old age reveal the stigma and negative attitudes associated with advanced age. “Ageism refers to the negative attitudes, stereotypes and behaviors directed toward older adults based solely on their perceived age” (Frankelstein, Burke & Raju, 1995, p.662-663).

Ideally ageism will be replaced by truths. For instance, mental health issues among the elderly can decline with mental health services. Further, older adults are not the victims of deterioration that comes with age but are the survivors of life and the strengths of the elderly must be recognized and celebrated and used as the cornerstone in intervention and prevention services (Zastrow, 1993). The way a senior ages depends on several factors including their lifestyle choices, culture they live in, as well as their supports (Thornton, 2002). This is a bulleted list as follows of different myths and stigmas that have been negatively associated with the elderly population.

The following is a list of negative stigmas and beliefs about seniors:

- All elderly people are ill or disabled (Thornton, 2002).
- Pain is a normal part of life and the aging process (Ellison, White, & Farrar, 2015).
- Elderly people live boring lives and do not have romantic and sexual relationships.
- Elderly are uneducated or even able to learn as the world is continuously changing around us (Thornton, 2002).
- The elderly people are mentally incompetent and are able to be educated and learn new tasks just as a younger person is able to.
- The elderly people are a financial drain on our medical institution (Zastrow, 1993).
- Barriers to delivering mental services to older people is ageism, the “negative image of and attitudes toward people simply because they are old. (Zastrow, 1993).

The invaluable presence of an elderly person is one that is too often overlooked. Positive attributes and beliefs about the elderly population:

- They provide the social and cultural continuity that holds our communities together.
- Wisdom comes with age and experience. The older generation is also a great storehouse of knowledge and history.
- Like a tree needs its roots for growth and nourishment, a society needs roots to keep it grounded in its traditional values and history.
- Grandparents are often available for babysitting and spending quality time with their grandchildren, teaching values and respect.

- Families who have active, healthy grandparents living nearby have the opportunity to develop strong relationships between the kids and their elderly relatives that can greatly enrich the lives of both generations. They can also provide positive role models for young children who probably have little contact with older adults and may regard aging as something negative and depressing.
- For many seniors, old age is a time to become deeply engaged in their churches, local politics, schools and cultural and community organizations.
- They know how to socialize and treat other people in face-to-face conversations without the need for modern technology.
- Many are more conscious of their diet and their health. They watch what they eat, and exercise in order to stay active.
- Seniors have time for themselves, to vacation, volunteer, take classes and garden, among many other activities they may not have had time to do when raising a family.
- Seniors become active in senior centers and organizations to meet other elderly people for social purposes such as dances, playing cards, bingo and dating (Pitlane Magazine, 2019).

Working with the Elderly

In the field of social work, it is important to be able to work with other disciplines of work including physicians, nurses, nurse assistants, chaplains, dietitians, volunteers, dentists, and other social workers at various agencies. There is a need to have client centered goals and plans of care from all disciplines that work with the client (Wright, Lockyer, Fidler, & Hofmeister, 2007).

Discipline	Role	Source
Social Worker	• Helps the client and family with funeral arrangements • Provides financial assistance • Provides resources • Psychosocial support needs to the clients and their families • Identifies and assists with environmental factors and barriers that arise • Assessments for mental health concerns	(Csikai & Weisenfluh, 2013) (Monroe & DeLoach, 2004) (Reese & Raymer, 2004)
Physician	• Attend's to client's long-term care needs • Leader of the team • Collaboration	(Wright, Lockyer, Fidler, & Hofmeister, 2007)
Nurse	• Informs team of medical concerns • Monitors client's vitals and measurements • Explains medications and health care needs	(Greene, 1984)
Nursing Assistant	• Help the client 's with activities of daily living (ADLs) including feeding, bathing, and dressing. • "Nurse aides' duties include functional, psychosocial, and delegated care activities such as physical care and emotional support"	(Huey-Ming, 2004)
Chaplain	• Spiritual Care • Provide education and support both with religion and non-religious support to clients and staff members. • bereavement supports • Help with funeral home decisions as well as help with leading a memorial service	(Williams, Wright, Cobb, & Shiels, 2004)

Discipline	Role	Source
Dietitian	• Monitor for proper nutrition • Monitor weight • Assess for malnutrition	(Kang et al., 2018)
Volunteer Coordinator	• Completes volunteer requests/referrals • Attends weekly meetings to discuss volunteers	(Claxton-Oldfield, & Jones, 2012)
Volunteers	• Make phone calls • Provide emotional support as being a friendly visitor • May aid with rides for various client needs	(Ghesquiere et al., 2015)

Elder Abuse and Neglect

Elder abuse and neglect are under reported in the United States for many reasons including fear and embarrassment by the elderly (O'Connor & Rowe, 2005). Elder victims of abuse risks that include; functional disability, lack of social supports, poor physical health, cognitive impairment, mental health issues, lower social economic status, gender, age, and financial dependence (Pillemar , Burnes, Riffin , & Lachs , 2016). There is an Adult Protective Services (APS) Hotline for reporting a suspected abuse or neglect situation referred to as centralized intake : 855-444-3911 (State of Michigan, 2019). It is important to understand that all social workers are mandated reporters of elder abuse and neglect (State of Michigan, 2019). There is not one specific cause for elderly abuse and neglect. There are many reasons including various dynamics, cultural norms, negligence and lack of education and support (Muehlbauer & Crane, 2006). Potential causes of abuse could be due to mental illness, substance abuse, and the need to abuse from the perpetrator (Pillemar , Burnes, Riffin , & Lachs , 2016). There are several types of abuse defined as follows in Table 1: Kinds of Elder Abuse and their Definitions (Muehlbauer & Crane, 2006, p.44).

TABLE 1

KINDS OF ELDER ABUSE AND THEIR DEFINITIONS

Kind of Abuse	*Definition*
Physical	Use of force that causes unnecessary pain or injury, even if the reason is to help, can be regarded as abusive behavior. Physical abuse can include deliberate or inadvertent hitting, beating, pushing, kicking, pinching, burning, biting, overmedicating, undermedicating, or force-feeding; improper use of physical or chemical restraints; and exposure to severe weather.
Emotional or psychological	Behavior that causes an older adult to have fear, mental anguish, or emotional pain or distress can be considered abusive. This kind of abuse can include name-calling, intimidation, insults, and threats; treating the older adult like a child; and isolating the older adult from family, friends, and social contact by force, threats, or manipulation.
Neglect	Neglect can range from withholding appropriate attention from the individual to intentionally failing to meet the older adults' physical, social, or emotional needs. It can include failure to provide food, water, clothing, medication, or assistance with activities of daily living or personal hygiene. In addition, failure to manage older adults' money responsibly and withholding necessary health care can be considered neglect.
Sexual	Any nonconsensual intimate contact, such as inappropriate touching, photographing the individual in suggestive poses, forcing the individual to look at pornography, forcing sexual contact with a third party, or any unwanted sexual behavior can be considered sexual abuse. This kind of abuse may also include acts such as sexual exhibition, rape, sodomy, or coerced nudity. Sexual abuse is not often reported as a kind of elder abuse.
Financial	Financial exploitation includes fraud, taking money under false pretenses, forgery, forced property transfers, purchasing expensive items without permission, or denying older adults access to their own funds or home. It includes the improper use of legal guardianship arrangements, powers of attorney, or conservatorships, as well as a variety of scams by salespeople, health-related services, mortgage companies, or friends.

Adapted from Kleinschmidt (1997).

It is important as a social worker to be able to assess the signs and symptoms of elder abuse. It can be difficult to recognize the signs and symptoms of abuse as some elderly are nonverbal and unable to share what is occurring (Muehlbauer & Crane, 2006). T able 2 below lists common signs and symptoms of elder abuse (Muehlbauer & Crane, 2006, p.46).

TABLE 2

SIGNS AND SYMPTOMS OF ELDER ABUSE

Kind of Abuse	*Sign or Symptom*
Physical	• Bruises or grip marks around the arms or neck • Rope marks or welts on the wrists or ankles • Repeated unexplained injuries • Dismissive attitude or statements about injuries • Refusal to go to the same emergency department for repeated injuries
Emotional or psychological	• Uncommunicative and unresponsive attitude • Unreasonably fearful or suspicious behavior • Lack of interest in social contacts • Chronic physical or psychiatric health problems • Evasiveness
Sexual	• Unexplained vaginal or anal bleeding • Torn or bloody underwear • Bruised breasts • Venereal diseases or vaginal infections
Financial	• Life circumstances that do not match the size of the estate • Large withdrawals from bank accounts, switching accounts, or unusual automated teller machine activity • Signatures on checks that do not match the older adult's signature
Neglect	• Sunken eyes or loss of weight • Extreme thirst • Bed sores

YouTube Video

This interactive element is not available in this format. Visit the link or scan the QR code to access it online.

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Adult Protective Services (APS) Case Study:Janice

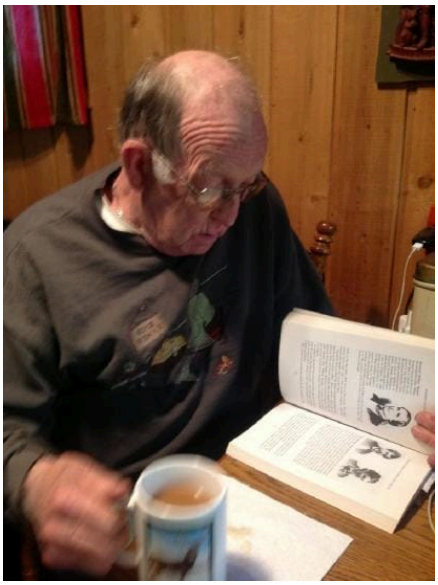
Janice, a 50 year old women is diagnosed with Schizophrenia and Bipolar Disorder. She was fired from her job as a professor from a University due to not taking her medications and making threats and allegations of a "witch hunt" for her. This client lives alone in a trailer in the middle of the woods. There is no heat or electricity in the home. Several medical professionals have called and reported that she is unable to take care of herself on her own. This client has not been deemed incompetent by two physicians. The APS worker attempts to visit the client and each time is asked to leave the premises. The APS worker noticed some bruises on Janice's wrists and her arms. The APS worker attempts to address the bruises when Janice says, "Get off my property and never come back or I will call the police!" The APS worker has reported these allegations to her supervisor as well as to the police department. The client has been hospitalized for her medications, but once out of the hospital the client does not continue taking medications. The client is currently not able to pay her bills and the home is in the process of being foreclosed from the client. The bank has reported that there have been several cash withdrawals from the account from ATMs all over the state. The client has refused the APS worker to assist and will not leave the home. The APS worker is unaware of any family or friends of this client in the area. There are also no shelters in the area that will take a client that is non-compliant with taking medications.

- If you were the APS worker, what other resources could you reach out to?

- What would you do to help the client?
- As the APS worker, can you identify any ethical dilemmas, explain?

Medical Care and Insurance

Medicare



Medicare is a supplemental insurance that was created in the U.S. after the Social Security Amendment in 1965 (Rajaram & Bilimoria, 2015) . People are eligible for Medicare if they are at least 65 years of age , have end stage renal disease or amyotrophic lateral sclerosis, or have another specific disability (Rajaram & Bilimoria, 2015) . There are certain needs that Medicare does not cover including long term skilled nursing facility stays. There are four different sections of Medicare including Part A, Part B, Part C, and Part D (Rajaram & Bilimoria, 2015). This link https://www.ssa.gov/benefits/medicare/ is where a senior can apply for Medicar e. Rajaram & Bilimoria (2015) explain the four parts of Medicare as:

Part A	• Inpatient hospitalizations • Short term stays in skilled nursing facilities • Home health care • Hospice care
Part B	• Outpatient services • Primary care appointments • Medical equipment • Lab tests • Vaccinations • Cancer screenings
Part C	• Have all benefits of Part A and B • Private health plans • Vision • Dental
Part D	Prescription drug coverage

Case Study: Jacob



You are working as the social worker for a Commission on Aging agency and one of your clients, Jacob walks into your office. Jacob is an 88-year-old Native American male. He is an U.S. Marine Corps Veteran. Medicare is Jacob's only insurance. Jacob shares with you that he was unable to purchase his medications last week because the cost is too high with his fixed income of social security.

- What would you do as the social worker to help Jacob?
- What resources do you think could be available for Jacob?

Advanced Directives

As seniors, we have many choices regarding health care and end of life wishes. The Do-Not-Resuscitate orders and Comfort Care Only orders are important for family members who may not know the wishes regarding life sustaining practices. Therefore, if these decisions are made prior and family is made aware , the wishes of the loved one is often carried out with much less stress and ease to both the family and the senior making the decision. If the decision is not made prior to the time it becomes necessary, the loved one may not have the opportunity to have their wishes known. If the DNR or the Advance Directive is not in place, the doctor will make every effort to resuscitate a senior. The Advance Directive and DNR is done in the event an elder is incapacitated to guide decisions about medical treatment.

A Living Will is a document that directs the care in the event of an elderly's mental incapacitation. A Durable Power of Attorney is a document in which a senior will appoint a person to make decisions in the event they are incapacitated and unable to make the decisions themselves. A Living Will is a document or type of Advance Directive in which a person gives specific directions about treatments that should be following in the event of his or her incapacitation, and usually addresses life-sustaining medical treatment such as removal from life supports, providing food and drink (Pietsch ad Braun, p. 41). Understanding rights as an elderly regarding your wishes for health care is essential as it alleviates much stress for those who would otherwise need to make these decisions. Most seniors have decided under which circumstances they would wish to be resuscitated. It is imperative that each senior make family members or their physician aware of their decisions. Most hospitals will allow these documents to be signed and notarized and filed at the hospital in the event of crisis. It is very important to have documents signed and available for use In the event of an emergency. (Pietsch and Braun, 2000, p. 41).

Placement

In many cases elderly people find they are unable to manage their own care in their homes without some assistance and modifications to their homes for safety purposes. Seniors can make their homes safe by installing ramps, safety bars in bathing

areas and widen doorways for walkers and wheel chairs. Oftentimes, the first step taken to keep the elderly in their own home or a family members home, is to hire a caregiver to aid with activities of daily living, medication management and meal preparation. The caregiver will often provide transportation to doctor and dental appointments, errands and any other travel.



Independent Living Facilities

Many elderly people find that it is either too costly to safely update their own homes or may live in a property with many stairs that are difficult to climb. In the event they need a safer environment, many will seek out independent living facilities where they live in a community of other elderly people where the apartments or homes are built with safety features already I place within the units and where there are many activities and social events specifically designed to help the resident avoid isolation and make new friends. Independent living is typically for those who do not have healthcare needs, but some may need a caregiver to come in and assist with bathing, household chores or to run errands. Many Independent living facilities have a dining room for meals and transportation available for medical appointments and weekly trips to run errands and outing for the residents (National Institute on Aging, 2019).

Assisted Living Facilities

Once care levels increase and the resident is unable to manage their own care without the assistance of daily caregivers, the resident may be encouraged to move to an assisted living facility. Many independent living facilities offer assisted living units on the same property, so the move is minimal. An assisted living level of care, depending on the needs of the senior are often set up to allow one to two to a room, where they may set up their own living areas and meals are often taken in the dining room. The seniors may need assistance ambulating to the dining room resulting in a staff member to assist them with a walker or in a wheel chair. In assisted living facilities, the seniors are usually able to move about the facility without much help, but staff and medical care is available 24/7. There are activities provided for the seniors to encourage them to leave their rooms and engage in social events. Many seniors who move to assisted living facilities state they wish they had moved much sooner as the facilities offers the seniors the opportunity to socialize with others their age and offer a plethora of activities and day trips that seniors who remain in their own homes may have been missing out on. It is not uncommon for family members to take their loved ones out for outside medical appointments, such as dental, medical tests not performed on site and family time. Some seniors are able to be checked out for a night or two in order to spend time with family. For those families who wish to take their loved one out of town, they may make arrangements with another facility in the town they are visiting to place their loved one in an assisted living facility, so as not to interrupt their care, but to allow the senior to continue to be part of the family actives. This is all coordinated with both assisted living facilities prior to travel (Caregivers Library).

Adult Group Homes

Another option for the elderly who are unable to socialize and ambulate, but do not need the level of care of skilled nursing, a group home might be an option for them. The social activities are limited, and the level of care is more individualized with 24/7

care and generally only 10 to 20 seniors living in the home at any given time. All transportation is generally offered, and meals are served family style with all seniors eating together. Many of the seniors in elderly group homes are unable to participate in social activates or engage in extensive conversation. This option is generally utilized once they are unable to manage to ambulate in the assisted living facility and has deteriorated to a high level of care but are not yet bed bound . Many senior can remain in the group home until end of life with hospice care. Some group homes offer “field trips” such as color tours and outings to see the holiday lights. These trips are short, and the seniors generally do not leave the bus (National Institute on Aging, 2019).

Skilled Nursing Facilities

Skilled nursing facilities, often referred to as nursing homes are designed for those who need constant care and are unable to ambulate or perform any of their own ADL’s. This is often the final placement prior to their death. Many suffer significant illness or have been deemed unsafe and unable to be provided the level of care in any offer type of facility. Meals are provided to the residents in their rooms where they do not need to leave their beds. For those who can ambulate but need extensive medical care, there is often limited social activities for them. They may meet in common areas to socialize but rarely do they leave the facility unless a family member checks them out for the day (Caregivers Library).

Memory care facilities are also essential for the elderly who suffer Alzheimer’s disease or dementia. These are often locked wings of assisted living facilities or locked group homes. The care is specialized and considered high level of care as the senior often cannot remember how to toilet themselves, dress, eat by themselves or shower. They need 24/7 care and are a risk for wandering which is the purpose of a locked facility (National Institute on Aging, 2019).

Elderly and the Community



As has been indicated in the above portion of this chapter, the elderly struggle with a variety of issues. But in accordance with their integration and acceptance in the community, various conditions of each community may make a difference in the severity of struggles they endure. Some communities are much more understanding of the needs of their elderly residents and provide social outlets for them. They also redesign their public areas with the elder’s needs in mind and utilize the experiences and intelligence of this population. This is often found in smaller upscale towns where the elderly population is high, and their needs are heard.

For those living in low income or medium income areas in their own homes, many live in areas where the lifestyle is fast paced, transportation is limited to local buses or trains and businesses do not cater to the elderly. Many times, the elderly become victims due to their vulnerability and inability to keep up. Society as a whole tends to have little patience for the aged. They are concerned for their own time and space; they often miss the opportunities they could take to assist someone in need. Understanding that we will all be old one day and know how it feels to be left behind (Merck Manual of Health and Aging, 2004), should keep us all humble and aware of the needs of the older population.

There are many organizations available for elders in need of services. Both public and private social service agencies can either provide services or will have social workers to help locate the appropriate resources for the elderly.

Some agencies included, but are not limited to:

- American Association of Retired Persons
- Area on Aging
- Rotary Club
- Veterans organizations
- Masonic Orders
- United Way
- AARP
- Salvation Army

These are only a few and many more may be available to those living in larger cities (Phillips and Roman, 1984, p. 105-108).

YouTube Video

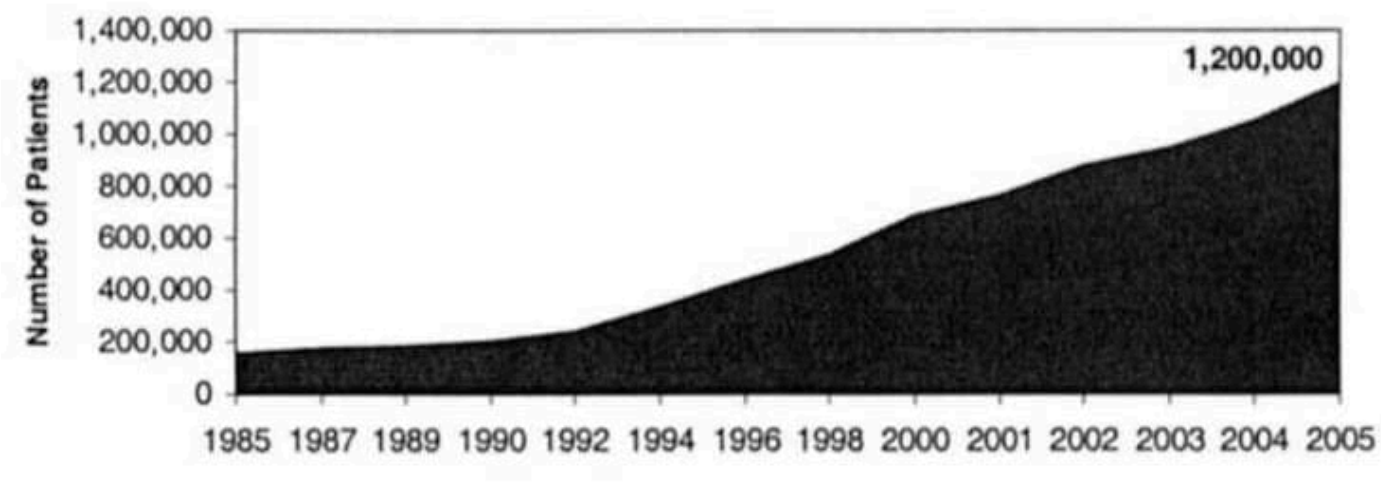
This interactive element is not available in this format. Visit the link or scan the QR code to access it online.

View this YouTube Video online

Video shows people laughing (Closed Caption)

Hospice Care

The original concept of hospice care comes from England and has become more popular in the United States (Holden, 1980). There are over three thousand hospices within the United States (Monroe & DeLoach, 2004). Hospice has continued to evolve and develop and ha s been integrated into the health care system (Monroe & DeLoach, 2004). The concept of hospice started when physician, Dame Saunders, worked with dying clients in 1948 . Saunder's work inspired the creation of St Christopher's Hospice in 1967 (National Hospice and Palliative Care Organization, 2016). Hospice was established in the United States in 1974 in Connecticut (National Hospice and Palliative Care Organization, 2016). It took a while to progress with hospice and achieve the hospice benefit through Medicaid in Tax Equity and Fiscal Responsibility Act of 1982. Then in 1984, "JCAHO initiated hospice accreditation" (National Hospice and Palliative Care Organization, 2016) Once the Medicare Hospice Benefit (MHB) was created in 1982, hospice care began to become more popular in the United States. Specifically, in 2005 when hospice care clients reached 1.2 million people. (Connor, 2008) As displayed in the chart below by Connor (2008):



Hospice patients served 1985-2005.

As found by National Hospice and Palliative Care Organization (2015) there needs to be two physicians that give a senior a life limiting diagnosis of 6 months or less. Clients can be on hospice at any place that they are comfortable being. The National Hospice and Palliative Care Organization (2018) asserted:

Hospice services can be provided to a terminally ill person wherever they live. This means a client living in a nursing facility or long-term care facility can receive specialized visits from hospice nurses, home health aides, chaplains, social workers, and volunteers, in addition to other care and services provided by the nursing facility. The hospice and the nursing home will have a written agreement in place in order for the hospice to serve residents of the facility (p.1).

There are for-profit, and non-profit hospices (Hospice Analytics, 2018). Hospice care has turned into a competition among hospices to give the best quality of care to the clients. There is a great benefit to having many different options for hospice care. It allows the client to have more control over their end of life decisions. There are more than 5,000 hospices in the United states. The hospices participate in the Medicare program, the first program began in 1974 and has expanded significantly since then across the United States (Fine, 2018). Hospice is growing as the baby boomer generation is aging, in 2020 it is predicted that 20 percent of the population will be elderly in the United States (Niles-Yokum & Wagner,2015).

What Hospice Care Offers



Hospice allows clients to be in the comfort of their homes and not be in a hospital environment. As stated by Holden (1980), “High person, low technology” is a good phrase to explain the idea of getting rid of all the hospital equipment and make the client more comfortable (Holden, 1980). Hospice care is not about dying; it is about living and having a good quality of life with celebration.

Having an interdisciplinary team implies that all the needs are being met for the client both spiritually, emotionally, and physically (McPhee, Arcand, & MacDonald, 1979). An interdisciplinary team is a group made up of the "physicians, nurses, social workers, chaplains, physiotherapists, dietitians, and volunteers" (McPhee, Arcand, MacDonald, 1979, p.1).

Hospice care is a valuable resource for those near the end of life. It can be a great resource for clients regardless of where their home is. It is beneficial for the clients in nursing homes because they get more professional care experts to a client (Amar, 1994).

National Hospice and Palliative Care Organization (2018) states the following:

> Hospice care is available 'on-call' after the administrative office has closed, seven days a week, 24 hours a day. Most hospices have nurses available to respond to a call for help within minutes, if necessary. Some hospice programs have chaplains and social workers on call as well (p.1). Both the social worker and nurse are suggested to be present for family at the time of death to offer support to family members and answer questions (Donovan, 1984).

Differences between Palliative Care and Hospice Care

Palliative Care	• Comfort care that allows for aggressive treatment (U.S. National Library of Medicine, 2018). • Can be used from start of diagnosis until death (American College of Physicians, 2018). • Serves hospital bound clients (American College of Physicians, 2018).
Hospice Care	• Does not serve clients that are in the hospital's care unless that is the only way to control the severity of the pain symptoms (American College of Physicians, 2018). • Care begins after treatment of the disease is stopped and when it is clear that the person is not going to survive the illness. • Most often offered only when the person is expected to live 6 months or less (The U.S. National Library of Medicine, 2018, p.1).
Both	• Offered to any person regardless of demographics, including: race, gender, religion, ethnicity, social economic status, and age (National Hospice and Palliative Care Organization, 2009). • Provide comfort (The U.S. National Library of Medicine, 2018)

Barriers to Hospice Care

Hospice can be a very difficult discussion and it can be challenging to bring this up to loved ones or a professional hospice staff member. This can be prevented by having the discussion earlier on before the last stages of life (National Hospice and Palliative Care Organization, 2018). Most people have little education on what hospice can offer and what the mission, values, and goals are (Cagle et al., 2015).

Many hospice clients have a great deal of pain. One of the barriers of hospice care is the controversial topic of opioid usage for pain particularly in older adults (Spitz, Moore, Papaleontiou, Granieri, Turner, & Reid, 2011). There are drugs that cause sedation to help with restlessness and pain. However, the ethical issue becomes whether it is better to allow the client to be in pain and able to communicate and eat on their own (Dean, Miller, & Woodwark, 2014). There are barriers to finding appropriate medications for pain management (Cagle et al.,2015). There is a concern about addiction, dependence, and abuse of the medications (Spitz et al., 2011). A fear that the opioids may not reach the client due to unethical doing by a caregiver is another reason to refuse opioid distribution (Spitz et al., 2011). Many physicians are hesitant to distribute opioids and look for alternatives to pain management for clients such as massage therapy (Spitz et al., 2011).

There are negative stigmas that have been associated with hospice and the end of life process. An idea to have a longer stay on hospice by using hospice to treat conditions that could not be stabilized while being at home (McPhee, Arcand, MacDonald, 1979). There is the stigma attached with hospice that is a form of giving up. There are false perceptions that taking medications

makes a senior a drug addict or weak for needing pain management control (Cagle et al., 2015).



Hospice clients may feel suicidal and depressed due to the fact they are near the end stages of life (Fine, 2001). Some agencies may monitor the length of visits, which can cause clients not to get the best care or feel as though they were engaged in an appropriate amount of time needed for a life review intervention (Csikai & Weisenfluh, 2013).

It could be very difficult knowing that your lifespan has 6 months or less to be lived. Some clients feel they have unfinished business to attend to. There is a primal fear of death. It may or may not been an unexpected diagnosis (Kumar, D'Souza, & Sisodia, 2013). Some elderly may be living a normal life and suddenly have pain. Once going to a doctor for a checkup, a client may be given an untreatable life-threatening diagnosis. However, some clients may be sick for a long time and not be afraid of dying and be completely at peace with the dying process. Suicidal ideation is common among hospice clients and it is important address why a client is having suicidal feelings.

Barriers are specifically formed when members of the interdisciplinary team do not collaborate appropriately prior to client care (Donovan, 1984). This causes a ripple effect for the client 's care. There are barriers with the services and resources available to the care team depending on the area. There may be resources available for client benefit in rural compared to urban areas.

Barriers can be very challenging to work through. It is critical to work with the team, which includes: a social worker, nurses, nurse aides, medical director, volunteer coordinator, music therapists, chaplains, and volunteers to brainstorm solutions to these barriers. Education is a good way to help people understand various aspects of social work that many have been mis conceptualized.

Ethical Considerations in Hospice Care

There are ethical dilemmas in all aspects of social work. Csikai (2004) asserted, "During this process hospital social workers may encounter ethical dilemmas regarding quality-of-life, privacy, and confidentiality, interpersonal conflicts, disclosure and truth telling, value conflicts, rationing of health care, and treatment options" (Csikai, 2004, p.1). Euthanasia and assisted suicide are also ethical dilemmas that comes up in conversations with clients on occasion (Csikai, 2004). People have seen this as a legal option in some states and staff struggle with this because it is not legal in all states to practice even when that is the client 's wish (Csikai, 2004).

Ethical Dilemmas in End of Life Care

It is important to talk about ethical dilemmas when needed and many refer to ethical committees or to their interdisciplinary teams (Csikai, 2004). In the National Association of Social Work (NASW) C ode of E thics to empower a client and give them control . It is mentioned in the NASW Code of Ethics the importance for social workers to promote self-determination under the value of dignity and worth of a person. However, the social work field is not black and white; t his causes a struggle when a clinician has to decide if a client is competent to make a decision (Ganzini , Harvath, Jackson, Goy, Miller, & Delorit , 2002). Many ethical dilemmas occur daily and hospice staff must address concerns with their supervisors or managers as needed to give the client the best outcome (Fine, 2001, p.131).Here are some examples of ethical dillemmas as follows in chart below.

- There is worry that the motives for suicide may not just be about the quality of life, but related to finances, feeling like a bother, and other ethical issues (Ganzini et al., 2002).

- There are concerns with the opioid epidemic and risks for abuse and addiction of drugs (Csikai, 2004).
- Is the client is safe in their own home? A client may be at risk of falling while alone, but if they are competent, they can choose to live alone in unsafe environments (Wilson, Gott, & Ingleton, 2011).
- Clinicians should assess for the risk of suicide in all client s who are depressed (Fine, 2001, p.131).

Death and Dying

There are several signs and symptoms that are common during the last few months of a client 's life. Some of the symptoms include respiratory issues, skin irritations, weakness, swelling, restlessness, confusion, and fatigue (Kehl & Kowalkowski, 2012). There is always a chance that a client may not experience these symptoms at all during the last few days of a client's life (Kehl & Kowalkowski, 2012). During the last few weeks hospice staff may refer to the client as "transitioning" meaning they are nearing the end of life (Kehl & Kowalkowski, 2012). Donovan (1984) explained, the social worker has a vital role within the hospice team. The social worker helps the client and family with funeral arrangements, financial assistance, resources, and support. Life review is one intervention that does reduce physical pain and depressive symptoms, improving the client's quality of life (Csikai & Weisenfluh, 2013).

The social worker and the nurse work hand and hand with the client. Both the social worker and nurse are suggested to be present for family at the time of death to offer support to family members and answer questions (Donovan, 1984). The social worker should be present throughout the client's journey through hospice to help with any issues that may arise (Reese & Raymer, 2004). Monroe & DeLoach explained, "The hospice social worker also makes clinical assessments, provides referrals, facilitates discharge planning, ensures continuity of care, serves as an advocate, offers crisis intervention, and serves as a counselor" (Monroe & DeLoach, 2004).

Grief and Loss

Every person will experience grief differently and will have various bereavement risk levels depending on the person and situation. As the social worker you will complete a bereavement risk assessment based on a specific scale. Most people will be able to function and return to their daily life activities following acute grief process. However, some may develop a mental health diagnosis because the grief may influence a person's ability to function in their daily lives (Ghesquiere, Aldridge, Johnson-Hürzeler, Kaplan, Bruce, & Bradley, 2015). If grief becomes severe and is left untreated or assessed it may lead to thoughts of suicide or even suicide (Ghesquiere et al., 2015). The social worker should do a bereavement assessment and this information should be distributed to the entire hospice care team especially the Bereavement Coordinator (Ghesquiere et al., 2015). There are different types of grief such as normal grief, anticipatory grief, and complicated grief.

Normal Grief	• An individual's behavior is acceptable for the circumstances and requires normal bereavement follow up (Egan & Arnold, 2003).
Anticipatory Grief	• "occurs before a death, usually at the time of diagnosis. A client may anticipate loss of good health (and in some cases a body part), independence, financial stability, cognitive ability, autonomy, and life itself" (Egan & Arnold, 2003, p.44)
Complicated Grief	• When a death is unexpected, the death is prolonged and even painful, or the relationships are complex and have past tension, and little support or resources (Egan & Arnold, 2003). • Symptoms of reactive distress to the death (e.g., disbelief or bitterness) and disruption in social relationships or identity" (Ghesquiere et al., 2015, p.1).

Self Care and Social Work

There is a need to practice self-care as it has shown to be beneficial to an elder's health and resilience (Lee & Miller, 2013). There has been a link between effective self-care and being able to cope with stress and traumatic situations. Self-care can help a social worker become a better advocate and have a life long career in social work (Lee & Miller, 2013). Social work leaders recognize the seriousness of the consequences of work-related fatigue, stress and compassion fatigue. "Figley (1995) coined the

term Psychological symptoms of this type of secondary traumatic stress include depression, anxiety, fear, rage, shame, emotional numbing, cynicism, suspiciousness, poor self-esteem, and intrusive thoughts or avoidance of reminders about client trauma". Physiological symptoms include hypertension, sleep disturbances, serious illness and a relatively high mortality rate in helping professionals (Beaton & Murphy, 1995).

Burnout has been an ongoing issue with workers in the human service field. It is a gradual emotional exhaustion that may lead to a negative attitude toward clients and reduced commitment to the profession (Maslach, 1993). When the work demand are high with limited rewards and appreciation, burnout occurs at a significantly high rate.



A YouTube element has been excluded from this version of the text.

Some effect means of self-care include:

- Start a "positivity" file.
- Get up and move.
- Shake up your routine
- Write it down (and throw it away).
- Activate your self-soothing system
- Take time out for yourself
- Work should be left at the office or job site.

Strengths and Challenges (Both)



There are benefits and barriers to the aging process and the transition into an elder. One challenge is that a selective few are forced to move from their home they have lived in their entire life into some type of facility due to not having caregivers or being able to care for themselves (Ellison, White, Farrar, 2015). Many elderly people also have experienced a significant amount of losses in their life including family, friends, a spouse, partners, and even children as they have aged (Ellison, White, Farrar, 2015).

During the aging process doctor visits may multiply, medical costs are rising, which can impact one's retirement budget. Challenges also include the declining of health that threatens a senior's day to day activities. Although it is inevitable health issues progress with age, it is important to prepare mentally prior to the occurrence by learning more about coping skills related to health issues. Challenges also include completing simple tasks once easily accomplished but escalating in difficulty as the body ages and weakens. It may become necessary to have a home care provider to assist with daily tasks. The elderly often worry about financial security. Most live on fixed incomes and are unable to afford the comforts of life they used to enjoy. Loneliness is a major concern of the elderly. They are unable to move about as they once did and find socialization difficult due to lack of mobility. Financial predators are those unscrupulous people looking to prey on the vulnerability of senior citizens by trying scare tactics to get them to provide banking information to them or to sell them unnecessary services or goods (Best for Seniors Online, 2019). Other challenges experienced by seniors are abuse and neglect in the nursing homes and assisted living facilities due to under-staffing issues, leading to discontented staff. Transportation and lack of mobility are also challenges of the elderly. They often must rely on others for help getting to doctors' appointments, grocery shopping or other necessary errands. Likely the hardest hurdle for seniors to manage is the continuous changes in technology that hinders those who are not familiar with current technology (Agency for Health Care Administration, 2013).

Although challenges are experienced by the elderly, many seniors experience positive and healthy benefits as they age. Seniors who believe in themselves and their capabilities, remain active and stay engaged intellectually have a higher probability of a less challenging experience as they age. Also, those who have strong spiritual beliefs often handle adversity due to their resiliency and faith. Focusing on the strengths and encouraging active and healthy lifestyles can make significant improvements in an elder's health of their body and mind (Merck Manual of Health and Aging, 2004). Seniors have a lifetime of valuable information to pass on to their family and friends. Many still believe a handshake is all that is needed to make an agreement. The elderly tend to hold to their values and beliefs of hard work and honesty. " By not listening, society is allowing parents, grandparents, and great grandparents to slip away without allowing them the opportunity to teach. As they leave us, we are refusing them the privilege to share with us the knowledge and invaluable presence that we too could one day offer our own children.
The presence of the elderly is worth more than silver and gold, their presence is priceless" (Debate. org, 20)

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8.3: Challenging Behaviors of Individuals with Developmental Disabilities

Focus Questions

- What are the characteristics and types of developmental disabilities?
- What are some of the major challenging behaviors that this population often engages in and how can they be defined and measured?
- What is the prevalence of challenging behavior of individuals with developmental disabilities?
- What risk factors are associated with the occurrence of challenging behaviors?
- What is applied behavior analysis and the principles that account for behavior?

Understanding Developmental and Intellectual Disabilities

Children and adults with developmental or intellectual disability require the assistance of interdisciplinary professionals and parents to support their full development across adaptive areas. There are often many areas of need seen in a changing context across the individual's lifespan. A developmental disability (Developmental Disabilities Assistance and Bill of Rights Act of 2000 PL 106-402) is a chronic mental and/or physical condition that occurs between 5 and 22 years-of-age and is likely to occur indefinitely (www.govtrack.us/congress/bills/106/hr4920) (Brown & Felce, 2007). For a diagnosis of developmental disabilities, the individual shows functional limitations in three or more categories of: self-care, receptive and expressive language, academic learning, mobility, self-direction, independent living, and economic self-sufficiency. The ability of individuals with developmental disabilities to interact with others in an appropriate manner, to take care of one's self and one's needs, and to maintain focus and active learning are critical skills. Failure to perform in a general education classroom is often linked to poor social skills (Salend, 2005). The related services, care, and treatment required to provide the individually tailored support needed may span professional areas such as: medical, speech-language pathology, special education, psychology, occupational therapy, physical therapy, counseling, and social work among others (www.acl.gov/Programs/AIDD/Index.aspx).

The current diagnostic criterion for developmental disabilities is based more on function (limitations and capabilities) than category. As seen in Table 1, the main developmental disabilities include intellectual disability, autism spectrum disorder (ASD), cerebral palsy, and seizure disorder (Odom, Horner, Snell, & Blacher, 2007). Some individuals may have social, emotional, and behavioral issues within the definition of the disability (Vaughn & Bos, 2009). A functional diagnostic system provides information for treatment possibilities and deemphasizes labels that may produce negative connotations and reactions by others (Panek & Smith, 2005; Scior, Connolly, & Williams, 2013).

Table 1: General description of categories of developmental disabilities and resource links

Developmental Disability	Description	Resources
Intellectual Disability	Characterized by significant limitations in both intellectual functioning and adaptive behavior, which covers many everyday social and practical skills (AAIDD, 2010; DSM V, 2013)	www.aaidd.org
Autism Spectrum Disorder	A developmental disorder involving a wide range of significant impairment of social communication and interaction with repetitive behavioral aspects or restricted range of interest (DSM V, 2013)	http://www.cdc.gov/-ncbddd/autism/index.html
Cerebral Palsy	Non-progressive, permanent brain damage that affects muscle movement, balance, and/or posture.	http://cerebralpalsy.org/-about-cerebral-palsy/what--is-cerebral-palsy/
Seizure Disorder	A sudden disruption of the brain's electrical activity accompanied by altered consciousness or behavior.	http://www.epilepsy-foundation.org/

According to a survey of over 100,000 parents, approximately 14% of American children have a developmental disability (Boyle et

al., 2011). In this study, developmental disability was very broadly defined and included learning disability, stuttering, and Attention Deficit Hyperactivity Disorder (ADHD) in addition to the categories listed in Table 1. The most common developmental disabilities include learning disability and ADHD with the prevalence of autism and ADHD increasing from 1997–1999 to 2006–2008 (Boyle et al., 2011). A recent United States nationally representative telephone survey of over 60,000 households with children found that the prevalence of autism spectrum disorder (ASD) was 2% among children ages 6-17 years in 2011-2012, an increase from 1.16% found in 2007 (Blumberg et al., 2013).

Behaviorally Defining & Measuring Challenging Behaviors

In addition to deficits in academic performance and adaptive behaviors, individuals with developmental disabilities often engage in challenging behaviors (Lowe et al., 2007; Poppes, Van der Putten, & Vlaskamp, 2010). Emerson (2001) defines challenging behavior as, "culturally abnormal behavior(s) of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behavior which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (p. 3).

General categories of challenging behaviors include aggression, stereotypy, self-injurious, or disruptive behaviors. These categories require additional description to allow reliable assessment and treatment procedures to be performed. More specifically, self-injurious behavior (SIB) may consist of the individual forcibly (loud smack sound) hitting one's own body with open or closed hand, or banging head against self or objects. A more specific and objective description of the behavior is necessary because one person's definition of a general category of behavior, such as aggression, may differ from another's, which is a problem in *reliability*. For instance, in one study in which 120 teachers were asked to define "disrespectful" behavior, over 17 different behaviors were given (e.g., talking back, not following teacher's directions, interrupting adults) (Landers, Servilio, Alter, & Haydon, 2011). A behavior category would be inaccurately measured if it means one thing to one person and quite another to someone else.

A behavioral definition must be objective, clear, specific, and complete such that two observers naïve to that person could read the definition and independently and reliably identify instances of the same behavior (Hawkins & Dobes, 1977). This approach to determining the accuracy of measurement and adequacy of definitions is called interobserver reliability. Accurate measurement of the behavior is necessary for assessment purposes, to implement treatment procedures accurately, and to evaluate treatment effectiveness (Martin & Pear, 2011). For example, one behavioral definition of self-injury involves biting self by upper and lower teeth making contact with skin resulting in pink marks or indentations on skin (see Matson, & Turygin, 2012 for additional definitions of self-injury). Likewise, tantrumming is inadequate as a description of challenging behavior since it refers to a general category of behavior that would be open to interpretation. More specifically and objectively, tantrumming might be defined as screaming above a normal conversational level and forcefully banging one or both fists on the table. Aggression might be defined as making contact with an open hand, fist, or foot to any body part of another person. See Table 2 below for a list of questions to determine if your behavior definition is adequate.

Table 2: Checklist to gauge adequacy of behavioral definition

Checklist to determine if the behavior of interest, challenging or desired behavior, is appropriately defined
• Can you count or time the behavior, or measure how long it takes before it occurs? • Did you use observable and measurable terms in defining the behavior? • Will a stranger know exactly what behavior to look for after reading your definition? • Can you explain what the behavior is not (i.e., give non-examples of the behavior)? • Can you break the behavior into smaller specific, and more observable units?

In addition to defining the behavior well, behavior measurement procedures must be specified. Behavior can be observed and measured in terms of how many times it occurs or its *frequency* (e.g., number of coughs, instances of throwing chairs, or interruptions), how long the behavior occurs or its *duration* (e.g., duration of screaming, out-of-seat, or off-task), the form or topography of the behavior (e.g., how a yoga move is made, or how hair is brushed), or how long it takes for the behavior to occur following a stimulus or its *latency* (e.g., how long before someone walks to school after being told to go, or does their homework after it has been assigned). A behavior can also be measured in terms of its remnants, called permanent product (e.g., throwing items can be measured by counting the items on the floor, destroying furniture may be measured by counting the disconnected pieces). The frequency or duration of behavior within a larger period of time can be measured (See Miltenberger & Weil, 2013 for more). This is termed continuous recording.

Reliable identification of the challenging behavior will facilitate assessment of its function so that effective interventions can be designed. We will review environmental reasons for challenging behavior after considering prevalence and associated factors.

Prevalence, Risk Factors, and Psychosocial Implications of Challenging Behaviors

The likelihood of professionals encountering individuals displaying challenging behaviors is fairly high. One prevalence estimate of challenging behaviors displayed by people with intellectual disabilities ranges from 15-17.5%, according to Koritsas and Iacono's (2012) review of 22 frequently-cited studies. It should be noted that estimates of prevalence of challenging behaviors for individuals with developmental disabilities varies depending on the methodology used (e.g., variations in definitions, assessment measures) and population addressed (e.g., institutional, residential, nationalities). When focusing on self-injurious behavior, a 19.1% prevalence rate was found in one state-wide parent survey of children with developmental disabilities (MacLean & Dornbush, 2012).

There are many co-occurring factors (such as diagnostic category and level of functioning) that may compound the difficulties that the individual with challenging behaviors and others around that individual face. Children with autism are more likely to show behavior problems compared to children without autism and more individuals with severe conditions are more likely to engage in challenging behaviors compared to those with less severe conditions (Totsika, Hastings, Emerson, Lancaster, & Berridge, 2011). In their sample of over 1,300 North American children and adolescents with autism, Felce and Kerr (2013) found that 88% of individuals with autism engaged in mild to severe aggression, with those cases mostly occurring to caregivers (56%). However, even with a sample of high functioning children with autism spectrum disorder, 72-86% had some sort of behavioral or emotional problems (Yoon, Ze, Tze, & Min, 2011).

Similarly, more severe levels of intellectual disability and autism have been found to be associated with the occurrence of challenging behaviors in a sample of adults with disabilities in Sweden (Lundqvist, 2013). More than half (62%) of these individuals had at least one challenging behavior as gathered through administration of the Behavior Problems Inventory (Rojahn, Matson, Lott, Esbensen, & Smalls, 2001) via interview method.

Multiple challenging behaviors and/or comorbid psychiatric conditions may be more likely to be present with individuals who display challenging behaviors (Rosenberg, Kaufmann, Law, & Law, 2011). Based on the use of the Self-Help and Behavior rating scale administered to 943 children with severe disability, Oliver, Petty, Ruddick, and Bacarese-Hamilton (2012) found that high frequency repetitive or ritualistic behavior was associated with a greater risk of severe self-injury. Moreover, low mood of people with severe and profound intellectual disabilities has been associated with challenging behaviors (Hayes, McGuire, O'Neill, Oliver, & Morrison, 2011). A higher rate of challenging behaviors was found with young children with atypical development and no ASD and comorbid psychopathology (e.g., anxiety behaviors, conduct problems, eating/sleeping problems, inattention/impulsivity) as measured by the Baby and Infant Screen for Children with Autism Traits (Matson, Mahan, Sipes, & Kozlowski, 2010). Likewise, higher rates of challenging behavior have been found with a sample of adults with developmental disabilities and symptoms of depression (Turygin, Matson, MacMillan, & Konst, 2013).

The presence of communication deficiencies has also been linked to the occurrence of challenging behaviors (Kevan, 2003; Matson, Boisjoli, & Mahan, 2009). In one interesting study examining the relationship between communication skills, social skills and challenging behaviors with 109 children with ASD though, the presence of challenging behaviors was associated with more impaired social skills than difficulties in communication (Matson, Hess, & Mahan, 2010).

It is important to note that the studies cited above examining *associated* risk factors with the occurrence of challenging behaviors involved some form of descriptive/correlational research method, which merely provides information about the type of association and its strength. Correlational results do not provide information about *causation* or cannot tell if one variable causes another; such as the proposition that poor communication skills cause challenging behaviors to occur. It may be that poor communication causes challenging behavior, challenging behaviors cause poor communication, or quality of early home environment causes both poor communication and challenging behaviors. The careful manipulation and control of confounding variables involved with an experimental research method rules out alternative explanations and that methodology is not present with correlational research designs. Correlational research simply portrays the relationship between two variables (e.g., positive relationship where both variables increase, negative relationship where one variable increases as the other decreases). In the research cited above, due to the nature of the variables studied (e.g., type of disability and occurrence of challenging behavior), only descriptive/correlational research is possible.

The ramifications of challenging behavior are pervasive. Severe behaviors such as aggressive, self-injurious, and disruptive

behaviors can be some of the most intractable and troublesome to deal with, contributing to staff and teacher stress and burnout (Hastings & Brown, 2002; Male & May, 1998). Parenting stress has been associated with higher levels of child behavior problems (Rezendes, & Scarpa, 2011). Totsika et al. (2011) found that mothers of children with autism are more likely to have emotional problems compared to mothers of children without autism. The occurrence of challenging behavior by the individual may also negatively affect attachment with support staff (De Schipper, & Schuengel, 2010). Staff may see themselves as less able to control the individual's behavior if it is severe and thus less likely to step in to intervene to improve it (Dilworth, Phillips, & Rose, 2011).

The occurrence of challenging behaviors may lead to the use of restrictive procedures to curb those behaviors (Matson & Boisjoli, 2009). Allen, Lowe, Brophy, and Moore (2009) reviewed social service agencies' plans for 901 individuals with developmental disabilities in South Wales, UK, and found that more severe aggressive behavior was associated with a higher use of restrictive procedures (e.g., seclusion, emergency restraint, medications).

Applied Behavior Analysis

Applied behavior analysis (ABA) principles and techniques provide a means of addressing the challenging behaviors of individuals with developmental disabilities. ABA consists of a variety of environmentally-based procedures to increase socially significant behaviors (Cooper, Heron, & Heward, 2007). ABA is based on learning principles and procedures, and many of the techniques used in this field have been empirically validated to be effective at changing overt (observable) and covert (e.g., thoughts, feelings, images) behaviors. The use of ABA has led to a greater understanding of the occurrence of both normal and abnormal behaviors and has resulted in the development of many empirically-based treatment procedures for challenging behaviors (Fisher, Piazza, & Roane, 2012).

Environmental Factors Maintaining the Individual's Challenging Behavior

The main factors that contribute to the occurrence of challenging behavior include the immediate environmental consequences that follow that behavior and the cues or antecedents that signal those desired consequences. A recent meta-analysis of over 170 empirical studies found that, in most clinical cases, a clear environmental reason for the individual's challenging behavior was identified (Matson et al., 2011).

Positive reinforcement and negative reinforcement are the basic environmental functions or maintaining variables for individuals' challenging behavior (e.g., Beavers, Iwata, & Lerman, 2013; Lancioni, Singh, O'Reilly, Sigafoos, & Didden, 2012; Matson, 2009). Positive reinforcement is a term used when events, objects, or sensory stimuli presented immediately following a behavior result in an increase in that behavior in similar situations (Martin & Pear, 2011). For instance, an adolescent who has severe intellectual disability and is in a wheelchair may grab at staff's clothes resulting in much negative attention from the staff member (e.g., a stern look and statement to, "Please don't do that!"). Although the staff member may be attempting to decrease the individual's behavior, if the grabbing behavior is increasing and occurring when someone is around, then that behavior may be maintained by positive reinforcement in the form of attention. Positive reinforcersare the specific consequences that increase the individual's behavior that they follow and can include attention, toys (tangibles), or food (edibles). It should be recognized that there are many consequences that are positive reinforcers for a child and that what is a positive reinforcer for one may not be for another. Attention (even in the form of reprimands), objects (e.g., toys, food, electronic devices), and specific events (e.g., seeing a show, going for a walk) can be positive reinforcers when they increase the behavior that preceded it.

Reinforcement may also be produced by engaging in the behavior itself without any mediation by others, termed automatic positive reinforcement. For instance, the individual might be engaging in excessive finger tapping as a function of the sensory stimulation produced by that behavior. Likewise, thumb sucking may occur because of the sensations it produces on the skin.

Another major function of challenging behavior is negative reinforcement (Lancioni, Singh, O-Reilly, Sigafoo, & Didden, 2012). negative reinforcement refers to stimuli or events that when removed or avoided immediately after a behavior increase its rate in similar situations (Martin & Pear, 2011). A negative reinforcer is an object or event that when it is immediately removed (*escape conditioning*) or prevented (*avoidance conditioning*) following a behavior results in that behavior being more likely to occur in similar situations. For example, a child at the dinner table may scream at the top of her lungs leading to the parent sending the child to her room. If that child screams at dinnertime more often, then negative reinforcement, in the form of "escaping" from the dinner table, may be occurring. As another example, a child who is having difficulty with his homework talks to nearby classmates to avoid completing the work. See Table 3 below for additional examples of challenging behaviors maintained by positive and negative reinforcement.

Table 3: Examples of Challenging Behaviors Maintained by Positive and Negative Reinforcement

Possible Environmental Causes of Challenging Behavior: Positive Reinforcement	**Possible Environmental Causes of Challenging Behavior: Negative Reinforcement**
The individual may *receive* one of the following after the behavior resulting in its increase:	One of the following may be *removed*or *avoided* after the behavior resulting in its increase:
Attention (e.g., reprimands given after a child screams) **Tangible** (e.g., hitting anther child to get a toy, grabbing someone's food) **Automatic (nonsocial sensory-based)** (e.g., sucking fingers due to the sensation it produces, regurgitation to stimulate the esophagus, screaming because of the sound produced, rocking due to inner ear stimulation)	**Demands/tasks** (e.g., tantrums result in unpleasant task or situation being removed) **Attention** (e.g., running away to remove undesired attention) **Automatic (nonsocial sensory-based)** (e.g., hitting head to relieve pain, being aggressive to remove noise or get out of a crowd)

As is the case with positive reinforcers, a stimulus that is a negative reinforcer for one individual may not be so for another. The best way to determine if something is a negative reinforcer is to test whether the rate of a behavior increases when certain events are removed immediately after that behavior compared to a condition in which no consequences are delivered following the behavior. To ensure consistency in the results and rule out confounding factors, this test should be replicated or repeated in an A-B-A-B fashion where A = no consequence and B = a consequence for behavior is provided.

A history of reinforcement for the occurrence of challenging behavior in addition to the presence of certain antecedent stimuli or conditions that "set the stage" or increase the likelihood for the behavior (e.g., difficult work assignment, certain person) should be identified. The purpose of assessment is to identify the reason or function for the individual's challenging behavior. An analysis of the function of behavior entails breaking the situation into smaller units to allow a clearer understanding and determination of the behavioral principle (positive reinforcement or negative reinforcement) involved in controlling the individual's behavior (Martin & Pear, 2011). The motivational condition, antecedent stimulus, behavior, immediate consequence, and long term effects should be identified to reveal the behavioral principle that is involved, as illustrated in the box below. A motivational operation refers to a temporary state or condition that changes the value of the reinforcer and the probability of behavior that leads to that reinforcer (Michael, 2000). For instance, after not drinking water for several hours while out in hot weather, the value of a drink as a positive reinforcer will increase and there is a greater likelihood of the individual asking for something to drink. Additional examples of how the individual's situation can be broken down, and thereby better understood by analyzing the motivational condition, antecedent stimulus, behavior, and immediate consequence is shown in Table 4 below.

Table 4: Examples of a behavioral analysis of the situation in terms of the motivating conditions, antecedents, and consequences for behavior

Motivational condition	Antecedent stimulus/ situation	Behavior	Immediate consequence	Long term effect	Behavioral principle
Hunger	Middle of night	Adolescent gets up and screams and yells	Provided with pudding	More likely to scream and yell in future similar situations	Tangible positive reinforcement
Lonely or no social interaction for hours	Presence of staff member	Young adult in wheel chair grabs staff member	Staff member says, "No, don't do that!"	More likely to grab staff members in similar situations	Attention positive reinforcement
Difficult assignment	Teacher says, "Complete this assignment"	Child gets out of seat and socializes with neighbor	Gets out of doing assignment	More likely to get out of seat and socialize when given difficult assignments next time	Escape negative reinforcement

Motivational condition	Antecedent stimulus/ situation	Behavior	Immediate consequence	Long term effect	Behavioral principle
Low levels of stimulation	Light switch present	Repeatedly flicks light on and off	Sensory stimulation of light flickering	More likely to flick lights when in a similar situation	Automatic positive reinforcement

Determining the function of an individual's challenging behavior can, at times, be difficult. For a small percentage of cases, the individual's behavior may be controlled by multiple functions or be unable to be specified (Beavers & Iwata, 2011; Mueller, Nkosi, & Hine, 2011). The challenging behaviors of 521 participants reviewed by Beavers and Iwata (2011), showed only 16.9% had multiple functions with most behaviors involving multiple response topographies. In a small percent of cases (roughly 4-12%), the individual's challenging behavior may be maintained by idiosyncratic variables or, particular antecedents or consequences specific to that case (Schlichenmeyer, Roscoe, Rooker, Wheeler, & Dube, 2013). As Schlichenmeyer et al. (2013) note in their review of the research literature, idiosyncratic variables such as preferred conversation (Roscoe et al., 2010), instructional style (Borrero et al., 2004), or the therapist leaving the room (Edwards et al., 2002) may be involved in setting the context for increased likelihood of the occurrence of the individual's challenging behavior. These idiosyncratic variables may be difficult to pinpoint unless assessment procedures are tailored to the individual's circumstances. Additional factors that may contribute to the individual's challenging behavior can be seen in Table 5 below.

Table 5: Possible relevant factors that may be related to the occurrence of challenging behavior

Organismic

- Motivational state (e.g., hungry, thirsty)
- Temporary bodily states (e.g., fatigue, menstrual cramps)
- Emotional state (e.g., jealousy, frustration) and other conditioned emotional responses (fear, anger, anxiety)
- State of health (e.g., flu, headache, allergies)
- Medication effects and side effects (e.g., lethargic)

Familial

- Abuse, neglect, nutrition, poverty, loss of work, death in family, socioeconomic, factors, ethnicity

School-related

- Size of room, number of people, teacher proximity, temperature, noise, lighting, unclear directions, unpredictability, inadequate help, unclear expectations
- Events, holidays, certain activities (e.g., dances), visitors

Special Education Perspective

Many children with behavior disabilities (BD) including challenging behaviors are served in general education classroom settings. Approximately 25% of all school age children identified with a disability are labeled as having a behavior disability (Vaughn & Bos, 2009). Twice as many males as females are labeled as having BD and more children who are African American are labeled than any other ethnicity (Vaughn & Bos, 2009).

School districts and agencies often lack personnel trained in the professional decision making process to handle these difficult situations and so must hire experts to provide training at high financial cost (Hall & Hall, 2003). It is of critical importance to develop partnerships between schools that lack the expertise and colleges and universities that can train teachers to manage challenging behaviors (Johns & Carr, 1995).

The movement for inclusion of students with disabilities in public schools has had a major impact on the way teachers are trained to work with all students and on the way students learn in the classroom setting (Mastropieri & Scruggs, 2010). The inclusion

movement, which began in the early 1990's after decades of integration of students with disabilities into the least restrictive environments (LRE) for learning, redefines the philosophy of teaching and learning so that all learners, regardless of abilities, have the opportunity to work on their academic and social skills alongside of their peers. Inclusion is the process of teaching so all students can process and understand the material in whatever way is best for them. Inclusive education is a core belief and set of teaching practices that supports the tenet that all students should be full members of the community (Shapon-Shevin, 2007, p. xii). However, students with challenging behaviors are often found to be segregated due to those behaviors. Professionals and families must work together to ensure that the effects of challenging behavior are addressed in inclusive educational settings that provide heterogynous groupings for students.

As inclusive classrooms across the United States continue to evolve according to legal mandates, teachers' beliefs and practices are still being challenged by the changes in the students who make up their classroom communities (Shapon-Shevin, 2007). As new, pre-service level teachers enter the field of education with training, they must demonstrate the dispositions, knowledge, and skills to work with all students. The instructional demands for teachers are staggering; many classes have students for whom English is not their primary language, students who have experienced trauma, students who are years behind their classmates, and students who lack basic experiences for understanding their world. For teachers, the demands are to assist students and their families in the identification and remediation of challenging behaviors that prevent full inclusion placements. However, the movement may not be successful especially for those students with significant behavioral needs if educators cannot find a way to identify, assess, and intervene in these significant behavioral challenges in classrooms. A strong need exists for effective methods to decrease the challenging behaviors of individuals with developmental disabilities.

Summary

Individuals with developmental disabilities may display a broad array of challenging behaviors and lack the social and adaptive behaviors that are necessary for functioning in everyday life. However, students with disabilities have the right to be educated in settings that are heterogeneous. Inclusion has been used to describe the education of students with disabilities in general education settings or inclusive settings with peers who can act as role models. Co-occurring conditions for the individual may be present and increase the difficulty and complexity of that case for the professional addressing the individual's needs. The first step when attempting to help the individual is to behaviorally define that person's challenging and desired behaviors, which can assist in its measurement, assessment, and treatment. Environmental factors, such as positive reinforcement and negative reinforcement, are major reasons for the occurrence of challenging behaviors and must be addressed in on-going assessment and treatment procedures. Applied behavior analysis is an empirically-based approach that can be used to teach adaptive and desirable behaviors and decrease the challenging behaviors observed in various settings with this population. Chapter 2 will review FA methods as a means to identify the function of individual's challenging behaviors.

Discussion Questions

1. What challenging behaviors are most important to address? What considerations are important when prioritizing which of several challenging behaviors should be targeted?
2. Discuss whether risk factors are likely to cause challenging behaviors. Explain why it is difficult to know what the cause or challenging behaviors is (hint: draw from your knowledge of research methods).
3. Why is it important to understand the function of an individual's challenging behavior?

Exercise 1: Behavior Definition

1. What are the characteristics of a well-defined behavior?
2. Are each of the following definitions of behavior adequate? If not, then revise the definition to improve it.
    1. Non compliance = a child does not complete the instruction delivered by the experimenter within 6 s of presentation of the instruction
    2. Stereotypy = flapping hands or arms, rocking torso, jumping and turning in circles, waving, mouthing
    3. Aggression = firmly grabbing and pulling on the experimenter or cursing
3. Read the following behavioral definitions and determine if you think the problem behavior in bold is well-defined. If your answer is "no," change the problem behavior by defining it appropriately.
    1. Tomika is very **disrespectful** in that she sasses her teachers when she does not want to do what they ask.
    2. Paula engages in **inappropriate interactions** with her peers by being quiet and disagreeable.
    3. **Inappropriate vocalizations** that Ternia says include loud or high-pitched statements such as "No!" and "I want to go home."

4. Define teasing.

Exercise 2: Identifying, Defining, and Measuring Behavior

With a partner, go to a public location (e.g., cafeteria, library, building hallway or courtyard) and identify a behavior that one or many individuals are displaying. Be sure that the behavior occurs fairly frequently (e.g., at least once per min).

1. Behaviorally define the behavior.
2. Indicate how to measure it (e.g., frequency, duration, latency, permanent product). Select a data sheet from Chapter 7 templates.
3. You and your partner should independently measure it.
4. Compare your data with your partner's. Did you agree on all occurrences of the behavior? Why or why not? How could you improve your definition of the behavior?

Exercise 3: Practice in Identifying Behavioral Principles

Next, determine for each of the following if this is an example of positive or negative reinforcement.

- Sally receives a point on her score card for making a perfect shot in basketball. She is shooting baskets better than ever.
  - Positive Reinforcement
  - Negative Reinforcement
- A child is in the dentist's seat and when the dentist goes to insert a tool in his mouth, the child shakes his head and says, "No!" The dentist removes the tool and moves away from the child. The dentist always has a hard time with this little fellow.
  - Positive Reinforcement
  - Negative Reinforcement
- Frederick is a teenager with an obesity problem who joins the gym, and regularly works out. His best friend works out with him and repeatedly tells him how he is getting stronger and fitter right after each session. Frederick goes to the gym more often.
  - Positive Reinforcement
  - Negative Reinforcement
- Whenever a teacher places a worksheet on the student's desk, the student then gets up and sharpens an already sharp pencil to get out of doing the work.
  - Positive Reinforcement
  - Negative Reinforcement
- In school art class, Almero made some paper cut-out flowers to give to his mom, which resulted in many hugs and kisses from his mom. He does this more often now.
  - Positive Reinforcement
  - Negative Reinforcement

Exercise 4: Analysis of Challenging Behavior Exercise

1. Think of someone you know who engages in a challenging behavior.
2. Behaviorally define the individual's challenging behavior so that it might be reliably observed and measured.
3. Speculate on the possible environmental reason for it by completing the following chart.

Motivating Condition	Antecedent	Behavior	Immediate Consequence	Long Term Effect	Behavioral Principle

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9: CHAPTER 9

9.1: Social Work and the Health Care System

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8: CHAPTER 8

8.1: Gerontology and People with Disabilities
8.2: Aging Population
8.3: Challenging Behaviors of Individuals with Developmental Disabilities

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9.1: Social Work and the Health Care System

Medical social work is viewed as one of the most significant fields in practice . It has been acknowledged as the first subspecialty discipline to practice in hospital, public health, and clinical settings (Allen & Spitzer, 2016).

Medical Social Work

Medical social work can be defined as a specific form of specialized medical and public health care that focuses on the relationship between disease and human maladjustment (NASW, 2012; Gehlert, 2011).

In the 20th century, social service departments in hospitals were developed to address problems associated with the increase of immigration and poverty. The need for medical social work in the United States has intensified due to the substantial inequality of health care resources. Individuals and families that live in poverty or who are a part of certain ethnic communities are additionally at a disadvantage because they are more prone to experience higher rates of acute and or chronic illnesses. Therefore, the unequal distribution of healthcare insurance coverage in the United States hinders some people from seeking medical treatments due to their socioeconomic status. In 2013, more than 42 million people in the United States were uninsured. Today, the number has only increased (NASW, 2016).

Medical social workers practice in a variety of healthcare settings such as hospitals, community clinics, preventative public health programs, acute care, hospice, and out-patient medical centers that focus on specialized treatments or populations. These professionals help patients and their families through life changing and sometimes traumatic medical experiences. They often monitor and evaluate a patient's mental and emotional health as they transition through a variety of medical treatments. Medical social workers also often find themselves helping the patient and family solve problems be that of financial difficulties or one-to-one counseling to help cope with new stressors (Mizrahi & Davis, 2008; NASW, 2016).

All medical social workers must familiarize themselves with cross-cultural knowledge in order to provide effective health care. They do this by familiarizing themselves with an array of different ethnicities, cultural beliefs, practices, and values that shape their family system. Medical social workers must have the ability to recognize how oppression can affect an individual's bio-psycho-social-spiritual well-being. As future social workers, being able to understand and identify these issues will enhance your skills as a professional to provide excellent health care (Mizrahi & Davis, 2008; NASW, 2016).

For more information regarding cultural competency in social work, refer to Chapter 3.

Goals of Practice

The National Association of Social Workers (NASW) Standard for Social Work Practice in Health Care Setting (2016), describes eight standards of practice for health care social workers to follow. The eight goals were created as a guideline so that medical social workers would deliver excellent care.

Eight Standards of Practice for Health Care Social Workers

- All medical social workers in the healthcare arena must practice in accordance with the social work code of ethics.
- Advocate for client's right to self-determination, confidentiality, access to supportive services and resources, and appropriate inclusion in decision making that affects their overall health and well-being.
- Encourage social work participation in the development, refinement, and integration of best practices in health care.
- Enhance the quality of social work services provided to clients and families in health care settings.
- Promote social work participation in system wide quality improvement and research efforts within health care settings.
- Provide a basis for the development of continuing education materials and programs related to social work in health care settings.
- Promote social work participation in the development and refinement of public policy at the local, state, federal, and tribal levels to support the well-being of clients, families, and communities served by the rapidly evolving U.S. health care system.
- Inform policymakers, employers, and the public about the essential role of social workers across the health care continuum.

The first and second standards of practice are extremely important to remember as you become professional social workers. All

medical social workers must practice in accordance to the social work code of ethics. The social work code of ethics is rooted in a set of core values. Social work's primary goal is to provide excellent service and to promote social justice for all patients, thereby ensuring that all medical and psychological services are met. Medical social workers must also embrace the importance of human relationships by building a positive and lasting rapport with clients. Always strive for professional competence by increasing the use of education and research and applying them to practice (NASW, 2016). For more information, please refer to Chapter 2 regarding the social work code of ethics.

Medical social workers advocate for the patient's right to self-determination. Every patient is entitled to make their own decision based on treatment recommendations. The treatment team may desire and advocate for the best medical care for their patient; however, it is ultimately the patient's decision to follow through with treatment. There are times when a patient may not be able to speak for themselves. You could encounter these situations when the patient is a child or if an adult has a cognitive impairment that enables them to make decisions for themselves. In these cases, the family has the authority to make the decision based on what they feel is the best course of action (NASW, 2016).

Case Study

In 1983, the University of Arizona was beginning to perform an experimental procedure on infants who were born with a congenital heart defect called Transposition of the Great Arteries (TGA). Katherine Frasier was born with this rare heart condition. Katherine's parents realized that their options to save their daughter's life were minimal because of the lack of research on TGA. The medical team insisted that they wait to do the procedure until Katherine has gone into congestive heart failure. The physicians at the hospital insisted the new experimental medical procedure would save their daughter's life. The team of physicians, social workers and nurses corresponded with the University of Boston Children's Hospital whom at the time was the only hospital who could successfully perform this operation.

At that time, Ms. Frasier's family did not have the financial resources to travel to Boston as a family. Traveling also meant that Katherine's father would not be able to attend because of his job in the military. The physicians repeatedly told her parents that this procedure was the only option and recommendation for treatment. However, they did not take into account that the procedure had never been done by the cardiologists at the University of Arizona. Katherine's parents decided that it would be best if the physicians found another form of treatment.

The pediatric social worker stayed in contact with the family hourly and provided emotional support to Katherine's family. She also insisted that the treatment team expand to other disciplines for more possible options.

Dr. Copeland, a world renowned heart transplant surgeon, was recommended to join the team. Dr. Copeland knew of another way to repair Katherine's heart. Katherine's parents agreed to allow him to operate that same day. Through the dedication of the social worker and treatment team that advocated for the Frasier's right to self-determination, Katherine is still leading a productive and fulfilling life advocating for her pediatric patients the way her social worker did 30 years ago.

Team Work

The use of multidisciplinary team is an effective part of healthcare treatment. A multidisciplinary team is defined as a group of professionals that specialize in different disciplines that come together to deliver quality health care that addresses the patient's well-being (Mitchell, Tieman & Shelby-James, 2008; Nancarrow et al., 2013; Allen & Spitzer, 2015). Using this approach allows the team to provide better-quality outcomes and to enhance client satisfactions.

There are also two other types of treatment teams in the healthcare setting:

1) An interdisciplinary team involves members from the same disciplinary background. An example would be: a team of medical social workers discuss possible treatment plans according to the results of a patient's assessment. Working in a team allows for individual ideas to be heard and as a group develop a specific treatment plan.

2) An interdisciplinary team that includes individuals from different disciplines who collaborate to resolve a variety of issues. Medical social workers, physicians, nurses, and activity therapists experience different types of interactions with patients in which different behaviors are assessed. Together these disciplines paint an overall picture of how team work can increase a patient's quality of life (Allen & Spitzer, 2015).

Biopsychosocial-Spiritual Assessments

The recommended health care approach to psychological evaluations is through the use of a biopsychosocial-spiritual assessment (NASW, 2016; Social Work Licensure Exam, 2008). This approach focuses on the individual as a whole and takes into account their biological, psychosocial, social, and spiritual sense of self. Together the interdisciplinary team can focus on the individual's treatment from all professional perspectives. Using this approach allows for each practice the ability to provide optimal health care (Gehlert & Browne, 2011).

The term biopsychosocial assessment or biopsychosocial-spiritual assessment is an approach you will hear throughout school. This model examines not just the medical aspect of care whose primary focus is on the biological causes of a disease. Rather, the biopsychosocial-spiritual model examines a patient's well-being through a holistic approach (Gehlert & Browne, 2011; McDaniel, Hepworth & Doherty, 2014; Allen & Spitzer, 2015).

Biopsychosocial Spiritual Assessment

The Biopsychosocial Spiritual (BPSS) Assessment offers a historical context for what the client presents with and assesses the client's history, strengths, and resources.

How do these four areas contribute to the client's current functioning?

- **Biology**: basic needs – the client's access to food, shelter, etc.
- **Psychosocial:** history, personality, self-concept, medication, diagnosis and treatment history
- **Social:** support system (friends, family, social environment). Knowledge of life stages and development are essential
- **Spiritual:** sense of self, sense of meaning and purpose in life, religion and its context in client's lif

ROPES method of identifying strengths: Resources, Options, Possibilities, Exceptions, and Solutions

(Social Work Licensure Exam, 2009)

Medical Social Work Job Descriptions

Overall Functions of a Medical Social Worker

According to *TheSocialWorkers in Hospitals and Medical Centers Occupation Profile* (2017), medical social workers employ a myriad of skills and approaches to ensure quality health care.

The following list is an example of tasks that most medical social workers use when providing services.

- Conducting initial psychosocial-spiritual assessments and screenings for patients and making referrals for individual, family and or group therapy if needed;
- Educating the patient and family members of the individual's illness and treatment options as well as possible consequences of various treatments or refusal of treatment;
- Helping patient and their families adjust to the hospital dynamics and exploring emotional and social responses to the illness and treatment;
- Educating the patient and family on the roles of the healthcare team. Assisting patients and their families in communicating with one another and to the members of the multidisciplinary team;
- Facilitating decision making on behalf of patients and families.
- Educating hospital staff on patient's psychosocial issues;
- Coordinating patient discharge with a safety plan and continued care planning by providing patient navigation services;
- Arranging resources/funds for finances, medications, medical equipment and other special needs services

(National Association of Social Workers, 2016)

Emergency Room Social Work er :

Emergency room social workers provide services to triage patients. One of their main functions is to diagnose and assess patients who show signs of mental illness. The medical social worker also performs discharge planning as a means of assurance that every

patient will have a safety plan when discharged from the hospital (Fusenig, 2012).

The following is a list of tasks that emergency room social workers may perform:

- Performs mental health assessments and suicide evaluations;
- Conduct stress evaluations;
- Death notifications to family members;
- Counsels victims of violent crimes, domestic violence, substance abusers and families of deceased or terminally ill patients;
- Refers patients to community resources;
- Provides financial assistance;
- Conducts child and adult protective service reporting;
- Conducts domestic violence and sex trafficking screenings;
- Diagnoses and conducts mental health intake evaluations to establish proper psychiatric care;
- Conducts discharge planning; knowledge of community resources and services

(Fusenig, 2012)

Hospice or Palliative Care Social Workers:

Hospice social workers work in a variety of different medical settings. At times, there are hospice organizations that come into a hospital to provide assistance to those who are nearing the end of their life.

The following is a list of tasks that hospice and palliative care social workers perform:

- Ensuring that patients and family members have access to resources that will provide physical comfort;
- Providing emotional and or spiritual support to patients and their family members;
- Lead support groups for family members and in-service trainings to nurses, physicians, and other social workers who are involved in the treatment process;
- Ensure proper medical transitions from palliative care to hospice care if needed;
- Act as care coordinators; providing treatment planning with other members of the patient's treatment team

(SocialWorkLicensure.Org, 2017)

Pediatric Cardiology Social Worker:

https://www.onlinemswprograms.com/in-focus/interview-with-andrea-kido-lcsw-on-clinical-social-work.html

The above link takes you to an interview with a pediatric and clinical social worker from Marin Community Clinics (MCC). She explains her role on the pediatric intensive care unit. She describes daily activities and the different types of challenges that one may experience working with children and their families (Louie, 2017).

Summary

Medical social workers play a very important role in the care and needs of all patients in the health care system. Above was brief introduction to the different types of medical social work job descriptions. Always keep in mind, as you pursue your education in social work, and possibly later in the health care field; the profession will always be centered on the code of ethics. Everything we do is focused on the rules and regulations of the social work code of ethics.

Recommended Readings and Videos

Video:

YouTube Video

This interactive element is not available in this format. Visit the link or scan the QR code to access it online.

View this YouTube Video online

What does a medical social worker do? Kristin Scheeler, MSSW, CAPSW, OSW-C

Websites:

Interviews With Medical Social Workers

Books :

Allen, K. M., & Spitzer, W. J. (2015). *Social work practice in healthcare: Advanced approaches and emerging trends*. Los Angeles: SAGE.

Gehlert, S., & Browne, T. (Eds.). (2011). *Handbook of healthsocial work. (*2nd ed.). Hoboken, NJ: Wiley.

Public Health Social Work

Public health social work originated in the early 20th century to control communicable diseases, poverty, sanitation, and hygiene. It is defined as a collection of human service programs that has one common goal: identify, reduce and or eliminate the social stressors among the most vulnerable populations. A public health social worker's main role is to establish preventative measures and to intervene in the health and social problems that affect communities and populations.

Epidemiological Approach

Public health social workers focus on the epidemiological approach to identify health related issues and diseases that affect certain populations. Epidemiology is a branch of medicine that researches the occurrence, delivery and possible control of diseases (CDC, 2017).

To better understand this approach, think of epidemiology as the basic science of public health. Epidemiology is a method that is used to develop and test a hypothesis (CDC, 2017).

Consider this: public health social workers and medical researchers are concerned with the occurrence and patterns of health events. In 2016, it was estimated that the population of Big Rapids, Michigan, is 10,475. Three-thousand students and faculty at Ferris State University in 2016 developed the same strain of bronchitis within a three-month period. The results allow public health workers to compare the same outbreak of bronchitis to other populations in the state of Michigan. A pattern has been established by the number of students and faculty at the university and in other cities that have the same strain of bronchitis. The occurrences also depend on the following variables: has the strain appeared in the same seasons? It is more prone to males or female? What is the average age of the individuals? Has it happened during the same weeks? Has it happened daily? The overall question is: what will public health social workers do about it?

Having the ability to compare the universities outbreak and the outbreaks throughout the state with the same symptomology will help to determine how the outbreak started and possibly the location where it began. In the end, findings will help provide evidence that will allow public health social workers to develop prevention and education interventions to help contain the outbreak.

Roles of a Public Health Social Worker:

- Find people who need help

- Assess the needs of your clients, their situations and support networks
- Come up with plans to improve their overall well-being
- Help clients to make adjustments to life challenges, including divorce, illness and unemployment
- Work with communities on public health efforts to prevent public health problems
- Assist clients in working with government agencies to receive benefits
- Respond to situations of crisis, including child abuse or natural disasters
- Follow up with clients to see if their personal situations have improved

(Allen & Spitzer, 2015)

Ethical Dilemma in Public Health

A good example of an ethical dilemma that most social workers would consider a concern is when public health clinics in hospitals call an individual who has contracted a sexually transmitted disease (STD). When women and men go into their family doctor for a yearly physical, they always check for STDs. If the results come back positive, the individual is notified by the doctor's office to discuss an intervention. The next phone call is from a public health department either in a hospital or out-patient clinic.

In order for public health officials to gather information concerning STDs in the community, they have the right to gain certain information that will help to control the disease. For a clearer understanding, let's refer to what is known as Health Insurance Portability and Accountably Act (HIPAA) (DHHS, 2003).

Whenever you go to the hospital you always sign a HIPAA disclosure form. By signing this form, you are allowing health care providers the means to share medical information without written consent. HIPAA also allows healthcare providers to share important information regarding an individual's treatment plan, diagnosis and medications to another healthcare provider (DHHS, 2003).

For example: Jane Doe goes to see her primary health physician at Spectrums Family Health Center in Grand Rapids Michigan. Jane Doe is rushed to the emergency room the same day at Spectrums Children's Hospital. The emergency room technicians will already have Jane Doe's information because it has been documented and saved on Spectrums Health Care System Network.

Going back to the example of STDs, if a person is at risk of contracting or spreading a disease their healthcare provider has the right to disclose information. The information is revealed because it is a public health concern that effects the community. Health care providers release this information to help prevent and control another incident (DHHS, 2017).

Advocacy and Policy for Medical and Public Health Social Work

One of the most important roles of all social workers is to advocate for their clients. In the healthcare system, social workers do this by representing, promoting change, speaking on behalf of the client, assessing rights and benefits, and securing social justice. It is pertinent that all receive fair and equitable access to all medical services and benefits (NASW, 2012).

The healthcare system is driven by policies that outline the rules and regulations of the organization. Policies are developed based off the organizations ideas of acceptable and well-defined standards of healthcare practices. These policies are also implemented to reduce chaos, confusion, and legal issues that may arise due to unethical practice.

Some of these policies include:

- Patient care recipient rights.
- Abuse and neglect, investigation policies.
- Administrative policies
- Information management policies – HIPAA
- Accreditation Standards
- Medication Procedures

All physicians, nurses, social workers, administrative staff, and patient care workers must abide by all policies to produce effective outcomes for the organization.

Summary

Not all public health social workers will be found in the scenario above. One of the main roles of a public health social worker is to provide communities and vulnerable populations with the resources to help eliminate a social epidemic. This is usually done through community outreach programs and governmental agencies that focus on interventions and education to help improve community living.

Intimate Partner Violence



Intimate partner violence

"Violence sprouts in intimacy. Except for police and army, family is, probably, the most violent social group and a home is the most violent social space of our society. A person is most likely to be hit or killed in his/her own home by another member of the family than anywhere else or by anyone else" (Stark & Flitcraft, 1996)

Intimate partner violence has been recognized in the United States and other countries as a significant public health issue. This type of violence is universally condemned due to its heinous nature. The term, intimate partner violence (IPV) is defined as any incident or pattern of behaviors (physical, psychological, sexual or verbal) used by one partner to maintain power and control over the relationship. IPV is also considered to be an act of violence that takes place between intimate partners (heterosexual, cohabitating, married, same sex or dating (McGarry, Ali, & Hinchliff, 2016; Stark & Filtcraft, 1998).

Internationally the definition of intimate partner violence is "the use of power, threatened actions against oneself, another person, or a group or community, that either results in the likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (Haegerich & Dahlberg, 2011, p. 392-393). This definition is important because IPV also affects other cultures, ethnicities, sex, and races differently. In some countries, such as the Democratic Republic of Congo, intimate partner violence is not considered a crime. Spousal rape has been accepted as a marital tradition. Domestic and sexual violence against children and young women has been an acceptable practice by older males. In Egypt, domestic violence "is firmly entrenched in the country's Muslim traditions" for example, Sharia Law (Achieng, 2017, p. 1).

Historically, in the United States, IPV has been considered an act of violence committed by men towards women. Although, this is still a societal belief, according to the *National Intimate Partner and Sexual Violence Surveyof 2010– 2012,* more than "1 in 4 men (28.5%) in the United States have experienced rape, physical violence and or stalking by an intimate partner in their lifetime and 1 in 7 men (13.8%) have experienced severe physical violence by an intimate partner (e.g., hit with a fist or something hard, beaten, slammed against something at some point in their lifetime" (Achieng, 2017, p.2).

Four Types of Violence

There are four different types of intimate partner violence. The most prevalent are defined in the text box below.

Physical Violence consists of touching or painful physical contacts that include intimidation of the victim through pushing, slapping, hair pulling, arm twisting, disfiguration, bruising, burning, beating, punching, and use of weapons.

Sexual Violence consists of making degrading comments, touching in unpleasant means of harm, addressing a partner in a degrading way during sexual intercourse which includes marital rape.

Psychological & Emotional Violence consists of threatening, intimidating, killing of pets, deprivation of fundamental needs (food, clothing, shelter, sleep), and distorting reality through control and manipulation.

Mandatory Reporting of IPV

In many intimate partner violence cases, victims have the tendency to not disclose to medical professionals or law enforcement due to possible repercussions from the offender. Many victims fear retaliation, family separations, violation of confidentiality and security. In these instances, a social worker could do more harm than possibly helping the situation.

As of 2002 only seven states have laws that make it mandatory to report actual or suspected victims of IPV (Hamberger, 2004). Most states have laws where reporting is an option, however conditions apply for protecting an individual's identity. Social workers can be put into these challenging positions because of confidentiality and following an ethical obligation. Some argue if an individual is in a IPV situation it should be reported to the police because it is considered a punishable crime.

Potential positive outcomes and limitations from mandatory reporting by medical social workers include:

- Increase victim's safety due to early detections and interventions;
- Improvement of patient care due to early identifications. This would allow
- physicians and social workers to preform rape kits, treatment of any diseases or injuries due to the assault;
- Allow social workers to immediately assess trauma and to advocate for resources as soon as the incident occurred;
- Could improve hospitals resources and outcomes by better documentation of DVA into medical records which will increase the availability of data to facilitate future research and;
- Mandatory reporting could undermine a key component of DV interventions of empowering the individual's rights to self-disclosure

(Hamberger, 2004)

Prevention of IPV in Healthcare

There are four primary steps that medical and public health social workers take to insure a prevention plan. Public health and medical social workers focus primarily on the individual, family, and community to help reduce violence and its consequences. To reduce the occurrences of violence, social workers and community action agencies develop interventions to educate communities through public awareness using television commercials, billboards, radio broadcasts, DV trainings, self-defense classes, and DV screenings in hospitals (Haegerich & Dahlberg, 2011).

Four approaches to prevention of IPV include:

- Measure the incidence and burden over time through public health surveillance.
- Identify factors that place people at risk for, or protect people from, experiencing violence as the victim or perpetrator.
- Developing and testing strategies through rigorous evaluation that modify risk and protective factors to prevent violence from occurring.
- Facilitating the dissemination, adoption, and adaptations of effective strategies in communities to affect change

(Dahlberg & Haegerich, 2011)

Recommended Readings, Websites and Videos

Readings

The National Partner and Domestic Violence Survey 2011

Violence Prevention: The Evidence

Domestic Violence Websites

National Domestic Violence Hotline

National N etwork to End Domestic Violence

Sex and Human Trafficking



Human trafficking isn't talked about

Human trafficking is defined as the recruitment, transportation, and or harboring of a person by means of threat, force or another form of coercion, abduction, fraud, and deception. It is through the abuse of power over vulnerable individual's that perpetrators are able to exploit them. It is often combined with extreme violence, torture and degrading treatment that leave psychological wounds for the rest of their lives. Human and sex trafficking is a violation of human rights. It is estimated to effect more than two million victims worldwide (Ahn, Albert & et.al, 2013; Gajic-Veljanoski & Stewart, 2007).

There are two different forms of human tracking: 1) forced labor and 2) sex trafficking. This section will focus on sex trafficking due to the increased prevalence in the United States. Additionally, this section will also focus on the roles that public and medical social workers take to identify victims and to provide proper medical care (Gajic-Veljanoski & Stewart, 2007).

Sex trafficking is defined as a commercial sex act which is conducted by force, fraud, coercion, or in which the child or adult is made to perform sexual acts for money. A majority of victims in the United States come from countries such as east and south Asia, Latin America, Russia, and Eastern European countries (Salett, 2006).

Medical social workers play a vital role in the identification of victims. Below is a list of clues that social workers and other medical professionals look for when assisting patients in hospitals. Victims have a tendency to not disclose their issues due to the fear of law enforcement, repercussions to family members and most are not aware of agencies that offer services specifically to the population.

Medical social workers can also help eliminate the potential of sex trafficking by:

- Identifying victims and assist them with the proper resources for medical, psychological and shelter;
- Serve on organizational committees or as board members who specifically focus on assisting sex trafficking victims and help to improve rehabilitation and reintegration into society and;

- Educate vulnerable populations such as children in schools or prostitutes that come through the emergency room on possible preventative measures and signs to look for when being encountered by certain populations

(Salett, 2006; Ahn, Albert & et.al, 2013)

What to Look For

- Multiple people in a cramped space
- People living with their employer
- Inability to speak to individuals alone
- Employers holding identity documentation
- Inability to move or leave current job
- Bruises or other signs of battery
- Submissive, fearful or depressed demeanor
- Little or no pay
- Recent arrivals from Asia, Latin America, Eastern European Countries, Canada, Africa or India

(Salett, 2006)

Facts and Statistics

The following facts and statistics were taken from the *U.S. Department of State Trafficking in Persons Report* (2017):

- Traffickers usually recruit victims from vulnerable populations such as: 1) young children who have run away from home. 2) adult females and males who have been involved in prostitution or escort services, 3) desire for a better future, 4) poor education, 5) history of abuse or violence, 6) single-parenting families, and 7) desperate socioeconomic status;
- Estimated global earnings of more than $31 billion a year;
- Worldwide, between 4 – 27 million individuals have been or are victims of sex trafficking or forced labor;
- The majority of victims (80%) are women and girls;
- Over 70% of trafficked women with children are single mothers;
- During recruitment processes, some are promised substantial earnings and jobs as nannies, waitresses, and modeling;
- In 2016, the National Center for Missing & Exploited Children estimated that 1 in 6 endangered runaways reported to them were likely sex trafficking victims;
- In a 2014 report, the Urban Institute estimated that the underground sex economy ranged from $39.9 million in Denver, Colorado, to $290 million in Atlanta, Georgia and;
- In 2016, we learned of 8,042 cases of human trafficking.

Summary of Intimate Partner Violence and Sex Trafficking in the United States

In health care settings, medical social workers will encounter victims and survivors of domestic violence and sex trafficking often. Having the knowledge of the increased prevalence of these two societal epidemics will allow social workers to identify victims, promote educational resources and to prevent the increase of violence.

Summary

This chapter examined the roles of medical and public health social workers. Medical social work is a sophisticated and challenging practice that is conducted in multidisciplinary and fast-paced environments. Therefore, professional social workers in this field need to have a clear and concise understanding of the NASW code of ethics and how it relates to patient care. Medical social workers are in charge of advocating for diverse, sometimes vulnerable individuals and communities. Hospitals and insurance companies have become engrossed with enhancing the intake of profits. Because of that, it seems they lack the desire to enhance and develop a promising health care system that will support all populations.

As incoming first-year students, it is important to educate yourselves by researching and enhancing your knowledge of all social work arenas. Medical social work is so important because it embraces the importance of team work, advocacy, and a true commitment to the individual's medical and personal health care.

Also remember, just because you may not hear about a societal epidemic (sex trafficking and domestic violence) does not mean it is not around you. Be a change agent who develops new therapeutic interventions that will enhance the quality of health care to the world.

Resources

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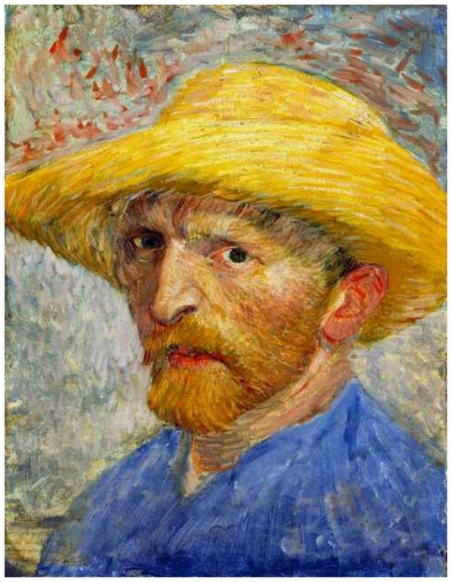
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10.1: Mental Health and Substance Use

Introduction

Mental health and substance abuse are both multifaceted, challenging, and dynamic areas of the human service field. As professionals in this field, social workers help to make long lasting, life altering changes in people's lives.

While numerous books have been written about mental disorders and substance use both broadly and specifically, this chapter will seek to introduce you to current information about mental disorders and substance use in the United States. This chapter will include, among other things, a brief history of both mental health and substance use, the current terminologies and definitions that professionals use in the field, some of the most commonly occurring disorders and/or substances that a social worker is likely to encounter in general practice, and briefly discuss the co-occurrence of mental disorders and substance use.



Van Gogh's Man in a Straw Hat

Vincent Van Gogh (self-portrait: Above) may have suffered from numerous conditions including bipolar disorder or manic-depressive disorder (Wolf, 2001) . He is an example of how mental disorders and creativity can go hand in hand and how people living with a mental disorder can still be productive members of society.

Before We Get Started

Before we begin, it is important to understand some of the keywords, definitions, and sources that will be used. These are a small sample of the vast vocabulary that is used to identify and describe the mental disorders and substance use disorders that social workers may encounter in professional settings.

Key Terms

- **Behavior** – the response of an individual, group, or species to its environment
- **Co-occurring** – to appear together in sequence or simultaneously.
- **Delusion** – a false belief or opinion.
- **Dual Diagnosis** – when a person has two separate illnesses and each illness needs a treatment plan (DBSA, 2016).
- **Hallucination** – a sensory experience of something that does not exist outside the mind, caused by various physical and mental disorders, or by reaction to certain toxic substances, and usually manifested as visual or auditory images.
- **Inpatient** – a patient who stays in a hospital while receiving medical care or treatment.

- **Mania** – excessive excitement or enthusiasm; craze.
- **Manic** – pertaining to or affected by mania.
- **Mental Disorder** – any of the various forms of psychosis or severe neurosis.
- **Outpatient** – a patient who receives treatment at a hospital, as in an emergency room or clinic, but is not hospitalized.
- **Prevalence** – being widespread; of in wide extent or occurrence.
- **Psychosis** – a mental disorder characterized by symptoms, such as delusions or hallucinations, that indicate impaired contact with reality.

Definitions retrieved via Dictionary.com (2017), unless otherwise noted.

Mental Health

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013), also known as the DSM-5, is a living document created by social workers, psychologists, medical doctors and many other professions. The DSM-5 is the primary reference source social workers and other helping professions use to describe a mental disorder. In this text, just as in the DSM-5, "mental disorder" will be used as a broad term to describe several issues related to emotion, mental state, and behavior. However, this text is not enough to help people with a mental disorder. It takes a generalist approach from social workers, as well as other health professionals, to not just identify the disorder but then advocate on behalf of that person, provide supportive services, and work with the many challenges that accompany mental health disorders. Being a generalist means that the social worker employs various methods of treatment, expertise and skills to assist the client. Examples of methods used might be a *strengthsbased approach* where the client is encouraged to focus on and use their inherent strengths (not just physical ones) to improve other areas of their life. Social workers also focus on the *person in environment*. This means that social workers are aware of the impact the person has on their environment and how the environment impacts the person.

According to the National Alliance on Mental Illness (NAMI), approximately 1 in 5 adults in the United States experience some type of mental disorder in a given year. This means that, in a population of over 325 million people, over 43 million people will experience some form of mental health issue within a year. Among those that do experience a mental disorder, 9.8 million of those will experience a "severe" mental disorder meaning that it dramatically interferes or limits their ability to function in their everyday life. Of all the adults in the United States with a mental disorder, only 41% received mental health services in the past year. For those with a severe disorder, only 63% received any form of treatment or services (NAMI, 2017). Looking at those numbers it is clear to see that the need to identify, de-stigmatize and help individuals living with mental disorders, will impact millions of people.

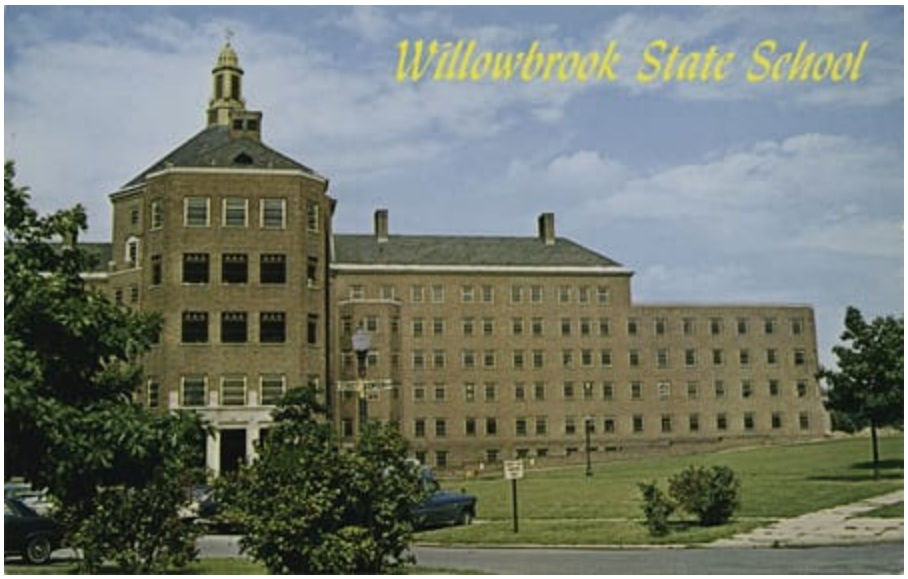
There are six categories of mental disorders that this chapter will focus on as well as the variety of disorders found within those categories. These categories contain some of the most common disorders that a social worker will encounter in her or his career. This chapter also provides a brief description of the disorders as well as the estimated occurrence, or prevalence, of each one within the United States.

The selected categories are:

- Anxiety Disorders
- Psychotic Disorders
- Bipolar Disorders
- Depressive Disorders
- Trauma Disorders
- Personality Disorders.

History of Mental Health

Historically, people suffering from a mental disorder have also suffered abuse, experimentation, torture, and even death. As you go forth as a member of the social work profession, it is imperative that you understand how long of a road it has been and how much further the profession needs to go in the ethical treatment of people with a mental disorder. This link to a 27-minute video provides an example of where we were at just a few decades ago. The Willowbrook State School in New York City is one example of a tragic and possibly disturbing look the past treatment of those with a mental disorder and the developmentally disabled.



Willowbrook State Institution

As you can see from the video, the Willowbrook Institute lacked funding, professionals, and knowledge of what their patients needed to be able to live successfully. Unfortunately, the Willowbrook Institute was not an isolated incident, nor was it a new occurrence. Historically, those with a mental disorder have been looked down upon, shunned, stigmatized, vilified, criminalized or tortured. This kind of treatment has been documented as far back as the middle ages of Europe all the way to the mid 1900's-United States where those with a mental disorder were placed in either hospitals or prisons.

This treatment continued up until 1963 when John F. Kennedy signed the Community Mental Health Act. President Kennedy described it as "a bold new approach", and provided federal grants to states to construct community mental health centers (CMHC), to improve the delivery of mental health services, preventions, diagnosis, and treatment to individuals who reside in the community. To be able to supply federal funding for these statewide institutions, the Medicaid Act was passed in 1965. This Act allowed community-based care facilities to charge for reimbursement of funds while excluding payments to psychiatric institutions.



JFK signing The Community Mental Health Act

The Community Mental Health Act resulted in a mass "deinstitutionalization" across the country, and by 1980 nearly 75% of the psychiatric hospital population had declined. By 2009 less than 2% of those suffering from a mental health disorder remained

in institutions. Unfortunately, this resulted in some unintended consequences. For example, community-based institutions could not keep up with the mass exodus of people from the psychiatric hospitals. This was the result of several factors such as a lack of space within the inpatient and outpatient settings, a lack of funding for proper care, and a lack of funding to improve care facilities. This lack of resources has negatively impacted the care and treatment of adults, children, families, and communities across the country.

Things to Be Aware Of

Having a mental disorder is often compared to having a physical illness (APA, 2015) and the comparison is one that professionals can often overlook. Just as there are varying degrees of physical illnesses, there are also varying degrees of mental disorders. The mental disorders can be managed in similar ways to physical ones. By maintaining medications, therapy, and problem-solving with the individual, social workers can help the person to not only stabilize, but excel in, their life. In fact, there are many successful individuals both in today's world and throughout history, such as Vincent Van Gogh, who have found ways to cope with their mental disorders. Van Gogh most likely had one, maybe even two, mental disorders. Despite, or maybe because of, these challenges he was able to produce some of the most iconic and famous pieces of modern art to this date.

Being aware of the following mental disorders will allow you, as a social worker to better understand what the person is experiencing and how to help them meet their needs in the best possible way.

While every case is different, it is important to start thinking about some of the ways that mental disorders may present themselves. To assist you in this task some brief case studies have been provided throughout the chapter. These case studies are based on the experiences and case notes of real people and professionals.

All information and statistics following are from the DSM-5 unless otherwise indicated.

Anxiety Disorders:

Anxiety disorders are characterized by shared features like excessive *fear* (the emotional response to real or perceived imminent threat) and *anxiety* (anticipation of future threat) and other related behavioral disturbances.

- Social Anxiety Disorder or "Social Phobia" is an extreme fear of being judged by others in social situations. The fear is so intense that it will disrupt or impair the person's ability to function in their everyday life. There is about a 7% prevalence in the United States for this disorder.
- Generalized Anxiety Disorder is an excessive, often unfounded, feeling of worry about the numerous everyday activities that a person could engage in. Approximately 2.9% of adults in the United States report symptoms or seek treatment for this disorder.
- Phobias are, simply put, an irrational fear of something. You may have heard of arachnophobia (fear of spiders) or acrophobia (fear of heights). In the United States, approximately 7%-9% of the population reports having a specific phobia and around 75% of this population will fear more than one object.
- Panic Disorder is defined as a debilitating fear or anxiety that occurs without any reasonable explanation. It is estimated that 2%-3% of the United States adult population will experience an episode of panic disorder in a year.

> **Case Sudy: Kristen**
>
> *Kristen is a 38-year-old divorced mother of two teenagers. She has had a successful, well-paying career for the past several years in upper-level management. Even though she has worked for the same company for over 6 years, she's found herself worrying constantly about losing her job and being unable to provide for her children. This worry has been troubling her for the past 8 months. Despite her best efforts, she hasn't been able to shake the negative thoughts.*
>
> *Kristen has found herself feeling restless, tired, and tense. She often paces in her office when alone. When she goes to bed at night, it's as if her brain won't shut off. She finds herself mentally rehearsing all the worse-case scenarios regarding losing her job, including ending up homeless (Case Studies, 2015).*
>
> What do you think Kristen might be diagnosed with?

Psychotic Disorders:

Psychotic disorders among the most serious and challenging disorders. This is because these disorders affect an individual's

interpretation of reality which then negatively impacts the person's ability to function in their environments. Across the spectrum of psychotic disorders there are common symptoms such as *hallucinations*, *delusions*, or *behaviors* that are considered socially abnormal.

- Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves (NAMI, 2016). These disturbances may present as hallucinations or delusions. Adults in the United States report a lifetime prevalence of 0.3%-0.7%, with an age of onset often occurring in the early to mid-20s.
- Delusional Disorder is the presence of one or more delusions. These delusions must be present for at least one month to the DSM-5 definition for this disorder. The prevalence of this disorder occurs in 0.2% of adults in the United States.
- Schizoaffective Disorder is characterized by schizophrenic symptoms, such as delusions or hallucinations, but with an added component of a mood disorder like mania and depression. About 0.3% of the United States adult population with be diagnosed with schizoaffective disorder in a year (NAMI, n.d.).

Case Study: Martin

Martin is a 21-year-old business major at a large university. Over the past few weeks his family and friends have overheard him whispering in an agitated voice even though there is no one nearby. Lately, he has refused to answer or make calls on his cell phone, claiming that if he does it will activate a deadly chip that was implanted in his brain by evil aliens.

His parents have tried to get him to go to a psychiatrist for an evaluation, but he refuses. He has accused them of conspiring with the aliens to have him killed so they can remove his brain and put it inside one of their own. He has stopped attended classes altogether. He is now so far behind in his coursework that he will fail if something doesn't change very soon (Case Studies, 2015).

What do you think Martin could be diagnosed with?

Bipolar Disorders:

A bipolar disorder can be defined as a variance in brain functioning that can cause unusual shifts in mood, energy, or activity levels. These shifts interfere with the person's ability to carry out day-to-day tasks. These disorders can display a range of heightened emotions in the form of manic episodes (extreme ups) to depressive episodes (extreme downs) (NAMI, 2016).

- Bipolar Disorder I is a period of mania presented as persistently elevated, irritable mood, and persistently increased activity accompanied by feelings of euphoria (being excessively cheerful) or feeling "on top of the world." The prevalence of adults in the United States with this disorder is 0.6%.
- Bipolar Disorder II is a milder form of mood elevation, involving mild episodes of mania, where one feels hyperactive and elated, that alternate with periods of severe depression, feeling down or sad for no obvious reason. Across a one-year span in the United States, about 0.8% of adults will meet criteria for this disorder.

Depressive Disorders:

Depression affects an estimated 300 million people globally and more than 15 million adults (6.7% of the population) in the United States. There are several levels of depression as well as minor levels that co-occur with other disorders or that are brought on by substance use/withdrawal.

- Major Depressive Disorder is a period of low mood for at least two weeks that is present most of the time in most situations. This may look like low self-esteem, low energy, or loss of enjoyment in pleasurable activities. Major depressive disorder will affect about 6.7% of the adult population in the United States (Facts and Statistics, 2016)
- Persistent Depressive Disorder, while lacking the severity of major depression, is a chronic, or ongoing, period of depression, usually for at least two years. Approximately 1.5% of the adult population of the United States will qualify under its criteria (ADAA, 2016)

Case Study: Jessica

Jessica is a 28-year-old married female. She has struggled with significant feelings of worthlessness and shame due to her inability to perform as well as she always has in the past . Jessica has found it increasingly difficult to concentrate at work . Jessica's husband has noticed that she has called in sick on several occasions. On those days, she stays in bed all day, watching TV or sleeping . He's overheard her having frequent tearful phone conversations with her closest friend which have him worried. When he tries to get her to open up about it, she pushes him away with an abrupt "everything's fine."

Although she hasn't ever considered suicide, Jessica has found herself increasingly dissatisfied with her life. She's been having frequent thoughts of wishing she was dead. She feels like she has every reason to be happy, yet can't seem to shake the sense of doom and gloom that has been clouding each day as of late.

What do you think Jessica might be diagnosed with?

Trauma Disorders:

- Post-traumatic Stress Disorder (PTSD) can be brought on after experiencing, witnessing, or hearing about a traumatic event. This is most often associated with military personnel/veterans or victims of war. However, traumatic events can be shootings, physical assaults, or rape. After a month of being removed from the event a person may experience sleeplessness, increased heart rate, mood shifts, physically lashing out, or any combination of responses. These changes may be brought on by any stimulus in the environment that reminds the person of the terrifying event or from experiencing recurring thoughts about the event. In the United States, about 3.5% of adults will report experiencing some form of PTSD within a given year.
- Acute Stress Disorder can be described as the symptoms of post-traumatic stress disorder lasting for three days to one month. If it lasts for longer than one month, it than meets the criteria for PTSD. Acute Stress Disorder is reported in less than 20% of non-assault related events; it is reported in 20%-50% from related events like rape, assault, or witnessing a mass shooting.

Case Study: Josh

Josh is a 27-year-old male whose fiancée of four years was killed by a drunk driver 3 months ago. She died in his arms in the middle of the crosswalk. No matter how hard he tries to forget, he frequently finds himself reliving the entire incident.

He had to quit his job because his office was located in the building right next to the place of the incident. The few times that he attempted to return to work were unbearable for him. He has since avoided that entire area of town.

Normally an outgoing, fun-loving guy, Josh has become increasingly withdrawn, "jumpy", and irritable. He's stopped working out, playing his guitar, or playing basketball, all activities he once really enjoyed. His parents worry about how detached and emotionally flat he's become.

(DeepDiveAdmin, 2015)

What do you think Josh might be diagnosed with?

Personality Disorders:

A personality disorder is a pattern of inner experiences and behavior that deviates from the expectations of the individual's culture, is continuous, enduring and inflexible; it often has an onset in adolescence or early adulthood and leads to distress or impairment in the person's life.

These types of personality disorders are often experienced by people seeking community mental health treatment and the homeless population, both areas social workers are employed. Some personality disorders that you might encounter include:

- Paranoid personality disorder which is a pattern of distrust and suspicion of others' motives. These motives may be interpreted as malevolent or harmful to the person experiencing the paranoia. Paranoid personality disorder may be as prevalent as 4.4% among adults in the United States.
- Schizoid personality disorder is a pattern of detachment from social relationships and a restricted range of emotional expression. The prevalence of this disorder ranges from 3.1%-4.9% of the United States adult population.
- Antisocial personality disorder is a pattern of disregard for, and violation of, the rights of others. Those who display the symptoms of this disorder may habitually lie, commit aggressive or violent acts with little to no remorse, and violate social norms. The prevalence of this disorder ranges from 0.2%-3.3%.

- Borderline personality disorder is a pattern of instability in interpersonal relationships, self-image, and affect. People with borderline personality disorder may be overly impulsive or not understand social norms. It is estimated that 1.6% to as much as 5.9% of the United States adult population will be diagnosed with this disorder.
- Narcissistic personality disorder is a pattern of grandiosity, need for admiration, and lack of empathy. 6.2% of the adult population will report for this disorder within a year.
- ● Obsessive-compulsive personality disorder is a pattern of preoccupation with orderliness, perfectionism, and control. This preoccupation may impair their social lives, health, or ability to function in the outside environment. The prevalence for this disorder ranges from 2.7%-7.9% in a one-year period among the adult population in the United States.

Practice Settings

There are two main practice settings where you as the social worker are likely to encounter people with mental disorders: inpatient (hospitals, medical & psychiatric) and outpatient (mental health clinics). Though there are some similarities in goals and strategies, the differences are certainly worth noting.

Inpatient services in these settings are provided by social workers who work with individuals or groups to provide treatment in a variety of forms. The inpatient worker also works with friends, family, and employers to help the person return to their outside life. The social worker may advocate and work with other agencies to provide assistance or resources for individuals under their purview of care.

When a patient is ready to leave a psychiatric facility, the social worker may connect them to an outpatient clinic. In these settings, outpatient workers assist the individuals or groups in maintaining healthy functioning in their environment through therapy or clinical activities. The social worker in this setting will conduct therapy or planning sessions, contact outside agencies, and advocate for their client's best interests.

Vulnerable Populations

While many people living with a mental disorder live fulfilling lives those who have a "severe" mental disorder are considered a vulnerable population. When we refer to people or a population as vulnerable this means it is "the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters" (WHO, 2017). This vast population overlaps with several other populations that will/have been covered in this book:

- Veterans
- Children
- Poor/Disenfranchised
- LGBTQ+
- Minorities
- Homeless
- Prisoners
- Seniors

Things to Be Aware Of

The field of mental health is not perfect. Studies can only give us so much insight into the symptoms, behaviors, predictors, prevalence and other criteria used in identifying mental disorders. The DSM-5, while a useful tool, is still scrutinized for numerous reasons. For instance, this is the fifth edition of this text meaning that things have changed in definitions and classifications across the decades. The DSM-5, unlike its four previous versions, is being treated as a "living document" and will be amended more frequently in coming years than its previous versions. With this idea of a "living document" in mind, it is important to ask some questions. Is the DSM-5 a tool that attaches "labels" to people, thereby inhibiting the treatment that they seek? Is it a tool used only for insurance purposes? Does the collaboration between various backgrounds help or hurt the cause for proper mental health care? There are many more questions, critiques, and changes surrounding, not just the DSM-5, but therapy styles as well as our ever-improving understanding of the brain and we in the social work profession must be aware of them.

These changes have resulted in improvements to how we approach the concept of "mental disorders" as well as adhere more closely to the social worker core values and perspectives. For example, homosexuality used to be classified as a mental disorder but now we know that is simply not the case. Gender dysphoria is now more closely understood as the anxiety experienced due to the pressures of social norms rather than an internal struggle. There are many other changes, both big and small, between the

DSM-IV and DSM-5 that are highlighted here.

But it's not enough to just be aware of what we do in clinical settings. We also must be cognizant of our understanding of trauma (in its many forms), of a client's resources and of society's perception of what a mental disorder is. These things will continue to morph throughout time so it is important to remain vigilant and flexible regarding the many changes that occur in our field.

Current Issues

At the time of this book's publication in late 2017, there are several pieces of legislation that could have important impacts on the services that social workers and other helping professionals offer. For example, the result of the debate over our national healthcare will have a profound impact on who receives Medicaid, how much the states will receive to supplement the costs of Medicaid funding, and what types of services will be covered. In the State of Michigan, for example, the legislators are looking to implement a bill that would take funding from direct providers like Community Mental Health and direct it towards private organizations. This link gives further description of this bill and will allow you, the reader, to form your own opinions http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_76181—,00.html

Regardless of what your decisions or thoughts are on these issues are, the social work profession must always be vigilant to who/what/where/why/when of funding. We must also be aware politically of who's in charge, what their agenda is, and if it impacts our profession, impacts the people we serve, and if it is in line with our professional ethics.

Substance Abuse/Use/Dependence

For decades, a war has raged across the globe. The financial costs have been high, the lives impacted even higher. During this time, we have been told to "Just Say No" and many have been arrested and imprisoned for participating in this war. The enemy in this war has taken many forms and continues to persist in modern times. It is not terror and it is not a tyrannical government. This is a war against drugs.

History of Substance Use

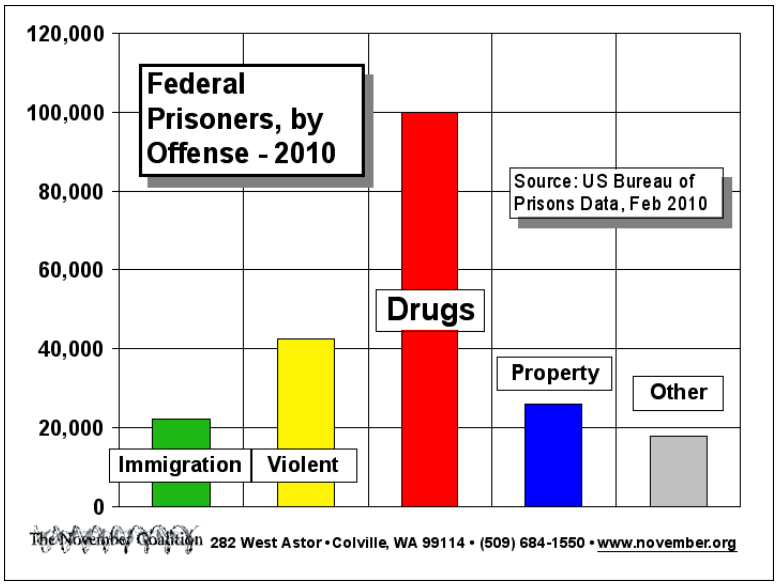
Discussing substance use/abuse would be incomplete without mentioning the "war on drugs" and the historical impact substances/drugs have had on our economy, population, education, law enforcement, and policy.

Made popular in 1971, President Richard Nixon declared drug abuse "public enemy number one." This statement came along with a dedication of more federal resources towards "prevention of new addicts and the rehabilitation of those who are addicted." This was not a new idea by any means. The drug war may have started as early as 1860 from certain laws at local levels. After that came the first federal law, the Harrison Narcotics Tax Act, which was signed into law in 1914. Then came Prohibition that, though ultimately unsuccessfully in its attempt to make alcohol illegal, was still an attempt at eliminating an object of public consumption (Thirty Years of America's Drug War a Chronology, 2014).

This is just the tip of the iceberg as far as the historical legislation of the war on drugs. But the question we should ask is: Are these policies and means of "combating drugs" really working?

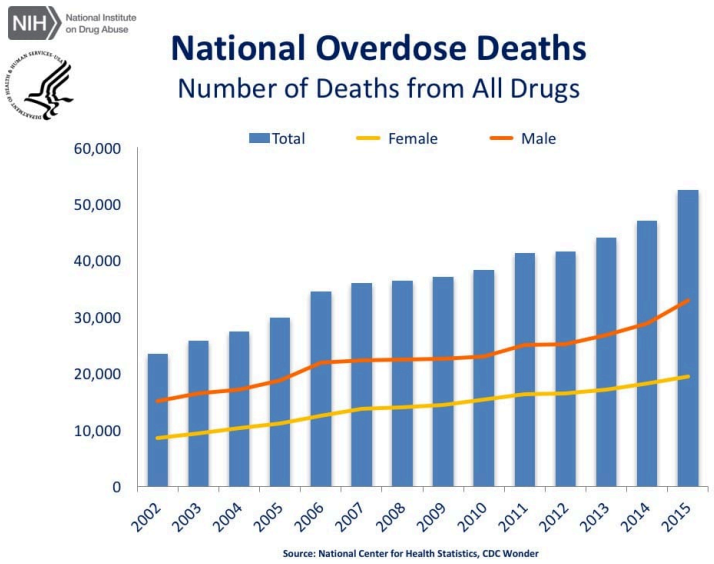
According to The National Center on Addiction and Substance Abuse (2017), over $51 billion dollars is spent annually in the United States to combat illegal drugs and their use. For every dollar spent however, only two cents goes towards prevention and treatment of those seeking assistance from a substance use disorder. The rest of the money goes towards prosecution, imprisonment, and hospital costs.

These policies have also lead to an increase the incarceration of individuals, many of whom are in jail or prison for possession, not selling or distribution (Bureau of Justice Statistics, 2007).



Federal Prisoners by Offense, 2010

And yet it has not helped address number of deaths from drug use.



National Overdose Deaths, Number of Deaths from All Drugs, 2002 – 2015

To be clear, this is not to say that there should not be drug laws. Rather, the suggestion here is to consider that maybe these laws and investments are causing more harm to the victims of drug use. Perhaps these laws are not designed to prevent their use or help users to rehabilitate, as Nixon originally intended all those years ago?

The World Health Organization (WHO) states:

> "Policies which influence the levels and patterns of substance use and related harm can significantly reduce the public health problems attributable to substance use, and interventions at the health care system level can work towards the restoration of health in affected individuals." (WHO, 2017)

Things to Be Aware Of

It is important to note that the DSM-5 does not use the term “addiction” as a classification term. Some in the helping professions believe the term “addiction” can carry a negative connotation and is a very ambiguous definition. Therefore, the phrase “substance use disorder” is used as a more neutral term by these professionals for the purposes of describing the variety of ways that this disorder can be identified.

Key Terms

- **Abstinence** – the act or practice of restraining oneself from indulging in something.
- **Depressant**– a drug that reduces bodily functioning or instinct (ex. Tranquilizers, Klonopin, or Xanax.
- **Hallucinations** – perception like experiences that occur with an external stimulus; vivid/clear, involuntary, and can occur in all levels of sensation.
- **Hallucinogen** – a drug that causes hallucinations (ex. PCP, Ketamine and Peyote).Harm Reduction – a set of strategies aimed at reducing negative consequences from drug use. Also hold a belief in/respect for the rights of the people who use drugs.
- **Inhalants** – vapors introduced to the body by breathing it in (ex. Paint thinners and many household chemicals).
- **Stimulant** – a substance that increases attention, energy, heart rate, and respiration (ex. Cocaine and Ritalin).
- **Opioids** – a compound derived from the opium plant (ex. Morphine, methadone, and heroine).

Definitions retrieved via Dictionary.com (2017), unless otherwise noted

But, as you head into the social work profession you may find often times that the terms addiction, substance use, substance abuse, and dependency may be used interchangeably or be used to refer to the same thing. For example, the term “addiction” or “addict” can be seen on government websites whereas DSM-5 employs the term “substance use disorder”. These words are explaining the same events, symptoms, and treatments but from two different professional standpoints, the medical (government) person centered.

The goal of the DSM-5, as well as the social work profession, is to mitigate or prevent the self-imposed and social stigmas that can result from being labeled as “an addict.” By limiting harmful stereotypes and using person centered language (i.e. saying someone has a disorder rather than calling them an addict), the client may view the disorder as a manageable part of their life rather than being all of who they are. This is an important concept for social workers to be sensitive to and it is with that in mind that this chapter will use the term Substance Use/Substance Use Disorder.

Substance Use Disorder (SUD)

Substance use disorder (SUD) is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance related problems.

There are four key criteria that people must meet to be considered as having a Substance Use Disorder are impaired control, social impairment, risky use, and pharmacological criteria.

All information and statistics following are from the DSM-5 unless otherwise indicated.

SUDs include but are not limited to things such as:

- Alcohol Use Disorder is defined by a cluster of behavioral and physical symptoms, which can include withdrawal, tolerance, and craving. The prevalence of this disorder is very common in the United States with an 8.5% rate among those 18 years and older.
- Cannabis Use Disorder consist of behavioral and physiological symptoms that result from a long or heavy duration of cannabis use. This use disorder will often co-occur with other, more severe, substance use disorders like alcohol, stimulants or hallucinogens. While the full prevalence may be underreported, a study by Hasin et al. (2015) reveal that three out of ten (30%) marijuana users will qualify as having a use disorder.
- Hallucinogens are any drug that can produce alterations in perception and mood (See: Key Terms). Across a twelve-month span, it is estimated about 0.5% of the adult United States population will report symptoms of this disorder.
- Inhalants are classified as any substance that people only consume through inhaling. The result of this type of use is a mind-altering nature. Inhalants include things like gasoline, aerosol spray, or prescription medicines called nitrites (National Institute on Drug Abuse, 2017). This use disorder is most common in youth with about .4% of 12-17-year-olds reporting

misuse although 10% of 13-year-olds do report using inhalants at least once.

- Opioids are a class of drugs that include the illegal drug heroin as well as legal drugs like morphine and codeine. These drugs deliver pain relief and euphoria when consumed. The consumption of prescribed opiates like morphine or OxyContin, becomes a substance use disorder when the opioids are consumed outside of a controlled environment or through self-administered dosages. In the United States, the prevalence of opioid use disorder is approximately 0.37% in adults.
- Stimulant use disorder is an abuse of substances like cocaine or methamphetamines. Symptoms of this disorder include cravings for stimulants, failure to control use when attempted, spending a great deal time obtaining and using stimulants, and withdrawal symptoms that occur after stopping or reducing use (SAMHSA, 2015)
- Tobacco use disorder occurs in people who use tobacco products in greater amounts or longer durations than originally intended. There is a strong desire to consume tobacco, increase intolerance to nicotine, and people may be unsuccessful at quitting tobacco products. The prevalence in the United States of tobacco use disorder is 13% (DSM-5, 2013) – a substantial number considering the estimated 66.9 million smokers of tobacco products (SAMHSA, 2015).

Substance Use Practice Settings

A social worker choosing the field of substance treatment will find themselves in two primary settings: inpatient and outpatient. Similar to the practice settings of mental disorders, substance use clinicians can work in inpatient clinics that house people trying to alleviate themselves of their substance use as well as enhance their health, an example of this can be seen in the film *28 Days* starring Sandra Bullock. These types of facilities may have individual or group counseling sessions, provide drug screens, and provide time for the individual to reflect on their situation (Davis, 2013).

Outpatient clinics are another option for practice settings. These facilities offer potential clients scheduling flexibility and are not as intensive or hands on as inpatient facilities. These types of facilities allow clients to receive services like counseling, education, medication and support information at their own pace (AddictionCenter.com, 2017).

Current Issues

In 2017 there is a current drug use trend in the United States referred to as the Opioid epidemic. According to the Centers for Disease Control and Prevention (CDC) (2017), the majority of drug overdose deaths in the United States, six out of ten, in fact, involve some form of an opioid. This epidemic appears to be rooted in the use of prescription opiates. According to CDC statistics, nearly half of the opioid overdoses in the United States were linked to prescription pills like OxyContin, Methadone, and Vicodin (CDC, 2017).

But what happens when the person who has been using prescription opioids can no longer afford them? They turn to heroin. According to CNN reporter, Dr. Sanjay Gupta (2016), the price for heroin is almost one tenth the price per milligram than it is for a prescription. This may be one of the many reason we see such a rise in heroin use and, is often the case, death. They may also experiment with more dangerous drugs, such as fentanyl, as has been the case of the residents of Ohio (Opiate Action Team, 2017).

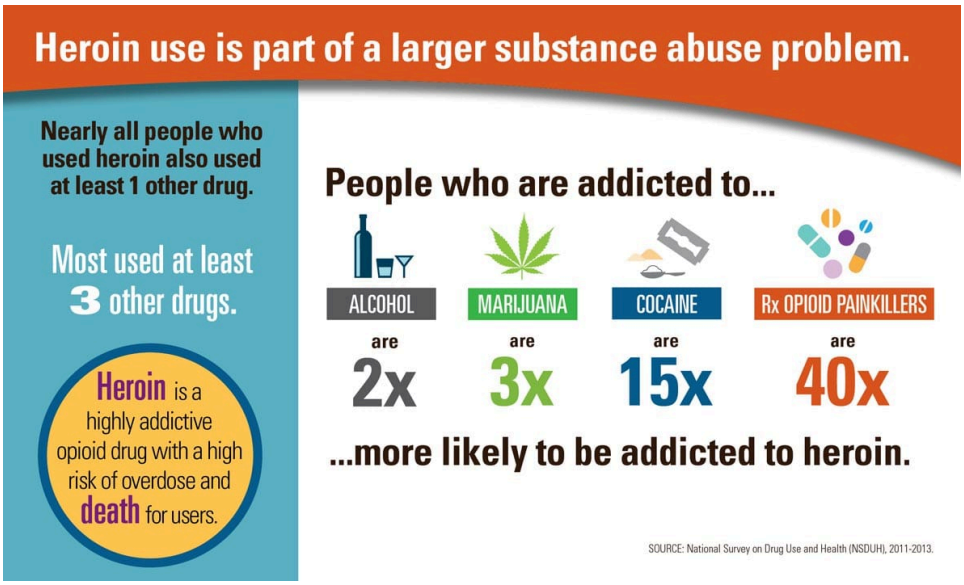


Chart showing that heroin use is part of a larger substance abuse problem

This increased trend in drug use has impacted a wide range of people and demographics, many of whom were never at "serious" risk for drug abuse before, like women, people with higher incomes, and the privately insured. Statistics show that 45% of people who used heroin were also addicted to some form of opiate painkiller (CDC, 2017).

Similar trends and concerns to that of Ohio can be seen across the United States.

https://www.hhs.gov/opioids/about-the-epidemic/index.html

http://www.npr.org/tags/141914251/opioids

http://www.radiolab.org/story/addiction

The above links provide examples of the impacts and strategies that people and agencies dealing with the dramatic impact that opioids are currently having, not just on the country but all over the world. According to a White House press release titled *President Trump's First Budget Commits Significant Resources to Fight the Opioid Epidemic* (2017), in the next year alone, the U.S. government will spend 12.1 billion dollars for treatment and prevention efforts. The U.S. will also provide 500 million dollars in grants so that states can work to reduce misuse, improve treatment, and increase access to treatment.

Social workers are at the forefront of combating this epidemic. Workers are meeting clients in hospitals as they recover from overdoses, counseling those seeking rehabilitation, work with insurance companies to distribute proper funds and ensure correct coverage, as well as educating youth on the dangers of opiates.

Philosophies of Treatment

As we can see, there is a large spectrum of substances that have different effects on the body and brain. If you choose to enter the field of substance treatment, you are bound to encounter different ways organizations or practitioners choose to treat their clients. Two main philosophies of substance treatment are Abstinence and Harm Reduction.

Some places may encourage the practice of *abstinence*. You may have heard this term regarding alcohol or sex because abstinence is defined as "the act or practice of restraining oneself from indulging in something" (Oxford Living Dictionaries, 2017). Some substance use treatment programs like Alcoholics Anonymous (AA) promote this type of behavior (DualDiagnosis.org, 2017).

According to *Principles of Harm Reduction* (2017), *harm reduction*, like many practices throughout social work, has the base philosophy of meeting people "where they are at" when it comes to their substance use. When working with a person who is suffering from a drug use problem (change the word problem) the social worker acknowledges that drugs are a part of part of this world, in both positive and negative terms (i.e. medications and illegal drugs). Rather than attacking or condemning the patient's

behavior, the clinician works with the person to minimize the use as well as the harmful effects of these substances thereby reducing the overall harm that is being done.

Both strategies have their limitations. For example, is it reasonable to ask someone to abstain without relapsing? How does a relapse impact the individual's recovery? Will it be condemned or understood as part of healing? Can a person really get clean if they are still on a substance? Do we continually tolerate relapse or establish consequences for the undesired behavior? How much time is the counselor and client willing to take? Will the approach be safe for the client to participate in?

According to DualDiagnosis.org, 30% of people who participate in harm reduction or moderation type programs will end up in an abstinence-only program. However, according to a study conducted across a 33-month period, the success rate of abstinence only programs is very low – 5.9% for females and 9% for males (Recovery: Abstinence vs. Moderation, 2017). However, there is a current trend in this area of treatment moving more toward the use of interventions with evidence of effectiveness but information is currently limited.

Mental Disorder and Substance Abuse

Whether you are a social worker in mental health or substance treatment, inpatient or outpatient, there is an almost guarantee that you will encounter people who have both a mental disorder and substance use disorder in your career. This is referred to as a *dual diagnosis* where the presence of a mental disorder occurs along with the use of a substance.

According to the National Institute on Drug Abuse (2017), people who have a substance use disorder are nearly twice as likely to also be diagnosed with either a mood or anxiety disorder. However, a mental disorder can also lead to substance use in a sort of chicken vs. egg situation. For example, let's say there is someone who has a diagnosis of depression who also uses a stimulant to try to alleviate it. Or perhaps someone has a diagnosis of alcohol use disorder and because of this use, they have developed depression. These are two potential examples of a dual diagnosis.

> **Case Study: Katie**
>
> *Katie is a 26-year-old female. She has come into services due to a previous suicidal attempt. Her initial assessment gives her a diagnosis of Major Depressive Disorder and a secondary assessment of Alcohol Use Disorder. She remembers drinking since she was about 12 years old; she reports that she drinks to lessen the feelings of "sadness and feeling down." She also reports that she feels "just as bad, if not worse" if she stops the drinking.Katie has attempted services in the past but discontinued them because she says, "I was fine after about 10 months of being with them so I stopped taking my medication and wanted to get on with my life." Katie reports that she has a boyfriend who is very supportive and a mother in town. Her father is out of the picture but Katie reports he also had a history of substance use.*
>
> Consider how you would approach this case: What are some things you would want to know? What would you address first? Why? Feel free to discuss this in class.

As you can see, it takes a discerning professional to figure out the best path of treatment, plan for change with the individual, provide supports, assist in maintaining healthy coping, and a vast array of other tasks and responsibilities.

Things to Be Aware Of

Mental disorders and substance use are more common than people would like to admit. It adversely impacts many parts of people's lives, whether directly or indirectly.

If you, or someone you know, is experiencing any signs or symptoms of a mental disorder or experiencing substance use please contact:

Mental Health Assistance 1

Mental Health Assistance 2

Substance Use Assistance

These websites are only an example of the many resources and supports available to people seeking help or assistance in

navigating difficult life changes.

As a social worker in these fields, your role will be to help clients through these, potentially difficult, times. You will connect their clients to local resources, advocate for best practices to achieve client goals and outcomes, and offer non-judgmental supports to their clients. You yourself may even be that resource that people contact for individual therapy/counseling, or group therapy/counseling.

Techniques, Tools, and Strategies

Social workers can seek several avenues to assist their clients. As you may already be aware, social work strives to institute evidence based practice (EBP) when dealing directly with clients. These practices may include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, or Motivational Interviewing.

Social workers must also be familiar with medications that have been prescribed for treatment and their potential benefits, drawbacks, or chance for abuse (i.e. opiates).

Social workers working in inpatient settings may also help guide their clients through the process of detox. This process can be a long, painful, arduous process for many people and the support that a caring social worker can provide is an invaluable resource.

Social workers may lead support groups. These are organizations, generally outpatient, where clients gather to share their stories, successes, setbacks, hopes, and needs as they recover or maintain their mental or physical health regarding their disorder or substance use.

Finally, it behooves the social worker to know the person they are assisting. Establishing rapport, trust, and familiarity with the client's personality, lifestyle, family structure, culture, and environment are invaluable pieces of information. The impact that a mental disorder or substance use disorder can have on these different systems are not isolated to one; rather these systems impact each other.

For example, someone experiencing a substance use disorder may withdraw from work or family functions seeking out isolation. They may make friends with similar substance use disorders, thereby creating a new environment that encourages the behavior. The person then may not have the support to seek positive change when they decide to finally pursue help.

Similarly, someone who is diagnosed as paranoid schizophrenic may not be able to function in their working environment. This lack of employment may impact their social circles and places of enjoyment, even where they now shop. This change in lifestyle may, in turn, impact family dynamics. The family, once a great support, may now be uninformed, resentful, or frightened of the sudden change in their loved one. The rejection of family may then have an impact on the belief in oneself to recover, cope and maintain their mental health.

Career Outlook

The area of social work that specifically deals with mental disorders and/or substance use has been around for decades and shows no signs of slowing down. In 2014 the number of social workers employed in the mental health and substance use fields was 117,800. The field is projected to add 22,300 jobs over the next 10 years, resulting in 19% job growth (U.S. Department of Labor, 2017).

Unfortunately, the Bureau of Labor Statistics (2017) also indicates that the social workers in the mental health and substance use fields tend to make less than their peers. Workers in mental health and substance use can expect to make an average of $42,700 compared to the top average pay of $60,230 from fields like private clinical or veterans administration workers. (NOTE: Payment tends to be degree dependent; those with BSW degrees tend to make less than those with MSWs.)

Summary

Social workers have, and will continue to, advocate for the understanding of and pursuit of social justice for some of the most misunderstood and vulnerable among us. These workers will encounter a variety of individual and co-occurring disorders in their profession.

Social workers in the mental health and substance use fields continue to improve treatment outcomes with a better understanding

of the brain, trauma, and evidence based practice (EBP) models to provide treatment and care. These treatments can be in a variety of settings from community mental health (CMH) facilities, to hospitals, to private clinics.

There are many challenges in the country, as well as the world, and social workers are well equipped to combat many of these challenges going forward. This field will continue to grow over the next decade although the funding and pay scale for services is currently in question.

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10.2: Therapeutic Orientations

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In the past century, a number of psychotherapeutic orientations have gained popularity for treating mental illnesses. This module outlines some of the best-known therapeutic approaches and explains the history, techniques, advantages, and disadvantages associated with each. The most effective modern approach is cognitive behavioral therapy (CBT). We also discuss psychoanalytic therapy, person-centered therapy, and mindfulness-based approaches. Drug therapy and emerging new treatment strategies will also be briefly explored.

Learning Objectives

- Become familiar with the most widely practiced approaches to psychotherapy.
- For each therapeutic approach, consider: history, goals, key techniques, and empirical support.
- Consider the impact of emerging treatment strategies in mental health.

Introduction

The history of mental illness can be traced as far back as 1500 BCE, when the ancient Egyptians noted cases of "distorted concentration" and "emotional distress in the heart or mind" (Nasser, 1987). Today, nearly half of all Americans will experience mental illness at some point in their lives, and mental health problems affect more than one-quarter of the population in any given year (Kessler et al., 2005). Fortunately, a range of psychotherapies exist to treat mental illnesses. This module provides an overview of some of the best-known schools of thought in psychotherapy. Currently, the most effective approach is called Cognitive Behavioral Therapy (CBT); however, other approaches, such as psychoanalytic therapy, person-centered therapy, and mindfulness-based therapies are also used—though the effectiveness of these treatments aren't as clear as they are for CBT. Throughout this module, note the advantages and disadvantages of each approach, paying special attention to their support by empirical research.



CBT is an approach to treating mental illness that involves work with a therapist as well as homework assignments between sessions. It has proven to be very effective for virtually all psychiatric illnesses. [Image: DFAT, https://goo.gl/bWmzaa, CC BY 2.0, goo.gl/BRvSA7]

Psychoanalysis and Psychodynamic Therapy

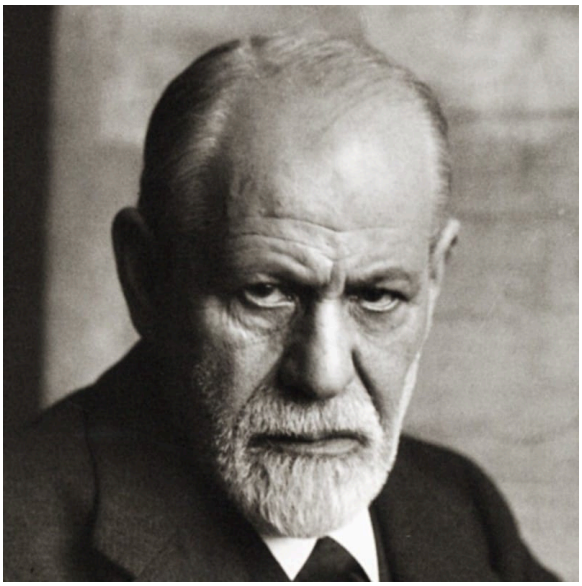
The earliest organized therapy for mental disorders was psychoanalysis. Made famous in the early 20th century by one of the best-known clinicians of all time, Sigmund Freud, this approach stresses that mental health problems are rooted in unconscious conflicts and desires. In order to resolve the mental illness, then, these unconscious struggles must be identified and addressed. Psychoanalysis often does this through exploring one's early childhood experiences that may have continuing repercussions on one's mental health in the present and later in life. Psychoanalysis is an intensive, long-term approach in which patients and therapists may meet multiple times per week, often for many years.

History of Psychoanalytic Therapy

Freud initially suggested that mental health problems arise from efforts to push inappropriate sexual urges out of conscious awareness (Freud, 1895/1955). Later, Freud suggested more generally that psychiatric problems are the result of tension between different parts of the mind: the id, the superego, and the ego. In Freud's *structural model,* the id represents pleasure-driven unconscious urges (e.g., our animalistic desires for sex and aggression), while the superego is the semi-conscious part of the mind where morals and societal judgment are internalized (e.g., the part of you that automatically knows how society expects you to behave). The ego—also partly conscious—mediates between the id and superego. Freud believed that bringing unconscious struggles like these (where the id demands one thing and the superego another) into conscious awareness would relieve the stress of the conflict (Freud, 1920/1955)—which became the goal of **psychoanalytic therapy**.

Although psychoanalysis is still practiced today, it has largely been replaced by the more broadly defined **psychodynamic therapy**. This latter approach has the same basic tenets as psychoanalysis, but is briefer, makes more of an effort to put clients in their social and interpersonal context, and focuses more on relieving psychological distress than on changing the person.

Techniques in Psychoanalysis



Building on the work of Josef Breuer and others, Sigmund Freud developed psychotherapeutic theories and techniques that became widely known as psychoanalysis or psychoanalytic therapy. [Image: CC0 Public Domain, goo.gl/m25gce]

Psychoanalysts and psychodynamic therapists employ several techniques to explore patients' unconscious mind. One common technique is called **free association**. Here, the patient shares any and all thoughts that come to mind, without attempting to organize or censor them in any way. For example, if you took a pen and paper and just wrote down whatever came into your head, letting one thought lead to the next without allowing conscious criticism to shape what you were writing, you would be doing free association. The analyst then uses his or her expertise to discern patterns or underlying meaning in the patient's thoughts.

Sometimes, free association exercises are applied specifically to childhood recollections. That is, psychoanalysts believe a person's childhood relationships with caregivers often determine the way that person relates to others, and predicts later psychiatric difficulties. Thus, exploring these childhood memories, through free association or otherwise, can provide therapists with insights into a patient's psychological makeup.

Because we don't always have the ability to consciously recall these deep memories, psychoanalysts also discuss their patients' dreams. In Freudian theory, dreams contain not only *manifest* (or literal) content, but also *latent* (or symbolic) content (Freud, 1900; 1955). For example, someone may have a dream that his/her teeth are falling out—the manifest or actual content of the dream. However, dreaming that one's teeth are falling out could be a reflection of the person's unconscious concern about losing his or her physical attractiveness—the latent or metaphorical content of the dream. It is the therapist's job to help discover the latent content underlying one's manifest content through dream analysis.

In psychoanalytic and psychodynamic therapy, the therapist plays a receptive role—interpreting the patient's thoughts and behavior based on clinical experience and psychoanalytic theory. For example, if during therapy a patient begins to express unjustified anger toward the therapist, the therapist may recognize this as an act of *transference*. That is, the patient may be displacing feelings for people in his or her life (e.g., anger toward a parent) onto the therapist. At the same time, though, the therapist has to be aware of his or her own thoughts and emotions, for, in a related process, called *countertransference*, the therapist may displace his/her own emotions onto the patient.

The key to psychoanalytic theory is to have patients uncover the buried, conflicting content of their mind, and therapists use various tactics—such as seating patients to face away from them—to promote a freer self-disclosure. And, as a therapist spends more time with a patient, the therapist can come to view his or her relationship with the patient as another reflection of the patient's mind.

Advantages and Disadvantages of Psychoanalytic Therapy

Psychoanalysis was once the only type of psychotherapy available, but presently the number of therapists practicing this approach is decreasing around the world. Psychoanalysis is not appropriate for some types of patients, including those with severe psychopathology or mental retardation. Further, psychoanalysis is often expensive because treatment usually lasts many years. Still, some patients and therapists find the prolonged and detailed analysis very rewarding.

Perhaps the greatest disadvantage of psychoanalysis and related approaches is the lack of empirical support for their effectiveness. The limited research that has been conducted on these treatments suggests that they do not reliably lead to better mental health outcomes (e.g., Driessen et al., 2010). And, although there are some reviews that seem to indicate that long-term psychodynamic therapies might be beneficial (e.g., Leichsenring & Rabung, 2008), other researchers have questioned the validity of these reviews. Nevertheless, psychoanalytic theory was history's first attempt at formal treatment of mental illness, setting the stage for the more modern approaches used today.

Humanistic and Person-Centered Therapy

One of the next developments in therapy for mental illness, which arrived in the mid-20th century, is called humanistic or **person-centered therapy** (PCT). Here, the belief is that mental health problems result from an inconsistency between patients' behavior and their true personal identity. Thus, the goal of PCT is to create conditions under which patients can discover their self-worth, feel comfortable exploring their own identity, and alter their behavior to better reflect this identity.

History of Person-Centered Therapy



The quality of the relationship between therapist and patient is of great importance in person-centered therapy. [Image: CC0 Public Domain, goo.gl/m25gce]

PCT was developed by a psychologist named Carl Rogers, during a time of significant growth in the movements of humanistic theory and human potential. These perspectives were based on the idea that humans have an inherent drive to realize and express their own capabilities and creativity. Rogers, in particular, believed that all people have the potential to change and improve, and that the role of therapists is to foster self-understanding in an environment where adaptive change is most likely to occur (Rogers, 1951). Rogers suggested that the therapist and patient must engage in a genuine, egalitarian relationship in which the therapist is nonjudgmental and empathetic. In PCT, the patient should experience both a vulnerability to anxiety, which motivates the desire to change, and an appreciation for the therapist's support.

Techniques in Person-Centered Therapy

Humanistic and person-centered therapy, like psychoanalysis, involves a largely unstructured conversation between the therapist and the patient. Unlike psychoanalysis, though, a therapist using PCT takes a passive role, guiding the patient toward his or her own self-discovery. Rogers's original name for PCT was *non-directive therapy*, and this notion is reflected in the flexibility found in PCT. Therapists do not try to change patients' thoughts or behaviors directly. Rather, their role is to provide the therapeutic relationship as a platform for personal growth. In these kinds of sessions, the therapist tends only to ask questions and doesn't provide any judgment or interpretation of what the patient says. Instead, the therapist is present to provide a safe and encouraging environment for the person to explore these issues for him- or herself.

An important aspect of the PCT relationship is the therapist's **unconditional positive regard** for the patient's feelings and behaviors. That is, the therapist is never to condemn or criticize the patient for what s/he has done or thought; the therapist is only to express warmth and empathy. This creates an environment free of approval or disapproval, where patients come to appreciate their value and to behave in ways that are congruent with their own identity.

Advantages and Disadvantages of Person-Centered Therapy

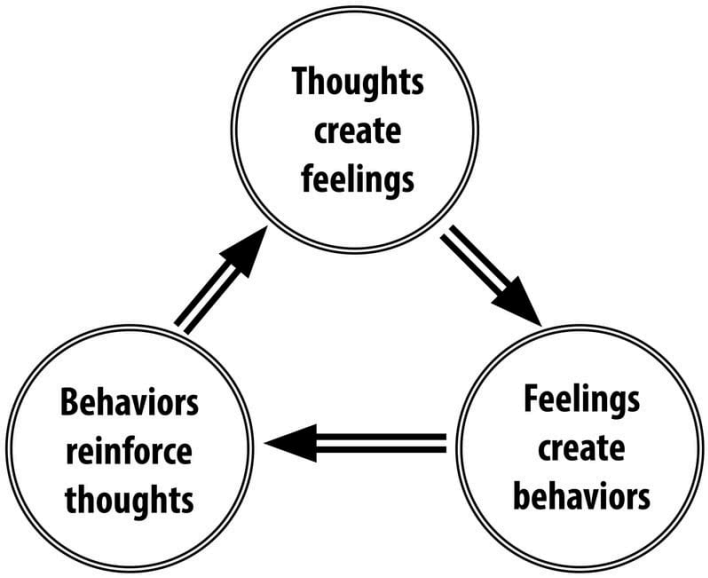
One key advantage of person-centered therapy is that it is highly acceptable to patients. In other words, people tend to find the supportive, flexible environment of this approach very rewarding. Furthermore, some of the themes of PCT translate well to other therapeutic approaches. For example, most therapists of any orientation find that clients respond well to being treated with nonjudgmental empathy. The main disadvantage to PCT, however, is that findings about its effectiveness are mixed. One possibility for this could be that the treatment is primarily based on *unspecific treatment factors*. That is, rather than using therapeutic techniques that are specific to the patient and the mental problem (i.e., *specific treatment factors*), the therapy focuses on techniques that can be applied to anyone (e.g., establishing a good relationship with the patient) (Cuijpers et al., 2012; Friedli, King, Lloyd, & Horder, 1997). Similar to how "one-size-fits-all" doesn't really fit every person, PCT uses the same practices for everyone, which may work for some people but not others. Further research is necessary to evaluate its utility as a therapeutic

approach.

Cognitive Behavioral Therapy

Although both psychoanalysis and PCT are still used today, another therapy, **cognitive-behavioral therapy (CBT)**, has gained more widespread support and practice. CBT refers to a family of therapeutic approaches whose goal is to alleviate psychological symptoms by changing their underlying cognitions and behaviors. The premise of CBT is that thoughts, behaviors, and emotions interact and contribute to various mental disorders. For example, let's consider how a CBT therapist would view a patient who compulsively washes her hands for hours every day. First, the therapist would identify the patient's maladaptive thought: "If I don't wash my hands like this, I will get a disease and die." The therapist then identifies how this maladaptive *thought* leads to a maladaptive *emotion*: the feeling of anxiety when her hands aren't being washed. And finally, this maladaptive emotion leads to the maladaptive behavior: the patient washing her hands for hours every day.

CBT is a present-focused therapy (i.e., focused on the "now" rather than causes from the past, such as childhood relationships) that uses behavioral goals to improve one's mental illness. Often, these behavioral goals involve between-session homework assignments. For example, the therapist may give the hand-washing patient a worksheet to take home; on this worksheet, the woman is to write down every time she feels the urge to wash her hands, how she deals with the urge, and what behavior she replaces that urge with. When the patient has her next therapy session, she and the therapist review her "homework" together. CBT is a relatively brief intervention of 12 to 16 weekly sessions, closely tailored to the nature of the psychopathology and treatment of the specific mental disorder. And, as the empirical data shows, CBT has proven to be highly efficacious for virtually all psychiatric illnesses (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012).



Pattern of thoughts, feelings, and behaviors addressed through cognitive-behavioral therapy.

History of Cognitive Behavioral Therapy

CBT developed from clinical work conducted in the mid-20th century by Dr. Aaron T. Beck, a psychiatrist, and Albert Ellis, a psychologist. Beck used the term **automatic thoughts** to refer to the thoughts depressed patients report experiencing spontaneously. He observed that these thoughts arise from three belief systems, or **schemas**: beliefs about the self, beliefs about the world, and beliefs about the future. In treatment, therapy initially focuses on identifying automatic thoughts (e.g., "If I don't wash my hands constantly, I'll get a disease"), testing their validity, and replacing maladaptive thoughts with more adaptive thoughts (e.g., "Washing my hands three times a day is sufficient to prevent a disease"). In later stages of treatment, the patient's maladaptive schemas are examined and modified. Ellis (1957) took a comparable approach, in what he called rational-emotive-behavioral therapy (REBT), which also encourages patients to evaluate their own thoughts about situations.

Techniques in CBT

Beck and Ellis strove to help patients identify maladaptive appraisals, or the untrue judgments and evaluations of certain thoughts.

For example, if it's your first time meeting new people, you may have the automatic thought, "These people won't like me because I have nothing interesting to share." That thought itself is not what's troublesome; the appraisal (or evaluation) that it might have merit is what's troublesome. The goal of CBT is to help people make adaptive, instead of maladaptive, appraisals (e.g., "I do know interesting things!"). This technique of **reappraisal, or cognitive restructuring**, is a fundamental aspect of CBT. With cognitive restructuring, it is the therapist's job to help point out when a person has an inaccurate or maladaptive thought, so that the patient can either eliminate it or modify it to be more adaptive.

In addition to *thought*s, though, another important treatment target of CBT is maladaptive *behavior*. Every time a person engages in maladaptive behavior (e.g., never speaking to someone in new situations), he or she reinforces the validity of the maladaptive thought, thus maintaining or perpetuating the psychological illness. In treatment, the therapist and patient work together to develop healthy behavioral habits (often tracked with worksheet-like homework), so that the patient can break this cycle of maladaptive thoughts and behaviors.

For many mental health problems, especially anxiety disorders, CBT incorporates what is known as **exposure therapy**. During exposure therapy, a patient confronts a problematic situation and fully engages in the experience instead of avoiding it. For example, imagine a man who is terrified of spiders. Whenever he encounters one, he immediately screams and panics. In exposure therapy, the man would be forced to confront and interact with spiders, rather than simply avoiding them as he usually does. The goal is to reduce the fear associated with the situation through *extinction learning,* a neurobiological and cognitive process by which the patient "unlearns" the irrational fear. For example, exposure therapy for someone terrified of spiders might begin with him looking at a cartoon of a spider, followed by him looking at pictures of real spiders, and later, him handling a plastic spider. After weeks of this incremental exposure, the patient may even be able to hold a live spider. After repeated exposure (starting small and building one's way up), the patient experiences less physiological fear and maladaptive thoughts about spiders, breaking his tendency for anxiety and subsequent avoidance.

Advantages and Disadvantages of CBT

CBT interventions tend to be relatively brief, making them cost-effective for the average consumer. In addition, CBT is an intuitive treatment that makes logical sense to patients. It can also be adapted to suit the needs of many different populations. One disadvantage, however, is that CBT does involve significant effort on the patient's part, because the patient is an active participant in treatment. Therapists often assign "homework" (e.g., worksheets for recording one's thoughts and behaviors) between sessions to maintain the cognitive and behavioral habits the patient is working on. The greatest strength of CBT is the abundance of empirical support for its effectiveness. Studies have consistently found CBT to be equally or more effective than other forms of treatment, including medication and other therapies (Butler, Chapman, Forman, & Beck, 2006; Hofmann et al., 2012). For this reason, CBT is considered a first-line treatment for many mental disorders.

Focus Topic: Pioneers of CBT

The central notion of CBT is the idea that a person's behavioral and emotional responses are causally influenced by one's thinking. The stoic Greek philosopher Epictetus is quoted as saying, "men are not moved by things, but by the view they take of them." Meaning, it is not the event per se, but rather one's assumptions (including interpretations and perceptions) of the event that are responsible for one's emotional response to it. Beck calls these assumptions about events and situations automatic thoughts (Beck, 1979), whereas Ellis (1962) refers to these assumptions as self-statements. The cognitive model assumes that these cognitive processes cause the emotional and behavioral responses to events or stimuli. This causal chain is illustrated in Ellis's ABC model, in which A stands for the antecedent event, B stands for belief, and C stands for consequence. During CBT, the person is encouraged to carefully observe the sequence of events and the response to them, and then explore the validity of the underlying beliefs through behavioral experiments and reasoning, much like a detective or scientist.

Acceptance and Mindfulness-Based Approaches

Unlike the preceding therapies, which were developed in the 20th century, this next one was born out of age-old Buddhist and yoga practices. **Mindfulness**, or a process that tries to cultivate a nonjudgmental, yet attentive, mental state, is a therapy that focuses on one's awareness of bodily sensations, thoughts, and the outside environment. Whereas other therapies work to modify or eliminate these sensations and thoughts, mindfulness focuses on nonjudgmentally accepting them (Kabat-Zinn, 2003; Baer, 2003). For example, whereas CBT may actively confront and work to change a maladaptive thought, mindfulness therapy works to acknowledge and accept the thought, understanding that the thought is spontaneous and not what the person truly believes. There are two important components of mindfulness: (1) self-regulation of attention, and (2) orientation toward the present moment

(Bishop et al., 2004). Mindfulness is thought to improve mental health because it draws attention away from past and future stressors, encourages acceptance of troubling thoughts and feelings, and promotes physical relaxation.

Techniques in Mindfulness-Based Therapy

Psychologists have adapted the practice of mindfulness as a form of psychotherapy, generally called **mindfulness-based therapy** (MBT). Several types of MBT have become popular in recent years, including *mindfulness-based stress reduction* (MBSR) (e.g., Kabat-Zinn, 1982) and *mindfulness-based cognitive therapy* (MBCT) (e.g., Segal, Williams, & Teasdale, 2002).



One of the most important advantages of mindfulness based therapy is its level of accessibility to patients. [Image: Wayne MacPhail, https://goo.gl/aSZanf, CC BY-NC SA 2.0, goo.gl/Toc0ZF]

MBSR uses meditation, yoga, and attention to physical experiences to reduce stress. The hope is that reducing a person's overall stress will allow that person to more objectively evaluate his or her thoughts. In MBCT, rather than reducing one's general stress to address a specific problem, attention is focused on one's thoughts and their associated emotions. For example, MBCT helps prevent relapses in depression by encouraging patients to evaluate their own thoughts objectively and without value judgment (Baer, 2003). Although cognitive behavioral therapy (CBT) may seem similar to this, it focuses on "pushing out" the maladaptive thought, whereas mindfulness-based cognitive therapy focuses on "not getting caught up" in it. The treatments used in MBCT have been used to address a wide range of illnesses, including depression, anxiety, chronic pain, coronary artery disease, and fibromyalgia (Hofmann, Sawyer, Witt & Oh, 2010).

Mindfulness and acceptance—in addition to being therapies in their own right—have also been used as "tools" in other cognitive-behavioral therapies, particularly in **dialectical behavior therapy (DBT)** (e.g., Linehan, Amstrong, Suarez, Allmon, & Heard, 1991). DBT, often used in the treatment of borderline personality disorder, focuses on skills training. That is, it often employs mindfulness and cognitive behavioral therapy practices, but it also works to teach its patients "skills" they can use to correct maladaptive tendencies. For example, one skill DBT teaches patients is called *distress tolerance*—or, ways to cope with maladaptive thoughts and emotions in the moment. For example, people who feel an urge to cut themselves may be taught to snap their arm with a rubber band instead. The primary difference between DBT and CBT is that DBT employs techniques that address the symptoms of the problem (e.g., cutting oneself) rather than the problem itself (e.g., understanding the psychological motivation to cut oneself). CBT does not teach such skills training because of the concern that the skills—even though they may help in the short-term—may be harmful in the long-term, by maintaining maladaptive thoughts and behaviors.

DBT is founded on the perspective of a **dialectical worldview**. That is, rather than thinking of the world as "black and white," or "only good and only bad," it focuses on accepting that some things can have characteristics of both "good" and "bad." So, in a case involving maladaptive thoughts, instead of teaching that a thought is entirely bad, DBT tries to help patients be less judgmental of their thoughts (as with mindfulness-based therapy) and encourages change through therapeutic progress, using cognitive-behavioral techniques as well as mindfulness exercises.

Another form of treatment that also uses mindfulness techniques is **acceptance and commitment therapy** (ACT) (Hayes,

Strosahl, & Wilson, 1999). In this treatment, patients are taught to observe their thoughts from a detached perspective (Hayes et al., 1999). ACT encourages patients *not* to attempt to change or avoid thoughts and emotions they observe in themselves, but to recognize which are beneficial and which are harmful. However, the differences among ACT, CBT, and other mindfulness-based treatments are a topic of controversy in the current literature.

Advantages and Disadvantages of Mindfulness-Based Therapy

Two key advantages of mindfulness-based therapies are their acceptability and accessibility to patients. Because yoga and meditation are already widely known in popular culture, consumers of mental healthcare are often interested in trying related psychological therapies. Currently, psychologists have not come to a consensus on the efficacy of MBT, though growing evidence supports its effectiveness for treating mood and anxiety disorders. For example, one review of MBT studies for anxiety and depression found that mindfulness-based interventions generally led to moderate symptom improvement (Hofmann et al., 2010).

Emerging Treatment Strategies



Recent improvements in video chat technology along with the proliferation of mobile devices like smartphones and tablets has made online delivery of therapy more commonplace. [Image: Noba, CC BY 2.0, goo.gl/BRvSA7]

With growth in research and technology, psychologists have been able to develop new treatment strategies in recent years. Often, these approaches focus on enhancing existing treatments, such as cognitive-behavioral therapies, through the use of technological advances. For example, *internet-* and *mobile-delivered therapies* make psychological treatments more available, through smartphones and online access. Clinician-supervised online CBT modules allow patients to access treatment from home on their own schedule—an opportunity particularly important for patients with less geographic or socioeconomic access to traditional treatments. Furthermore, smartphones help extend therapy to patients' daily lives, allowing for symptom tracking, homework reminders, and more frequent therapist contact.

Another benefit of technology is **cognitive bias modification**. Here, patients are given exercises, often through the use of video games, aimed at changing their problematic thought processes. For example, researchers might use a mobile app to train alcohol abusers to avoid stimuli related to alcohol. One version of this game flashes four pictures on the screen—three alcohol cues (e.g., a can of beer, the front of a bar) and one health-related image (e.g., someone drinking water). The goal is for the patient to tap the healthy picture as fast as s/he can. Games like these aim to target patients' automatic, subconscious thoughts that may be difficult to direct through conscious effort. That is, by repeatedly tapping the healthy image, the patient learns to "ignore" the alcohol cues, so when those cues are encountered in the environment, they will be less likely to trigger the urge to drink. Approaches like these are promising because of their accessibility, however they require further research to establish their effectiveness.

Yet another emerging treatment employs *CBT-enhancing pharmaceutical agents*. These are drugs used to improve the effects of therapeutic interventions. Based on research from animal experiments, researchers have found that certain drugs influence the biological processes known to be involved in learning. Thus, if people take these drugs while going through psychotherapy,

they are better able to “learn” the techniques for improvement. For example, the antibiotic d-cycloserine improves treatment for anxiety disorders by facilitating the learning processes that occur during exposure therapy. Ongoing research in this exciting area may prove to be quite fruitful.

Pharmacological Treatments

Up until this point, all the therapies we have discussed have been talk-based or meditative practices. However, psychiatric medications are also frequently used to treat mental disorders, including schizophrenia, bipolar disorder, depression, and anxiety disorders. Psychiatric drugs are commonly used, in part, because they can be prescribed by general medical practitioners, whereas only trained psychologists are qualified to deliver effective psychotherapy. While drugs and CBT therapies tend to be almost equally effective, choosing the best intervention depends on the disorder and individual being treated, as well as other factors—such as treatment availability and **comorbidity** (i.e., having multiple mental or physical disorders at once). Although many new drugs have been introduced in recent decades, there is still much we do not understand about their mechanism in the brain. Further research is needed to refine our understanding of both pharmacological and behavioral treatments before we can make firm claims about their effectiveness.

Integrative and Eclectic Psychotherapy

In discussing therapeutic orientations, it is important to note that some clinicians incorporate techniques from multiple approaches, a practice known as **integrative or eclectic psychotherapy**. For example, a therapist may employ distress tolerance skills from DBT (to resolve short-term problems), cognitive reappraisal from CBT (to address long-standing issues), and mindfulness-based meditation from MBCT (to reduce overall stress). And, in fact, between 13% and 42% of therapists have identified their own approaches as integrative or eclectic (Norcross & Goldfried, 2005).

Conclusion

Throughout human history we have had to deal with mental illness in one form or another. Over time, several schools of thought have emerged for treating these problems. Although various therapies have been shown to work for specific individuals, cognitive behavioral therapy is currently the treatment most widely supported by empirical research. Still, practices like psychodynamic therapies, person-centered therapy, mindfulness-based treatments, and acceptance and commitment therapy have also shown success. And, with recent advances in research and technology, clinicians are able to enhance these and other therapies to treat more patients more effectively than ever before. However, what is important in the end is that people actually seek out mental health specialists to help them with their problems. One of the biggest deterrents to doing so is that people don’t understand what psychotherapy really entails. Through understanding how current practices work, not only can we better educate people about how to get the help they need, but we can continue to advance our treatments to be more effective in the future.

Outside Resources

Article: A personal account of the benefits of mindfulness-based therapy
https://www.theguardian.com/lifeandstyle/2014/jan/11/julie-myerson-mindfulness-based-cognitive-therapy

Article: The Effect of Mindfulness-Based Therapy on Anxiety and Depression: A Meta-Analytic Review
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2848393/

Video: An example of a person-centered therapy session.

Video: Carl Rogers, the founder of the humanistic, person-centered approach to psychology, discusses the position of the therapist in PCT.

Video: CBT (cognitive behavioral therapy) is one of the most common treatments for a range of mental health problems, from anxiety, depression, bipolar, OCD or schizophrenia. This animation explains the basics and how you can decide whether it's best for you or not.

Web: An overview of the purpose and practice of cognitive behavioral therapy (CBT)
http://psychcentral.com/lib/in-depth-cognitive-behavioral-therapy/

Web: The history and development of psychoanalysis
http://www.freudfile.org/psychoanalysis/history.html

Discussion Questions

1. Psychoanalytic theory is no longer the dominant therapeutic approach, because it lacks empirical support. Yet many consumers continue to seek psychoanalytic or psychodynamic treatments. Do you think psychoanalysis still has a place in mental health treatment? If so, why?
2. What might be some advantages and disadvantages of technological advances in psychological treatment? What will psychotherapy look like 100 years from now?
3. Some people have argued that all therapies are about equally effective, and that they all affect change through common factors such as the involvement of a supportive therapist. Does this claim sound reasonable to you? Why or why not?
4. When choosing a psychological treatment for a specific patient, what factors besides the treatment's demonstrated efficacy should be taken into account?

Vocabulary

Acceptance and commitment therapy
A therapeutic approach designed to foster nonjudgmental observation of one's own mental processes.

Automatic thoughts
Thoughts that occur spontaneously; often used to describe problematic thoughts that maintain mental disorders.

Cognitive bias modification
Using exercises (e.g., computer games) to change problematic thinking habits.

Cognitive-behavioral therapy (CBT)
A family of approaches with the goal of changing the thoughts and behaviors that influence psychopathology.

Comorbidity
Describes a state of having more than one psychological or physical disorder at a given time.

Dialectical behavior therapy (DBT)
A treatment often used for borderline personality disorder that incorporates both cognitive-behavioral and mindfulness elements.

Dialectical worldview
A perspective in DBT that emphasizes the joint importance of change and acceptance.

Exposure therapy
A form of intervention in which the patient engages with a problematic (usually feared) situation without avoidance or escape.

Free association
In psychodynamic therapy, a process in which the patient reports all thoughts that come to mind without censorship, and these thoughts are interpreted by the therapist.

Integrative or eclectic psychotherapy
Also called integrative psychotherapy, this term refers to approaches combining multiple orientations (e.g., CBT with psychoanalytic elements).

Integrative or eclectic psychotherapy
Also called integrative psychotherapy, this term refers to approaches combining multiple orientations (e.g., CBT with psychoanalytic elements).

Mindfulness
A process that reflects a nonjudgmental, yet attentive, mental state.

Mindfulness-based therapy
A form of psychotherapy grounded in mindfulness theory and practice, often involving meditation, yoga, body scan,

and other features of mindfulness exercises.

Person-centered therapy
A therapeutic approach focused on creating a supportive environment for self-discovery.

Psychoanalytic therapy
Sigmund Freud's therapeutic approach focusing on resolving unconscious conflicts.

Psychodynamic therapy
Treatment applying psychoanalytic principles in a briefer, more individualized format.

Reappraisal, or Cognitive restructuring
The process of identifying, evaluating, and changing maladaptive thoughts in psychotherapy.

Schema
A mental representation or set of beliefs about something.

Unconditional positive regard
In person-centered therapy, an attitude of warmth, empathy and acceptance adopted by the therapist in order to foster feelings of inherent worth in the patient.

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11.1: Social Work in Criminal Justice Settings



Introduction

As you have learned from previous chapters, a social worker can find themselves involved in numerous diverse systems depending on their client population and area of specialty. One of the most intimidating and controversial of these systems is the United States criminal justice system. Whether a social worker is tasked with working with inmates housed in jail/prison, rehabilitating individuals on probation/parole, investigating potential child abuse, or defending the rights of crime victims, the criminal justice system is sure to have an enormous impact on nearly every aspect of a client's case and personal life. In order to best aid clients who have found themselves wrapped up in this complex system it is crucial that we as social workers have at least a basic knowledge of what the system is, how it works, basic terminology, and most importantly, the rights held by not only our clients but each person who is a citizen of this country.



What is Criminal Justice?

The United States Criminal Justice System

The United States criminal justice system is the set of agencies and processes established by the United States government to control crime and impose penalties on those who violate laws. It is directly involved in apprehending, prosecuting, defending, sentencing, and punishing those who are suspected of criminal offenses. Contrary to popular belief, there is no one system of justice within the United States, but rather a combination of multiple smaller jurisdictions which are determined by the individual's area of residence, type of offense, and more. The most common of these include state (police) and federal (FBI) jurisdictions.

The simplest way to compare these two is to think of an individual who commits multiple crimes in one state with an individual who commits one or multiple crimes in one state and then moves to another. Since the individual in the second scenario has moved, the two states involved would be competing for jurisdiction, making it necessary to involve the Federal Bureau of Investigations (FBI) as they have national jurisdiction. Other examples of jurisdictions include county, city, tribal government, or military installation (NCVC, 2008a).

Components of Criminal Justice

These descriptions are taken from NCVC's The Criminal Justice System *unless otherwise noted.*

Most of these criminal justice systems consist of five components- law enforcement, prosecution, defense attorneys, courts, and corrections. Each of these play a unique but critical role in criminal justice proceedings.

Law enforcement officers are tasked with hearing and investigating reports for crimes which happen in their jurisdiction. These officers investigate crimes by gathering and protecting evidence, making arrests, providing testimony during court processes, and conducting follow-up investigations as needed.

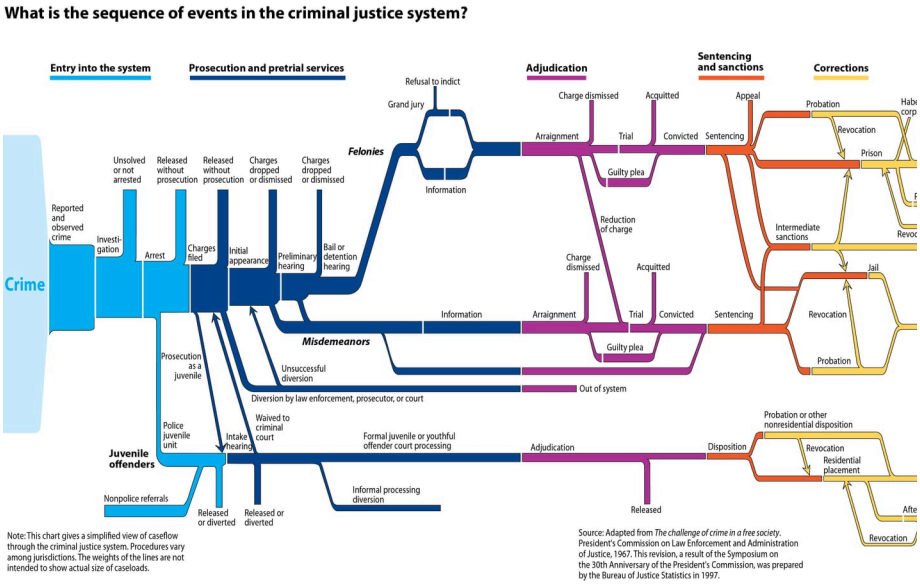
After law enforcement officers investigate a criminal offense, it is up to the prosecution to represent the state or federal government throughout the court process. Prosecutors must review the evidence gathered by officers and determine whether to file formal charges against the suspect or to drop the case. They are also tasked with presenting the evidence in court, questioning witnesses, determining what charges a suspect will be charged with, and more.

While the prosecution represents the state or federal government, it is the job of defense attorneys to represent the individuals accused of a criminal offense. They can either be hired by the defendant themselves or assigned by the court since legal representation is a basic right outlined in the Constitution.

Both the prosecution and defense attorneys are involved in the courts which are run by judges. Their role is to ensure that the law is followed along with overseeing what happens in court. Judges are able to determine whether or not to release offenders before a trial, accept or reject plea agreements, oversee trials, and sentence individuals convicted of illegal acts. Judges are easily some of the most powerful individuals in the criminal justice system.

Finally, after an individual has been investigated, tried, convicted, and sentenced, they enter the last criminal justice component of corrections including jails and prisons. These terms are often used interchangeably, but in reality jails are used to house individuals sentenced to less than one year of incarceration as well as those awaiting trial, while prisons house individuals sentenced to be incarcerated for a year or more. Correction officers are tasked with supervising convicted individuals in jail or prison, and also include probation (jail) and parole (prison) officers who are responsible for monitoring these individuals either after they have completed their sentence or in some cases in lieu of incarceration. Corrections officers typically prepare pre-sentencing reports on the individual which are used to help judges decide on sentences as well as overseeing the day to day custody of incarcerated inmates (NCVC, 2008a).

*The image provided outlines the process from arrest to incarceration including the components discussed above. As a social worker within criminal justice settings it is often beneficial to be aware of the complexity of criminal justice proceedings as well as basic timelines in order support and advocate for clients. For more information and detailed descriptions of each step in the criminal justice system process, see The American Bar Association's guide, *How Courts Work*.



What is the sequence of events in the criminal justice system? www.bjs.gov/content/

The Courts

In order to understand the role of a social worker in court room proceedings, a basic understanding of the various types of courts and their roles are first required. Look to the next sections to learn a few of the most common types of courts that a social worker may find themselves involved in.



Courthouse in Washoe County, Nevada

The descriptions below were obtained from Michigan Courts, The Learning Center website .

United States Supreme Court

The Supreme Court of the United States is the “highest” court in the land. It has ultimate authority to hear appeals in nearly all cases decided in the federal court system. It can also hear appeals from state high appellate courts that involve a “federal question,” such as an issue involving a federal statute or arising under the Constitution of the United States. This essentially

means that an individual who disagrees with a decision reached in a lower court has the right to apply for a second opinion from a higher court. They are able to practice this right by moving all the way from local courts to the top of the diagram, the US Supreme Court which can not be overruled. With that said, fewer than 100 cases are actually heard and decided by the Supreme Court each year.

There are currently nine justices on the Supreme Court: one chief justice and eight associate justices. These individuals can be thought of as a team of judges who are considered to be some of the most ethical individuals in the country nominated only by the President of the United States. The key to the number of justices is that it is an odd number when the decision on a case comes down to a vote. In order for a decision to be reached, a minimum of five justice votes are required either for or against the defendant. After each side's argument has been presented the justices crafts a written explanation of their decision called an opinion. With that said, there can be more than one "opinion" since not all of the Justices need to agree in order for a decision to be reached. Most commonly opinions are either titled as "the majority opinion", or "the minority opinion" and outline the details of the "winning" and "losing" arguments.

The main conditions for a Justice to hold office is found in Article III Section 1 of the Constitution, "[t]he Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behavior, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office" (Constitution, 2017). Essentially this means that Justices serve for life, only being replaced due to death, retirement, or impeachment for unethical behavior. Since 2005, John G. Roberts Jr. has served as the Chief Justice and the oldest and longest serving justice is 80-year-old Anthony Kennedy appointed in 1988.

Supreme Court facts and landmark cases are available through the following links at ConstitutionFacts.com:

https://www.constitutionfacts.com/us-supreme-court/fascinating-facts/

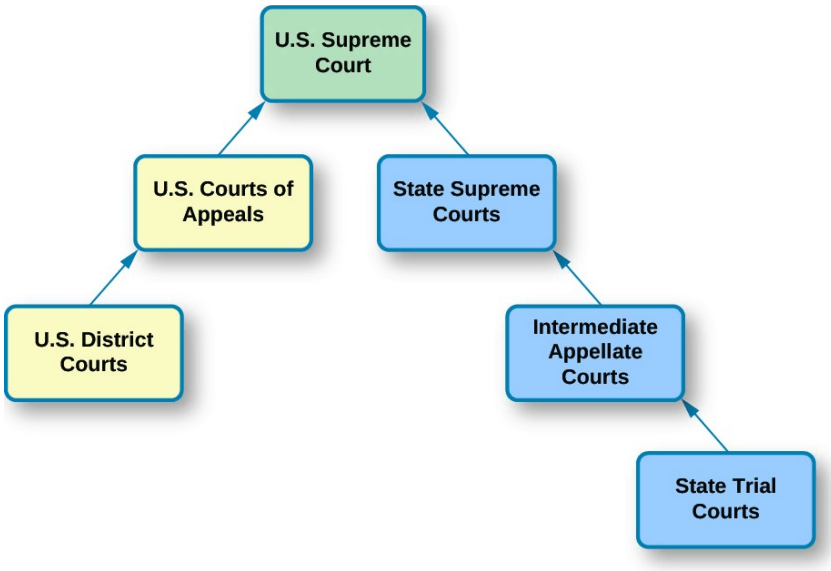
https://www.constitutionfacts.com/us-supreme-court/landmark-cases/

Michigan Supreme Court

The State of Michigan Supreme Court is the highest court in the state and can be overruled only by the Supreme Court of the United States. The Michigan Supreme Court has seven justices, one of whom is elected to be the Chief Justice as in the US Supreme Court. Following the diagram provided below, the state and federal court systems can be thought of like a pyramid starting with local courts and working all the way to the US Supreme Court. At this level, if an individual is dissatisfied with a decision from the Michigan Court of Appeals they can complete a written "application for leave to appeal". This essentially means that they would like to invoke their right to appeal a court decision which they believe is unjust. The Michigan Supreme Court receives approximately 2,000 applications each year and "grants leave" – meaning they will hear the case – in about 100 of these cases. Unlike the US Supreme Court however, in order for a decision/ majority opinion to be reached at this level, a minimum of four of the seven Justices must agree.

Michigan Court of Appeals

The Court of Appeals is a relatively new court that began in 1965. It is an "intermediate" court between the Circuit Court (where trials take place) and the State Supreme Court. Individuals who are dissatisfied by a Circuit Court decision go first to the Court of Appeals. In most cases, the person who loses in Circuit Court has the right to appeal to the Court of Appeals where the case will be argued before three judges who must reach a majority decision (2 out of 3) much like the higher courts described above. The Court of Appeals hears about 6,000 cases each year, and listens to arguments regularly in Detroit, Lansing, and Grand Rapids, and Northern Michigan.



Flowchart of the U.S. court system

Local Courts

Circuit Court

The Circuit Court is a general trial court. It has jurisdiction in all civil cases involving more than $25,000, all felony cases, all serious misdemeanor criminal cases, and all family cases. The Family Division has jurisdiction over divorce, child custody, child support, paternity investigations, adoptions, name changes, juvenile proceedings, emancipation of minors, parental consent, and personal protection proceedings. The Family Division also houses the Friend of the Court, which handles cases involving child custody, parenting time, and support.

Probate Court

The Probate Court handles wills, administers estates and trusts, orders treatment for individuals who are developmentally disabled, and appoints guardians and conservators. In 2013, Probate Court handled 64,114 case filings.

District/Municipal Court

The District Court handles most traffic violation cases and hears both criminal and civil cases, including small claims and landlord-tenant disputes. All criminal cases for people 17 years old or older originate in district court. The defendant is told the charges, rights, and possible consequences. If the charge is a misdemeanor punishable by less than one year in jail, the District Court conducts the trial. For charges punishable by more than one year, the case goes to Circuit Court.

Small Claims Court

A division of the District Court, the Small Claims Court hears civil cases of $5,500 or less. A case may be presented to a judge or an attorney magistrate. In 2013, 55,719 claims were filed here. A magistrate is a civil officer with the power to administer and enforce laws similar to a judge.

Court of Claims

The Court of Claims is part of the Court of Appeals. The court hears and determines all civil actions filed against the State of Michigan and its agencies. These cases include highway defect, medical malpractice against state-owned medical facilities and state-employed medical practitioners, contracts, constitutional claims, prisoner litigation, tax-related suits, and other claims for money damages.

Amendments of the Constitution

The criminal justice system is ultimately governed by the Constitution of the United States of America. The Constitution is responsible for outlining the basic, inalienable rights of each citizen of the United States. Obtaining an understanding of these rights is particularly relevant to social workers working with criminal justice populations in order to be able to determine if a client's rights are being denied and what protections have been put in place to defend these rights.

Some examples most pertinent to criminal justice populations include Amendment 4 which protects individuals against unlawful search and seizure, and Amendment 8 which protects against cruel and unusual punishment.

To review these amendments as well as the entire Constitution, please follow this link: http://constitutionus.com/



The Constitution of the United States – Preamble

What is a Criminal Justice Social Worker?

Now that you have an idea of what the criminal justice system is and how it functions, how does social work come into play? With today's increasingly controversial, challenging, and ever-changing legal system, criminal justice social work (also referred to as forensic justice social work) is rapidly rising as a vital public service for offering psychological and behavioral services in the criminal justice system (Coyle, 2017). Although the field of criminal justice social work is relatively new, the number of court cases and growing prison populations nationwide are creating a large demand for social workers with knowledge and/or experience within the criminal justice system.

While many mistakenly believe that criminal justice social work is limited to evaluating and treating criminal defendants in psychiatric hospitals, it is important to realize that the field is much broader and includes all social services within the civil and criminal justice systems on nearly every level. It is also important to note that, like many aspects of society, the media's portrayal of criminal justice social work is highly inaccurate. For example, these workers are often depicted as performing and analyzing lab work which is rarely the case unless the workers specializes in research roles. It is also unlikely as a worker that you will run into the Jeffrey Dahmers of the world on a regular basis, rather you will be treating and advocating for individuals who often have significant histories of trauma and have simply made poor life decisions. So, if in reality this career is not what the media portrays it as, what exactly does a criminal justice social worker do? (Coyle, 2017).

A criminal justice social worker's day-to-day activities largely include providing consultation to law enforcement personnel, law makers, attorneys, paralegals, community members, correctional officers, doctors, and psychiatrists on interdisciplinary teams (NCVC, 2017a). Criminal justicesocial workers often provide their clients with emotional support, guidance in navigating the court/legal systems, connections to relevant resources, housing application assistance, and individual and policy advocacy. Further, criminal justice social workers typically use their legal expertise to work within court systems in settings such as child and family agencies, hospitals, mental health agencies, substance abuse agencies, correctional facilities, prisons, and faith-based institutions.

Criminal justice social workers are also responsible for diagnosing criminal populations, making recommendations about mental status, serving as expert witnesses, training law enforcement personnel, referring defendants to community resources, and developing advocacy programs in the criminal justice system. These roles are more than likely where the inspirations for television and other media forms stem from. However, although diagnosing criminal populations is part of what criminal justice social workers do, this task realistically makes up very little of a worker's activity and is not nearly as glamorous and intense as one might see in a movie. For example, while again it is accurate that a criminal justice social worker may work with criminal populations, other vulnerable populations served include but are not limited to:incarcerated youth and adults, recently released inmates, children who are victims of neglect, and victims of domestic or sexual abuse (MSW Guide, 2017).In order to better outline the types of populations criminal justice social workers commonly work with and what they do, please refer to the following case study:

Case Study

"Jonathan" is a 37-year-old , Caucasian male who identifies as heterosexual and non-religious. He is currently in prison for domestic assault against his wife of 11 years. Although he claims to love his wife, Jonathan states that he frequently struggles to control his anger , especially after a night of heavy drinking . After being interviewed by the prison social worker it was revealed that Jonathan was abused by his father while he was a child, and he also commonly saw them fight both verbally and physically. During the initial interview Jonathan struggled to make the connection between his own traumatic upbringing and his current beliefs and behaviors.

C ases such as these are incredibly common within the criminal justice system since, as outlined in previous chapters, unresolved traumas can so often be linked to negative behaviors as adults. For Jonathan's case the main tasks of a criminal justice social worker would include assessing Jonathan's risk to himself or others based on his past and current behaviors, developing a treatment plan to combat symptoms of anger and possible substance abuse, educating Jonathan on various coping skills to control his anger/ drinking, working to increase communication skills as an alternative to violence, meeting weekly or bi-weekly for individual therapy with subjects such as adjustment to prison and childhood trauma, detailed documentation of all activities, advocacy, testifying in court, and more. Although this case study does present a common issue that bridges social work and the criminal justice system it is just one of countless possibl e client populations.

For additional examples of specific career opportunities and client populations, refer to the next section.



Prisoners in a group therapy session

Specific Careers as a Criminal Justice Social Worker:

As a social worker in the criminal justice system there are a wide array of career options each with specific skill requirements, education requirements, salary ranges, and of course daily tasks. Although the previous sections discuss the most common tasks of a criminal justice social worker, each of the many career options listed below are equipped with their own unique challenges and rewards. This section will outline just a few of the countless job prospects for individuals with a mental health degree as well as a passion for helping those caught up in the criminal justice system.

If you are interested in learning more about any of the following career options including degree requirements, salary, job outlook, and more, please visit the website www.payscale.com.

CPS/APS Worker

CPS and APS are common acronyms that future social workers are sure to see in their careers. They stand for Children's Protective Services (CPS) and Adult Protective Services (APS). These careers are easily some of the most controversial and emotionally taxing that a social worker can enter (Education Career Articles, 2012). The job titles can be broken down into Investigations and Ongoing services, which are tasked with determining whether or not an allegation of abuse on a child or adult is true (investigations), or are responsible for working directly with families who have been substantiated for some form of abuse or neglect (ongoing). Unlike the common misperception these workers are not solely responsible for the removal of children from their parents, although this is a necessary part of the job in the most severe of situations for the safety of the child.

However, these workers also rely heavily on providing parenting training and other necessary resources with the ultimate goal of keeping families together. Similar to CPS, APS investigations workers determine when a vulnerable adult (mentally ill, elderly, etc.) is being improperly taken care of or taken advantage of. A common example of this is elderly adults who are being physically or financially abused by family members or other care providers. Although these individuals are not "removed" in the same sense as a victimized child may be, it is the role of the APS worker to see that the abusive situation is terminated.

The most common social work skills utilized by CPS/ APS workers include case management, investigation, documentation, collaboration with other agencies and families, and quick decision-making. These careers also require frequent traveling within the worker's county of employment in order to attend home visitations and/ or court. (Education Career Articles, 2012).

Youth Correctional Counselor

Counselors working with youth in the criminal justice system help rehabilitate young offenders (Study.com, 2017b). Counselors generally work in a juvenile correctional facility, such as a detention center or residential facilities that youth are referred to by the Department of Health and Human Services, Children's Protective Services, or Foster Care. Here counselors are responsible for supervising the youth by enforcing discipline, making and maintaining records, and implementing constructive activity programs. Counselors may also be responsible for making recommendations such as the appropriate destination for a youth after they are released from placement. For example, a counselor who believes a youth is not capable of being unsupervised, may be unsuccessful, or simply has nowhere to go, may recommend an additional residential facility, foster care, or may even help the individual obtain independent housing in his or her community. In addition to working through various traumas with the incarcerated youth, juvenile justice counselors frequently work with youth and their families together in order to teach new skills designed to strengthen the support system of the youth, minimize conflict if/ when the youth is able to return home, or even provide specialized interventions including addiction recovery and anger management. (Study.com, 2017b).

Prison/jail social worker

Also commonly referred to as correctional social workers, prison social workers are trained mental health professionals with the purpose of reducing rates of recidivism (re-arrest) in the future. Prison social workers use their knowledge and skills to prevent recidivism by addressing psycho-social issues such as past trauma, providing education, and offering social service recommendations to successfully reintegrate offenders into the community upon release. A prison social worker's responsibilities include performing psychological assessments to determine inmates' level of mental health functioning, evaluating the presence of mental health or substance abuse disorders, providing individual or group counseling sessions, teaching inmates life skills in rehabilitation groups, and preparing inmates for their release. Along with the clinical duties prison social workers are responsible for a wide array of administrative tasks such as authoring treatment plans, documenting thorough notes/ files, and communicating with other professionals on inmates' cases. (Social Work Degree Guide, 2017).

Probation and Parole Officer

Parole officers identify and supervise offenders who are eligible for conditional release from prison before they have completed their sentences (Roberts, 2017). In order to earn parole, prisoners must obey prison rules, perform prison jobs well, and show progress in rehabilitation and therapy programs.

In comparison, probation officers are responsible for monitoring those offenders who will be placed on probation as an alternative to jail time. The key difference between the two comes down to sentence length with prison almost always housing offenders with sentences of more than one year, while jails house both offenders awaiting sentencing and those whose sentences are less than one year. The tasks of probation and parole officers are essentially the same aside from the slight difference in the populations

of offenders served (Roberts, 2017).

Some probation/ parole officers work inside correctional institutions, preparing reports for parole boards. They assess prisoners' lives before and during incarceration; how prisoners' families will affect their rehabilitation; and what job prospects prisoners might have if released. Based on the officers' reports and interviews with the prisoners and their families, the boards choose certain prisoners for release. Field officers on the other hand work with parolees once they have returned to their communities. Their daily tasks include helping the offenders find jobs, schools, or therapy programs, meeting with them regularly, performing drug tests, and completing detailed paperwork including meeting notes, progress reports, and treatment recommendations. Some officers also supervise halfway houses in which small groups of offenders live together to share experiences and lend each other support. (Study.com, 2017a).

Sex offender clinician

Counseling individuals convicted of sexually motivated crimes is easily one of the most difficult and emotionally taxing career paths available to social workers within the criminal justice system. It is certainly not a job that is right for everyone, and requires a great deal of confidence as well as the ability to treat all people with dignity/ respect regardless of how you view their actions. On a daily basis, sex offender clinicians are responsible for psychological testing, counseling groups, conducting sex offender programming therapy sessions, interviewing inmates for psychosexual evaluation and recommendation purposes, emergency evaluations and management, diagnosing, case management, working with case managers and contracted professionals, psychological consultation to prisons, testifying in court, and more (Hubbard, 2014).

It is most common for this job to exist within a prison setting or in a support group that is required for sex offenders on parole within the community. This is one of the highest paid positions for therapists within the criminal justice system because of i ts intense nature and specialty; these positions are almost always reserved for the most experienced professionals within the field due to their difficult nature (Hubbard, 2014).

Victim advocate

If advocacy and helping those in crisis is your calling, a career as a victim advocate may be perfect. Rather than working with offending populations as is most common for a criminal justice social worker, victim advocates, as the name implies, are tasked with assisting victims of crimes on many different levels. Victim advocates are professionals trained in mental health or criminal justice related professions, but often require only a bachelor's degree. These workers offer victims information about legal processes and their rights, emotional support after experiencing a traumatic crime, assistance finding resources and completing paperwork, and more. Victim advocates often support their clients by accompanying them to court and even offer clinical services when appropriately trained. Many advocates are employed by crisis hotlines or the courts themselves or as group counselors within the community. For this career path, the ability to speak a second language is particularly valuable. (NCVC, 2008b.).

Substance abuse counselor

A substance abuse counselor is another example of the specialized populations with which clinical social workers in the criminal justice system can work (Substance Abuse, 2017). These counselors work with individuals who use or abuse drugs and alcohol with the goal of overcoming addiction. As you may recall from previous chapters, substance abuse is a notoriously difficult mental disorder as it almost always involves relapse. Due to the difficult nature of this particular career, a substance abuse counselor must be patient, non-judgmental, and especially careful to treat clients with dignity and respect. Frequently done in group therapy sessions, a substance abuse counselor works with clients to overcome the both the motivations to use substances and the effects of their use on their personal and professional lives. These professionals also act as a key support system to aid individuals in making a plan to become substance free and maintain sobriety for years to come.

The main tasks of a substance abuse counselor include creating and monitoring a personalized recovery plan for each individual client on a case load. These plans help clients identify their motivations to use, behaviors which encourage use and/or sobriety, outline consequences of use, identify strategies to prevent relapse, and of course the creation of goals throughout the treatment process. As with most social work careers, a career as a substance abuse counselor involves a great deal of paperwork, case documentation, and collaboration with outside professionals including probation/ parole officers when applicable. (Psychology School Guide, 2017).

Mitigation Specialist

A mitigation specialist (mitigate=reduce severity) is a member of a defense attorney team that participates in courtroom proceedings (NLADA, 2016). These specialists possess clinical skills and must be extremely organized and detail oriented. The

overall job function of a mitigation specialist is to reduce the potential punishment of his/ her client by identifying a factor that warrants a reduction in severity for sentencing. Social workers are often sought after for these positions due to their clinical skills and ability to extract sensitive information from clients in a positive and professional manner.

These specialists are responsible for compiling biopsychosocial assessments, analyzing the significance of the information obtained as it relates to personality/behavioral development, and determining the need for services such as counseling. One example of a typical case for a mitigation specialist may be to complete a psychosocial assessment (a type of life history interview) with a client and learning that although the individual may be responsible for their crime, their IQ is well below average. This information is then used in order to mitigate or "reduce the severity" of the individual's sentence. As with victim advocacy, the ability to speak a second language is considered highly valued in this field. (NLADA, 2016).

Counselor W orking with Mandated Clients

Although this is not a specific job title, counseling individuals who are mandated to attend therapy poses its own unique set of challenges. Essentially the word "mandated" means that individuals are required to attend counseling and are often entering services unwillingly (Shallcross, 2010). These populations commonly include individuals caught up within the criminal justice system due to courts frequently referring individuals who are deemed to be a risk to themselves or others for counseling services. Some examples of these populations include some of those listed above such as: individuals who abuse substances, individuals who are violent (often discovered through violent crimes), those who are found to be responsible for the abuse/ neglect of a child or adult, people who commit sexual offenses, and more. Although it consists of many of the same therapeutic techniques as a general counselor, those who do not enter counseling willingly have the potential to be extremely difficult to work with. For example, while most individuals who voluntarily enter counseling are willing to openly discuss their reasons for seeking services, individuals such as those on probation/parole who have been referred to mandatory counseling are often unable to recognize why counseling is even necessary.

Counselors working with these populations have to be particularly skilled in communication as it is common for mandated clients to refuse to participate in counseling. This difficulty poses yet another problematic situation for workers as they are frequently required to report client progress to probation/ parole officers. Since social workers typically want to help their clients, the idea of reporting to court officials often creates ethical dilemmas about how much to share considering how the reports can impact their clients (Shallcross, 2010).

The following tips were obtained from *Counseling Today* and can be found by following the link provided: https://ct.counseling.org/2010/02/managing-resistant-clients/

- Avoid acting like an expert (focus on client goals)
- Empathize with clients
- Gently confront excuses
- Let the client set the pace
- Do not engage in power struggles
- Always treat clients with dignity and respect

*If you feel that your client is potentially dangerous, look to these additional tips:

- Inform coworkers that you will be in session with this client (develop a code word signifying that you need help)
- Ask your supervisor about installing panic buttons in therapy offices
- Avoid working alone/ at night with this client (or at all if possible)
- Do not allow the client to position themselves between you and your exit
- Make an excuse to leave if you feel uncomfortable
- Limit sharing personal information
- Know your agency's emergency policies

Tips for Testifying in Court

Now you have a basic understanding of what the various court systems are and how they interact with each other, but where do social workers fit in? In short, as a citizen of the United States it is always helpful to have a fundamental understanding of the legal system which governs us. For social workers, however, this becomes even more critical as so many of the clients we work with become involved in the legal system in combination with our own services. Without holding at least a minimal understanding of what our clients are facing, it is almost certain that we would struggle to help them to the best of our ability by offering advocacy

and comfort. With that said, a social worker should never offer legal advice to a client as it is not their area of expertise and, as you learned in the ethics chapter, could result in a breach of the NASW core value of competence.

While much of what a social worker does in relation to court is offering support to clients, it is not uncommon for their role to involve testifying in court which essentially involves providing spoken evidence to the court. This is especially true for professions including CPS/ foster care workers and probation/ parole officers. For even the most seasoned social workers the idea of testifying regarding a client's case can stir up fear and dread. Having to speak in court is almost always a nerve racking experience in and of itself, but when social workers must also balance the legal requirement to tell the truth while on the stand with wanting to do what is right for their client, the situation becomes even more tricky and potentially ethically ambiguous.

The next section will offer a number of helpful tips to avoid being stumped on the stand by even the most talented attorney, and has been adapted for social workers based on the website listed here: https://www.justice.gov/usao-mdpa/victim-witness-assistance/tips-testifying-court

Refresh Your Memory

Before you testify in court perhaps the most crucial piece of advice that can be given is to review your notes and plan ahead. Since it is often part of a social worker's job to provide the court with documentation it is not uncommon for court officials to provide you with these documents while you are on the stand. However, this should never be expected and a good social worker will always come prepared with their own case documents. Also, it is often helpful to highlight any particularly meaningful events, dates, or times in these notes for easy access. Never feel as if you cannot refer to your notes before answering a question; simply ask for a moment to review the facts to be sure. It is always better to take that time to check than to be wrong! Doing this will help you avoid suggestions by attorneys. Do not agree with their estimates or conclusions unless you arrive to the same one independently. Finally, it is important to note than any documents brought in by a worker can be seized as evidence by the judge. In order to avoid this, it is best to bring only documents already submitted to the court, and always analyze possible consequences for both the client and yourself if a document were to be seized as evidence.

Speak In Your Own Words

Don't try to memorize what you are going to say. Doing so will make your testimony sound "pat" and unconvincing. Instead, be yourself, and prior to trial go over in your own mind the matter about which you will be questioned.

Appearance Is Important

A neat appearance and proper dress in court are important. An appearance that seems very casual or very dressy will distract the jury during the brief time you're on the stand, and the jury may not pay attention to your testimony.

Speak Clearly

Present your testimony clearly, slowly, and loud enough so that the juror farthest away can easily hear and understand everything you say. Avoid distracting mannerisms such as chewing gum while testifying. Although you are responding to the questions of a lawyer, remember that the questions are really for the jury's benefit.

Do Not Discuss the Case

Jurors who are or will be sitting on the case in which you are a witness may be present in the same public areas where you will be. For that reason, you MUST NOT discuss the case with anyone. Remember too, that jurors may have an opportunity to observe how you act outside of the courtroom.

Be Professional

When you are called into court for any reason, be serious, avoid laughing, and avoid saying anything about the case until you are actually on the witness stand.

Being Sworn In As A Witness

When you are called to testify, you will first be sworn in. When you take the oath, stand up straight, pay attention to the clerk, and say "I do" clearly.

Tell the Truth

Most important of all, you are sworn to TELL THE TRUTH. Tell it. Every true fact should be readily admitted. Do not stop to figure out whether your answer will help or hurt either side. Just answer the questions to the best of your memory.

Do Not Exaggerate

Don't make overly broad statements that you may have to correct. Be particularly careful in responding to a question that begins, "Wouldn't you agree that...?". The explanation should be in your own words. Do not allow an attorney to put words in your mouth.

Listen Carefully

When a witness gives testimony, they are first asked some questions by the attorney who called them to the stand. For you, this is an Assistant United States Attorney (AUSA). The questions asked are for the purpose of "direct examination." When you are questioned by the opposing attorney, it is called "cross examination." This process is sometimes repeated several times in order to clearly address all aspects of the questions and answers. The basic purpose of direct examination is for you to tell the judge and jury what you know about the case. The basic purpose of cross examination is to raise doubts about the accuracy of your testimony. Don't get mad if you feel you are being doubted during the cross examination. The defense attorney is just doing their job.

Do Not Lose Your Temper

A witness who is angry may exaggerate or appear to be less than objective, or emotionally unstable. Keep your temper. Always be courteous even if the attorney questioning you appears discourteous. Don't appear to be a "wise guy" or you will lose the respect of the judge and jury.

Respond Orally To The Questions

Do not nod your head for a "yes" or "no" answer. Speak aloud so that the court reporter or recording device can hear and record your answer.

Think Before You Speak

Listen carefully to the questions you are asked. If you don't understand the question, ask to have it repeated, then give a thoughtful, considered answer. NEVER give an answer without thinking about phrasing and potential consequences for both you and your client. While answers should not be rushed, pauses to simple questions are unnecessary and could imply a lack of knowledge or professionalism.

Explain Your Answer

Explain your answer if necessary. Give the answer in your own words, and if a question cannot be truthfully answered with a "yes" or "no", it's okay to explain your answer.

Correct Your Mistakes

If your answer was not correctly stated, correct it immediately. If your answer was not clear, clarify it immediately. It is better to correct a mistake yourself than to have the attorney discover an error in your testimony. If you realize you have answered incorrectly, say, "May I correct something I said earlier?" Sometimes witnesses give inconsistent testimony – something they said before doesn't agree with something they said later. If this happens to you, don't get flustered. Just explain honestly why you were mistaken. The jury, like the rest of us, understands that people make honest mistakes.

Do Not Volunteer Information

Answer ONLY the questions asked of you. Do not volunteer information that is not actually asked for. Additionally, the judge and the jury are interested in the facts that you have observed or personally know about. Therefore, don't give your conclusions and opinions, and don't state what someone else told you, unless you are specifically asked. Also, remember that as a social worker or even a non-professional witness, you can only provide your OPINION on a case or client. It is ok to specifically designate that a statement that you are about to make is your opinion as a professional.

Don't Set Yourself Up For Error

Unless certain, avoid generalizing statements such as, "That was all of the conversation," or "Nothing else happened." Instead

say, “That is all I recall” or “That is all I remember happening.” It may be that after more thought or another question, you will remember something important and by making generalized statements you could appear not knowledgeable, unprofessional, or in extreme cases could appear to be attempting to withhold information from the court.

Objections By Counsel

Stop speaking instantly when the judge interrupts you, or when an attorney objects to a question. Wait for the judge to tell you to continue before answering any further.

Only Testify To What You Know

Although you should be confident and definitive in your answers whenever possible, it is important to understand that, when testifying regarding client behavior, you can only discuss personal opinions based on your professional experience. When asked a question regarding client behaviors it is helpful to begin your answer with “In my professional opinion.” This is done in case any additional information or analyses change the worker’s clinical interpretation which can then be adjusted in court without appearing not knowledgeable.

*In addition to these tips, the NASW-Endorsed professional liability program which regularly assists NASW members in preparing to testify as a witness can serve as an excellent resource. For more information, follow this link:www.naswassurance.org/malpractice/malpractice-tips/witness/

Conclusion

Th e criminal justice system in the United States is immensely complicated and fascinating system which holds a great deal of power over the many lives it governs. Through reading this chapter you should now be able to identify various components of the criminal justice system including the courts, the process from arrest to incarceration, the Co nstitution of the United States, and more. In addition to these facts readers should be aware of the numerous ways in which the criminal justice system and the field of social work overlap. Combining these professional fields results in an incredibly interesting career path, as well as an extremely difficult one.

P ossessing a strong passion for advocacy is vital to success within this career path due to the highly contrasting viewpoints of mental health and criminal justice workers. Although it is sometimes easy to forget, the social work profession believe in the fact that each person, regardless of their offenses, is worthy of dignity and respect. This is not always a belief that is respected in society as a whole and particularly within a system which often promotes punishment in opposition to rehabilitation . This only makes it that more important that social workers become involved . Ultimately if you are passionate about advocating for vulnerable individuals, believe that each person has rights, can be unbiased and non- judgmental, and love the idea of working in a challenging, fast-paced, and rewarding field, this could be just the career path for you.

Legal Terminology for Social Workers

*All definitions were obtained from *Michigan Criminal Law & Procedure, third edition (Beatty et al., 2014).*

Abuse – The cruel or violent treatment of a human or animal.

Accessory – Someone who intentionally helps another person commit a felony (examples – giving advice before the crime, helping to conceal the evidence or the perpetrator). An accessory is usually not physically present during the crime.

Accomplice – Someone who helps another person (known as the principal) commit a crime. Unlike an accessory, an accomplice is usually present when the crime is committed. An accomplice is guilty of the same offense and usually receives the same sentence as the principal.

Accused – A person or persons formally charged but not yet tried for a crime.

Acquittal – A legal judgment, based on the decision to either a jury or a judge, that an accused is not guilty of the crime for which he or she has been charged or tried.

Actus Rea – The guilty act, otherwise states as a wrongful deed rendering the actor criminally liable.

Adjudication – The trial phase of a juvenile criminal proceeding.

Admissible Evidence – The evidence that a trial judge or jury may consider, because the rules of evidence deem it reliable.

Admission – Confession of a charge, an error, or a crime; acknowledgment.

Affidavit – A written statement made under oath, swearing to the truth of the contests of a document.

Allegation – A claim or statement of what a party intends to prove; the facts as one party claims they are.

Arraignment – The first appearance of the defendant before a judge or magistrate following his or her arrest in which the defendant is formally advised of charges, attorney may be appointed, and bail is set.

Arrest – The taking, seizing, or detaining of another person.

Assault — An attempt to commit a battery or an illegal act that caused the victim to reasonably fear a battery.

Bail/Bond – The money or property given to the court as security when an accused person is released before and during a trial with the agreement that the defendant will return to court when ordered to do so. Bail is forfeited if the defendant fails to return to court.

Battery — A forceful, violent, or offensive touching of the person or something closely connected with the victim.

Brief — A written argument by counsel arguing a case, which contains a summary of the facts of the case, pertinent laws, and an argument of how the law applies to the fact situation. Also called a memorandum of law.

Chain of Custody — The one who offers real evidence must account for the custody of the evidence from the moment it reaches his or her custody until the moment it is offered into evidence.

Custody — The person is under arrest or the person's freedom has been deprived in any significant way.

Defense Attorney — An attorney who safeguards guaranteed rights of the accused.

Delinquent — A juvenile offender.

Deposition — An interview under oath.

Domestic Relationship — For purposes of the Domestic Violence Statute, a relationship that includes spouse or former spouse, resident or former resident of the same household, or persons who have a child in common.

Domestic Violence — An assault or assault and battery that occurs within a domestic relationship.

Due Process of Law — Procedures followed by law enforcement and courts to ensure the protection of an individual's rights as assigned by the Constitution.

Entrapment— Occurs if (1) the police engage in impermissible conduct that would induce an otherwise law-abiding citizen to commit a crime in similar circumstances, or (2) the police engage in conduct so reprehensible that it cannot be tolerated by the court. 1

Felony — An offense for which the offender may be punished by death or imprisonment in state prison for more than one year.

Guardian Ad Litem — A guardian appointed by the court to represent the interests of infants, the unborn, or incompetent persons in legal actions.

Hearsay — A statement, other than the one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.

Holding — A court's determination of a matter of law, a specific legal principle contained in an opinion, or a court's ruling concerning a specific question.

Indictment— A formal written accusation issued by a grand jury or similar entity charging one or more people with a crime.

Indigent — An individual who has been found by a court to be indigent (stricken by poverty) within the last 6 months, who qualifies for and receives assistance, or who demonstrates an annual income below the current federal poverty guidelines.

Interrogation — Questioning in a criminal investigation that may elicit a self-incriminating response from an individual.

Jail — A facility that is operated by a local unit of government for the detention of a persons charged with, or convicted of, criminal offenses. Houses those convicted of offenses with sentences less than one year as well as those awaiting trial.

Jurisdiction — The official power to make legal decisions and judgements.

Jury — A body of people (typically twelve in number) sworn to give a verdict in a legal case on the basis of evidence submitted to them in court.

Magistrate — Magistrates assist the district court judge and are responsible for hearing informal civil infraction hearings, issuing search and arrest warrants, and set bail/ accept bond.

Mens Rea — Guilty mind (motive).

Mentally Incapable — When a person suffers from a mental disease or defect which renders that person temporarily or permanently incapable of appraising the nature of his or her conduct. (Also referred to as NGRI-Not Guilty By Reason of Insanity).

Miranda Warning / Miranda Rights — By law (*Miranda v. Arizona* ruling by the United States Supreme Court) anyone being questioned by authorities must first receive a 'Miranda Warning'. This requirement exists to prevent the police or other authorities from taking advantage of a person who does not know or fully understand their rights and thus speaks to the police and answers their questions without an attorney present. The Miranda Warning consists of the authorities explaining certain rights to a person before questioning them. These include: 1) You have the right to remain silent. 2) If you choose to speak, anything you say can be used against you in court. 3) If you decide to answer any questions, you may stop at any time and all questioning must cease. 4) You have a right to consult with your attorney before answering any questions. You have the right to have your attorney present if you decide to answer any questions, and if you cannot afford an attorney, one will be provided for you or appointed for you by the court without cost to you before any further questions may be asked.

Misdemeanor — A violation of a penal law of this state that is not a felony or a violation of an order, rule, or regulation of a state agency that is punishable by imprisonment or a fine that is not a civil fine.

Neglect — To fail to sufficiently and properly care for an individual or animal to the extent that the individual or animal's health is jeopardized.

Notice to Appear — For minor offenses of 93-day misdemeanors or less, an appearance ticket may be issued in lieu of custodial arrest except in the cases of domestic violence and Personal Protection Order violations.

Perjury — Occurs when a person knowingly makes a false statement that is material to the case after taking a recognized oath.

Petition — A request for court action against a juvenile or removal for protective services.

Preliminary Breath Test (PBT) — A hand-held instrument utilized to determine presence or amount of alcohol in a person's system.

Preliminary Examination — A hearing to determine if probable cause exists to believe a crime has been committed and to determine if probable cause exists that the defendant committed the offense.

Prison — A facility that houses prisoners committed to the jurisdiction of the department of corrections. Individuals housed here are must be sentenced to a minimum of one year.

Privilege — Certain confidential communications that cannot be used against a person (attorney/ client).

Probable Cause — Facts and circumstances sufficient to cause a person of reasonable caution to suspect the person to be arrested is committing or has committed a crime, or that the place to be searched contains the evidence sought.

Prosecuting Attorney — The chief law enforcement officer in a county, who authorizes complaints and represents state and county in all civil and criminal matters in county courts.

Protective Order — A personal protection order entered pursuant to law; conditions reasonably necessary for the protection of one or more named persons as part of an order for pretrial release, probation, removal from home, etc.

Reasonable Suspicion — An objective basis, supported by specific and articulable facts, for suspecting a person of committing a crime.

Ruling — The outcome of a court's decision on a specific point or a case as a whole.

Search Warrant — A legal document authorizing a police officer or other official to enter and search premises.

Specific Intent — The prosecution must prove not only that the defendant did certain acts, but that he or she did the acts with the intent to cause a particular result.

Subpoena — A writ or order commanding a person to appear before a court or other tribunal, subject to a penalty for failing to appear.

Summons — A writing used to notify a person of an action that was commenced against him or her.

Testimony — The evidence given by a witness under oath. It does not include evidence from documents and other physical evidence.

Vulnerable Adult — An individual age 18 or over who, because of age, developmental disability,mental illness, or physical disability requires supervision or personal care or lacks the skills to live independently.

Warrant for Arrest (Bench Warrant) — Document issued by a judge if the information contained in the complaint establishes probable cause to substantiate the offense charged.

Write – A judicial order directing a person to do something

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11.2: The Criminal Justice System

Learning Objectives

- Describe what is meant by the "working personality" of the police.
- Discuss the quality of legal representation of criminal defendants.
- Explain whether incarceration reduces crime in an effective and cost-efficient manner.

Introduction

The criminal justice system in a democracy like the United States faces two major tasks: (1) keeping the public safe by apprehending criminals and, ideally, reducing crime; and (2) doing so while protecting individual freedom from the abuse of power by law enforcement agents and other government officials. Having a criminal justice system that protects individual rights and liberties is a key feature that distinguishes a democracy from a dictatorship.

How well does the US criminal justice system work in both respects? How well does it control and reduce crime, and how well does it observe individual rights and not treat people differently based on their social class, race and ethnicity, gender, and other social characteristics? What are other problems in our criminal justice system? Once again, whole books have been written about these topics, and we have space here to discuss only some of this rich literature.

Police

The police are our first line of defense against crime and criminals and for that reason are often called "the thin blue line." Police officers realize that their lives may be in danger at any time, and they also often interact with suspects and other citizens whose hostility toward the police is quite evident. For these reasons, officers typically develop a *working personality* that, in response to the danger and hostility police face, tends to be authoritarian and suspicious (Skolnick, 1994). Indeed, it is not too far-fetched to say that police-citizen relations are characterized by mutual hostility and suspicion (Dempsey & Forst, 2012).

Two aspects of police behavior are especially relevant for a textbook on social problems. The first is police *corruption*. No one knows for sure how much police corruption occurs, but low-level corruption (e.g., accepting small bribes and stealing things from stores while on patrol) is thought to be fairly common, while high-level corruption (e.g., accepting large bribes and confiscating and then selling illegal drugs) is thought to be far from rare. In one study involving trained researchers who rode around in police cars, more than one-fifth of the officers being observed committed some corruption (Reiss, 1980). Several notorious police scandals have called attention to rampant corruption amid some police forces. One scandal more than three decades ago involved New York City officer Frank Serpico, whose story was later documented in a best-selling book (Maas, 1973) and in a tension-filled film starring Al Pacino. After Serpico reported high-level corruption to his superiors, other officers plotted to have him murdered and almost succeeded. A more recent scandal involved the so-called Rampart Division in Los Angeles and involved dozens of officers who beat and shot suspects, stole drugs and money, and lied at the trials of the people they arrested (Glover & Lait, 2000).

The other relevant behavior is *police brutality* or, to use a less provocative term, the *use of undue* (also called *unjustified* or *excessive*) force by police. Police, of course, are permitted and even expected to use physical force when necessary to subdue suspects. Given the context of police work noted earlier (feelings of danger and suspicion) and the strong emotions at work in any encounter between police and suspects, it is inevitable that some police will go beyond the bounds of appropriate force and commit brutality. An important question is how much police brutality occurs. In a recent national survey, about 1 percent of US residents who had had an encounter with the police in 2008 believed that excessive force was used against them (Eith & Durose, 2011). This is a low figure in percentage terms, but still translates to 417,000 people who may have been victims of police brutality in one year.

How well do the police prevent crime? To answer this question, let us be clear what it is asking. The relevant question is not whether having the police we do have keeps us safer than having no police at all. Rather, the relevant question is whether hiring more police or making some specific change in police practice would lower the crime rate. The evidence on this issue is complex, but certain conclusions are in order.



In terms of crime reduction, the ways in which police are deployed matter more than the actual number of police. Joery Bruijntjes – Polizia Locale – CC BY-NC 2.0.

First, simply adding more officers to a city's existing police force will probably not reduce crime, or will reduce it only to a very small degree and at great expense (Walker, 2011). Several reasons may explain why additional police produce small or no reductions in crime. Much violence takes place indoors or in other locations far from police purview, and practical increases in police numbers still would not yield numbers high enough to guarantee a police presence in every public location where crime might happen. Because criminals typically think they can commit a crime with impunity if no police are around, the hiring of additional police is not likely to deter them.

Additional police may not matter, but how police are deployed *does* matter. In this regard, a second conclusion from the policing and crime literature is that *directed patrol* involving the consistent deployment of large numbers of police in high-crime areas ("hot spots") can reduce crime significantly (Mastrofski, Weisburd, & Braga, 2010). *Crackdowns*—in which the police flood a high crime and drug neighborhood, make a lot of arrests, and then leave—have at most a short-term effect, with crime and drug use eventually returning to their previous levels or simply becoming displaced to other neighborhoods.

Criminal Courts

In the US legal system, suspects and defendants enjoy certain rights and protections guaranteed by the Constitution and Bill of Rights and provided in various Supreme Court rulings since these documents were written some 220 years ago. Although these rights and protections do exist and again help distinguish our democratic government from authoritarian regimes, in reality the criminal courts often fail to achieve the high standards by which they should be judged. *Justice Denied* (Downie, 1972) and *Injustice for All* (Strick, 1978) were the titles of two popular critiques of the courts written about four decades ago, and these titles continue to apply to the criminal courts today.

A basic problem is the lack of adequate counsel for the poor. Wealthy defendants can afford the best attorneys and get what they pay for: excellent legal defense. An oft-cited example here is O. J. Simpson, the former football star and television and film celebrity who was arrested and tried during the mid-1990s for allegedly killing his ex-wife and one of her friends (Barkan, 1996). Simpson hired a "dream team" of nationally famous attorneys and other experts, including private investigators, to defend him at an eventual cost of some $10 million. A jury acquitted him, but a poor defendant in similar circumstances almost undoubtedly would have been found guilty and perhaps received a death sentence.

Almost all criminal defendants are poor or near poor. Although they enjoy the right to free legal counsel, in practice they receive ineffective counsel or virtually no counsel at all. The poor are defended by public defenders or by court-appointed private counsel, and either type of attorney simply has far too many cases in any time period to handle adequately. Many poor defendants see their attorneys for the first time just moments before a hearing before the judge. Because of their heavy caseloads, the defense attorneys do not have the time to consider the complexities of any one case, and most defendants end up pleading guilty.

A 2006 report by a New York state judicial commission reflected these problems (Hakim, 2006, p. B1). The report concluded that "local governments were falling well short of constitutional requirements in providing legal representation to the poor," according to a news story. Some New York attorneys, the report found, had an average yearly caseload of 1,000 misdemeanors and 175 felonies. The report also found that many poor defendants in 1,300 towns and villages throughout the state received no legal representation at all. The judge who headed the commission called the situation "a serious crisis."

Another problem is plea bargaining, in which a defendant agrees to plead guilty, usually in return for a reduced sentence. Under our system of justice, criminal defendants are entitled to a trial by jury if they want one. In reality, however, most defendants plead guilty, and criminal trials are very rare: Fewer than 3 percent of felony cases go to trial. Prosecutors favor plea bargains because they help ensure convictions while saving the time and expense of jury trials, while defendants favor plea bargains because they help ensure a lower sentence than they might receive if they exercised their right to have a jury trial and then were found guilty. However, this practice in effect means that defendants are punished if they do exercise their right to have a trial. Critics of this aspect say that defendants are being coerced into pleading guilty even when they have a good chance of winning a not guilty verdict if their case went to trial (Oppel, 2011).

The Problem of Prisons

The United States now houses more than 1.5 million people in state and federal prisons and more than 750,000 in local jails. This total of about 2.3 million people behind bars is about double the 1990 number and yields an incarceration rate that is by far the highest rate of any Western democracy. This high rate is troubling, and so is the racial composition of American prisoners. More than 60 percent of all state and federal prisoners are African American or Latino, even though these two groups comprise only about 30 percent of the national population. As "Alcohol and Other Drugs" notes, African Americans and Latinos have been arrested and imprisoned for drug offenses far out of proportion to their actual use of illegal drugs. This racial/ethnic disparity has contributed to what law professor Michelle Alexander (2010) terms the "new Jim Crow" of mass incarceration. Reflecting her concern, about one of every three young African American males are under correctional supervision (in jail or prison or on probation or parole).

The corrections system costs the nation more than $75 billion annually. What does the expenditure of this huge sum accomplish? It would be reassuring to know that the high US incarceration rate keeps the nation safe and even helps reduce the crime rate, and it is certainly true that the crime rate would be much higher if we had no prisons at all. However, many criminologists think the surge in imprisonment during the last few decades has not helped reduce the crime rate at all or at least in a cost-efficient manner (Durlauf & Nagin, 2011). Greater crime declines would be produced, many criminologists say, if equivalent funds were instead spent on crime prevention programs instead of on incarceration (Welsh & Farrington, 2007).

Criminologists also worry that prison may be a breeding ground for crime because rehabilitation programs such as vocational training and drug and alcohol counseling are lacking and because prison conditions are substandard. They note that more than 700,000 inmates are released from prison every year and come back into their communities ill-equipped to resume a normal life. There they face a lack of job opportunities (how many employers want to hire an ex-con?) and a lack of friendships with law-abiding individuals, as our earlier discussion of labeling theory indicated. Partly for these reasons, imprisonment ironically may increase the likelihood of future offending (Durlauf & Nagin, 2011).

Living conditions behind bars merit further discussion. A common belief of Americans is that many prisons and jails are like country clubs, with exercise rooms and expensive video and audio equipment abounding. However, this belief is a myth. Although some minimum-security federal prisons may have clean, adequate facilities, state prisons and local jails are typically squalid places. As one critique summarized the situation, "Behind the walls, prisoners are likely to find cramped living conditions, poor ventilation, poor plumbing, substandard heating and cooling, unsanitary conditions, limited private possessions, restricted visitation rights, constant noise, and a complete lack of privacy" (Kappeler & Potter, 2005, p. 293).

Some Americans probably feel that criminals deserve to live amid overcrowding and squalid living conditions, while many Americans are probably at least not very bothered by this situation. But this situation increases the odds that inmates will leave prison and jail as *more* of a threat to public safety than when they were first incarcerated. Treating inmates humanely would be an important step toward successful reentry into mainstream society.

People Making a Difference

Making a Difference in the Lives of Ex-Cons

- >The text notes that more than 600,000 inmates are released from prison every year. Many of them are burdened with drug,

alcohol, and other problems and face bleak prospects for employment, friendships, and stable lives, in general. Since 1967, The Fortune Society has been making a difference in the lives of ex-convicts in and near New York City.

- >The Fortune Society's website (http://www.fortunesociety.org) describes the group's mission: "The Fortune Society is a nonprofit social service and advocacy, founded in 1967, whose mission is to support successful reentry from prison and promote alternatives to incarceration, thus strengthening the fabric of our communities." About 70 percent of its more than 190 employees are ex-prisoners and/or have histories of substance abuse or homelessness. It is fair to say that The Fortune Society was working on prisoner reentry long before scholars discovered the problem in the late 1990s and early 2000s.
- >The group's president, JoAnne Page, described its halfway house where inmates stay for up to two months after their release from prisons: "This is what we do. We bring people home safely. There's a point when the crime happened. The sentence was served, and the rehabilitation must begin. We look at a human being as much more than the worst they ever did." Recalling that many of her relatives died in the Holocaust, Page added, "What my family experience did was to make me want to be somebody who fights institutions that damage people and who makes the world a little safer. Prisons are savage institutions."
- >In addition to its halfway house, the Fortune Society provides many other services for inmates, ex-inmates, and offenders who are put on probation in lieu of incarceration. It regularly offers drug and alcohol counseling, family services, adult education and career development programs, and classes in anger management, parenting skills, and health care. One of its most novel programs is Miss Betty's Practical Cooking and Nutrition Class, an eight-week course for ex-inmates who are young fathers. While a first reaction might be to scoff at such a class, a Fortune counselor pointed to its benefits after conceding her own immediate reaction. "When I found out about the cooking classes, I thought, 'So they're going to learn to cook, so what?' What's that going to do? But it's building self-esteem. For most of these guys, they're in a city, they've grown up on Kool-Aid and a bag of chips. This is building structure. They're at the point where they have really accomplished something...They're learning manners. You really can change patterns."
- >One ex-convict that Fortune helped was 22-year-old Candice Ellison, who spent more than two years in prison for assault. After not finding a job despite applying to several dozen jobs over a six-month span, she turned in desperation to The Fortune Society for help. Fortune bought her interview clothes and advised her on how to talk about her prison record with potential employers. Commending the help she received, she noted, "Some of my high school friends say it's not that hard to get a job, but for people like me with a criminal background, it's like 20 times harder."
- >The Fortune Society has received national recognition for its efforts. Two federal agencies, the Department of Justice and the Department of Housing and Urban Development, have featured The Fortune Society as a model program for helping ex-inmates. The Urban Institute featured this model in a video it developed about prisoner reentry programs. And in 2005, the American Society of Criminology presented the Society its President's Award for "Distinguished Contributions to the Cause of Justice." These and other examples of the national recognition won by The Fortune Society indicate that for more than four decades it has indeed been making a difference.
- >*Sources:* Bellafante, 2005; Greenhouse, 2011; Richardson, 2004

Focus on the Death Penalty

The death penalty is perhaps the most controversial issue in the criminal justice system today. The United States is the only Western democracy that sentences common criminals to death, as other democracies decided decades ago that civilized nations should not execute anyone, even if the person took a human life. About two-thirds of Americans in national surveys favor the death penalty, with their reasons including the need for retribution ("an eye for an eye"), deterrence of potential murderers, and lower expenditure of public funds compared to a lifetime sentence. Social science evidence is irrelevant to the retribution argument, which is a matter for philosophy and theology, but it is relevant to many other aspects of the death debate. Taken together, the evidence on all these aspects yields a powerful case *against* the death penalty (Death Penalty Information Center, 2011).

First, capital punishment does not deter homicide: Almost all studies on this issue fail to find a deterrent effect. An important reason for this stems from the nature of homicide. As discussed earlier, it is a relatively spontaneous, emotional crime. Most people who murder do not sit down beforehand to calculate their chances of being arrested, convicted, and executed. Instead, they lash out. Premeditated murders do exist, but the people who commit them do not think they will get caught and so, once again, are not deterred by the potential for execution.

Second, the death penalty is racially discriminatory. While some studies find that African Americans are more likely than whites who commit similar homicides to receive the death penalty, the clearest evidence for racial discrimination involves the race of the victim: Homicides with white victims are more likely than those with African American victims to result in a death sentence (Paternoster & Brame, 2008). Although this difference is not intended, it suggests that the criminal justice system values white lives more than African American lives.



The death penalty is racially discriminatory and does not deter homicide. Thomas Hawk – Miami Police – CC BY-NC 2.0.

Third, many people have been mistakenly convicted of capital offenses, raising the possibility of *wrongful executions*. Sometimes defendants are convicted out of honest errors, and sometimes they are convicted because the police and/or prosecution fabricated evidence or engaged in other legal misconduct. Whatever their source, wrongful convictions of capital offenses raise the ugly possibility that a defendant will be executed even though he was actually innocent of any capital crime. During the past four decades, more than 130 people have been released from death row after DNA or other evidence cast serious doubt on their guilt. In March 2011, Illinois abolished capital punishment, partly because of concern over the possibility of wrongful executions. As the Illinois governor summarized his reasons for signing the legislative bill to abolish the death penalty, "Since our experience has shown that there is no way to design a perfect death penalty system, free from the numerous flaws that can lead to wrongful convictions or discriminatory treatment, I have concluded that the proper course of action is to abolish it" (Schwartz & Fitzsimmons, 2011:A18).

Fourth, executions are expensive. Keeping a murderer in prison for life costs about $1 million in current dollars (say 40 years at $25,000 per year), while the average death sentence costs the state about $2 million to $3 million in legal expenses.

This diverse body of evidence leads most criminologists to oppose the death penalty. In 1989, the American Society of Criminology adopted this official policy position on capital punishment: "Be it resolved that because social science research has demonstrated the death penalty to be racist in application and social science research has found no consistent evidence of crime deterrence through execution, The American Society of Criminology publicly condemns this form of punishment, and urges its members to use their professional skills in legislatures and courts to seek a speedy abolition of this form of punishment."

Key Takeaways

- Partly because the police often fear for their lives, they tend to have a "working personality" that is authoritarian and suspicious. Police corruption and use of undue force remain significant problems in many police departments.
- Although criminal defendants have the right to counsel, the legal representation of such defendants, most of whom are poor or near poor, is very inadequate.
- Prisons are squalid places, and incarceration has not been shown to reduce crime in an effective or cost-efficient manner.
- Most criminologists agree that capital punishment does not deter homicide, and they worry about racial discrimination in the use of the death penalty and about the possibility of wrongful executions.

For Your Review

1. Have you ever had an encounter with a police officer? If so, how would you describe the officer's personality? Was it similar to what is described in the text?
2. The text argues that improvement in prison conditions would help reduce the probability of reoffending after inmates leave

prison. Do you agree or disagree with this statement? Explain your answer.

Additional Resources

- Listen to the following NPR Podcast – One Lawyer's Fight For Young Blacks And 'Just Mercy'
- Also, see this article: Warde, B. (2013). Black male disproportionality in the criminal justice systems of the USA, Canada, and England: A comparative analysis of incarceration. *Journal of African American Studies, 17*(4), 461-479. doi:http://dx.doi.org/10.1007/s12111-012-9235-0

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12: CHAPTER 12

12.1: Service Members and Social Work

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11.1: Social Work in Criminal Justice Settings
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12.1: Service Members and Social Work

Introduction

You will likely find veterans in just about every facet of the social work profession. For example, veterans are young and old, and come from very diverse backgrounds. Veterans have families, spouses, and children. They struggle with poverty and experience homelessness. They seek aid from state and federal assistance programs, and struggle with mental and physical health disorders, both military-related and non. Veterans pursue employment, and often struggle to bridge the gap between military and civilian life, battle addictions, and are part of the criminal justice system. Though military core values stress excellence and a "never lose" mentality, veterans are no strangers to defeat. Regardless of whether you set out to work with veterans or not, it is very likely that you will interface with them at some point or another. Throughout this chapter, general background information on cultural aspects of veterans, as well as common benefits and services available to former members of the armed forces will be discussed. Specific to this section of the chapter, the question of "what is a veteran?" will be reviewed, and will include some key characteristics of military life, rank, and pay. Some insight on basic military organization and structure, core values and some common misconceptions, will also be addressed, along with the differences between Active Duty and Part-time components. Additionally, common military language and how it might impact services will also be provided. Hopefully better prepare you for the day a veteran knocks on your office door seeking aid.

With all that in mind, it's important to stress that when talking about any cultural information, it is impossible to avoid generalizations. We, the authors, as veterans ourselves, feel safe talking for some, but not for all. This is basic information, after all. We have a chapter to define what could easily take volumes to adequately articulate. With that in mind, the views and opinions shared from this point forward are that of our own, and were peer-reviewed by members of academia and by those currently working in and/or are a part of the veteran community.

Section I. Components of the Military

Army

https://www.army.mil/



Seal – Department of the Army

The United States Army serves as the land-based branch of the U.S. Armed Forces. The U.S. Code of Military Justice (UCMJ) defines the Army in Section 3062 of Title 10, U.S. Code of Military Justice. It's mission is to preserve the peace and security, provide a defense for the United States and the Commonwealths and possessions and any areas occupied by the United States. It supports the national policies implementing the national objectives overcoming any nations responsible for aggressive acts that imperil the peace and security of the United States.

Navy

http://www.navy.mil/



Seal – Department of the Navy

The mission of the United States Navy is to protect and defend the right of the United States and our allies to move freely on the oceans and to protect our country against her enemies. UCMJ defines the Navy in Section 3062 of Title 10, U.S. Code of Military Justice.

Marines

http://www.marines.com.mil/



Seal – United States Marine Corps

The United States Marine Corps (USMC) is a branch of the United States Armed Forces responsible for providing power projection, using the mobility of the US Navy to deliver rapidly, combined-arms task forces on land, at sea, and in the air.

Air Force

http://www.af.mil/

Seal – Department of the Air Force

According to the National Security Act of 1947 (61 *Stat*. 502), which created the USAF: §8062 of Title 10 US Code defines the purpose of the USAF to preserve the peace and security, and provide for the defense, of the United States, the Territories, Commonwealths, and possessions, and any areas occupied by the United States. The stated mission of the USAF today is to "fly, fight, and win in air, space, and cyberspace."

U.S. Coast Guard

https://www.uscg.mil/

The Coast Guard is one of our nation's five military services. It's core values—honor, respect, and devotion to duty – are the guiding principles used to defend and preserve the United States of America. The Coast Guard protects the personal safety and security of our people; the marine transportation system and infrastructure; our natural and economic resources; and the territorial integrity of our nation–from both internal and external threats, natural and man-made. We protect these interests in U.S. ports, inland waterways, along the coasts, and on international waters.

Each branch of service has their own traditions, trademarks, flags, uniforms, requirements, boot camp, and way of training; however, combined they stand together for the protection of freedom, equality, and rights govern to us by us. The men and women who serve the United States are regular people but when they join the military service a higher standard of personal conduct, integrity, respect, honor, and sacrifice is expected.



Different branches of the military have different uniforms, histories, and tradiations

Section II. Military Culture

Military culture is comprised of the environment veterans have been a part of, and has had a major impact on the lives lead since exiting the military. It is important for those that have never served in the military to be familiar with some fundamentals of military service. Before moving on to specific information, there are a few key terms and characteristics that help describe some common threads that make up the backbone of military culture. These components include *Camaraderie, Pride and Esprit de Corps, Tradition,* and *The Mission*.

Camaraderie

The first term, *camaraderie,* is arguably the largest component of military culture. The relationship dynamics that arise out of a group of individuals whose success or failures dictates the groups' fate is a hint of the camaraderie experienced in the military. The companionship that comes out of that type of environment is lifelong.

To further reinforce this point, refer to the following quote from an article from the newspaper that focuses and reports on matters concerning the armed forces, *Stars and Stripes*:

"It's an unbreakable trust and kinship forged as men push their brains and bodies to the limits each day, together, in an environment that won't forgive them should one man mess up. One guy keeps the next guy going, to keep all the brothers from falling."

(Ziezulewicz, 2009)

This TED talk by Sebastian Junger entitled *Why Veterans Miss War* might help describe the strong sense of camaraderie a little better. https://www.youtube.com/watch?v=TGZMSmcuiXM

Pride and Esprit de Corps

Pride is undoubtedly a term you are familiar with. To a member of the military, pride (which could also be called Military Bearing) is a driving force behind much of our actions. The uniforms and the way they are worn, the walk, the talk: it is very explicit, strenuously orchestrated, and delivered with the highest possible standards of excellence. It's meant to present an imposing force that inspires faith in our allies, and fear in our enemies. It stirs competition between service members, especially with those in different branches of the military (Sion, 2016). It boosts confidence to the point of thinking and feeling invincible. Pride is understandably a huge driving force in the actions of all those who don the uniform (Schumm, 2003, p.837). All of this is magnified by what the military refers to as esprit de corps.

Esprit de corps is essentially the glue that keeps a group of military men and women united; the common spirit that invokes enthusiasm, devotion, and pride in the unit a service member is part of. With hope and aspirations of being the best, they strive to bring honor to those serving with them and to those that served before them in the same unit. A phenomenal example of this can be found in the following video, *Marine Corps Silent Drill Platoon Stun a Packed Arena*. On the surface, this is a spectacle aimed to entertain. Under the surface, the preparation, precision, and delivery are all aspects of pride. Pride in themselves, pride in their brothers and sisters they serve with, pride in their unit (esprit de corps), and meant to invoke pride in the country's military. The next component, tradition, has its roots in pride and esprit de corps.

Tradition



Four generations of a military family from Cumberland County, Tennessee

Any group of Soldiers, Marines, Airmen, or Seamen are organized into various-sized groups commonly referred to as units. (More on military organization will be detailed further in this chapter.) Each unit has its own traditions and each military member is part of those traditions, carrying on a *tradition* of honor, pride, ability, courage, and competence. The things service members do while assigned to that unit echo throughout time and bring honor or shame to those the individual is serving with, and those that served before him or her. In the HBO series *Band of Brothers*, the Army's 82nd Airborne Division was glorified for their valor, courage, and bravery during various operations of World War II. Such a fine example can be tarnished and that reputation dwarfed by just a few poor decisions of an overzealous service member.

The Mission

The last term is potentially the most important one, and potentially the most ambiguous. The *mission* is any task that a service member or group is focused on at any given moment. And that task becomes the embodiment of their being until the task is completed. That task can be small or large and may require individual effort or a group approach. Furthermore, each specific unit within the military carries on its own specific mission, regardless of the size of the unit. Within the military, the Mission, especially when in combat, always comes first. It is placed in higher priority than hopes, dreams, health, and safety.

What is a Veteran?

So now that you have a basic understanding of what it is like to serve in the United States military, the next topic to be addressed is the term Veteran. What is a Veteran? This may seem a simple question at first, but in actuality it is a very murky subject. This is evident by conducting a quick online search for "what is a veteran." Search results yield a new definition for practically every different site you go to. Quite frequently, the various sites contradict one another, as well. While most declare that anybody who has served in the military is a veteran, regardless of any other details, some sources include more specific categories, such as total time served in the military, if they served at times of conflict or war, or type of discharge character. To make matters worse, there is confusion among former service members as to what a veteran is, as well.

The safest answer can be gathered from the Department of Veterans Affairs (VA). The following exert helps to clear some of the fog: “Title 38 of the Code of Federal Regulations defines a veteran as a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable (Veterans Authority, 2017).”

The different branches of the military, differences between Active Duty and the part-time components, as well as the different discharge characters will be detailed later in this chapter. For now, the above definition suggests that if they served at all in any branch of the military and were not dishonorably discharged, they are classified as a veteran. This same definition will be utilized for the purposes of this chapter. However, the initial question of what is a veteran is not entirely answered yet.

As a social worker, rarely will you yourself have to award veteran status to any individual. If and when you do, the program you are working with will have its own detailed and specific criteria to establish veteran status. For example, when this author (Brian) administered the Supportive Services for Veteran Families (SSVF) grant, a veterans-exclusive, VA-funded grant with aims of ending homelessness among veterans, the criteria stated that a veteran was an individual who had served at least one day on active duty outside of initial training, and also received any discharge character other than dishonorable (Department of Veterans, 2016).

Other veteran benefits awarded through the VA have their own eligibility criteria. This means a veteran may be eligible for some benefits, such as healthcare, and be ineligible for others, such as education benefits or small business loans. This may help in explaining why some veterans are not fans of the VA. Likely due to a lack of consistent definition, there are many former service members who do not view themselves as veterans. Some may even get defensive or react with guilt or shame when asked, “are you a veteran?” The most important take away from this portion of the text is that the term veteran is foggy at best. If you need to know if an individual was formerly affiliated with the military for whatever reason, you may find the best approach is to simply ask if they ever served in the military. This removes “veteran” from the equation entirely, and may assist in developing rapport with the individual as well (Conard, Allen, & Armstrong, 2015).

Rank Structure and Pay

All individuals affiliated with the military are given a rank in some form or another. Even civilian contractors that are affiliated with the military often have a rank structure that, according to some, has corresponding weight and gravitas as military rankings. Each different military branch has its own unique rank structure. Very specific information regarding the various rank structures can be found at Military.com via the following link: http://www.military.com/join-armed-forces/military-ranks-insignias.html)

To provide a very basic overview, each branch of the military has essentially two separate rank structures: *enlisted* and *officers*.

Enlisted: Enlisted service members are those who were recruited into the military via a recruiter and do not have a military commission. This category can be additionally separated into three categories: *lower-enlisted, non-commissioned officers,* and *Senior non-commissioned officers*.

Beginning with the lower-enlisted, these men and women are typically either new to the military, or as a result of disciplinary action have been demoted. In all branches of the military, ranks E-1 through E-4 would fit into this category. They are typically new, have little responsibility outside of taking care of themselves and their assigned equipment, and have the lowest level of pay.

Non-commissioned Officers (ranks E-5 through E-6), also referred to as NCOs, are enlisted personnel that have been awarded their rank through a designated promotion board, have a wide range of knowledge regarding their assigned specialty and of various military regulations and doctrine, and can also be found leading small- to medium-sized groups of service members.

Senior NCOs includes ranks E-7 through E-9, have an abundance of experience and training, having served in their respective branches for at least 15 years or more, are the highest trained enlisted service members. They typically have mastery over multiple specialties and can be found leading medium- to large-sized groups (Military.com, n.d.a).

Officers: Officers are traditionally the leaders within the military and are responsible for strategy. An officer might command *what* to do, and it typically falls to a lower-ranked officer or (more likely) an NCO to figure out *how* to do it. There are significantly fewer officers in the military than enlisted personnel, and all officers are higher ranked than any enlisted service member. In other words, an O1 brand new to the military technically outranks an E9 with 35 years of experience. A subsection of officers exists which are Warrant Officers. Warrant Officers do not have quite as much authority as standard officers, per se; however, Warrant Officers are often experts of their given specialty, and their knowledge and experience affords them just as much (though usually more) respect as their officer kin (Military.com, n.d.a).

As for pay, a chart of all paygrades, which are equivalent to the individual’s rank, can be found at the below link. It must be noted

that this is a basic pay scale, and does not include information regarding the various additional funds an individual can receive, such as Basic Allowance for Housing (BAH), Basic Allowance for Sustenance (BAS), Hazardous Fire Pay, and Family Separation Pay. **http://militarybenefits.info/2017-military-pay-charts/**

General Organization

If you've ever heard such phrases as Platoon, Company, Battalion, Squadron, Wing, or Regiment, these are words that describe the size of the unit, which command the unit belongs to, and a general description of its capabilities and potential purpose. A ton of information is available about all the specific words, acronyms, and annotations, but the specifics are not necessarily important here. Suffice it to say, the military is organized in an incredibly intricate manner, and has accompanying policy that dictates precisely how much personnel and equipment it needs to accomplish its unique mission. Very basic information pertaining to military structure can be found **here** (Vetfriends.org, n.d.).

As a social worker, the takeaway from this section is this: the unit each individual veteran has served in is often at the core of the pride he or she has for his or her time in the military. These units are incredibly important to veterans. It may be greatly beneficial for you to look into some background history of your client's unit, as nearly every unit within the military has its own website detailing its history and traditions. This could be a very quick and easy way to gain a lot of rapport with your client.

Active Duty and Part-Time Components

Each branch of the military is comprised of those on Active Duty, and those as part of either the Reserve or National Guard components. The differences between them are fairly obvious: Active duty is serving in the military full-time, while National Guard or Reservists typically serve in the military one weekend each month, with an additional two-week training event each year. It is important to note that while Active Duty and Reserve members are federally funded and monitored, National Guard members are state-funded and report to the Governor of whichever state they originate from. National Guard units are the modern equivalent of state militias (National Center for PTSD, 2012).

Beyond how often the various components don the uniform and serve, or who signs their paychecks, there is a very explicit difference in the benefits and prestige of each component as well. Refer back to the section where what a veteran is was discussed. As far as the majority of federal VA benefits are concerned, National Guard members or Reservists are not viewed as veterans unless they have served on Active Duty in support of either a local or state emergency or combat operation. For example, National Guard members and Reservists deployed to assist the areas struck by Hurricane Katrina were likely placed on Active Duty (effectively making them Active Duty members, albeit temporarily) and henceforth qualified for a variety of benefits they were otherwise ineligible for. Meanwhile, those that honorably completed their weekend duties and two-week training exercises per year with no other periods of service likely found themselves with little to show for it after their military contracts expire, aside from the memories and experiences, and a pension if they served long enough (Veterans Authority, 2017).

Core Values

Much as Social Workers follow the NASW Code of Ethics, each branch of the military has its own unique set of values that all members adhere to. Those values are as follows:

Army – *Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, Personal Courage*

Navy, Marine Corps – *Honor, Courage, Commitment*

Air Force – *Integrity first, Service before self, and excellence in all we do*

Whilst serving in the military, the above core values become each individual's creed while they serve, and each veteran likely still follows those values well after their terms of service ends. As some of you may have noticed, the one common value in all of them is honor. With that in mind, as you work with veterans in the future, if you establish yourself as an honorable person you will likely earn the respect and trust of your client. Adversely, if you do not display honorable qualities, you will lose that respect and trust and will likely not get it back. Consistency and honesty is the key. In our experience, veterans are typically apprehensive to work with civilians, and some may be actively looking for a reason not to trust you. Make it hard for them to not trust you. Earn respect, and you will likely be awarded with an intense loyalty (Department of Defense of Core Values, 2009).

Communication

Within the military, clear, concise communication is a requirement. Lives depend on it. The military often utilizes a phonetic alphabet to aid in this. This means that while civilians would say *A, B, C,* a veteran would likely say *Alpha, Bravo, Charlie,* etc. It isn't necessarily to learn the phonetic alphabet (though it couldn't hurt and might create some common ground with you and your client), but being clear on your communication is paramount. Veterans are trained to pay close attention to the words others say, and will likely let you know that your message was received and understood (*Roger, Lima Charlie/Loud and Clear, Wilco/Will Comply,* ring any bells?). Veterans will cling to the words you use, and will likely follow them like it's their mission. Help them out and be very clear.

For example: *I will see you next Thursday, June 15th, at 2:15 pm in my office. Bring documents 1, 2, and 3. You'll need a pen and a pad of paper to write on.* Not *See you Thursday around 2 with the stuff we talked about.* Talking in ambiguities will likely cause anxiety for a veteran, and could potentially impact your relationship. Furthermore, for those of you soft-spoken social workers out there: those veterans with hearing disturbances notwithstanding, speaking softly or quietly to the point you can barely be heard or understood is likely to frustrate the veteran, not to mention cause undue stress at not fully receiving or understanding your message.

Common Misconceptions

Before this section comes to a close a few common misconceptions exist, and might cloud perspective on veterans. Some of these are warranted. Others are not. For those that are not, it is necessary to shine some light on them and hopefully readjust potentially faulty thinking. It is hoped that clearing up some of these issues that may be skewing your understanding of service members may make it easier for you to work with veterans.

All-Volunteer Military: Though there is still the Selective Service, which actively identifies individuals for the Draft should the need arise, there are no "draftees" currently serving in the military. The Draft has been out of commission since 1973. All current US Military members enlisted at their own free will, conquering the arduous enlistment process and clearing all the rigorous specifications (USA.gov, 2017).

Political Mono-Partisan: It seems that many view members of the military as being a part of the conservative or Republican party. This is not necessarily true. Though research acknowledges that military members and veterans slightly favor conservative beliefs, there is still a large percentage of veterans that maintain progressive or liberal views, as well. Veterans belong to an incredibly diverse array of demographics and backgrounds, and have a variety of political affiliations (Newport, 2009).

Humans, not robots: Ingenuity, thinking out of the box, following instincts is highly encouraged within the military, and development of such skills begins during the initial training, and continues throughout the military experience. Veterans do not just blindly follow orders. Veterans prepare, coordinate, assess, complete, and when necessary, question. However, veterans also recognize a purpose greater than themselves, and will do whatever is necessary. And as always, the mission comes first.

Not stupid: The complex initial testing to enlist in the military aside, veterans strive to make themselves better and more capable. This is done for individual value and sense of worth, but also for the betterment of the unit and to increase its abilities to assist those we are fighting with (Military.com, 2014).

War is missed, but not enjoyed: War is part of the job. In fact, one could easily argue that it is *the* job. When service members are not in combat, they are preparing for it. Though combat can bring about thrills, adrenaline, and excitement unlike any other (potentially on a manic level), there isn't a veteran out there who hasn't experienced fear at the thought of going to war (Davis, 2012).

Veterans are not violent: They are capable and ready for violence, true. But that is not to say all veterans are prone to violence. For the most part, those in the military do not wish to harm others. War is hell, and can create extremely stressful and chaotic circumstances. The result is typical of the environment they are in. It is human nature to ensure one's own continued survival. When in combat, situations might necessitate action. Those same actions are not glamorized or romanticized. Rather, they are typically the material that makes up the veteran's nightmares and regrets and that is carried throughout the veteran's life. Though it is easy to pass judgement, please remember that there is a world of difference between being there and watching it on television (Davis, 2012).

Section III. Uniform Code of Military Justice



Artist's drawing inside a military courtroom

The Uniform Code of Military Justice (UCMJ), is the foundation of military law in the United States. It was established by the United States Congress in accordance with the authority given by the United States Constitution in Article I, Section 8, which provides that "The Congress shall have Power... To make Rules for the Government and Regulation of the land and naval forces (UCMJ, 2008)." www.au.af.mil/au/awc/awcgate/ucmj.htm

UCMJ exists separate from the Unites States (US) Constitution. Military members "rights" are not as extensive as civil rights because members of the armed services are bound by discipline and duty. UCMJ is the only form of "constitutional law" where individuals, whom serve in the armed forces, are subjected to "double" jeopardy which means individuals can be convicted by "civilian law" and "military law" for the same offense.

Discharges



Honorable disocharge papers

There are seven types of discharge and two categories of due process: administrative and punitive. Administrative covers such military discharge as honorable, general, other than honorable (OTH), and entry level separation (ELS). Punitive covers bad conduct (BCD), officer discharge (dismissal), and dishonorable discharge.

Honorable Discharge: When a military member receives good or excellent rating for their service time.

General Discharge: When a military member receives a satisfactory rating and does not meet all expectation of conduct.

Other than Honorable: The most severe type of administrative due process. Examples include: security violations, misuse of violence, conviction by a civilian court system, or being found guilty of adultery.

Entry Level Separation: If an individual leaves the military prior to completing 180 days of service. These individuals are not recognized by their state or federal government as "veterans."

Bad Conduct Discharge: Only passed on to enlisted military member and is processed through court martial. This due process often comes with military prison time.

Officer Discharge: Because commissioned officers cannot receive a BCD or dishonorable discharge nor can they be reduced in rank, they receive a dismissal notice. This notice equates to a dishonorable.

Dishonorable Discharge: When a service member's actions are considered reprehensible. Examples are murder, sexual assault (adult or minor), and child abuse or maltreatment. Individual's whom receive such punitive action are not allowed under Federal law to own or possess a firearm and forfeit all military and veteran benefits.

The UCMJ was enacted by Congress in 1950. The purpose of the UCMJ was to establish a set of standards that outline procedure, substantive criminal law, and procedural safeguards. Prior to the UCMJ each system of military (Navy, Airforce, Army, and Marine Corps) established their own form of law known as Articles of War. The UCMJ united all systems of law developed by individual entities to ensure that military members accused of violating a "law" were subject to the same administrative or punitive charges and procedural rule(s) (UCMJ, 2008).

The UCMJ provides three levels of court systems known as court-martials (general, special, and summary). General court martial handles the more serious offenses and is similar to civilian trial courts. Special court martial handles intermediate level offenses. Special court martial impose such sentences like: six months of confinement (an individual is restricted to barracks, ship, or base movement only and for a certain amount of time allowed for personal reasons), forfeiture of pay, reduction in rank, and bad-conduct discharge. A summary court martial is issued by a commanding officer who handles minor offenses. The maximum penalties include confinement for one month, forfeiture of two-thirds of a month's pay, and reduction in rank.

Court of Criminal Appeals (CCA) hear all cases involving death, punitive discharge (bad conduct, dismissal, or dishonorable), or imprisonment for a term of one year or more. Each branch of service has their own CCA judges and a CCA typically involves a panel review of three judges. The U.S. Court of Appeals for the Armed Forces (USCAAF) is the highest civilian court which is responsible for reviewing the decision of all military courts. Any case(s) where the death penalty is imposed are forwarded by the judge advocate to the USCAAF.

Additional information can be found at the below links.

- https://www.loc.gov/rr/frd/Military_Law/pdf/background-UCMJ.pdf
- www.jagcnet.army.mil/Sites/jagc.nsf/0/EE26CE7A9678A67A85257E1300563559/$File/Commanders%20Legal%20HB%202015%20C1.pdf
- https://www.youtube.com/watch?v=ZrapxpNMwhQ
- https://www.youtube.com/watch?v=x6zFbTihfEk
- >https://www.youtube.com/watch?v=7NDiigSOI2A

Key Words

Uniform Code of Military Justice, court martial, court of appeals, dishonorable, honorable, other than honorable, entry level separation, bad conduct, general, officer discharge

Section IV: Family Life



Army Captains Ron and Rikki Opperman play with their children outside their home here. (U.S. Army photo by Capt. Antonia Greene/Released)

Throughout this chapter, the intricacies of military culture, the military's own unique judicial system, and the differences between the various military branches has been discussed. A closer look at the day-to-day events and family life is appropriate. Though it may be hard to believe, day to day life within the military is not too different from civilian life. There's a job to be done, a daily routine to follow, and outside responsibilities that need attention. Bills, expenses, debt, school, professional development, and goal-setting are part of the life as well. Service members have hopes, dreams, and desires much like anybody else. They also have families. This section will review some more specific information regarding the family life of service members and veterans.

Family life within the military can be successful and rewarding. Extra levels of support and protection are in place to ensure family life stays as consistent as possible and every opportunity of success is offered. Alternatively, it can also be a very precarious environment. We've been at war for a generation now; the young men and women currently fighting overseas could be as young as two or three years old when airplanes collided with the World Trade Center nearly 16 years ago. It's understandably hard to maintain stability within a relationship when the knowledge that your wife or husband, the father or mother of your children, could be called upon to go overseas and potentially never come home. That knowledge is something that lingers overhead like the worst of storm clouds, and adds tension to relationships that already come with their own intrinsic difficulties. Relationships are tough. Even more so when added stressors are brought to the forefront by the daily challenges and risks that being part of the military can bring.

Military Spouses and Dependents

Spouses and Dependents of service members are an integral part of military life. It is certainly within the realm of possibility to have both service members with spouses and children, or with families with multiple service members. In fact, if you'd reviewed the pay scales previously noted in this chapter, you might have noticed that service members are awarded additions to their paycheck for each dependent they have. These funds are increased by a fair amount when on deployment in support of combat operations overseas (Military Benefits, 2017).

It's important to remind you that the mission always comes first. Always. Men and women who wear the uniform are called upon to serve their country wherever necessary, and under any circumstances (within reason). When that call goes out, it's answered. However, it's important to note that the military is not in the habit of leaving dependents without their beneficiaries, at least without a plan. Each branch of the military has supportive elements in place for service members and their dependents. The military understands an individual cannot perform to their full potential whilst being concerned with what is happening with their wife, husband, or children at home. With that said, service members are required to have a plan in place for their dependents should that call be made. Who is going to take care of your dependents? For how long? How are the finances being taken care

of? What happens when crises occur? These are just basic questions that need to be answered for the plan to be accepted. And once the plan is made, it can rarely be deviated from (Duttweiler, n.d.).

These plans are crucial. In fact, service members with dependents might be deemed as “non-deployable” without such plan in place, and may be blocked from participating in deployments. Though this may seem a quick and easy way to avoid heading to combat, it’s not quite that simple and could result in UCMJ disciplinary action up to and including discharge from the military. To conclude this matter, a service member cannot deploy with his brothers- and sisters-in-arms unless a plan is in place for his dependents, and to not be deployable is essentially a taboo within the military and can be punishable by discharge. This rule applies in households with one service member involved. In families when both spouses are service members, this rule applies doubly so: each service member must come up with a plan as mentioned earlier, and must also include the scenario of both service members being deployed at the same time. The mission does come first, but that does not mean the military is disinterested in the safety and well being of its members’ spouses and children (Duttweiler, n.d.).

Deployment Cycles

As already mentioned, the United States has been at war for quite some time. The military has adjusted its own tactics and most units within the military are on a specific deployment cycle. Before the specifics of such cycle is covered, it should be noted that there are several supportive-based units within the military that are not necessarily part of this cycle. Not all service members are responsible for conducting combat operations. Some, in fact, are exempt from these rotations, and are strictly devoted to other tasks.

A variety of units within each branch of the military are devoted to training; their overall mission is to train the next generation of soldiers, sailors, marines, or airmen. In a rotation that runs consistently throughout the year, new service members hoping to earn the right to serve in the military are cycled in and out, and either successfully join the ranks of their respective branches, or do not and either fail, quit, or are rejected.

Additionally, some units within the military are tasked with operating designated training zones and their mission is to prepare units by conducting combat-related training prior to deployment. Fort Polk, Louisiana’s Joint Readiness Training Center (JRTC), and Fort Irwin, California’s National Training Center (NTC) and a variety of others, for example, host year-round wargames (for lack of a better term) with a variety of different units from all branches of the military to ensure they are as ready as can be for any scenario they might face whilst in combat (U.S. Army, 2014).

Another example are the various support units that keep the military running. It takes a large host of men and women to keep these efforts in line and working smoothly. The military, believe it or not, is an incredibly well-oiled machine. This is not achieved by accident. Many service members and civilian contractors are in place to keep things running smoothly.

The rest of the men and women serving in the military who are not part of the above examples typically operate as part of a deployment cycle. These units train independently, with other units, at the training facilities such as NTC or JRTC mentioned above, and even with other militaries from allied nations. This occurs for a set amount of time, and concludes with a deployment in support of combat operations overseas. These deployment cycles vary in length between units and branches of the military. And while some units within the military have advanced training and can be deployed to combat zones in as little as 72 hours, such deployments are typically scheduled months or years in advance. This means that, for the most part, current deployments are usually not a surprise. They obviously are in the event a new conflict occurs. This is why readiness is such a crucial aspect of military life (Pincus, House, & Adler, n.d.).

Divorce Rates

There was a time when divorce rates were significantly higher in the military. A fairly large spike in divorce rates occurred in the early 2000’s shortly after the war on terrorism saw hundreds of thousands of service members deploy in support of combat operations overseas. A study posted in the Huffington Post found that of the 462,444 military marriages that occurred between 1999 and 2008, those that occurred prior to the attacks on September 11, 2001 “were 28 percent more likely to divorce within three years of marriage if one or both spouses experienced a deployment to Afghanistan or Iraq that lasted at least one year” (Military divorce risk, 2013, para. 2).

As mentioned earlier, it seems this would not remain consistent. The same article suggested that those who married after 9/11/2001 had a lower divorce rate, suggesting that perhaps they knew what they were getting into and expected frequent stints of being away from one another. This decline in divorce rates amongst service members continues according to **this** article on Military.com, and further suggests that not only have military families grown accustomed to frequent deployments and stints of

separation, but have also weathered the storm, as deployments are not happening in quite as rapid succession. In fact, divorce rates have nearly returned to their pre-9/11 rates (Philpott, 2012).

Section V. Health Related Concerns

In 2008, The Department of Veterans Affairs (VA) introduced a new mental health handbook that provides guidelines for VA hospitals and clinics across the US. The new handbook specifies exactly what mental health services VA hospitals and clinics are required, by federal law, to offer all veterans and their families (Department of Veterans Affairs, 2014).

These guidelines include the following mental health requirements:

- Focus on Recovery: This approach requires the focus on individual strengths, a strength base approach.
- Coordinated Care for the Whole Person: VA workers collaborate to provide health care for each veteran to give safe and effective treatment.
- Mental Health Treatment in Primary Care: Each VA clinics uses Patient Aligned Care Teams (PACTs) manage the Veteran's healthcare. A PACT is a medical team that includes mental health experts.
- Mental Health Treatment Coordinator: Mental Health Treatment Coordinator (MHTC) provide specialty mental health. The MHTC is goal oriented, providing individual or group care.
- Around-the-Clock Service: Mental health care is to provide seven days a week, 24 hours a day. If a VA facility does not offer such service, they are required to provide service through non- VA medical clinics.
- Care that is Sensitive to Gender & Cultural Issues: VA requires each PACT team to receive training regarding military culture, gender differences, and ethnicity.
- Care Close to Home: More VA clinics are opening in rural areas. Mobile clinics are becoming available. The VA is collaborating with community services to provide a larger scope of health services.
- Evidence-Based Treatment: Evidence-based treatments (EBT) are interventions backed by research to provide effective care for multiple health concerns. Each mental health team receives training on current EBT's to ensure the best updated care is being offered.
- Family & Couple Services: In many cases veterans and their families/guardians also require treatment(s): family therapy, marriage counseling, grief counseling, drug addiction, anger management, etc.

Research provided by the VA (2014) suggests, the following mental health concerns rank the highest among veterans; posttraumatic stress disorder (PTSD), depression, substance abuse, traumatic brain injury (TBI), suicide, chronic pain, and sexual assault. Social workers that work with military members and/or families should be familiar with each issue listed.

The VA (2014) defines these mental health concerns as follows:

- PTSD occurs after an individual has experienced, witnessed, or viewed a traumatic event. Symptoms may include relieving the event, avoiding places or things associated with the event, an increase of negative thoughts and emotions, feeling numb, and/or tense (hyperarousal) (Litz, 2009).
- Depression disorder interferes with one's personal life, daily routine, and normal functioning. These symptoms do not pass over a short period of time (Lapierre, 2007).
- Substance use disorder (SUD) is identified as the tolerance to drink greater amounts of alcohol over time, inability to stop drinking or use of drugs, and withdrawal (feeling sick when trying to stop drinking or using drugs) (Bennett, 2014).
- Traumatic Brain Injury occurs when a person experiences a blow to the head or a joggling of the brain. People who experience TBI often experience a change in consciousness, disorientation, loss of memory, and confusion. Most TBI's occur during "combat" conditions (Hoge, McGurk, Thomas, et al., 2008).
- Suicide is behavior which actively seeks self-destruction. Such behaviors are often provoked by the feeling/emotion(s) of loss or hopelessness (Jakupcak, Cook, Imel, et al., 2009).
- Chronic pain is pain that last for six or more months and limits daily activities (work, depressed mood or increase anger, sleep disturbance, withdrawal from family or friends, or hard to participate in physical activities). Chronic pain is different from *acute pain* because it last beyond the healing of an injury (Brandt, Goulet, Haskell, et al., 2012).
- Sexual assault is intentional sexual contact utilizing force, physical threats, abuse of authority, acts of adultery, acts that violate the Uniform Code of Military Justice (UCMJ), or when a person is unable to consent to sexual activity (Burns, Grindlay, Grossman, et al., 2004).

Social workers who work within the VA follow a mission statement that maximizes health and well-being of all military members, families, and communities through the use of EBT. Their vision is leading by example, setting high standards, and establishing innovative psychosocial care and treatment.

“The values established by the VA and UCMJ suggest, that all social workers who serve military members, veterans, military communities, and their families must advocate for optimal health care by respecting the dignity and worth of the individual, understanding military socio-cultural environments, empower veteran’s as the primary member of their PACT, respect the individual role and expertise of the veteran, focus on the needs of at-risk-population within military communities/families, promote learning (fostering knowledge, enhances clinical social work practice, advances leadership, and focuses on administrative excellence), exemplifies and models professional and ethical practice, and promotes conscientious stewardship amongst organizational member(s) and within community services” (VA, 2014).

The Veterans Bureau General Order (1926) was the first to establish a social work program inside the VA. This program allowed 14 social workers who were predominately highered to work on psychiatric and tuberculosis victims. From 1926 to 1946, Irene Grant Dalymple, pioneered the social work medical environment into the current mental health settings seen in today’s VA. Her involvement set the stage for the current social work programs that were instrumental in establishing health care systems adapted by the VA after World War I. Prior to WWI, social work services were contracted outside the VA to non-military service type facilities. Due to her contributions, the VA now provides services of health care, mental health, group and family care plans, vocational and psychosocial rehabilitation, and programs to assist with adjustment/coping skills to be reunited back into civilian society.

Today, social workers working in the VA have evolved into a professional service responsible for the treatment of military members, military communities, and family members. These responsibilities include but are not limited to treatment approaches which address individual social problems, acute/chronic conditions, terminal patients, and bereavement. “VA social workers ensure continuity of care through the admission process, evaluation procedure, treatment, and follow-up treatment” (VA, 2017, July 24, para. 8). All continuity of care must include discharge planning and providing case management services.

Populations of veterans needing services are: homeless, the aged, HIV/AIDS patients, spinal cord injury, Ex-Prisoners Of War, Operation Enduring Freedom/Operation Iraqi Freedom veterans, Vietnam and Persian Gulf Veterans, WWI and WWII Veterans, Korean War Veterans, Active/Inactive/Reserve/National Guard members, and their families.

Social workers help coordinate program such as:

- Community Residential Care (CRC)
- Financial or housing assistance
- Getting help from such agencies as Meals on Wheels
- Applying for benefits (health care, vision, optical, mental health, dental, financial, educational, and more)
- Ensuring that members of the PACT know your concerns and decisions
- Arranging for respite care
- Marriage or family counseling
- Moving into an assisted living or nursing home
- Bereavement
- Substance Use Disorder prevention or treatment
- Abuse, mistreatment, being taken advantage of, maltreatment, or need of a guardianship
- Parents who feel overwhelmed with child care
- Parents or spouses dealing with failing health concerns
- Mental health or medical needs
- Need direction of services or other unspecified needs

How can Social Workers help Veterans with problems and concern?

VA social workers have experience in assessment, crisis intervention, high-risk screening, discharge planning, case management, advocacy, education, and psychotherapy. Social workers help with all types of services, plus many more. The VA social workers motto: “If you have a problem or a question, you can ask a social worker. We’re here to help you!” (U.S. Department of Veterans Affairs, 2017, July 24, para. 13).

Key Words

Uniform Code of Military Justice, Veteran Administration (VA), Evidence-based treatment (EBT), posttraumatic stress disorder (PTSD), traumatic brain disorder (TBI)

Section VI: Resources for Veterans

It could easily be argued that as long as our nation is involved in conflicts overseas, there will continue to be great efforts to ensure the men and women involved in those conflicts are well taken care of when they return home, and even more so when they retire their uniform and exit the military. There are many available services for veterans, yet access can be challenging. Veteran services are largely area-specific. Web links to state and federal programs will be included in each of the following subsections, but to learn about all the services available will require some searching on your part.

The Department of Veterans Affairs

This is the largest source of support for veterans. The Department of Veterans Affairs is a federal agency within the United States government whose purpose is to fulfill President Lincoln's promise "[t]o care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's veterans" (United States Department of Veterans Affairs, (2015). When it comes to providing services to veterans, the race starts here. This agency has the incredible burden of assisting with millions of pensions, service-related disability claims, education benefits, life insurance claims, healthcare benefits, and much, much more. If you've been paying attention to the news over the past several years, it's no surprise to hear they are struggling to meet the ever-growing needs of service members and veterans. Regardless, the VA is the primary service provider for veterans. For a generalized look at what this organization can provide, check out their website's benefits section **here**. Additionally, for a look at state-funded veteran services, take a look **here**.

County VA offices and VSOs

Like the federal Department of Veterans Affairs, there are also County Veteran Affairs offices. While they are directly linked to the federal VA, they are funded by the local county and usually employ Veteran Service Officers (VSOs). These VSOs assist veterans in completing the rigorous paperwork involved in applying for benefits. And since they are typically locally funded, they likely have access or knowledge of local programs, grants, and services that are not directly administered by the VA. A listing of VSOs can be found **here**.

Mental Health

In addition to Department of VA offices and County VA offices, many larger cities often have Community-Based Outpatient Clinics (CBOCs). Though these CBOCs are often primarily utilized to provide veteran health care, they are typically staffed by one or more Licensed Masters level Social Worker (LMSW), Licensed Professional Counselor (LPC), or Psychologists. Vet Centers are also available in select cities. Vet Centers are connected with the VA, but typically operate independently with the sole purpose of providing individual- and group-therapy to veterans in their identified *catchment* area or area of responsibility. For smaller communities that may not have a CBOC or Vet Center, the VA likely has an agreement or contract setup with a local private agency, though this is not always the case. It's a safe bet that the smaller the city, the more likely a veteran will have to travel to get access to veteran-specific services. Utilizing the *Hospital Locator* here is a quick and effective way at finding local VA mental health services. Take a look!

Veteran Suicide

One last section is necessary when talking about veterans and mental health struggles. Sadly, veteran suicide rates are high. According to a report posted in the *Military Time*s, roughly twenty veterans commit suicide every day, and despite making up only 9% of the population, represent 18% of all American suicides.

The VA has a 24/7/365 Crisis hotline that can be reached via phone (800.273.8255), text (838255) or via online chat regardless if they are registered for any veteran services or not (Suicide Prevention).

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