1 An Integrating Framework for Human Behavior Theory and Social Work Practice

Introduction

The *person-in-environment* (or person-in-situation, biopsychosocial, psychosocial) perspective has historically been the central organizing focus of the social work profession's approach to the helping process. This perspective underscores "the interdependence of individuals within their families, other social networks, communities and larger environments" (Northern & Kurland, 2001, p. 49). From its inception, the profession has drawn from a variety of disciplines (for example, psychology, sociology, biology, anthropology, economics, and political science) to inform its theoretical base for practice. Over time, it has attempted (with greater or lesser degrees of success) to synthesize data from these disparate fields to develop a theory base and practice models that reflect its traditional dual focus: to enhance the biopsychosocial functioning of individuals and families and to improve societal conditions (Greene, 1991).

This chapter will set the stage for the chapters that follow by providing a framework for integrating the wide range of theories and information presented throughout this text. This framework rests on ecosystemic concepts and is informed by a variety of postmodern paradigms that emphasize social justice, multicultural competence, strengths and empowerment perspectives, and principles of developmental contextualism. It assumes the interrelatedness of the personal, interpersonal, and wider social spheres and informs a model for social work practice that integrates skills at the micro, mezzo, and macro levels. We begin by providing a historical overview of the social work profession as it relates to human behavior theory and practice. We will present fundamental assumptions of an ecosystemic approach, as well as an introduction to contemporary perspectives that build on and refine that approach.

Human Behavior Theory and Social Work Practice: A Historical Perspective

The Roots of Modern Social Work Practice: A Person-in-Environment Focus

Modern social work practice can trace its roots to several social movements of the 19th century, and to two, relatively distinct, perspectives on the origin of human problems: those perspectives that viewed the *person* as the focus for change, and those that saw problems in the *environment* as contributing most significantly to human distress. Three movements that illustrate these perspectives are described in the following sections.

The Person The first of these movements had its roots in the development of the relief aid and charity organization societies in the United States during the 1880s. Here, early social workers, or *friendly visitors,* visited homes to help families resolve

social and emotional problems (Richmond, 1917). This movement focused on the need for change within individuals and families and "one might say the *person* part of the person-in-environment was emphasized" (Greene, 1991, p. 10). Inspired by scientific advances in such fields as medicine and engineering, the Charity Organization Societies began to develop a scientifically based theoretical foundation for practice—one that emphasized diagnosis and cure and called for more education and training for practitioners (Kirst-Ashman & Hull, 2009). This person-based perspective underlies traditional approaches to social casework.

The Environment In the late 19th and early 20th centuries, both the settlement house movement and the emergent social welfare system in the African-American community tended to emphasize the "*in-environment* part of the formulation" (Greene, 1991, p. 10).

The Settlement House Movement The settlement house movement developed in response to the social effects of the Industrial Revolution. As America became increasingly industrialized, people from rural areas in the United States (as well as immigrants from other countries) moved to American cities in search of economic opportunities. They were frequently forced to live in the poor, overcrowded parts of these cities and to contend with such adverse conditions as deteriorating housing, inadequate sanitation, and lack of worker protections. In the case of foreign immigrants, issues related to the need for adaptation to the new culture added to their stress. The first settlement house was developed in New York City in 1886, and by the turn of the century, there were many such programs across the country. These programs provided educational, medical, and social services designed to help poor Americans and recent immigrants better understand and cope with their new, complex environments. Settlement house workers such as Jane Addams "accepted the role of applied sociologist" (DeHoyos & Jensen, 1985) and used social action as a means of creating a better society. They lived and worked with poor people, challenging the status quo by advocating for such programs as public housing and public health, supporting legislation designed to improve people's lives, such as child labor laws and the granting of women's suffrage, and mobilizing people in poor communities to help improve their own lives (Popple, 1995; Smith, 1995).

Social Welfare Systems in the African-American Community During the time that Jane Addams and other settlement house workers were trying to address the needs of poor European Americans, the African-American community was establishing several major social welfare organizations of its own (Carlton-LaNey, 2001). Within a societal context that advocated segregation between African and European Americans and a social science community context that largely viewed African Americans as an inferior race (Newby, 1965), organizations such as the National Association of Colored Women (NACW), the National League on Urban Conditions Among Negroes (NLUCAN), and the American branch of the Universal Negro Improvement Association (UNIA) eventually grew to form "the foundation and framework for social welfare service delivery in the African American community" (Carlton-LaNey, 2001, p. xiii) and were founded on what was later

termed an empowerment perspective. This perspective, which focuses on reducing the sense of powerlessness engendered in oppressed people by their social status, will be discussed later in this chapter (see also Chapter 5, "The Family in Society," and Chapter 7, "Communities and Organizations," for further discussion of this perspective). For the moment, it is important to understand the context in which African-American citizens found themselves during the so-called Progressive Era (1898–1918), as social work became professionalized and increasing numbers of private social welfare agencies were developing. With institutionalized racism permeating American life, African Americans were denied access to resources and opportunities; discrimination in housing, employment, education, health care and so forth made the road to overcoming poverty plagued with obstacles.

> The problems to which these groups responded included an array of life-threatening social ills. Clearly, racism and its attenuating grasp made life harsh and oppressive for African Americans. This institutionalized racism permeated American life, denying access for African Americans to opportunities and resources. The race lens through which nearly all of life's circumstances were viewed, and significant decisions addressed, was always in place. Furthermore, among African American social

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> welfare leaders, life circumstances had produced a "profound distrust of white people" in spite of the fact that some were valued benefactors and others even carried the label "friend" (Carlton-LaNey, 2000; White, 1999, p. 98). . . . many other social problems existed among African Americans. . . . Because of poverty, the quality of life for African Americans in both the South and nationwide was miserable. Hemingway (1980) noted that the typical African-American Carolinian, for example, "lived in a weather-beaten, unpainted, poorly ventilated shack, subsisted on a thoroughly inadequate diet and was disease ridden. Hook worms, pellagra and a variety of exposure-induced ailments consistently plagued him, limiting his life expectancy rate" (p. 213). Their northern, urban counterparts did not fare much better. They, too, found life harsh and difficult; however, circumstances in the North offered some room for self-respect and the hope for a better future. Nonetheless, the road to overcoming poverty was plagued with discrimination in housing and employment; inadequate education, health care and diet, and disproportionate rates of delinquency, crime and death. (Carlton-LaNey, 2001, p. xiv)

The Emergence of the Medical Model

The movements described served as precursors to modern professional social work practice. In addition to their differences in approach and emphasis, each of these movements drew, over time, from different bodies of theory to inform their practices. Mary Richmond, an early social caseworker, wrote the first formal social work practice text, *Social Diagnosis,* in 1917. Although Richmond's work relied heavily on sociological research that emphasized the effects of the environment on personality development (Cooper & Lesser, 2005), this strong connection between sociology and social casework weakened considerably after World War I and during the Great Depression, when societal problems often seemed too overwhelming for *sociological fixes.* Searching for a scientific base for practice, *person*-oriented social caseworkers were increasingly drawn to the nascent discipline of developmental psychology and the medical model of psychoanalytic theory as conceived by Sigmund Freud (see Chapter 3, "Theories of Development"). This growing interest in psychological processes shifted the focus of social work practice away from environmental concerns toward a view of human problems as primarily intrapsychic in nature. Soon, the *person's* internal psychological problems were seen as the root cause of all forms of human difficulties, poverty included.

This *medical model* approach gained dominance in the profession during the 1920s and 1930s. With the enormous economic upheavals of the Great Depression, social caseworkers found themselves working more and more frequently with middle-class clients whose adjustment issues were responsive to this focus. The profound, reality-based issues affecting America's poor required a sociologically based approach and wider societal changes that were beyond the rather narrow scope of social casework as it was being practiced at that time. Ultimately, many of these structural problems were addressed with relative success by broad social reforms instituted by the federal government over time.

Empowerment Perspectives: Integrating Group Work and Emphasizing Racial Justice and Social Change

A pioneer in the area of helping to move social work toward a more even balance between the *person* and *environment* perspectives was E. Franklin Frazier, the director of the Atlanta School of Social Work from 1922–1927. Frazier, an African-American sociologist, had a somewhat conflicted relationship with the social work profession, despite the fact that he was instrumental in helping to establish and accredit the first African-American school of social work (the Atlanta School of Social Work).

> Three of Frazier's intellectual and social commitments united him in part with social work and at the same time led to significant disjunctures with the profession. These are (1) a worldview that included socialism and the empowerment of the African American community through economic cooperation; (2) a radical commitment to racial justice, including an intense dedication to the kind of rigorous and scientific education that would "(fill) the Negro's mind with knowledge and (train) him in the fundamental habits of civilization" (Frazier, 1924d, p. 144); and (3) a controversial effort to use the combined tools of psychoanalysis and social inquiry to probe the internal operation of race prejudice and racial oppression in both Whites and Blacks. (Kerr-Chandler, 2001, p. 190)

Frazier's attraction to social work came from its integration of three fields that interested him: psychology, social study, and interest in working people. He was particularly interested in using Freud's work to understand the psychology of racism (Frazier, 1924a, 1924b, 1924c, 1924d, 1925, 1926, 1927), as well as the internal constraints that prevented African Americans from moving forward. However, Frazier's interest in using Freud's work to explore the "characteristics ascribed to insanity" (Frazier, 1927, p. 856) as they related to Southern racism was rejected by the relatively conservative social work community, which was reluctant to threaten the segregationists within its midst (Carlton-LaNey, 2001).

Despite the dominance of the medical model and the high status granted to the psychiatric social work practice, descendants of the early settlement house movement gradually began to establish themselves within the social work profession during the 1930s. These workers, with their emphasis on *social change, advocacy,* and *community-oriented* group-work programs, had drawn on theories of practical democracy and group dynamics to inform the theoretical base for their practice. Of particular significance was the work of Grace Coyle (1930), a social worker whose dissertation, *Social Process in Organized Groups,* drew on her work in settlement houses, YWCAs, and industrial settings and helped to establish group work as a method of social work practice that could be effective in a wide variety of agency settings (see Chapter 6, "Group Work"; Northern & Kurland, 2001; Toseland & Rivas, 2004).

The Diagnostic School and the Family Therapy Movement

Further challenges to the professional dominance of the medical model and its narrow focus on the client's internal conflicts came in the 1940s, when the *diagnostic school* of social work theory and practice began to exert its influence.

This school of thought held that all human problems had both psychological and social aspects (Cooper & Lesser, 2005) and proponents of this approach originated the term *psychosocial* to reflect their more balanced, dual-focused view of the human condition. During World War II and the years that followed, disciples of the diagnostic, psychosocial school drew on concepts from ego psychology to develop their theoretical base for practice. Ego psychology, an offshoot of Freudian theory, focused less on intrapsychic motivation and more on how individuals learn to cope with their environments and how interactions between the person and environment may affect personality development (see Chapter 3, "Theories of Development"). During the 1950s, the gap between psychological and sociological perspectives was further bridged, as social workers became increasingly interested in the developing family therapy movement, with its emphasis on how families change and develop over time, how the behavior of one family member influences another, and how to help families to function more effectively.

Historical Division by Professional Fields and Methods of Practice

Due in large part to the profession's two-pronged philosophical evolution, social workers in direct practice tended, for many years, to be identified by a particular method (for example, casework, group work, community organization, and administration), or field of practice (for example, medical, psychiatric, industrial, child welfare, education). Social caseworkers, with their emphasis on locating problems with the individual (*the person*), and the more socially oriented group and community workers, maintained fairly separate professional identities and in fact did not even merge into a single professional organization until the formation of the National Association of Social Workers (NASW) in 1955. Despite the professional merger, the practical divisions by method and field of practice persisted for many years.

Reform Approaches

With the advent of the 1960s came a renewed interest in social issues and social action—the War on Poverty, Civil Rights movement, Women's and Gay Liberation movements—all had a profound effect on the practice of social work (DeHoyos & Jensen, 1985). Although the dominance of the medical model had been attenuated somewhat during the 1940s and 1950s, with renewed interest in environmental influences on human behavior, the profession had remained grounded in a primarily psychological approach to human behavior. It gave a nod to the environment as an important influence on personality development, but the literature reflected little real attention to sociological research.

As the 1960s unfolded, a reform approach began to take hold as calls for more outreach programs and more serious study of specific social forces and the nature of their influence became louder. Sociological models, particularly those related to ethnicity, social class, and social roles were increasingly introduced into the social work literature (DeHoyos & Jensen, 1985).

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An Integrating Framework for Human Behavior Theory: The Foundation for Multilevel Practice

It became increasingly clear that none of the traditionally dominant theories that viewed human behavior as fixed in place (either by genetic programming, past intrapsychic phenomena, or environmental stimuli) were adequate, in isolation, to explain the complexities of human growth and development throughout the life cycle. With the developments associated with the reform approach came increased pressure for theoretical models that could challenge the dominant, deterministic perspectives, help integrate practice methods (Middleman & Goldberg, 1987), and support the expansion of social work services from the psychological to the interpersonal, to the broader sociocultural arena (De Hoyos & Jensen, 1985).

In this section, we will describe the social systems model and the ecological perspective, both of which provide the foundation for contemporary, multilevel social work practice and for thinking about human behavior and development in the postmodern era.

The Social Systems Model

It was also during the 1960s that general systems theory began to gain stature in the scientific community through the work of a biologist, L. Bertalanffy (1962). A *system* is a complex whole comprised of component parts that work together in an orderly way, over an extended period of time, toward the achievement of a common goal. *General systems theory* is a set of rules for analyzing how systems operate and relate to one another, a concept that can be applied to many fields of study. It was embraced by the social work community and applied to social systems. A *social system* is a person or group of persons who function interdependently to accomplish common goals over an extended period of time.

Social workers felt this conceptual framework provided a way to bridge the profession's historical interest in both the person and the environment. In other words, the *systems model*, as it applied to social systems, seemed to provide the social work practitioner with a means to view human behavior through a wide lens that allowed for assessment of the client across a broad spectrum of human conditions—as a person, as a member of a family, and as a participant in the community and the wider society (DeHoyos & Jensen, 1985). The *person-in-environment system* becomes the unit of analysis (for example, the child in the context of family, school, or peers).

Psychosocial Assessment and the Social Systems Model Social Work practitioners use an assessment process to understand the nature of the presenting situation; the social worker gathers information about the many systems involved (including the individual's past and present biological, cognitive, and emotional functioning and family and wider social networks, such as employment, education, religious, and other relevant sociocultural systems). In collaboration with the client, the social worker forms an opinion of which system(s) appears to be most in need of intervention to most effectively resolve the problem for which the client is requesting assistance (Hollis, 1972). This system is referred to as the focal or target system.

For example, if a young boy is referred to a social worker because of problem behaviors he exhibits at school, the assessment process may reveal that the child's behavior is a symptom of frustration due to an undiagnosed learning disability (neurobiological and psychological systems); anxiety over strife at home (psychological and family systems); reaction to an overwhelmed teacher in an overcrowded classroom (school and/or community system); and/or any combination of these or other issues. Decisions about intervention follow accordingly, with the social worker focusing attention on the system(s) most in need of change and most likely to effect a positive change in the overall situation (a focal system).

The social systems model allowed for the easy integration of knowledge from a wide variety of biological, psychological, and sociological sources and treated the person–environment as a single system, with the person and environment being inseparable and continually shaping one another. Here, biological functioning, psychological functioning, and sociocultural functioning are related in a contingency fashion. A disturbance of any part of this system affects the system as a whole (Wapner & Demick, 1999).

Transaction and Reciprocal Causality Central to this model are the concepts of transaction and reciprocal causality. The term *transaction* refers to a process of acting and reacting between systems and is defined as a constant exchange between systems, in which each shapes and influences the other over time. This process of mutual influence is referred to as *reciprocal causality*. It must be understood that there is no simple cause-and-effect relationship between any two systems, including the person and his/her environment. Rather, there is a reciprocal or circular relationship in which, in the case of the person–environment unit, environmental forces affect the individual's behavior, whereas at the same time, the individual brings forth behaviors and other personal characteristics that help to create conditions in the environment with which he/she must then deal. For example:

> An 18-month-old boy is hungry and tired and begins to whine and cling to his mother. His mother is busy cooking dinner, helping her elder children with their homework, and dealing, by telephone, with her own elderly mother's latest medical crisis. Needless to say, this mother is feeling frustrated and overwhelmed, and she begins to yell in response to the toddler's whiny demands. The toddler reacts to his mother by losing what little control he has left, falling to the ground, kicking and sobbing. The mother now feels more overwhelmed, frustrated, and guilty and begins to lose patience with her two elder children. In response to their mother's sharpness, these children protest loudly, slamming their notebooks shut as their mother storms out of the room.

This example illustrates the circular nature of the transactions among members of this family system, with the toddler's demands triggering the mother's anger, the mother's angry reaction triggering the toddler's tantrum, which leads the mother to lose patience with her elder children, who respond emotionally, disrupting their homework and provoking more anger from their mother.

The concept of reciprocal causality also gives rise to the premise that a change in one part of a system or in the relationship between parts will create change in the whole system. (See Table 1.1.) This same example may be extended to illustrate that premise. Imagine the same situation, except that when the toddler begins to whine and cling, the mother is instead able to collect her thoughts enough to realize that the child is hungry and needs soothing. Instead of yelling, she musters up her last bit of self-control, picks the toddler up, offers him a glass of milk, and is then able to put him in his high chair. The toddler's needs are met, the situation de-escalates, the mother retains a sense of control and competence, and the elder children complete their homework. Here, by altering one small part of the person–environment configuration (the mother's initial response to the toddler), the outcome of the entire transaction is altered.

The social systems model is based on several fundamental assumptions that are important to understand if one is to fully appreciate the nature of the person-in-environment gestalt. These are described in Table 1.1.

TABLE 1.1

The Social Systems Model: Fundamental Assumptions

All forms of matter "from sub-atomic particles to the entire universe" can be viewed as systems, and all systems have certain common properties that cause them to behave according to a common set of "rules" (Anderson & Carter, 1990).	This is a basic assumption of a social systems approach. It is this assumption that makes generalist practice possible. That is, this is the principle that allows us to view a school system as a client as easily as we see an individual person as such. If both function as systems, then both share common characteristics, both will behave in certain predictable ways, and both will potentially be responsive to social work intervention. This statement, of course, oversimplifies the issues for the sake of explanation, but we believe it is nonetheless true at its core. As noted by Berger and Federico: The physical and social sciences share the belief that the universe has some underlying order and that behavior, be it the behavior of atomic particles or interacting individuals, is a patterned, regulated activity than can be understood and in many instances, predicted and controlled (Berger & Federico, 1982).
Every system is at the same time a unit unto itself, made up of interacting parts, and a part of a larger whole.	Anderson and Carter (1990) borrow the term *holon* (Arthur Koestler, 1967) to describe this phenomenon: Each entity is simultaneously a part and a whole. The unit is made up of parts to which it is the whole, the suprasystem, and at the same time, is a part of some larger whole of which it is a component or subsystem. The individual human being is on one hand, a whole system composed essentially of three subsystems that interact to promote the individual's development through life: the biological system (the physical body), the psychological system (thoughts, feelings, and behaviors) and the sociocultural environmental system (the social and physical environments). On the other hand the individual human being is itself a subsystem (i.e., component part) of a supra system (a larger system); that is, the family. As a family member (subsystem of the family), the individual works with other family members (other subsystems) to maintain family functioning. These examples, which are again simplified for the sake of understanding, can be extended, ad infinitum, with the family seen as a subsystem of a community, the community as a subsystem of a nation or larger culture, and a nation as a subsystem of a global community.

(Continued)

TABLE 1.1

The Social Systems Model: Fundamental Assumptions (Continued)

The whole system is different from the sum of its parts: it has definite properties of its own (Anderson & Carter, 1990).	Each social system has an identity of its own that is different from the identities of its individual members. It is the way in which the individual members relate to one another, how they organize themselves to work together toward their common purpose, which gives the social system its unique identity. For example, two hospitals may serve the same patient population, employ the same type and number of staff, and share the same mission. Despite these similarities in composition, each may have distinctly different reputations with regard to quality and medical outcomes of care. Many factors, including distribution of power, patterns of organization and communication, degree of involvement with the community etc. may, in effect, form two distinct institutional cultures. Simply put, when the component parts of systems are combined, they take on characteristics that they did not possess in isolation. The social worker must acknowledge and respect this wholeness whether he/she is examining an individual, a family, an organization or the broader society if social work intervention is to be effective.
A change in one part of a system or in the relationship between parts will create change in the system as a whole.	Because systems are composed of interrelated parts that operate in transaction with one another, "whatever affects one part of the system affects all parts to some degree" (Hollis, 1972, p. 11).
Every system must be able to adapt to changing internal and external demands and challenges while continuing to maintain its identity and its unique sense of wholeness. Some degree of stress and tension is therefore a natural and, indeed, necessary part of any adaptive system's existence as it interacts with its environment and develops over time.	As noted previously, all systems are goal oriented or purpose driven. That is, the system's components, or subsystems, work together to achieve common goals. When the system's components are able to work together effectively, the system is said to be "functional" or "adaptive." In other words, a functional system is one in which: • The system is flexible enough to change as necessary in response to constantly changing conditions and demands from within and from the environment. • While remaining flexible, the system is cohesive enough to maintain its sense of "wholeness." The subsystems are able to fulfill their individual needs and purposes while working together successfully fulfill the overall system's goals over time. • The system works to maintain a "good fit" with its environment, and as the system develops, it becomes increasingly capable of responding to change and improving its system–environment "fit."

	Obviously, the reverse will be true for dysfunctional or maladaptive systems. Here, the system's components are less successful in working together to achieve the system's goals. Such a system may be so internally disorganized that its components are unable to work together effectively. On the other hand, the system may be rigid and inflexible, and therefore less able to adjust to changing circumstances and demands. Over time, such a system will be less and less likely to develop the capacities required to respond to changing circumstances while maintaining effective functioning.

Characteristics of Living Systems As noted in Table 1.1, all systems, smaller than the smallest cell, to the global community and beyond, share certain common properties. The following section will first introduce and define some of these properties and will clarify how each affects a system's overall ability to function effectively. We have selected, for discussion, six characteristics that are basic to the workings of all living systems. These are boundaries, adaptation, steady state, energy, communication, and organization; each is described in Table 1.2.

TABLE 1.2

Characteristics of Living Systems

Boundaries	Every system has boundaries. Boundaries can be defined as the borders or lines of separation that distinguish the system from the rest of its environment. Boundaries also regulate the flow of energy into and out of the system (Greene, 1991; Zastrow & Kirst-Ashman, 1997). Boundaries may be physical (e.g., a person's skin physically distinguishes the person from the environment) or conceptual (e.g., who is a member of a particular family system and who is not). As the regulators of energy flow, a system's boundaries may be relatively open or relatively closed (Anderson & Carter, 1990; Greene, 1991). Systems with relatively open boundaries are more receptive to interchanges of energy (e.g. information, resources) among the various parts of the system and between the system and its environment. Functional systems have relatively open boundaries that permit energy to flow in and out of the system, enabling them to maintain a steady state as they grow and develop. Systems whose boundaries are relatively closed are less receptive to such interchanges of energy. In these systems, energy reserves tend to run down. Here, the system may find itself increasingly hard-pressed to maintain a steady state and to continue to develop and function effectively over time.

(Continued)

TABLE 1.2

Characteristics of Living Systems (Continued)

Adaptation	As any system interacts with its environment over time, it experiences pressure or tension as the environment makes demands on it, presenting it with challenges to its ability to function. Adaptation refers to a system's capacity to adjust to changing environmental conditions and demands. Functional systems respond to the environmental pressure by making changes to adjust to new demands. These changes or adjustments serve to reduce the tension and to cause the system to grow and develop. Over time, adaptive systems tend to achieve a better *fit* with their environment, growing more complex (or *differentiated*), increasingly able to effectively handle challenges and demands. The ability to change and grow in response to new circumstances is crucial to a system's continued viability and effectiveness (Zastrow & Kirst-Ashman, 1997). Adaptation however, is not a passive process whereby the system simply adjusts to whatever environmental circumstances present themselves. It is an active process in which human beings strive to achieve the most congruent person-in-environment system state or *fit* possible between their own needs and abilities and the characteristics of their environment. There are critical person-in-environment transitions at every stage of the life cycle. If the fit is not good, they may choose to make changes within themselves, in their environment, or in both. These changes are known as adaptations (Germain, 1991).
Steady State (also referred to as "equilibrium"	Every system constantly strives to maintain a balance between changing in response to internal and external demands, while at the same time preserving its unique identity and sense of wholeness. We will refer to this dynamic balance as a steady state (although it is sometimes referred to as equilibrium; see Anderson & Carter, 1991 for distinctions). The maintenance of this balance is essential for a system's viability over time. If some internal or external stressor disturbs the steady state, the system must work to restore the balance by making adjustments in its functioning. A functional system can maintain and restore a steady state by remaining flexible, alert and responsive to continuously changing internal and external circumstances while it grows and develops, maintains its sense of wholeness, and actively pursues its goals. A dysfunctional system has difficulty maintaining and restoring a steady state. If the system is unable to recover successfully from a disruption to its steady state, its overall effectiveness and, indeed, its very existence may be seriously threatened. According to Anderson and Carter (1990): Systems never exist in a condition of complete change or complete maintenance of the status quo. Systems are always both changing and maintaining themselves at any given time. The balance between change and maintenance may shift drastically toward one pose or another but if either extreme is reached, the system would cease to exist. (p. 26)

Energy	Energy is basic to the functioning of all systems. According to Zastrow and Kirst-Ashman energy is the "natural power of involvement between people and their environments" (Zastrow & Kirst-Ashman, 1997). Energy can take many forms, for example, financial resources, information, emotional support, physical assistance, etc. Energy is essential to a system's ability to cope with change and to develop and grow while continuing to preserve its identity and to maintain its steady state. For a system to be functional, energy must be able to flow into the system from the environment (input), out from the system into the environment (output), as well as internally among the system's components. When a system is functioning effectively, maintaining a steady state, taking in and generating energy, a synergistic effect occurs, whereby energy increases. This causes the system to develop and grow in complexity, acquiring characteristics that increase its overall viability. Dysfunctional systems tend to restrict the internal and external flow of energy, isolating themselves from the environment. Here, energy reserves eventually become depleted, making it increasingly difficult for the system to maintain a steady state and to function effectively.
Communication	Communication is a process in which information, a specific type of energy, is transferred between the parts of a system and between the system and its environment. Functional communication serves to transmit information clearly and directly. A functional communicator demonstrates the flexibility to clarify messages as necessary, asking and responding to questions, restating messages, and maintaining focus on the issue(s) at hand. Feedback is one form of communication in which a system receives information about how it is performing, from the environment or from within, and then reacts to this information as appropriate. If the system receives negative information or negative feedback about its performance, it may choose to modify or adapt its behavior or to make a change in its environment. Positive feedback lets the system know that it is functioning effectively. A system's ability to establish effective patterns of communication and feedback mechanisms is crucial to its ability to adapt and function effectively (Anderson & Carter, 1990; Greene, 1991).
Organization	Over time, systems organize themselves to facilitate the exchange of energy and the system's ability to function effectively and achieve its goals. The system becomes increasingly differentiated and complex; subsytems develop and relationships among parts of the system are structured in various ways to facilitate the exchange of energy; roles are differentiated to divide the labor and put the system into working order. Vertical hierarchies are established that regulate the distribution of power, control, and authority.

Practice Example 1.1 illustrates fundamental concepts of the social systems model.

PRACTICE EXAMPLE 1.1

A Hospital in Crisis

In the mid 1980's, I accepted a position as a social work administrator in an urban medical setting that provided services to persons with developmental disabilities. One such service was an inpatient hospital unit. As originally conceived, this specialized hospital unit was to provide medical and habilitative care to patients with severe developmental disabilities and extraordinary medical needs. It was expected that these patients would be discharged back to the community, once their medical conditions were stabilized. Many of these patients had previously lived in state institutions, and few, if any, had families who could provide care. The plans for discharge therefore, presupposed the development of a continuum of community-based residential and habilitation programs that would provide necessary services, in accordance with federal law, in a less restrictive (and less costly) community environment.

Although the hospital's patient population had previously been severely underserved, the hospital unit had been developed at a time when government policies toward people with developmental disabilities were quite progressive. It was fully expected that the future would bring our patients an array of appropriate community-based services. In reality however, the development of such community-based services had proceeded more slowly than had been anticipated. This was due in part, to changes in the national political climate that led to significant reductions in federal funding for social programs during the 1980's. This paucity of appropriate community services left many of our inpatients languishing in the hospital far past the time that their medical conditions warranted such an intensive level of care.

By the mid-1980's, our difficulties with regard to timely patient discharge were compounded by three new and largely unanticipated challenges which faced many urban healthcare systems at that time. First, it was just becoming apparent that the problem of HIV/AIDS, initially thought to be a health crisis limited to gay men, was far more widespread than had been previously imagined. As knowledge increased about the virus, its modes of transmission and its detection, the number of people characterized as "at-risk" for infection seemed to grow exponentially to include such diverse populations as recipients of blood transfusions, drug addicted individuals, and the heterosexual partners of infected individuals as well as babies born to infected mothers.

The second major healthcare challenge arose out of the growing abuse of crack cocaine, a form of the drug that was widely accessible due to its low cost. A side effect of this "epidemic" was the rising number of infants born with serious medical and developmental problems associated with prenatal drug exposure.

Third, and on a more positive note, major technological advances in medicine had recently made it possible for extremely premature, low birth-weight newborns to survive at rates never before possible. Although many of these children went on to enjoy good health and normal development, many others suffered serious medical and developmental complications. This group included, but was not limited to, babies who had experienced prenatal exposure to crack-cocaine and/or HIV.

These three developments threatened to overwhelm the healthcare community. Fear over HIV/AIDS was fueled by ignorance. In fact, little was known for certain about the disease, newly developed diagnostic tests were often unreliable, and effective forms of treatment were years away. Premature infants with extremely low birth-weights and those exposed to crack-cocaine *in utero* presented unusual and extraordinary medical and developmental issues. Health care professionals, who were hard-pressed to diagnose and treat these new patient populations, found it almost impossible to predict what their future needs would be.

As the social work administrator, I was ultimately responsible for the success of the hospital's discharge planning program. Again, this meant that once a patient's medical condition

improved enough that hospitalization was no longer necessary, the social work department was mandated by Federal and State regulations to see to it that each patient received all necessary health and habilitative services in the "least restrictive" community environment possible. As noted previously, this was problematic at best. Although some community resources did exist for our older, less fragile patients, these were relatively scarce and difficult to access. On the other hand, the community seemed totally unprepared to provide for our youngest, most complex patients. This left the hospital (along with many other urban hospital centers), in the position of housing a patient population that soon came to be known in the popular press as "boarder babies". These "boarder babies" had extraordinary developmental and health needs, and remained in hospitals essentially because they had nowhere else to go. Many had highly unstable family situations with parents who were struggling with drug addiction, AIDS and/or poverty and who were in no position to assume the care of a seriously ill child. Other patients came from more stable homes, but their parents' realistic fears and uncertainties about providing such a high level of care, combined with a real dearth of community services, had prevented them from returning home.

Soon after assuming my position as social work administrator, I realized that the hospital's problems with discharge planning were far more complex than I'd anticipated. In addition to the very real problem of a shortage of appropriate community resources for our patients, the social work staff seemed to have succumbed to frustration and to have given up on trying to find homes for our patients, believing that any effort toward that aim would be futile at best. This belief seemed also to permeate all parts of the hospital system. Many of the medical and habilitative staff seemed convinced that a large portion of the patients would be better off remaining in the care of hospital personnel despite the fact that their medical conditions no longer warranted hospital care. Patients' families had grown comfortable with the care their very fragile children had been receiving and were not at all anxious to have them leave the safety of the hospital setting. The hospital administration also seemed reasonably comfortable with the situation, despite the fact that the State Health Department had cited the facility for inadequate discharge planning services. Although the State had threatened to apply sanctions, for the moment the hospital continued to receive its relatively high rate of payment per patient, and so, felt little pressure to exert a great deal of effort to comply with the health department's demand for more active planning. I however, felt enormous pressure to create a successful discharge planning program. As the administrator responsible for these services, I knew I would be held accountable for any lack of compliance with State regulations. I was also aware, from previous work experience in community based programs for people with developmental disabilities, of the improved quality of life our patients would experience living in the community. Having successfully "deinstitutionalized" many clients in the past, I knew we could create a successful program despite the scarce resources.

After carefully assessing the situation, I realized that my first intervention needed to be to facilitate a change in attitude among the social work staff. I felt this would set in motion a string of changes inside and outside the hospital system which would, I hoped, eventually lead to appropriate community placements for our patients.

I began my intervention by raising the issue of discharge planning at our weekly social work staff meetings, initially exploring the staff's past efforts toward discharge planning and the obstacles they encountered. Discussions about patients' needs and the benefits of community living quickly gave way to a venting of their feelings of frustration and hopelessness around this issue. Realizing that they needed to experience some success, I suggested two or three community based programs which I knew could provide appropriate services for some of our older, less fragile patients. I assisted the staff in preparing referral materials and in arranging

(Continued)

appointments for our social workers to visit those agencies, evaluate their programs, forge relationships with them and discuss referrals of specific patients. The staff began to feel excited as a handful of our patients left the hospital for the community. Admittedly, those patients were among our least needy, most stable group, but their successful discharges served to motivate and energize the social workers into further action.

In an effort to locate community based programs for even our most "hard-to-place" patients, we decided to broaden our search to cover a wider geographic area. The staff developed a questionnaire, which they mailed to community agencies across the state. This questionnaire was designed to fully acquaint us with statewide community-based services. Focusing their attention on those agencies whose responses described the kinds of services we were looking for, social work staff enlisted the cooperation of some of our medical and habilitative personnel and arrange group site visits to programs around the state. As the process unfolded, we were able to locate several agencies willing to accept even some of our "harder to place", more fragile patients.

Our "boarder babies" however, presented more difficulties. As noted, most of these babies needed to live in stable homes with a full range of community support services in place. Family instability, lack of appropriate support services and/or parental anxiety and ambivalence presented major obstacles to such a plan. The social work staff, now energized by success, began to aggressively pursue planning for these children. As some of the babies had been abandoned by their parents, staff began to exert pressure on the city's Department of Children's Services to pursue the legal processes necessary to free them for adoption. Realizing that they could not depend on the over-extended city agency to expeditiously locate foster and adoptive families, social work staff began to reach out and form relationships with private agencies who were just beginning to develop foster and adoption programs for children with special medical and developmental needs. For those children who were fortunate enough to have more stable family situations, the social workers provided intensive counseling to parents to help them resolve their conflicted feelings about assuming full-time responsibility for children with multiple problems and uncertain prognoses.

Although locating stable homes was an important first step, many obstacles to discharge remained ahead. Parents (whether they were adoptive, foster or by birth) all required highly specialized training to deal with the children's varying medical and nursing needs, appropriate educational and therapeutic services had to be located, medical equipment and support services had to be approved and funded and in some cases, issues of inadequate housing and family financial resources had to be resolved before the children could safely go home.

In addition to the many external obstacles, the social workers were surprised to meet with quite a bit of resistance from our own in-hospital medical and nursing staff who were not convinced that the babies could receive adequate care by non-professionals (i.e. parents) outside the relative shelter of the hospital environment. Needless to say, support and cooperation from the medical and nursing staff was critical for many reasons. In addition to needing their advice and guidance regarding the types of community health care services we needed to obtain, we needed, we needed them to train the families in patient care techniques before the children could go home.

On an administrative level, I applied continuous pressure on the hospital administration by keeping them apprised of our progress, needs and problems. Despite the tension, the social work staff worked hard to directly collaborate with the doctors and nurses, soliciting their opinions and expertise, addressing any and all concerns promptly and maintaining close communication throughout the process.

Although the process of change often seemed endlessly fraught with obstacles, within a three year period we had developed a thriving, successful discharge program which essentially transformed the hospital back to the short-term medical facility it was originally meant to be, and provided a vehicle for our patients to lead their lives in the "least restrictive" environment (i.e. outside the institution, in the community with medical and educational services to support their development) possible.

Analysis of Practice Example 1.1 from a Social Systems Perspective

In Practice Example 1.1, the hospital itself may be viewed as a system. The hospital system is composed of transacting subsystems that mutually influence one another. These subsystems include the patients and their families, the hospital administration, and the medical, nursing, habilitative, and social work departments. The hospital system may be seen as a holon, as it operates in transaction with its environment. This environment includes its geographic location, a low-income section of a large metropolitan area, as well as the wider health-care community of which the hospital is a part. Other subsystems of the health-care community are all agencies that oversee the hospital's functioning and/or provide funding for its services (for example, the Office of Developmental Disabilities, the Department of Health, the Department of Children's Services), as well as various community-based agencies serving similar patient populations across the city and state. The hospital system and its community also transact with the wider society within which they are embedded. From this perspective, broad social forces such as the culture and its values, the political and economic climate, and any variety of social developments may be seen as important influences. In this case, environmental forces influencing the functioning of the hospital system include the relatively progressive political and economic climate at the time during which the hospital was originally conceived, as well as the eventual changes in the political and economic climate, which restricted funding for social programs and delayed development of anticipated community services for the hospital's original patient population. Additional influential environmental forces include the rising epidemics of HIV/AIDS and crack cocaine abuse, as well as advances in medical technology, which increased survival rates for the epidemics' youngest victims.

Reciprocal Causality: Systems in Transaction The concepts of reciprocal causality and transactional functioning between systems is clearly illustrated in this example, as changes in the political and economic climate began to create changes in the functioning of the hospital system. As the hospital found itself dealing with catastrophic social problems in an increasingly resource-poor environment, it began to invest less and less effort toward discharging its "medically ready" patients. The environmental response to this change in the hospital system's internal system of controls is the Department of Health's threat to apply sanctions. This led to a further series of internal changes, beginning with the hospital's designation of a social work administrator to be responsible for discharge planning. The social work administrator's decision to focus her initial intervention on the functioning of the social work department illustrates the concept of the focal system (that is, the system most in need of change to most effectively resolve the problem at hand). As the administrator's interventions gradually led to changes in the focal system and the social work staff began to actively pursue community resources, the community responded with changes of its own. Programs began to accept referrals of the hospital's patients, and gradually these patients began to move out into the community. Further change occurred when the Department of Health lifted the threat of sanctions. This served to energize the hospital system, with the social work staff initiating aggressive partnerships with community-based agencies to develop new services for the "boarder babies." As these efforts began to bear fruit, further changes in the hospital's internal functioning

occurred, with the hospital's discharge process eventually making it possible for the boarder babies to return to the community.

Adaptation The hospital system faced many environmental obstacles and challenges to its ability to fulfill its goal of discharging patients to the community once they no longer needed hospitalization. The hospital system initially had difficulty adapting to these challenges, and eventually its very existence was threatened by the possibility of sanctions from the Department of Health. The hospital system was eventually successful in adapting to these challenges by making internal changes (for example, hiring a new administrator to develop an active discharge planning program) and external changes (for example, working with other agencies to develop appropriate community resources). These adaptations resulted in a better "fit" with its environment (for example, the Department of Health removed the threat of sanctions, and the community ultimately provided the hospital's patients with appropriate services) and caused the hospital system to develop and grow into a more complex, viable system (e.g., it now had an active discharge planning program with a strong network of community relationships in place and could therefore better function to fulfill its intended purpose).

Energy Flow and Steady State The example clearly demonstrates the importance of energy flow to a system's functioning. As the hospital system became overwhelmed by the many environmental obstacles it faced with regard to discharge planning, it began to close off the flow of energy coming in (input) and going out (output) of the system. The social workers limited their efforts to reach out to the community (output), and as a result, less and less information about resources came in (input). Eventually, the hospital system began to lose its sense of identity, gradually coming to more closely resemble a nursing home than a hospital. Its supply of energy gradually ran down, resulting in a sense of inertia, especially in the area of discharge planning. Ultimately, the hospital system's very existence was threatened as the Department of Health prepared to institute sanctions against it. A viable steady state was gradually restored as the hospital system began to export energy via the social workers' increased efforts to explore community resources and establish connections with other agencies. Energy then flowed in from the community in the form of resources, information, and working alliances. The resultant synergy allowed for an increased flow of energy within the system, with the various subsystems (such as medical, nursing, habilitation, and administrative departments) eventually working together effectively toward their common goal.

Communication and Feedback Mechanisms The hospital system received negative feedback about its discharge planning efforts from the Department of Health, and it responded by beginning a process of, first, internal (increasing its efforts toward discharge planning) and then external (working to develop new community resources) change. In Practice Example 1.1, when the hospital initially tightened its boundaries, it limited its access to resources, however scarce, in the community. As noted, this led to a sense of inertia that eventually threatened its continued existence. As it opened its boundaries, forming alliances with resources in the community, it became increasingly energized, gradually regaining its ability to function effectively and to better its fit with its environment.

The Ecological Perspective

The social systems model, as it related to social work, evolved as the profession struggled to integrate its often abstract and complex terminology and concepts into its theory base. By the 1970s and 80s it had expanded to include the ecological perspective (Germain, 1979a, 1979b, 1979c, 1981, 1987, 1991). Although rooted in systems theory and using systems concepts to integrate information, the ecological perspective provides a broader base from which to integrate theories from several disciplines and to more fully explore the nature of the relationship between the individual and the environment. For example, this perspective incorporates concepts from role theory (among many others) to explain how behavior and relationships are affected by sociocultural factors. From an ecological perspective, social roles determine not only how a person in a particular position behaves, but also how others behave toward that person. "In short, roles serve as a bridge between internal processes and social participation" (Greene, 1991, p. 276). In addition to social roles, patterns of communication, individual coping behaviors, interpersonal networks, and characteristics of the physical and social environment that either support, or impede, human development are examined in the context of the complex, reciprocal interactions between the person and environment. Here, the concept of the environment includes the physical (natural and constructed), the interpersonal (all levels of social relationships), and the sociocultural (social norms and rules and other cultural contexts; Harkness & Super, 1990). As is the case in the social systems model, the individual is understood in the context of his or her environment—the person and environment are viewed as parts of the same system operating in continuous transaction—mutually influencing, shaping, and changing one another.

Goodness of Fit: An Evolutionary Perspective The overarching view of human development from an ecological perspective is an evolutionary one: people are born with genetically based potentials that are either nurtured or impeded by transactions with the environment throughout the life course. A central tenet of this perspective is the notion of "goodness of fit" between the person and the environment. This refers to a reciprocal process in which a good fit results when the physical and social environment provides the resources, nurturance, and support the individual needs to grow and develop in an adaptive manner. Notably, this perspective recognizes that diverse environments are necessary to support the needs, goals, and life experiences of diverse human beings, acknowledging that no one type of social or physical environment can be considered optimal for all people. Of particular interest are complex social networks such as family members, coworkers, community groups, and so forth that have the potential to provide mutual aid and contribute to growth, development, and emotional and physical well-being. Likewise, such social toxins as oppression, racism, and classism that devalue and disempower certain individuals and groups may serve to impede growth and well-being.

The ecological perspective builds on the traditional view that the central task of the social work profession is to maintain a focus on both the environment and the individual person's coping capacities, and that depending on the situation at hand, the goal of the social worker is to work to change again. The view is transactional in nature—improvement in an individual's coping and problem-solving skills, and an increase in an individual's self-esteem and sense of competence, will "facilitate

primary group functioning . . . and (positively) influence organizational structure's social networks and physical settings" (Germain & Gitterman, 1979, p. 20).

Fundamental Concepts of the Ecological Perspective Several specific concepts are fundamental to the ecological perspective and are viewed as expressions of person–environment transactions. These are human relatedness, competence, self-direction and self-esteem, adaptiveness, coping, life stress, and power and oppression. These are described in Table 1.3.

TABLE 1.3

The Ecological Perspective: Fundamental Concepts

Human relatedness, competence, self-direction and self-esteem	Human relatedness, competence, self-direction, and self-esteem are seen as interdependent, innate processes that first emerge through the earliest attachment relationships and continue to develop as life progresses and the individual's social networks expand. It is important to note that each of these qualities is seen as an expression of person–environment transactions—that is, each depends on attributes of both the person and the environment for its development. Each of these qualities first emerges during early childhood, as the individual first interacts with his/her primary caretakers and each continues to develop as the individual continues to interact with an ever-widening social and physical environment. Depending on the nature of these person–environment transactions the qualities of relatedness, competence, self-direction, and self-esteem may be supported and nurtured or inhibited in their development. **Relatedness** refers to the human being's inborn capacity to form attachments to other people; the ability to connect to others through attachments and other social affiliations is seen as a central component of optimal functioning throughout the life span. **Competence** is the ability to feel "effective" within one's environment; that is, it is the ability to feel self-confident, trust one's judgment, achieve one's goals and engage in positive relationships with others (Germain, 1991). **Self-direction** refers to the capacity to maintain a sense of control and purpose in the face of internal strivings and impulses as well as environmental pressures; that is, it is the feeling of personal power that enables one to make choices and decisions and to take effective action on behalf of oneself and one's primary groups. The ecological perspective also recognizes that the ability to be self-directing is highly influenced by one's social position and it recognizes the social worker's responsibility to help disempowered people restore their personal power. **Self-esteem** refers to the person's positive feelings about him/herself; these develop as the individual experiences feelings of relatedness, competence, and self-direction over time. Self-esteem incorporates the concept of self-efficacy, or a belief in one's effectiveness. One's self-identity or self-concept continues to develop throughout the life span, and these "are subject to greater opportunities and greater threats as the child moves into larger circles of relatedness where her or his personal and cultural characteristics will be appreciated or rejected by others" (Germain, 1991, pp. 26–27).

Adaptiveness	Basic to the ecological approach is the idea that human beings and their environments continually exert mutual influence to achieve maximum "goodness of fit"—one in which social networks and organizations, physical, cultural, political, and economic forces support peoples' inborn desire to grow and to achieve their goals. If the fit is not good, people may seek to make changes within themselves, in their environment or, in both. These changes are known as adaptations (Germain, 1991).
Coping capacity	Coping capacity is viewed as a transactional process that reflects the person-in-environment relationship. According to Germain (1991): Two major functions of coping are problem solving (what needs to be done to reduce, eliminate or manage the stressor) and regulating the negative feelings aroused by the stressor (Coyle and Lazarus 1980). They are interdependent functions inasmuch as each is a requirement of the other, and each supports the other. Progress in problem-solving leads to the restoration of self-esteem and to the more effective regulation of the negative feelings generated by the stressful demands. Progress in managing feelings and restoring self-esteem frees the person to work more effectively on problem solving … problem solving skills, although they are personal resources, require training by environmental institutions such as the family, the school, the church or temple, or the hospital. Similarly, the person's ability to manage negative feelings and to regulate self-esteem depends, in part, on social and emotional supports in the environment. Successful coping also requires additional personality attributes such as motivation, self-direction, which depends on the availability of choices and opportunities for decision making and action as well as access to material resources. (Mechanic, 1974a; White, 1974). (Germain, 1991, pp. 21–22)
Life stress	The ecological perspective emphasizes the idea that stress is not just a function of individual or environmental characteristics. It is, rather, a biospsychosocial phenomenon that emerges as a result of person–environment transactions. Attention is given to both the external and internal aspects of the stressful experience, including the environmental stressor (external), the physiological response (internal), and the resultant emotional and cognitive response. Additionally, the subjective aspects of the stress experience are highlighted; that is, depending on such factors as culture, age, gender, mental and emotional condition, and so on, the same situation may be viewed as stressful by some, exciting by others, and barely noticeable by still others Although some degree of stress is positive and necessary to challenge the individual to grow and develop, "problems in living" (Germain & Gitterman 1980) occur when the person's ability to deal with stressful events or situations is severely strained. According to Germain and Gitterman (1980), problems in living may arise from any of three interconnected aspects of life: (a) life transitions and/or new demands and roles that come with advancing development, (b) dysfunctional interpersonal processes in one's family or other personal social networks, or (c) demands of the physical and/or social environment, including problems related to organizational and community resources.

(Continued)

TABLE 1.3

The Ecological Perspective: Fundamental Concepts (Continued)

Power and oppression	The ecological perspective underscores the need for social workers to be mindful of value conflicts and culturally based assumptions "masquerading as knowledge" (Germain, 1991, p. 12). This implies the need for awareness of the impact of culture, ethnicity, racism, and oppression on human development and behavior. It calls for acknowledgment on the part of the practitioner of his/her own cultural biases and of the impact of issues related to social power and oppression on the human condition. For example, social power may be withheld from some groups on the basis of such characteristics as age, race, ethnicity, gender, religion, sexual orientation, social class, and/or a variety of physical traits and conditions. The abuse of power by dominant groups is related to such societal ills as poverty, unemployment, and inadequate social supports in education, health care, and housing. Inequities in the distribution of power define the contexts in which members of vulnerable groups develop and function—these contexts impose enormous stress on affected individuals and threaten their mental, physical, and social well-being.

Contemporary Perspectives: An Ecosystems Approach for the Postmodern Era

Despite some difference in origin, language, scope, focus, and applicability, the terms *social systems model* and *ecological perspective* are frequently used interchangeably. As previously noted, contemporary social work's perspective on human behavior and its relationship to practice integrates concepts from both social systems and ecological models to create what we will, for the sake of practicality, referred to as an ecosystems approach; this creates an overarching framework that provides a "systemic, contextual and transactional focus for defining problems and solutions" (Lightburn & Sessions 2006, p. 23). The approach has continued to evolve and has been increasingly influenced by a postmodern perspective that reflects an appreciation of the existence of multiple truths and multiple ways of knowing, based on context, culture, power differentials, and so forth. The contemporary ecosystemic view that human behavior and development can only be understood in the context of social relationships and broader social forces has transformed not only our thinking, but also our practice. Table 1.4 shows a multicontextual framework (Carter, 1993 in Carter & McGoldrick, 2005) for assessment that allows the clinician to "consider relevant issues in every system that may impact a client's situation" (Carter & McGoldrick, 1998, p. 16). The constructs described next represent some of the

TABLE 1.4

Social Work Assessment: Multiple Dimensions

The Individual	Immediate Household	Extended Family	Community and Social Connections	Larger Society
• Age • Gender roles and sexual orientation • Temperament • Developmental or physical disabilities • Culture, race, ethnicity • Class • Religious, philosophical, spiritual values • Finances • Autonomy skills • Affiliative skills • Power/privilege or powerlessness/abuse • Education and work • Physical or psychological symptoms • Addiction and behavioral disturbances • Allocation of time • Social participation • Personal dreams	• Type of family structure • Stage of family life cycle • Emotional climate • Boundaries, patterns, and triangles • Communication patterns • Negotiating skills • Decision-making process	• Relationship patterns • Emotional legacies, themes, secrets, family myths, taboos • Loss • Socioeconomic level and issues • Work patterns • Dysfunctions: addictions, violence, illness, disabilities • Social and community involvement • Ethnicity • Values and/or religion	• Face-to-face links between individual, family, and society • Friends and neighbors • Involvement with governmental institutions • Self-help, psychotherapy • Volunteer work • Church or temple • Involvement in children's school and activities • Political action • Recreation or cultural groups	• Social, political, economic issues • Bias based on race, ethnicity • Bias based on class • Bias based on gender • Bias based on sexual orientation • Bias based on religion • Bias based on age • Bias based on family status (e.g., single parent) • Bias based on disability • Power and privilege of some groups because of hierarchical rules and norms held by religions, social, business or governmental institutions • How does a family's place in hierarchy affect relationships and ability to change?

Source: B. Carter & M. McGoldrick (Eds.). (2005). *The Expanded Family Life Cycle: Individual, Family, and Social Perspectives* (3rd ed.). Boston: Allyn & Bacon/Pearson Education. Reprinted by permission of the publisher.

most salient components of contemporary thinking; these will provide a frame for the chapters that follow.

A Social Justice Orientation

The value of social justice has become increasingly prominent as an organizing principle of ecosystemic practice (Swenson, 1998). Several contemporary perspectives embody and support the relevance of a social justice orientation to the clinical process. As noted earlier, most postmodern perspectives on human behavior acknowledge the existence of multiple truths, and at some level they challenge our most fundamental notions about the meaning and construction of knowledge and reality. For example, social constructionist thought emphasizes that knowledge is socially created—that is, people create meaning by filtering information through the lens of their personal experiences, values, and previous understanding. Postmodernism emphasizes that "ideas that become privileged as knowledge are those that support powerful interests (and which powerful interests support)" (Swenson, 1998, p. 530). In other words, traditional mental health theories (having emerged from a white, heterosexual, Western European perspective) use the norms of the dominant majority groups as the standard against which other groups are to be understood. From this perspective, the experiences of minority group members seem "not quite normal" and require some form of explanation, whereas the majority group experience is perceived simply as normal and therefore not requiring any explanation at all (Green, 2007). Contemporary ecosystemic practice utilizes principles of feminist, profeminist, multicultural, and narrative family systems. Gay affirmative and disability affirmative therapies that view differences in ethnicity, race, gender, sexual orientation and ability as normal variations and emphasize that it is often societal discrimination and prejudice based on those variations that leads to a host of pathological symptoms (Green, 2007).

> This is the crux of the minority model, the shift in focus from personal, individual and problem in isolation, to group, environment, attitudes, discrimination—from individual pathology to social oppression. (Olkin, 1999, p. 28, as quoted in Green, 2007)

Worldview

The construct of worldview is central to postmodern, ecosystemic practice. Worldview has traditionally referred to beliefs, assumptions, and values that emerge from a specific cultural context (Ibrahim, 1984) and how these influence a client's cognitive structures, affects, and behaviors. Again, more recently, attention has been paid to variables, in addition to culture, that interface with worldview, including societal norms, educational level, social class, gender, religion, life stage, sexual orientation, and disability/ability status (Ibrahim, 1991, 1999). The ability to provide high-quality, effective services to diverse groups, rests on the understanding that they may each have diverse worldviews that affect their priorities,

interpretations of reality, perspectives on human nature, standards of normalcy, and ideas about what constitutes effective forms of help. An understanding of the client's worldview greatly increases the clinician's ability to provide useful (and ethical) assistance throughout all phases of treatment, including diagnosis, treatment planning, and implementation and evaluation of the effectiveness of services (Ibrahim, Roysircar-Sodowwsky, & Ohnishi, 2001).

Contemporary thinking also emphasizes the need for clinicians to recognize the relativity of their own worldviews and to examine their contextually based assumptions and values; this level of self-awareness is necessary for the clinician to provide effective services to diverse populations (Lightburn & Sessions, 2006; Sue, 2001).

Globalization and Multicultural Competence

As the population of the United States has become increasingly diverse, and as technology shrinks and rapidly transforms our world, the concept of multicultural competence has become a central consideration of social work practice from an ecosystemic perspective. The notion of multiculturally competent practice emerged from the recognition, noted earlier, that because our traditional theories of human behavior and approaches to practice grew from Western European (the psychodynamic movement) and American (reinforcement theories of American behaviorism) contexts, "the worldview they espouse as reality may not be that shared by racial/ethnic minority groups in the United States nor by those who reside in different countries" (Parham, White, & Ajamu, 1999, in Sue 2001, p. 796). The effects of this history have given rise to the recognition that, in comparison to the help given to majority populations, services to ethnic and racial minority communities have often been of significantly lower quality and that problems of accessibility, discrimination, and culturally inappropriate intervention have persisted. For example, formulating an accurate diagnosis is difficult within cultures; these difficulties are magnified when the clinician and client are from different social–cultural contexts and the clinician is unfamiliar with the contextual assumptions that the client has internalized. These assumptions may be particularly salient when they apply to the meaning and implications of a presenting problem, as well as what processes might be most effective in helping to resolve that problem (Castillo 1997; Lonner & Ibrahim, 1996). In addition, given the global influence of Western cultures, many countries rely on Western models as they develop systems of health care; for maximum effectiveness, these models must be adapted to provide care within the context of appropriate cultural norms.

In recent years, our understanding of the meaning of culture, identity, and minority group status has broadened. For example, Greene (1997) defined culture as "the behaviors, values and beliefs that characterize a particular social group and perhaps distinguish it from others" (p. xi). As a result, our concept of multicultural counseling has expanded beyond considerations related to race and ethnicity to include the ways that other components of identity such as age, socioeconomic class, religion, skin color, gender, regional affiliation, and sexual orientation affect worldview and the degree of privilege or discrimination one

experiences. Robinson (1999) discussed the idea of multiple identities that exist within the self and how these are affected by their position "in a society that differentially allocates privilege" (p. 000)

Empowerment and Strengths-Based Perspectives

Empowerment Perspectives These were discussed from a historical perspective earlier in this chapter, and the effects of powerlessness and oppression are briefly outlined in Table 1.3. (also see Chapter 7, "Communities and Organizations"). Because one's social position has a profound effect on one's access to resources, opportunities, and the ability to make proactive choices that affect one's life, family, and cultural group, and because certain vulnerable groups occupy social positions that block such access, disempowerment in the form of discrimination, racism, and oppression is a major contributing factor to emotional distress in minority populations (Germain, 1991; Schriver, 2005; Sue, 2001). Empowerment practice focuses on changing the distribution of power; it seeks to increase the ability of vulnerable individuals/groups to be self-directing, make choices, and act effectively to advance their own interests (Germain, 1991).

A Strengths-Based Perspective The concepts described earlier also underlie what has been termed the strengths-based perspective—in the words of Gibelman and Furman (2008, p. 199), "the strengths perspective looks to the power of people to overcome and surmount adversity (Rapp, 1998; Saleebey, 1999)." Once again, because traditional theories of human behavior and development were grounded in a White, European worldview, racial/ethnic differences were often interpreted as deficits, or abnormalities (Guthrie, 1997; Lee, 1993; White & Parham, 1990). A strengths-based perspective is one that seeks to identify the factors that support the resilience of people and groups across the life span and to build on these personal and social assets to promote growth and change (Hill, 1998). Intervention from a strengths-based perspective "is about more than managing symptoms and coping; it is about liberation, hope, resilience and transformation" (Lightburn & Sessions, 2006, p. 10)

Developmental Contextualism

Contemporary developmental theories use an ecosystemic framework and incorporate concepts from attachment, family systems, and other sociocultural theories to explain development across the life cycle (Carter & McGoldrick, 2005, p. 5). Building on the ecosystemic premise that the person and environment operate as a unified whole, current developmental thinking postulates that understanding human development requires understanding of "the endless interaction of internal and external and how the one is constantly influencing the other" (Bowlby, 1988, p. 000). A related and equally important proposition is that individual development can only be understood in the context of significant emotional relationships—that human identity is inseparable from one's relationships

with others. Here, healthy, human development necessitates finding a satisfactory "balance between connectedness and separateness, belonging and individuation, accommodation and autonomy" (Carter & McGoldrick, 2005, p. 9). Current thinking also posits that historical and social processes have a profound effect on development; for example, people who grew up in the era of the Great Depression were socially and emotionally shaped by historical forces and life experiences different from those experienced by the group known as the baby boomers.

Central to a developmental contextual approach is its consideration of positive development, adaptive behavior, and human resilience, as well as the belief that one must understand successful development before one can understand disordered development. This approach focuses attention on maturational milestones, life transitions, psychosocial factors, and the plasticity and reciprocity of the individual's relationship with his or her environment. Here, intervention aims to help move the individual from a maladaptive developmental pathway to a more adaptive one by strengthening positive, protective influences and reducing environmental risk. Key concepts of this approach are described next. Part II of this text examines human behavior across the life span from a developmental contextual perspective.

Attachment The concept of attachment is considered to be particularly significant in many developmental theories. The predisposition to develop affectional bonds is viewed as an innate need and capability that evolved for reasons of protection and survival and is now built into the human genome. Patterns of emotional regulation, strategies for behavioral control, the development of a sense of self-esteem, and self-reliance are developed within the context of the early attachment relationship(s) (Blatt, 1995 in Ollendick, p. 93; Cassidy, 1994). The child develops an internal working model of his/her primary attachment relationship that contains information about the self and the primary caregiver(s); the quality of these models then becomes predictive of later behavior in other relationship contexts (Elicker, Englund, & Sroufe, 1992 in Ollendick, p. 95) and, to some extent, the person's overall resilience or vulnerability to life stress.

Developmental Pathways In this view, the course of development is not fixed in a series of stages; rather, development is seen as occurring within a complicated system of social contexts. The nature of an individual's transactions with his or her environment shapes the developmental process, creating pathways along which development proceeds. Throughout the life span, the person experiences critical person–environment transitions, prompted by internal or external changes (for example, some form of trauma or the onset of a chronic medical condition). As long as environmental (especially relational) factors remain favorable, or improve, the person will continue along an adaptive pathway, one that supports resilience and healthy development. However, if the nature of the particular person–environment transaction is negative, thereby lessening the "goodness of fit" between the person and the environment, the person may move onto a more maladaptive pathway. This may lead, to a greater or lesser extent, to some form of vulnerability in development. Although the direction of development can

change at any point as one proceed through the life cycle, change becomes, to some degree, limited by the pathways one has already taken.

Risk and Resilience Central to current developmental thinking is the consideration of positive development, adaptive behavior, and human resilience, as well as the belief that one must understand successful development before one can understand disordered development. Contemporary developmental theories pay particular attention to the concept of resilience. This concept gained prominence as researchers, studying the effects of psychosocial risk, noticed that people who were exposed to the same risk factors were often affected differently by them. In other words, some people developed serious problems, others were only minimally affected, and still others seemed to become stronger as a result of the experience of adversity. "Resilience is not a trait or an endpoint. Rather, it is the cumulative acquisition and expression of emotions, ideas, capacities, behaviors, motivations, understanding and resources that lead a person to be more capable of overcoming or withstanding life's adversities and ordeals" (Saleebey, in Lightburn & Sessions, 2006 p. 48). Research has identified three basic types of resilience; these include the ability to recover from trauma, demonstration of competent behavior under prolonged stress, and the achievement of positive developmental outcomes under high-risk conditions (Kirby & Fraser, 1997, p. 13).

A cornerstone of the literature on resilience is the attention paid to risk and protective factors that exist within the individual, family, community, and wider culture. Risk factors are any influences that "undermine adaptation or amplify the vulnerability of the individual" (Saleebey, 2006, p. 48). These may include inherent vulnerabilities in the individual (for example, having a developmental disability), impairments in primary group functioning (for example, being raised by an alcoholic parent), or socioeconomic and institutional factors such as chronic poverty, lack of access to health care, or quality education (Davies, 2004). The term "risk accumulation" is used to describe the effects of multiple risks—that is, risk factors become increasingly pernicious as their number increases because they operate in transaction with one another, facilitating one another's negative effects, and increasing stress and vulnerability. Situations in which risk processes operate over time and in which few protective factors exist are predictive of the most negative outcomes (Davies, 2004, p. 66).

Protective factors are those elements, whether internal or environmental, that enhance coping capacity and the ability to adapt to life stress, and that generate opportunities for growth. (Davies, 2004; Saleebey in Lightburn & Sessions, 2006). Protective factors may include such individual qualities as self-efficacy, empathy, social problem-solving skills, reality testing, temperament, intelligence, sense of humor, and so forth and/or qualities of the environment such as a cohesive, supportive, and harmonious family and access to social resources such as quality education and comprehensive health care (Garmezy, 1993 in Lightburn & Sessions, 2006, p. 48; Kirby & Fraser, 1997 in Davies, 2004). As is the case with risk factors, protective factors appear to be most effective as their number and duration increase.

Summary

We began this chapter by providing a historical overview of the social work profession and the evolution of its theory base. We have explicated a framework that can be used to integrate the material presented throughout this text. This framework rests on ecosystemic principles and is informed by postmodern paradigms that emphasize social justice, multiculturalism, world-view, strengths-based and empowerment perspectives as well as principles of developmental contextualism. It provides the foundation for a model of social work practice that allows for multilevel assessment and intervention. "It is the social work practitioner's ability to see meaningful consistencies in the data derived from multiple sources and methods, to integrate and accurately explain contradictory assessment findings in a way that allows for a meaningful description of the client that separates the clinician from the technician" (Johnson & Sheeber, l999, p. 45). Our description of this framework sets the stage for the chapters that follow. The ideas presented in this chapter will form a thread; they will reappear in a variety of forms throughout the remainder of this book, and will serve to connect seemingly disparate issues. It will therefore be of great value to the student to periodically revisit this section for reference and clarification.