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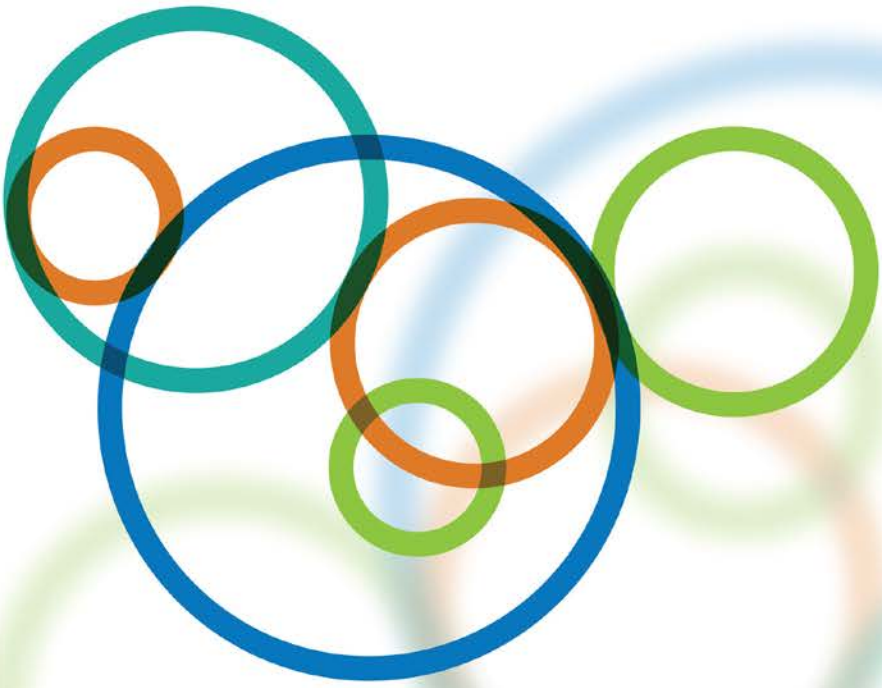
The Skills of Helping Individuals, Families, Groups, and Communities

EIGHTH EDITION



Lawrence Shulman

Council on Social Work Education Educational Policy and Accreditation Standards by Chapter

The Council on Social Work Education's Educational Policy and Accreditation Standards requires all social work students to develop nine competencies and recommends teaching and assessing 31 related component behaviors, listed as Educational Policy (EP) Competencies 1–9 below. The multicolor icons (see figure at right) and end of chapter "Competency Notes" connect these important standards to class work in the chapters identified below with bold blue type.

The 9 Competencies and 31 Component Behaviors (EPAS, 2015)	Chapter(s) Where Referenced
Competency 1—Demonstrate Ethical and Professional Behavior:	**All chapters**
a. Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to context	**1, 2, 5, 7, 11, 12, 16**
b. Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations	**1–4, 6, 8–11, 13, 15, 16**
c. Demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication	**1–7, 10–12, 14**
d. Use technology ethically and appropriately to facilitate practice outcomes	**1, 2, 15**
e. Use supervision and consultation to guide professional judgment and behavior	**1, 2, 4**
Competency 2—Engage Diversity and Difference in Practice:	**1–6, 8–13, 15, 16**
a. Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels	**1–3, 5, 6, 8–13, 15, 16**
b. Present themselves as learners and engage clients and constituencies as experts of their own experiences	**1–3, 5, 9–11, 13, 15**
c. Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies	**1–3, 8–11, 13, 15, 16**
Competency 3—Advance Human Rights and Social, Economic, and Environmental Justice:	**1, 8–10, 12**
a. Apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels	**1–13, 15, 16**
b. Engage in practices that advance social, economic, and environmental justice	**1–5, 7, 8, 11–13, 16**
Competency 4—Engage in Practice-informed Research and Research-informed Practice:	**1**
a. Use practice experience and theory to inform scientific inquiry and research	**1, 2, 6, 13**
b. Apply critical thinking to engage in analysis of quantitative and qualitative research methods and research findings	**1, 2, 4**
c. Use and translate research evidence to inform and improve practice, policy, and service delivery	**1, 2, 4, 7, 8, 13, 15**
Competency 5—Engage in Policy Practice:	**1, 2, 7**
a. Identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services	**1, 4, 6–11**
b. Assess how social welfare and economic policies impact the delivery of and access to social services	**1, 2, 4, 6–11**
c. Apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice	**1, 2, 4–16**

The 9 Competencies and 31 Component Behaviors (EPAS, 2015)	Chapter(s) Where Referenced
Competency 6—Engage with Individuals, Families, Groups, Organizations, and Communities:	**1, 2, 4**
a. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies	**1, 5, 14**
b. Use empathy, reflection, and interpersonal skills to effectively engage diverse clients and constituencies	**1, 4, 5, 8, 12–14**
Competency 7—Assess Individuals, Families, Groups, Organizations, and Communities:	**1, 2, 4, 13, 14**
a. Collect and organize data, and apply critical thinking to interpret information from clients and constituencies	**1–6, 8–16**
b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies	**1, 3–9, 13–16**
c. Develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies	**1, 3–5, 9–16**
d. Select appropriate intervention strategies based on the assessment, research knowledge, and values and preferences of clients and constituencies	**1, 3–5, 9–16**
Competency 8—Intervene with Individuals, Families, Groups, Organizations, and Communities:	**1, 2, 4, 13–15**
a. Critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies	**1–6, 8–16**
b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies	**1, 3–5, 7–9, 13, 14, 16**
c. Use inter-professional collaboration as appropriate to achieve beneficial practice outcomes	**1, 2, 4, 5, 7–13, 15**
d. Negotiate, mediate, and advocate with and on behalf of diverse clients and constituencies	**1–13, 15, 16**
e. Facilitate effective transitions and endings that advance mutually agreed-on goals	**1, 4, 10, 12, 15, 16**
Competency 9—Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities:	**1, 2, 4**
a. Select and use appropriate methods for evaluation of outcomes	**1, 4**
b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the evaluation of outcomes	**1, 4, 5, 13**
c. Critically analyze, monitor, and evaluate intervention and program processes and outcomes	**1, 4, 13, 14**
d. Apply evaluation findings to improve practice effectiveness at the micro, mezzo, and macro levels	**1, 4**

EIGHTH EDITION

Enhanced Edition: Updated throughout with the 2015 EPAS Standards

The Skills of Helping Individuals, Families, Groups, and Communities, Enhanced

EMPOWERMENT SERIES

LAWRENCE SHULMAN

University at Buffalo
The State University of New York

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To my wife Sheila, with love

Brief Contents

PART I

A Model of the Helping Process 1

1 An Interactional Approach to Helping 2
2 Oppression Psychology, Resilience, and Social Work Practice 51

PART II

Social Work With Individuals 73

3 The Preliminary Phase of Work 74
4 Beginnings and the Contracting Skills 108
5 Skills in the Work Phase 161
6 Endings and Transitions 242

PART III

Social Work With Families 279

7 The Preliminary and Beginning Phases in Family Practice 280
8 The Middle and Ending Phases in Family Practice 319
9 Variations in Family Practice 339

PART IV

Social Work With Groups 369

10 The Preliminary Phase in Group Practice: The Group as a Mutual-Aid System 370
11 The Beginning Phase With Groups 419
12 The Middle Phase of Group Work 474
13 Working With the Individual and the Group 545
14 Endings and Transitions With Groups 622

PART V

Macro Social Work Practice: Impacting the Agency/Setting, the Community, and Effecting Social Change 651

15 Professional Impact and Helping Clients Negotiate the System 653
16 Social Work Practice in the Community—Philosophy, Models, Principles, and Practice 699

PART VI

Practice Models and Evidence-Based Practice 749

17 Evidence-Based Practice and Additional Social Work Practice Models 750

Contents

Preface xxvii

PART I A Model of the Helping Process 1

CHAPTER 1

An Interactional Approach to Helping 2

Problematic Social Work Encounters in Early Sessions 2
The Interactional Social Work Practice Theory 4
Elements of a Practice Theory 5
Models, Skills, and Empirical Support 6
The Client–System Interaction 7
The Medical Model and the Paradigm Shift 7
First Interview With a Depressed Client 9
Integrating Assessment and Engagement: Behavior as Communication 10
Dynamic Systems Theory: The VISA Center Example 11
Intersectionality, Interlocking Oppressions, and Social Location 16
Fanon: The Oppressor Within and the Oppressor Without 16
Underlying Assumptions in the Interactional Model 18
Assumption of Symbiosis 19
Assumption of Obstacles in the Engagement 22
Assumption of Strength for Change 27
The Social Work Profession: A Brief Historical Perspective 29
The Roots of the Profession 29
The Function of the Social Work Profession 32
Social Work Skill and the Working Relationship 35
The Integration of Personal and Professional Selves 39
Research Findings 42
Study Design 43
Description of Study Participants 43
Study Limitations 43

Values and Ethics in Social Work Practice 44
Definitions of Values and Ethics 44
National Association of Social Workers Code of Ethics 45
Ethical Problems and Dilemmas 46
Factors That May Affect Ethical Decision Making 47
Chapter Summary 49
Related Online Content and Activities 49
Competency Notes 50 Updated with the 2015 EPAS Standards.

CHAPTER 2

Oppression Psychology, Resilience, and Social Work Practice 51

Oppression Psychology 52
The Oppression Psychology of Frantz Fanon 52
Internalized Negative Self-Images 53
Oppression Models and Inter- and Intracultural Practice 54
Indicators of Oppression 54
Resilience Theory and Research 59
Developmental Psychology Theory and Research 60
Resilience and Life-Span Theory 64
Cognitive Hardiness 65
Implications for Social Work Practice 66
Older People's Strategies and Ways of Coping 66
Chapter Summary 71
Related Online Content and Activities 71
Competency Notes 72 Updated with the 2015 EPAS Standards.

PART II Social Work With Individuals 73

CHAPTER 3

The Preliminary Phase of Work 74

Communications in Practice 75
Obstacles to Direct Communication 75
Examples of Indirect Communication in Practice 76
Preliminary Phase: Tuning In to the Self and to the Client 78
Tuning In to the Authority Theme 79
The Impact of Diversity and Culturally Competent Practice 83
Intercultural Practice: The Latino Example 86
Intracultural Practice 87

Elements of the Working Relationship: The Therapeutic Alliance 87
Making and Catching Mistakes: First Session of a Parents' Group 89
Affective Versus Intellectual Tuning In 91
Use of Supervision in Learning to Tune In 91
Tuning In to One's Own Feelings 93
Different Levels of Tuning In 94
Responding Directly to Indirect Cues 99
My Research Findings 102
The Impact of Agency Culture: The *Agency Client* 103
Avoiding Stereotyping: The ***Agency Client*** 104
Stereotyping a Group of Clients 104
Chapter Summary 106
Related Online Content and Activities 106
Competency Notes 106 **Updated with the 2015 EPAS Standards.**

CHAPTER 4

Beginnings and the Contracting Skills 108

"The First Meeting Is Really Important, You Know!" 109
The Dynamics of New Relationships 110
Factors Affecting First Interviews 113
Contracting in First Sessions 116
The Impact of Context on Practice 116
Some Additional Variant Elements in Contracting 119
Author's Research Findings on Contracting 120
Contracting Over Time 121
Contracting With Resistant Clients 123
Models for Assessment in the Beginning Phase 137
Social Work's Approach to Assessment and Diagnosis 137
Alternative Assessment Approaches 138
The Impact of the Use of Structured Assessment Instruments 139
A Model for Assessing Assessment Models 140
Culturally Diverse Practice in the Beginning Phase 141
Working With Mexican Americans 143
Working With African Americans 145
Working With American Indians 149
Working With Canadian Indians 150
Counseling Muslim Americans 151
Issues in Cross-Racial Practice 153
Education and Training for Culturally Sensitive Practice 154
Ethical and Legal Considerations in the Beginning Phase 155

Informed Consent 155
Confidentiality and Privileged Communications 156
Chapter Summary 159
Related Online Content and Activities 159
Competency Notes 159 Updated with the 2015 EPAS Standards.

CHAPTER 5

Skills in the Work Phase 161

A Model of the Work Phase Interview 162
Work Phase Summary 163
Preliminary Phase (Sessional) 163
Beginning Phase (Sessional) 163
Middle Phase (Sessional) 164
Endings and Transitions (Sessional) 166
Sessional Tuning-In Skills 167
Tuning In to the Client's Sense of Urgency 167
Tuning In to the Worker's Own Feelings 169
Tuning In to the Meaning of the Client's Struggle 171
Tuning In and the Worker's Realities of Time and Stress 172
Tuning In to the Worker's Own Life Experiences 173
Sessional Contracting Skills 174
Working From the Client's Sense of Urgency 174
Research on Sessional Contracting 176
Impact of the Medical Paradigm on Sessional Contracting 177
Elaborating Skills 178
Containment 178
Moving From the General to the Specific 180
Focused Listening: The Complex Communication Process 181
Questioning 182
Reaching Inside of Silences 183
Empathic Skills 186
Reaching for Feelings 190
Displaying Understanding of the Client's Feelings 191
Putting the Client's Feelings Into Words 192
Research on Empathy 193
Sharing the Worker's Feelings 196
Integrating the Personal and the Professional 196
When the Worker Is Angry With the Client 197
A Worker's Investment in the Success of the Client 199
A Worker Sharing Feelings Associated With Life Experiences 200
Boundary Issues in Sharing the Worker's Feelings 200

Sexual Transference and Countertransference Feelings 202
Research on Sharing Feelings 203
Making a Demand for Work 204
Client Ambivalence and Resistance 205
Integrating Support and Confrontation: The Empathic Demand for Work 207
Partializing Client Concerns 208
Holding to Focus 210
Checking for Underlying Ambivalence 211
Challenging the Illusion of Work 212
Pointing out Obstacles 213
Supporting Clients in Taboo Areas 214
Dealing With the Authority Theme 218
Identifying Process and Content Connections 221
Process and Content That Address the Authority Theme 221
Impact of the Worker's Emotions 222
Sharing Data 225
Providing Relevant Data 226
Providing Data in a Way That Is Open to Examination and Challenge 227
Providing Data as a Personal View 228
Helping the Client See Life in New Ways 229
Sessional Ending and Transition Skills 230
Summarizing 231
Generalizing 232
Identifying the Next Steps 233
Rehearsing 233
Identifying "Doorknob" Communications 235
Ethical and Legal Issues in the Middle Phase 236
Ethical Issues in Withholding Information 237
The Duty to Warn 238
Staying Up-to-Date With Evolving Circumstances and the Law 239
Chapter Summary 240
Related Online Content and Activities 240
Competency Notes 240 Updated with the 2015 EPAS Standards.

CHAPTER 6

Endings and Transitions 242

Making the Third Decision 242
General Difficulty in Ending Important Relationships 243
Ending the Worker–Client Relationship 243

The Dynamics and Skills of Endings 244
Flow of Affect in the Ending Phase 244
Timing and the Ending Phase 245
Stages of the Ending Phase 246
Denial 246
Indirect and Direct Expressions of Anger 248
Mourning 251
Trying It on for Size 254
The Farewell-Party Syndrome 255
The Skills of Transitions 255
Identification of Major Learning 256
Identification of Areas for Future Work 259
Synthesizing the Ending Process and Content 261
Transitions to New Experiences and Support Systems 262
Variations on Endings 263
Ending a Relationship That Never Really Began 263
Endings Caused by the Termination of the Worker's Job 267
Endings Caused by the Death of the Client 269
Suicide on a Caseload 271
Ethical Issues Associated With End-of-Life Decisions 276
Chapter Summary 277
Related Online Content and Activities 278
Competency Notes 278 Updated with the 2015 EPAS Standards.

PART III Social Work With Families 279

CHAPTER 7

The Preliminary and Beginning Phases in Family Practice 280

What Constitutes a Family? 281
Social Work With Families: Family Support and Family Counseling 282
Setting—Specific Work With Families 283
The Unique Issues Associated With Family Dynamics 283
Integrating Other Models and Approaches Into Family Practice 284
Selected Concepts From Family Therapy Theory 284
Psychodynamic Approach 284
Bowen Family Systems Theory 286
Freeman's Implementation of the Bowen Model and the Stages of Practice 286

Person-Centered Approach 287
Cognitive-Behavioral Family Therapy 287
Multisystemic Therapy Model 288
GLBT Clients and Their Families of Origin 289
Core Concepts Across Theories 290
Family Assessment Models 291
Families and the Organismic or Systems Model 291
Family Assessment Tools 292
The Preliminary Phase—Tuning In to the Family 294
Tuning In to a Recently Immigrated Greek Family 295
The Two-Client Concept and the Worker's Role 296
The Mediation Role for the Social Worker 297
Countertransference in Working With Families 299
The Beginning Phase: Contracting With the Family 299
The Problem-Oriented First Family Interview for the Beginner 300
Discussion of This First Family Session 304
The Impact of Culture and Community 306
Working With the Culture 307
Racism, Oppression, and the Native American Family 308
Research Findings on Race and Practice With the Native Population 308
Oppression, Resilience, and the Psychology and Sociology of People of Color 309
Chapter Summary 317
Related Online Content and Activities 317
Competency Notes 317 Updated with the 2015 EPAS Standards.

CHAPTER 8

The Middle and Ending Phases in Family Practice 319

The Middle Phase in Family Practice 319
A Framework for Analyzing a Family Session 320
The Work Phase Model 320
Dealing With Family Secrets 322
A Mother's Degenerative Illness: The Family Secret 323
A Middle Phase Family Session 324
The Record-of-Service Device 324
The Ending and Transition Phase of Family Practice 333
Goals of the Ending/Transition Phase 333
Emotional Reactions to the Ending Process in Family Counseling 334

Ending the Sessions Before They Are Finished 334
The Impact of Ignoring Issues of Race, Class, and Culture in the Ending Phase of Family Practice 335
Ending a Relationship With a Family Because of a Change in the Worker's Job Status 336
Chapter Summary 337
Related Online Content and Activities 337
Competency Notes 337 Updated with the 2015 EPAS Standards.

CHAPTER 9
Variations in Family Practice 339

The Impact of Setting and Service 340
A Family's Fear of Invasive Practice: Subverting the Contract 340
Rural Areas and Limited Services 341
The Child Welfare Setting 341
Work With Foster Parents 341
Potential Problem Areas in Work With Foster Parents 342
Work With Children in Residential Care 349
Work With Teen Parents and Their Families of Origin 354
Family Practice in the School Setting 356
Work With a Single-Parent Family 363
Practice With Armed Forces Families: On Base, Predeployment, and Postdeployment 364
Chapter Summary 367
Related Online Content and Activities 367
Competency Notes 367 Updated with the 2015 EPAS Standards.

PART IV Social Work With Groups 369

CHAPTER 10
The Preliminary Phase in Group Practice: The Group as a Mutual-Aid System 370

What Is Mutual Aid? 371
The Dynamics of Mutual Aid 372
Sharing Data 372
The Dialectical Process 373
Discussing a Taboo Area 374
The "All-in-the-Same-Boat" Phenomenon 376
Developing a Universal Perspective 376
Mutual Support 377

Mutual Demand 378
Individual Problem Solving 379
Rehearsal 380
The "Strength-in-Numbers" Phenomenon 383
Summary of the Dynamics of Mutual Aid 383
Obstacles to Mutual Aid 384
Identifying the Common Ground 384
The Complexity of the Group-as-a-Whole 384
Difficulty of Open Communications in Taboo Areas 385
The Role of the Group Leader 385
Preparing for Group Practice 387
Engaging Other Professionals in Developing the Group 387
Achieving Consensus on the Service 388
Identifying Group Type and Structure 391
Group Versus Individual Counseling 391
Agency or Setting Support for Groups 393
Group Composition, Timing, and Structure 394
Group Member Selection 396
Group Timing 401
Group Structure, Setting, and Rules 403
Section Summary 404
Interviewing Prospective Members 405
Strategizing for Effective Referrals 405
Group Leader Skills in the Initial Interviews 407
Screening Criteria for Group Practice 409
Ethical Issues in Group Practice 411
Guidelines for Practice in Group Work 412
Confidentiality and Group Counseling: Unique Dilemmas 416
Chapter Summary 416
Related Online Content and Activities 417
Competency Notes 417 Updated with the 2015 EPAS Standards.

CHAPTER 11

The Beginning Phase With Groups 419

The Dynamics of First Group Sessions 420
What Do We Know About First Group Sessions? 420
What Would We Like to Achieve—Our Valued Outcomes? 422
The Contracting Skills: Establishing a Structure for Work 423
Illustration of a First Group Session: The Couples' Group 426

The Initial Stage of the First Session 426
The Middle Stage of the First Session 438
The Ending and Transition Stage of the First Session 444
Recontracting After the First Session 448
Recontracting With Your Own Group 448
Coleadership in Groups 453
Reflective Practice in Group Coleadership 454
Positive Potential in Coleadership 455
Skill in Dealing With Coleader Conflicts in the Group 456
A Final Comment on Coleadership 459
Open-Ended, Single-Session, and Internet Online Groups 460
The Open-Ended Group 460
The Single-Session Group 463
Internet Online Groups 466
Telephone-Mediated Group Work 469
Single Purpose Groups: Bullying in the School as an Example 470
Chapter Summary 472
Related Online Content and Activities 472
Competency Notes 472 Updated with the 2015 EPAS Standards.

CHAPTER 12

The Middle Phase of Group Work 474

The Middle or Work Phase in Group Work 474
The Role of the Group Leader 476
Reaching for Individual Communication in the Group 476
Reaching for the Group Response to the Individual 480
Reaching for the Work When Obstacles Threaten 484
Avoiding Individual Counseling in the Group 485
Group Work Skill Factors in the Middle Phase 486
The Preliminary Stage 487
Sessional Tuning In 487
The Beginning Stage 488
Sessional Contracting 488
The Middle Stage 489
Flow of Affect Between the Group Members and the Leader(s) 490
Elaborating Skills 490
Empathic Skills 496
Sharing the Group Leader's Feelings 501
Making a Demand for Work 503

Supporting Group Members in Taboo Areas 510
Identifying Process and Content Connections 515
Sharing Data 517
Helping the Group Members See Life in New Ways 522
The Ending and Transition Stage 522
Summarizing 523
Generalizing 523
Identifying the Next Steps 524
Rehearsing 524
Identifying "Doorknob" Communications 525
Activity in Groups 527
Functions of Activity in a Group 528
Two Categories of Activity Groups 528
Activity Groups Where the Activity Is the Purpose 529
Activity Groups With Direct Therapeutic or Educational Purposes 530
Chapter Summary 543
Related Online Content and Activities 543
Competency Notes 544 Updated with the 2015 EPAS Standards.

CHAPTER 13

Working With the Individual and the Group 545

The Concept of Role in a Dynamic System 546
The Impact of Oppression on Social Role 546
Formal and Informal Roles in the Group 547
The Scapegoat 548
Strategies for Addressing the Scapegoating Pattern 555
The "Deviant" Member 556
Extreme Versus Mild Deviance 557
Reaching for the Underlying Message of Deviant Behavior 558
Deviant Behavior as a Functional Role 559
The Internal Leader 561
The Gatekeeper 565
The Defensive Member 567
The Quiet Member 569
Group Leader Strategies 570
The Monopolizer 574
The Group-as-a-Whole 576

Describing the Group-as-a-Whole 577
The Group as an Organism 578
Developmental Tasks for the Group 579
The Relationship to the Leader: The Authority Theme 581
The Bennis and Shepard Model—The Issue of Authority 581
The Group Leader as the Outsider 584
The Group Leader's Demand for Work 585
The Group Leader's Limitations 591
The Group Leader as a Caring and Giving Person 592
Authority Theme Summary 593
Group Member Relationships: The Intimacy Theme 594
Cohesion and Alliance to the Group-as-a-Whole 594
The Bennis and Shepard Model 595
The Stone Center: Intimacy and the Relational Model 599
Developing a Culture for Work 608
Norms and Taboos 608
Bion's Emotionality Theory 609
Helping Members to Develop a Structure for Work 614
Helping Group Members to Negotiate the Environment 616
The Homans Social Systems Model—Relating to the Environment 618
Chapter Summary 619
Related Online Content and Activities 620
Competency Notes 620 Updated with the 2015 EPAS Standards.

CHAPTER 14

Endings and Transitions With Groups 622

The Ending Phase of Group Practice 622
The Dynamics and Skills of Endings 624
Flow of Affect in the Ending Phase 624
Timing and the Ending Phase 626
Stages of the Ending Process 626
Denial 627
Anger 627
Mourning 628
Trying It on for Size 629
Farewell-Party Syndrome 629
Group Leader Strategies With Regard to Ending 630
Group Leader Strategies With Regard to Transition 630
The Group Leader Takes a Leave of Absence: Transitioning to an Interim Leader 631

Individualizing the Ending and Transition to Meet Individual Needs 632
Three Additional Group Illustrations 633
Ethical Issues Related to Endings 647
Chapter Summary 648
Related Online Content and Activities 649
Competency Notes 649 Updated with the 2015 EPAS Standards.

PART V Macro Social Work Practice: Impacting the Agency/Setting, the Community, and Effecting Social Change 651

CHAPTER 15

Professional Impact and Helping Clients Negotiate the System 653

Macro Practice 653
A Social Systems Approach 655
Toward a Unified Social Work Practice Theory 656
The Individual–System Interaction 657
Mediating the Individual–System Engagement 658
Confrontation, Social Pressure, and Advocacy 669
Establishing a Working Relationship With the System 674
Professional Impact on the System 675
Factors That Make Professional Impact Difficult 676
From Individual Problems to Social Action 678
Illustrations of Agency Change 679
Professional Impact and Interstaff Relationships 684
The Agency as a Social System 685
Problems Associated With "Process-Focused" Staff Meetings 687
Dealing With Process in Relation to a Problem or Issue 687
Impact on Relations With Staff at Other Agencies 694
Chapter Summary 697
Related Online Content and Activities 697
Competency Notes 698 Updated with the 2015 EPAS Standards.

CHAPTER 16

Social Work Practice in the Community—Philosophy, Models, Principles, and Practice 699

The Development of Community Social Work Practice 700
Empowerment-Oriented and Progressive Practice Models 701

Principles of Effective Community Organizing 702
Community Organizing Philosophy and Models 703
Grassroots Community Organizing 704
The Phases of Work in Grassroots Community Practice 706
The Preliminary and Beginning Phase of Community Practice 706
Rural-Based Community Organization Practice 709
The Use of the Internet in Community Practice 710
The Neighborhood as Community 712
The Role of the Worker in the Community 713
The Middle or Work Phase of Practice 714
The Ending/Transition Phase of Practice: The Milieu as Community 734
Social Workers and Social Action 743
Social Action in the Community 743
Advocacy Groups and Political Activity 746
Chapter Summary 747
Related Online Content and Activities 747
Competency Notes 747 Updated with the 2015 EPAS Standards.

PART VI Practice Models and Evidence-Based Practice 749

CHAPTER 17

Evidence-Based Practice and Additional Social Work Practice Models 750

Evidence-Based Practice (EBP) 752
Ethical Considerations, Clinical Judgments, and Practice Wisdom 752
Manualized Interventions, a Note of Caution, and the Issue of Sustainability 753
Motivational Interviewing (MI) 754
Stages of Change 755
MI Interventions 756
MI Research 757
Solution-Focused Practice (SFP) 764
Major Assumptions on the Nature of the Helping Relationship 764
Role of the Solution-Focused Group Leader 766
Defining Techniques 766
Cognitive-Behavioral Therapy (CBT) 768
Major Assumptions on the Nature of the Helping Relationship 768

Other Models and Theories 771
Feminist Practice 771
Feminist Practice Typology 771
The New Psychology of Women and the Relational Model 772
Indicators of Oppression in a Feminist Practice Model 775
Feminist Perspectives on Work With Other Populations 779
Research and Practice in Women's Groups 780
Working With Lesbians, Gays, Bisexuals, and Transgender Clients 781
The Oppression Perspective 781
Strategies for GLBT Sensitive Practice: The School Social Worker Example 782
Group Work With Gay, Lesbian, Bisexual, Transgender, Queer, and Questioning Clients 784
Religion and Spirituality 791
Definitions 791
Intervention Examples: The Spiritual/Religious Autobiography 794
Other Intervention Examples 794
Practice in Response to Trauma and Extreme Events 795
The Impact of a Traumatic Event: A Strengths Perspective 796
Crisis Theory and Crisis Intervention 797
Crisis Intervention Stress Management: A Group Example 798
Trauma Groups 799
Trauma Practice With the Active Military and Veterans: Addressing Posttraumatic Stress 802
Impact of Trauma on the Professional: Vicarious and Secondary Traumatic Stress (STS) 804
A Single-Session Vicarious Traumatization Model for Trauma Workers 804
Secondary Traumatic Stress (STS) in Child Welfare Practice 805
Impact of STS on Delivery of Services: The Child Welfare Example 807
Chapter Summary 811
Related Online Content and Activities 811
Competency Notes 811 **Updated with the 2015 EPAS Standards.**

Glossary 813

References 823

Case Index 835

Name Index 838

Subject Index 841

Council on Social Work Education Educational Policy and Accreditation Standards by Chapter

The Council on Social Work Education's Educational Policy and Accreditation Standards requires all social work students to develop nine competencies and recommends teaching and assessing 31 related component behaviors, listed as Educational Policy (EP) Competencies 1–9 below. The multicolor icons (see figure at right) and end of chapter "Competency Notes" connect these important standards to class work in the chapters identified below with bold blue type.

The 9 Competencies and 31 Component Behaviors (EPAS, 2015)	*Chapter(s) Where Referenced*
Competency 1—Demonstrate Ethical and Professional Behavior:	All chapters
a. Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to context	1, 2, 5, 7, 11, 12, 16
b. Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations	1–4, 6, 8–11, 13, 15, 16
c. Demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication	1–7, 10–12, 14
d. Use technology ethically and appropriately to facilitate practice outcomes	1, 2, 15
e. Use supervision and consultation to guide professional judgment and behavior	1, 2, 4
Competency 2—Engage Diversity and Difference in Practice:	1–6, 8–13, 15, 16
a. Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels	1–3, 5, 6, 8–13, 15, 16

b. Present themselves as learners and engage clients and constituencies as experts of their own experiences	1–3, 5, 9–11, 13, 15
c. Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies	1–3, 8–11, 13, 15, 16
Competency 3—Advance Human Rights and Social, Economic, and Environmental Justice:	1, 8–10, 12
a. Apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels	1–13, 15, 16
b. Engage in practices that advance social, economic, and environmental justice	1–5, 7, 8, 11–13, 16
Competency 4—Engage in Practice-informed Research and Research-informed Practice:	1
a. Use practice experience and theory to inform scientific inquiry and research	1, 2, 6, 13
b. Apply critical thinking to engage in analysis of quantitative and qualitative research methods and research findings	1, 2, 4
c. Use and translate research evidence to inform and improve practice, policy, and service delivery	1, 2, 4, 7, 8, 13, 15
Competency 5—Engage in Policy Practice:	1, 2, 7
a. Identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services	1, 4, 6–11
b. Assess how social welfare and economic policies impact the delivery of and access to social services	1, 2, 4, 6–11
c. Apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice	1, 2, 4–16
Competency 6—Engage with Individuals, Families, Groups, Organizations, and Communities:	1, 2, 4
a. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies	1, 5, 14
b. Use empathy, reflection, and interpersonal skills to effectively engage diverse clients and constituencies	1, 4, 5, 8, 12–14
Competency 7—Assess Individuals, Families, Groups, Organizations, and Communities:	1, 2, 4, 13, 14
a. Collect and organize data, and apply critical thinking to interpret information from clients and constituencies	1–6, 8–16

b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies	1, 3–9, 13–16
c. Develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies	1, 3–5, 9–16
d. Select appropriate intervention strategies based on the assessment, research knowledge, and values and preferences of clients and constituencies	1, 3–5, 9–16
Competency 8—Intervene with Individuals, Families, Groups, Organizations, and Communities:	1, 2, 4, 13–15
a. Critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies	1–6, 8–16
b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies	1, 3–5, 7–9, 13, 14, 16
c. Use inter-professional collaboration as appropriate to achieve beneficial practice outcomes	1, 2, 4, 5, 7–13, 15
d. Negotiate, mediate, and advocate with and on behalf of diverse clients and constituencies	1–13, 15, 16
e. Facilitate effective transitions and endings that advance mutually agreed-on goals	1, 4, 10, 12, 15, 16
Competency 9—Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities:	1, 2, 4
a. Select and use appropriate methods for evaluation of outcomes	1, 4
b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the evaluation of outcomes	1, 4, 5, 13
c. Critically analyze, monitor, and evaluate intervention and program processes and outcomes	1, 4, 13, 14
d. Apply evaluation findings to improve practice effectiveness at the micro, mezzo, and macro levels	1, 4

Preface

Introduction and Underlying Assumptions

The focus of this book is method—what social workers do as their part in the helping process. I believe that the dynamics of giving and taking help are not mysterious processes incapable of being explained. Helping skills can be defined, illustrated, and taught. The helping process is complex; it must be presented clearly and broken down into manageable segments. Theories and simple models need to be developed to provide tools for understanding and guiding interventions.

This book represents an effort to conceptualize and illustrate a generalist practice model without losing the detail of the specific ways that social workers practice. The term *generalist* has been used in different ways over the years, sometimes to refer to practice models so abstract and on such a high theoretical level that one has difficulty finding the social worker or client in the description. The focus here is not just on what is common about what we know, value, and aspire to, nor on our common models for describing clients (e.g., systems, strengths perspective, cognitive-behavioral, ecological, or psychodynamic theory), but on the common elements and skills of the helping person in action.

Underlying this approach is the belief that social workers need to be prepared to offer clients service in the modality (individual, group, family, community) that is most suitable to the client, rather than the one that is most comfortable for the worker. One goal of this book is to help the reader appreciate that once a level of skill is developed in working with individuals, it is possible to expand on that understanding and elaborate that skill when working with more than one person at a time (e.g., family, group, or community organization). A number of additional assumptions follow.

The Assumption of a Core (Constant) Element to the Helping Process

This book is based on the assumption that we can identify an underlying process in all helping relationships. This process and its associated set of core skills can be observed whenever one person attempts to help another. These dynamics and skills are referred to as the constant elements of the helping process. The reader will note how central concepts and skills appear first in the chapters on working with individuals and then reappear as the focus shifts to families, groups, communities, organizations, agencies, and even social action activity in pursuit of

social policy change in the agency, in the community, and on State and national levels.

For example, the importance of developing a positive working relationship, sometimes referred to as the "therapeutic alliance" in clinical practice, and the interactional skills required to develop this relationship cut across modalities of intervention (e.g., individual, family, or group work) as well as theoretical orientation (e.g., solution-focused therapy, cognitive-behavioral therapy, or motivational interviewing).

The impact of time on the helping relationship as well as on each individual contact also introduces constant elements. Understanding the helping interaction to have preparatory, beginning, middle, and ending phases helps to explain certain dynamics, such as the indirect ways clients may raise difficult issues at the start of a session as well as the phenomenon known as "doorknob therapy"—when clients reveal a powerful issue at the end of the session, sometimes literally as they leave the office.

Variant Elements to the Helping Process

As you read this book, these common elements and skills will become clearer and will be observable in any situation in which you see a social worker in action. Although there is a constant core to helping, there are also variant elements introduced by a number of factors.

For example, the reader will note the importance of the concept and skill of contracting in first sessions that is central to all helping relationships. The skills of clarifying purpose and the social worker's role, reaching for client feedback, finding the common ground between the two, and addressing issues of authority are of crucial importance to develop an initial structure that frees the client to begin the work. The idea that one must choose structure versus freedom is one of a number of false dichotomies—where we think we need to make a choice between two opposite ideas. In reality, a good structure—through steps such as contracting with a client—should create freedom for the social worker and the client, not restrict it.

While this is a core or constant element to practice, the manner in which the contracting takes place and the issues—or what I will call "themes of concern" to the client—will vary according to the impact of these variant elements.

These elements can include the following:

- The setting for the engagement (e.g., school, hospital, family counseling agency, child welfare agency, or community-action–focused organization)
- The modality of practice (e.g., individual or family counseling, group practice, community organizing, or policy advocacy)
- The age and stage of the client's life cycle (e.g., child, teenager, young adult, or elderly and retired)
- The particular life issues the client brings to the encounter (e.g., emotional and/or physical health issues, addiction, unemployment, physical or sexual abuse, poverty, posttraumatic stress from military or other traumatic involvements, or parenting concerns)
- Whether the client is participating voluntarily or involuntarily (e.g., the difference between a voluntary group for parents of teenagers seeking help

in dealing with their kids and a DWI group for clients mandated to attend by the court because of a driving-while-intoxicated conviction)

- Demographic elements that may interact with the social and/or emotional problems (e.g., race, ethnicity, sexual orientation, physical ability, or economic class)
- Whether the client is being seen in an agency or host setting (e.g., school or hospital) or in a private practice setting

The discussion of specific and detailed examples of practice in action, not just general case presentations, will help the reader to see both the constant and variant elements in all of these examples as well as many others that are common to our practice.

The social worker also brings personal elements to the process related to such factors as education and experience, personal life events, and the effectiveness of the support and supervision available to the worker. For example, there is some benefit to having been a parent when one is leading a parenting group. However, a skilled worker who understands that the process of mutual aid involves group members helping one another, and that the group leader learns at least as much from the group members as he or she teaches, can still effectively lead such a group. A social worker does not have to have "walked the walk" and "talked the talk" (i.e., been in recovery and participated in recovery groups such as Alcoholics Anonymous [AA]) in order to be helpful to a client struggling to begin or maintain the recovery process as long as the social worker is open to new learning from a range of sources (e.g., literature, supervision, workshops) as well as learning from the client.

Despite the varying aspects of practice, when we examine interactions closely, the similar aspects become apparent. This book addresses a range of helping situations in the belief that each social worker can incorporate the model into his or her own work context. In addition, findings drawn from my studies of social work practice, supervision, management, and medical practice—as well as the research of others—provide empirical support for the importance of the core skills that make up the constant elements of practice. The book not only reviews "evidence-based" practice models, when available, but also draws on practice wisdom—what I refer to as emerging models—that still awaits research support that would qualify these approaches to be formally described as evidence-based.

The Skills of Professional Impact

An additional assumption in this text is the existence of common elements that help make us more effective when we work with other professionals. This area of skill development is termed *professional impact*. The argument will be made, and illustrated using numerous examples, that the skills of direct practice (e.g., contracting, listening, the ability to empathize, and being honest with one's own feelings) are just as important in work with other professionals (e.g., teachers, doctors, judges, other social workers) and systems (e.g., schools, hospitals, courts, agencies) as they are in work with our clients.

These skills and others are important when one is mediating a client–system engagement (e.g., the high school student in conflict with a teacher) or is actively advocating for a client to receive services (e.g., those withheld by a health insurance company). In fact, these skills take on an increased importance when

working with other professionals. A social worker who wants another professional, perhaps from another discipline, to understand and emphasize with a client can be more effective if the worker can understand and empathize with the other professional. The argument will be made in this book that one must at times "speak loudly," that is, confront other systems, while also being prepared to "speak softly," that is, work effectively with other professionals. A range of encounters illustrates the professional impact skill model developed in this book.

Although the subject of professional impact is addressed and illustrated in detail in Chapter 15 dealing with macro practice (working with larger systems), it is not possible to address practice with individuals, families, and groups without introducing the importance of the social worker's role in dealing with the system. Therefore, the idea of the system (e.g., agency, school, hospital) as the "second client" is a theme in all of the chapters leading up to the more detailed discussion in Chapter 15.

Organization of the Book

To simplify the complex task of describing the core methodology, a single frame of reference described as the interactional model (IM) is presented. Included is a description of a theory of the helping process, several models (middle-range descriptions) that connect theory and practice, the identification of skills needed to put the framework into action, and empirical data that support the major elements of the framework. A summary of other models, both evidence-based and emerging models, is provided in Chapter 17 to help place the interactional model into context. Elements of other practice models in Chapter 17 are also referenced throughout the text as examples of how concepts can be integrated into a single framework to both elaborate and strengthen the approach to practice.

In considering how to organize this book on the issue of where to present theory, an argument could be made to place the content of Chapter 17, a theory chapter, in Part I. On the other hand, a case could also be made for including less theory in Part I while moving as quickly as possible to the practice skills and illustrations. Based upon my own experiences as a practice teacher, I decided to add greater emphasis in the early chapters on brief descriptions of the other models as I drew upon them for their useful concepts and interventions. The reader will have to wait until Chapter 17 for a fuller discussion of the evidence-based and emerging models now available to social workers; however, it is quite possible for someone to read Chapter 17 earlier.

Organization of the Six Parts of the Book

Part I of the book consists of two chapters that introduce the major theoretical constructs of the interactional model and set the stage for the text. An introduction to the impact of values, ethics, law, and so forth on practice is also provided, as is a discussion of the types of ethical dilemmas a social worker may face and methods for resolving them if possible. The four chapters in Part II focus on work with individuals, examining this process against the backdrop of the phases of work: preliminary, beginning, work, and ending/transition phases. Illustrations

in these chapters, drawn from a range of settings, point out the common as well as variant elements of the work.

In Parts III and IV, we examine the complex issues of working with more than one client at a time. These parts focus on social work with families and groups, respectively. The common elements of the model established in Part I are reintroduced in the context of work with families and groups. These sections are also organized using the phases of work; once again, we examine the unique issues involved in the contexts of preparing, beginning, working, and ending with families and groups.

Part V moves from the micro or clinical level to include two chapters that focus on the macro level, exploring the skills involved in work with communities and with people in the larger systems and organizations that are important to clients. Chapter 15 illustrates the dynamics and skills involved in influencing one's own agency or setting as well as other organizations. Many of these ideas and strategies are introduced and illustrated in earlier chapters as integral elements of any social worker's role. Chapter 16 introduces the core concepts of community and principles of community practice. The chapter provides examples that illustrate how social workers help members of a community (e.g., a neighborhood, a housing project, or a ward group in a psychiatric hospital) to empower themselves by focusing on community issues that relate to their personal concerns. Conversations with teachers, doctors, and politicians help illustrate effective impact on other professionals. The social worker's responsibility to engage in social action within the community and in political action is also highlighted in Chapter 16. Once again, the core skills and the impact of time and the phases of work are used as organizing principles.

Part VI of the book contains a final chapter that provides an overview of a number of different models of practice. This allows the reader to put the interactional model into context. Concepts from evidence-based models such as cognitive-behavioral therapy (CBT), solution-focused therapy (SFT), and motivational interviewing (MI) are presented and illustrated with individual and group examples. An introduction to the concept of evidence-based practice as well as the criteria for evaluating models puts the three presented models in context.

Additional models that have emerged from research and practice wisdom, but do not yet qualify as evidence-based, are presented in the second part of Chapter 17. These include: self-in-relation, feminist, psychodynamic, brief treatment, religion and spirituality, trauma and extreme events, mindfulness, and social work with lesbians, gays, bisexuals, and transgender clients. Also addressed are models for dealing with secondary trauma experienced by helping professionals. Many concepts from these models are introduced and incorporated throughout the earlier chapters wherever they can help the reader understand and practice more effectively. In Chapter 17, the models themselves come to the foreground for a more in-depth discussion.

What's New in This Edition?

In approaching this edition revision, I was fortunate once again to have input from a number of social work faculty, solicited by my publisher, some of whom use the book for their classes and others who currently do not. I have been able

to incorporate a significant number of suggestions, and I am grateful to the reviewers who took the time to respond. Of course, I could not integrate all of the suggestions, especially when some were inconsistent with my assumptions and practice model or conflicted with other reviewer suggestions. A brief list of some critical changes as well as a discussion of the changes follows.

- A greater emphasis has been placed on the impact of setting with specific sections dealing with the impact of working in child welfare, health and mental health settings, addiction treatment settings, and school social work. Each of these sections begins with a discussion of what social workers do in the particular setting.
- There is an updating of the research findings including those related to evidence-based practice and how they can be integrated into a generalist framework.
- The discussion of practice models includes additional content on evidence-based practices, feminist practice, religion and spirituality, mindfulness, working with LGBT clients, and practice in response to trauma and extreme events.
- There is an expanded discussion of the role and skills of the social worker when advocating policy changes with attention to the importance of political involvement on the local, state, provincial, and national levels. A discussion of the views of C. Wright Mills (1959) that suggest the connections between public issues and private troubles provides a philosophical and theoretical basis for this social work role.
- The rapid emergence of social media interactions for both children and adults has also added sources of strength as well as serious threats particularly for children. The significant increase in bullying, both in person and cyber-bullying, related to high-profile suicides of students is integrated into the discussion of school social work. Findings from my own three-year project, working with students suspended from the Buffalo, New York, school system for violence, weapons possession, and drug abuse, are included. In addition, a discussion based on a New York State–funded school violence prevention project I direct, providing services in an inner-city Buffalo elementary-middle school, illustrates this important and emerging social work role.
- The first chapter has an expanded discussion of paradigms and paradigm shifts, providing a more detailed description of the comparison between the four-step medical model (study, diagnosis, treatment, and evaluation) and the interactional model.
- Finally, expanded attention to the dynamics and skills involved in inter- and intracultural practice is included under the concept that these issues may always be evident in practice relationships and if not dealt with can be significant obstacles to the development of the working relationship (or as it is now described in the literature as the therapeutic alliance). In addition to population groups discussed in the previous edition, attention to the unique issues faced by Muslim Americans and Muslim immigrants has been included.

Evolving Practice Knowledge in Response to Disasters

The seventh edition of this book was published in 2012. Since that time, social workers have continued to deepen their understanding and skill in many emerging practice areas. The changes in the nature of practice in response to the AIDS and other epidemics, homelessness, the elderly, problems of addiction to crack cocaine and other substances, the powerful impact of economic changes including loss of jobs and loss of homes experienced in the still recent mini-depression, and sexual violence in society and in the military remain at the forefront of practice. The impact of posttraumatic stress and other emotional and physical problems experienced by soldiers returning from both wars has finally received a well-deserved increase in attention and treatment. Our understanding of the effects of community traumas—such as 9/11, the Katrina hurricane, the shooting of students and teachers at Sandy Hook elementary school in Newtown Connecticut, the deep oil drilling disaster in the Gulf of Mexico—and the accompanying devastation is growing, as are our strategies for responding. Work in each of these areas has also changed at a rapid pace, as new understanding of the issues has led to new strategies for intervention.

Current Issues Affecting Practice

In addition, clients and social workers have been impacted by the implementation of significant social policies, such as managed care and welfare reform, and now the implications of the recently passed Affordable Health Care legislation often referred to as "Obamacare." These continue to profoundly affect the lives of clients and the nature of our practice. Many of these major social changes have also challenged our profession to consider professional ethical issues that have arisen, such as our responsibility to provide end-of-life care or how we can ethically work within restrictions raised by continued legislation and court challenges in respect to abortion and other issues. Illustrations drawn from these areas bring practice theory closer to the realities of today's students and practitioners. Finally, an expanded body of knowledge with respect to work with lesbian, gay, bisexual, and transgender (LGBT) clients is also included.

As in each of the earlier editions, this book shares theories and constructs about human behavior—some supported by research, others drawn from experience in practice—when relevant to specific practice issues. In this way, what is known about the dynamics of helping, oppression and vulnerability, resilience, group process, substance abuse, family interaction, the impact of critical social and personal events, and so on is directly linked to the worker's interactions with the client and with relevant systems.

In addition, an expanded emphasis on the emerging research on secondary trauma as it impacts social workers, both the immediate trauma of working with clients in response to major crisis (e.g., Sandy Hook) as well as the accumulative trauma of working with clients over time on issues such as extreme emotional, physical, and sexual abuse, is included. A key concept is that social workers cannot attend effectively to the needs of others if their emotional and physical needs are ignored. My work on supervision and the "parallel process" is more fully incorporated suggesting that how front-line social workers are supervised will have a profound impact on their work with clients. In addition, the crucial mutual-aid support that workers can get from peers is discussed. The impact of stressors on front-line supervisors, for example, in child welfare, is also addressed.

Integration of Interactional Research

My research and theory-building work (Shulman, 1991), designed to develop a holistic theory of practice, is integrated into this edition. This theory recognizes the complexity of social work practice. Focusing solely on the social worker–client interaction ignores many factors such as supervision, availability of resources, client motivation and capacity, the impact of cost-containment efforts, and the effects of trauma on the client and secondary trauma impact on the worker (e.g., death of a client). Chapter 1 contains a description of these studies and their central findings.

This book systematically addresses these findings along with other elements of practice. It also updates our current knowledge base of research findings from the work of other researchers both within social work and in related professions. All too often professions operate as if in an information silo, only reading their own professional literature, for example, without integrating knowledge developed by related professions. My experiences as cofounder and co-chair of a five-year international and interdisciplinary conference on clinical supervision, funded by the National Institute of Drug Abuse, and as coeditor of a clinical supervision journal have brought me into close professional contact with a number of outstanding colleagues from related professions (e.g., psychology, counseling, nursing, and marriage and family counseling). This joint work has strengthened my belief in the need to incorporate related models and research where appropriate.

Strengths and Resiliency Perspectives

The book also continues to build on a strengths and resiliency perspective when considering practice with oppressed and vulnerable populations. Social workers not only need to understand the socioeconomic factors that contribute to individual, family, and community problems but also must recognize, understand, and respect the existing strengths and resiliencies that have helped people cope. The major ideas of this socially oriented framework for understanding individual, family, group, and community behavior are presented in the first chapter of the book and then illustrated with appropriate examples throughout the text. The material on this topic has been updated to reflect our current knowledge in these areas.

Evidence-Based and Emerging Models

This concept of working with clients' strengths is continued and expanded in this edition and incorporates promising new emerging models and updated research (e.g., the importance of religion and spirituality) and evidence-based practices that have been identified as consistently helpful to different populations (e.g., motivational interviewing, cognitive-behavioral therapy, and solution-focused therapy). In addition to discussing and illustrating these models and intervention strategies in work with individuals and families, the discussion of evidence-based intervention in groups has been significantly expanded.

In keeping with the importance of support in supervision for front-line workers, findings in relation to the use of evidence-based practices in supervision are also discussed. In both direct supervision and direct practice, the argument will be made for an integrated model that draws on more than one theory and builds a practice model for each social worker that expresses his or her own artistry. The

false dichotomy between science and art is discussed with the position taken that science should increase our personal artistry rather than restrict it. The problem with sustainability in implementing evidence-based practices, as noted by the NIH, will be partially attributed to overly strict adherence to protocols that restrict rather than free the social worker's practice.

I also take the position that the adoption of any one model to fit all situations and clients is not advocated. It can be seductive, especially for students or beginning practitioners, to try to achieve some level of certainty in their work. It is part of human nature to try to come to closure and to avoid or ignore ambiguity in a quest for certainty. However, this effort can lead to trying to fit the client to the model rather than responding with an intervention that fits the client.

An alternative suggested in this book is to use concepts, theories, and intervention strategies from a range of evidence-based practices in designing and implementing a framework that fits the client, the setting, the modality of practice, the problem, and so forth, making effective use of some of the excellent concepts and interventions that are proving to be helpful.

Textbook Features

A major feature in this edition is the inclusion of Practice Points and Practice Summaries within the text. I have used the term **practice points** in bold at the start of a paragraph that contains a discussion of the important ideas that are illustrated in the example that follows. I have used the words **practice summary** at the start of a paragraph that follows a practice example. These two additions should make the connections between the practice model and the illustrations that follow or precede it stand out more clearly to the reader. Thus, even in the longer examples, the reader will have a concurrent discussion and analysis of the practice excerpts.

A reference list and glossary are provided at the end of the book. In addition, subject, author, and case example indexes are provided. This will allow for quick access to specific material. For example, the subject index will direct readers interested in adolescents to all of the places in the book that address that age group. Readers could also go to the case example index and find references to the case material that involves adolescents, whether in individual, family, group, or community work.

The book is intended to address the practice needs of the foundation-year social work student in either a bachelor or master of social work program. It is substantive enough to serve as a text for a full-year practice course. It is designed so that it can be used over a number of courses, starting with a one-semester practice course and then continuing in method-specific courses. For example, the depth of discussion and the large number of examples in the book and online make it useful for advanced courses, such as one on group work. (Note: The group practice described in this model is presented in detail in this author's book entitled *Dynamics and Skills of Group Counseling,* Cengage, 2011.)

The more experienced practitioner will also find this book helpful for continued learning. It provides models that help articulate concepts that the practitioner may have already developed through experience in practice. Using these models, any practitioner can become more systematic and effective. A clearly developed framework will increase consistency and help explain why some sessions go well and others do not.

Additional Resources for the Eighth Edition

Additional resources have been provided for this edition for both the student reader and the instructor.

Student Ancillaries

There are two significant video student supplements to this edition available on MindTap at www.CengageBrain.com. These videos provide the student with illustrations of the identified skills as well as excerpts from a workshop I have conducted.

The first program, entitled *The Interactive Skills of Helping* (ISH), was produced by two of my colleagues, Mark Cameron and Denise Krause, with the production assistance of Steven Sturman. The program contains role-play excerpts that illustrate the core skills, such as tuning in and contracting. For each skill, there are three segments. The first demonstrates the skill in a role-play graciously acted out by University at Buffalo colleagues and students. A variety of worker–client situations provide the substance of the practice. By way of contrast, the second excerpt, called "the blooper," demonstrates lack of the skill. The third element is a brief discussion and debriefing between the "worker" and me, exploring her or his thinking and feelings during the previous two segments. This can also serve as an illustration of a clinical supervision process. (For a discussion of this Interactional Model in the supervision process, see Shulman, *Interactional Supervision,* 3rd edition, NASW Press, 2010.)

A second video, entitled *Engaging and Working with the Hard-to-Reach Client* (EWHRC), shows excerpts from an interactive workshop I conducted with a volunteer group of child welfare workers. Although the examples come from child welfare, the principles discussed can easily be applied to other populations. The workshop is organized using the phases-of-work framework that provides structure for this text. The workshop segments combine a presentation by me, discussion, detailed case examples, and an illustration of the mutual-aid process as participants support one another. In many ways, the workshop is an example of an educational mutual-aid support group, with the workshop leader attempting to demonstrate many of the dynamics and skills of the interactional model in his role as teacher.

To become familiar with the contents, the reader should first view the welcome section of the first program and the introduction section of the EWHRC program, as well as the table of contents of both.

Instructor's Ancillaries

An online Instructor's Manual, Test Bank, and Microsoft PowerPoint® presentations slide show developed by the author are available on the instructor's companion website at www.CengageBrain.com.

Finally, Some Advice to Social Work Students

While serving as Dean at the University at Buffalo School of Social Work for 6 years, I gave the same advice to each of our master of social work graduating

classes. I told them that I thought we would have done our job as faculty well if we accomplished the following:

- Equipped them with a beginning professional understanding and skill level for practice
- Helped them to understand that they needed to tolerate ambiguity and stay open to new ideas so as not to come to premature closures
- Taught them how to continue their learning using client feedback, research findings, their supervisors, and their colleagues, both from within the profession and from other disciplines
- Helped them to understand that, as social workers, they always had two clients: the one(s) they worked with directly as well as their second "client"—the agency, the host setting (e.g., school or hospital), the community, the political systems, and the social policies that powerfully impacted their clients
- And finally, challenged them to see their professional development as a lifelong task, during which they would not be afraid to risk, to learn from mistakes, to shorten the distance between when they made a mistake and when they returned to the client to correct the mistake, and to continue to grow by making ever more sophisticated mistakes

I share these same suggestions with the readers of this text, who may just be embarking on their exciting and satisfying careers as professional social workers.

Acknowledgments

I would like to acknowledge the many people who contributed to this book. William Schwartz first described the interactionist perspective on which much of my work has been based. Bill's substantial body of work initiated a paradigm shift for our profession and was the first to introduce to social work the ideas of mutual aid, contracting, the demand for work, and other concepts. He died in 1982 and is still missed; however, he remains very much alive in this text.

I would also like to thank my wife, Sheila, who has always been supportive of my work in more ways than I can say.

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PART I

A Model of the Helping Process

Part I consists of two chapters that introduce and illustrate the major themes of the interactional approach to social work practice. Chapter 1 sets the stage for the rest of the book with a discussion of the underlying assumptions of the model, a brief history of the profession, and the importance of integrating the personal and professional selves by rejecting the false dichotomy between the two. Finally, a new section introduces the concept of paradigms and paradigm shifts. I will suggest it is time to abandon the medical paradigm—the four-step model borrowed from medicine consisting of study, diagnosis, treatment, and evaluation—and consider a more interactional approach. Chapter 2 explores two central theories of human behavior and the social environment: an oppression model and one that focuses on the client resilience that informs our practice. Other theoretical frameworks are integrated in the chapters that follow.

CHAPTER ONE

An Interactional Approach to Helping

CHAPTER OUTLINE

Problematic Social Work Encounters in Early Sessions

The Interactional Social Work Practice Theory

The Client–System Interaction

The Medical Model and the Paradigm Shift

Underlying Assumptions in the Interactional Model

The Social Work Profession: A Brief Historical Perspective

The Function of the Social Work Profession

Social Work Skill and the Working Relationship

The Integration of Personal and Professional Selves

Research Findings

Values and Ethics in Social Work Practice

Problematic Social Work Encounters in Early Sessions

In the hundreds of workshops on practice I have conducted over the past years, a number of common problems are usually raised by participants. These are the moments when experienced, novice, and student social workers feel at a loss on how to respond. Some examples follow:

- A young, unmarried social worker is having her first interview with a middle-aged mother of six children who is having parenting problems when the client suddenly turns to her and asks: "And how many children do you have?" Having none, and feeling defensive, the worker responds by saying, "We are here to talk about you, not me." The social worker can then sense the mother shutting down.
- A social worker with some experience but new to working in a substance abuse recovery agency starts a group first session for men who have been mandated to attend by the court, or go to jail, and finds all of the men staring ahead with arms folded sending a nonverbal signal about not wanting to be there. He wants to get some conversation going but, after introducing himself and explaining

the purpose of the group, is greeted by silence. He wonders if he should have brought a film!

- A social work first-year student is assigned to lead an *anger management* group in a middle school for students who have been referred by their teachers for behavioral problems but can't get past the first few minutes because the students respond to his opening statement with loud, boisterous, angry, acting out behavior demonstrating exactly why they were referred to the group. The assistant principal looks into the room and asks: "Do you need some help controlling these kids?"
- A new social worker in a hospital stops in to see a 90-year-old female patient to ask if she needs any help from social services. After a nice conversation, as the worker is about to leave, she asks if the patient would like to speak with her again the next day. The woman says she would like that very much, "God willing!" As the social worker walks to the elevator, she says to herself: "Oh, my God, she doesn't know if she will be alive tomorrow."
- An African American, male, child welfare worker in the protection unit of a child welfare agency is assigned to visit a Caucasian family in a mostly White, working-class neighborhood as a result of an anonymous telephone call suggesting parental neglect. The wife responds to his questions referring to him as "Sir." After a few minutes, the silent husband says to the wife, with a sarcastic tone: "You don't have to call him sir." The social worker feels angry at what he perceives as a racist comment but keeps going as if he did not hear it. When he discusses the home visit with his Caucasian supervisor, he does not mention the husband's comments.
- A Latina worker meets with a Latina client for a first session in an agency in which she is the newest and only Hispanic staff member. After introductions, the client says: "I am glad you are my worker because you know these other workers I have met here don't understand our people." The worker senses the effort to make an alliance but is not sure how to respond. Her feelings are compounded by her reactions to her first few agency staff meetings when she also felt the staff did not understand Hispanic clients.
- At a first family counseling session the father reports, with anger, examples of his teenage daughter's misbehaviors. The mother sits silently staring at the ground. The daughter looks close to tears. The father demands of the worker how long it will take for the worker to *fix* his kid. The worker is thinking, "With a father like this I'd be acting out as well."
- The community organization (macro) social work student is assigned to help develop a tenants' association in a public housing project. After door-to-door recruitment, a large group of tenants arrive for the first meeting and share angry stories of mismanagement and bad treatment by the staff and the housing manager. After listening and acknowledging the strong feelings, the social worker asks for volunteers to form a tenants' committee to address the problems. The request is greeted with silence. The social worker responds: "Well, to get started, maybe I should speak to the manager."
- Family support workers from a family counseling agency attend an interdisciplinary meeting with professionals from the referring child welfare agency, the clinic psychologists working with the child, and the visiting nurse meeting with the mom once a week. From the start of the meeting,

it is clear that each discipline has its own ideas of how to assess the issues and develop an appropriate treatment plan. The social worker is frustrated at what she experiences as a subtle battle over "who owns the client?" The actual conversation is an "illusion of work" with nothing real happening. The social worker leaves frustrated by the meeting and no further ahead in figuring out how they can all best help this client.

- The social worker has a new client—a teenage boy referred by the school—who responds to every question in the first session with either a "yes" or a "no" without elaboration. It feels to the worker like pulling teeth.
- A hospital-based group for parents dealing with children who have a serious illness meets every week, but as soon as the discussion gets close to painful feelings, one parent takes the conversation off to what seems like an unrelated topic and monopolizes the meeting. The other parents are obviously frustrated, as is the group leader.

These and many other specific examples are addressed in this book in an effort to understand the process (the interaction) in new ways and to develop strategies for the social worker to respond more effectively. In each case, there is a "next step" that can be taken by the social worker that has the potential to move the work ahead assuming the worker can reach the part of the client, even the mandated clients required to attend, ready to change. These interventions are guided by an interactional practice theory that can provide a structure for analyzing issues and responding effectively.

This chapter introduces the central ideas of this interactional social work practice theory. First, a brief discussion of the process of theory building in social work will place this effort in context. Clients will be viewed in a dynamic interaction with many important social systems, such as the family, peers, school, and hospital. This chapter also presents the underlying assumptions about the nature of the relationship between people and their social surroundings.

Our discussion of the assessment process will center on a strengths perspective rather than on client pathology (one version of the medical model). The role of the social work profession in mediating the individual–social engagement will be traced to the roots of the profession, which has historically been concerned with both private troubles and public issues.

Social work practice skill will then be described as the method by which the social worker strives to develop a positive working relationship with the client, currently referred to in the literature as the therapeutic alliance, a relationship that allows the social worker to be helpful. The impact of the social worker's personal self—that is, the effect of his or her feelings, ethics, or values—on his or her professional practice will also be examined. In addition, the chapter will explore the concept of *paradigms* and *paradigm shifts*, suggesting the need to shift from the traditional four-step medical model way of thinking about practice to a more dynamic and interactional approach.

The Interactional Social Work Practice Theory

This book builds on the interactional model of social work practice, which draws on a number of diverse theories that guide the helping professions. By the late


EP 6a

1980s, the helping professions were in what Kuhn described as a *pre-scientific stage* (1962). The social work profession had just begun to use theories to translate empirical research into practice. In a scientific stage, by contrast, the results of research are used to modify theories, which are then used to guide new research.

In the 1990s, the profession was moving toward a scientific stage and beginning to develop an empirically based practice theory. Today, I believe that the helping professions have made the transition and are now, in Kuhn's term, in the early phase of a scientific stage of development. As such, this book integrates recent research results from both quantitative and qualitative methods. It addresses models that have been described as evidenced-based practice as well as emerging approaches, which have not yet reached this stage.

Because the social work profession is still in the early stages of this crucial theory-building process, a wide range of views is possible. In recent years, social work has seen a significant expansion of efforts to strengthen theory building by employing empirical approaches. I have completed my own effort to develop a holistic, empirically based theory of social work practice, which has at its center the interactional approach to helping (Shulman, 1991). Ideas from that model have been included in this book, as have findings from my studies associated with that effort.

In particular, I emphasize the impact of oppression on clients experienced because of their race, gender, sexual orientation, physical and mental ability, and so forth; this is countered by a discussion of resilience theory and the strengths perspective as models for understanding human behavior and how clients can overcome powerful obstacles in their lives.

All practitioners eventually develop their own practice frameworks, some more and some less explicit, and judge them by how well they explain their practice. The framework for social work described in this book has been most helpful to me in my practice, theory building, and research. It is not engraved in stone, however. Having evolved for over 50 years, it will continue to be used as a framework only as long as it appears to do the job. You should test its ideas, as with all models, against your own sense of reality and use those portions that seem helpful. I encourage my students to "write your own book." I do not mean that literally—although I hope and expect that some will—but rather to suggest that they need to create their own models of the helping process.

Many of the skills and intermediate models in this book are not bound by one approach and can easily fit into other theoretical frameworks. Ideas from other models, some of which are identified and summarized in Chapter 17, are integrated whenever they help to enrich the core framework. For example, strategies and interventions from solution-focused practice models join the list of available practitioner tools in the beginning phase of practice. Concepts that underlie the motivational interviewing (MI) approach also fit nicely within this framework when considering how to engage clients—particularly those who are mandated and resistant. Assessment and intervention concepts described in cognitive-behavioral therapy are also useful in helping clients in the early stages of practice become unstuck in self-defeating internalizations.

Elements of a Practice Theory

Because I refer to practice theory, models, and skills throughout the text, a brief explanation of how I use these terms may be helpful. A practice theory first

describes what we know about human behavior and social organizations. The social worker then establishes a set of specific goals or outcomes based on these underlying assumptions. Finally, a description of the worker's interventions to achieve these specific goals completes the practice theory. Simply put, what we know about people (knowledge) informs our thinking about what we wish to achieve in our practice (valued outcomes) and this, in turn, guides our interventions (skills).

This approach to theorizing about practice is used throughout the text. For example, when we examine the beginning phase of work, assumptions about how people behave in new situations are related to outcomes the worker wishes to achieve during the first sessions. These outcomes, in turn, are linked to specific activities of the worker, described in more detail later as *contracting*.

As an example, clients have some degree of uncertainty about if and how a counseling relationship can be helpful to them and whether the social worker will understand their concerns. This understanding of how clients generally approach a new counseling relationship leads the social worker to set a goal in the first sessions of aiding the client to understand the kind of help that can be offered, the social worker's role, and the potential overlap—or common ground—between the client's presented need and the agency service. Based upon this understanding and these immediate goals, the social worker will use the skills of clarifying purpose, clarifying his or her role, and seeking client feedback. (These specific skills are described in more detail in Chapter 4.) For our purpose here, they demonstrate how what we know about clients in new situations (knowledge) relates to our immediate goals (valued outcomes), which in turn inform the social worker of the skills and interventions (contracting) needed in the beginning phase of work. These are the elements of a practice theory as described in this book.

Models, Skills, and Empirical Support

The term *model* is used to describe a representation of reality. One would construct a model to help simplify the explanation or description of a complex process or object. Anyone who has visited a planetarium knows (at least after a certain age) that the balls circling the sun on the ceiling are not real planets. This is a model of the solar system and as such is a representation of reality.

In this text, models are used to describe helping processes (e.g., the dynamics and skills required in a beginning, middle, or ending phase session), individual and social psychologies (e.g., resiliency and oppression theory), and the entities with which professionals work (e.g., families, groups, communities, or organizations).

The term *skill* refers to a specific behavior that the worker uses in the helping process. Many of the skills described in this text are core relationship skills, which are useful in the performance of professional as well as personal tasks. For example, empathic skills are needed by parents, spouses, and friends. I have come to believe that, for many helping professionals, the development of self-knowledge and the enhancement of personal skills are an important part of what originally inspired us to consider the helping professions. Helping others—as every candidate's application for admission to a school of social work identifies as a core motivation—is also important. The focus here will be on the use of these skills as they relate to the social work professional function, but it would not be surprising if readers associate them, at times, to other important interpersonal relationships in their lives.

Finally, although I have been conducting empirical testing of the hypotheses contained in this practice theory, this work should be seen as an ongoing process. The grounded theory approach to theory building, first described by Glaser and Strauss (1967) in the field of sociology, guides my work. Formal and informal observations from practice are used to develop constructs of the theory. Formal research is conducted both to test propositions and to generate new ones. Some of the most interesting findings of my earlier studies did not support my initial hypotheses. These helped me to expand the theoretical constructs and led to the development of the more general and holistic theory presented in the text that complements this book (Shulman, 1991, 2016a, 2016b).

Many of the core findings about skill from my earlier research have been supported by research in social work and related fields. Some propositions have begun to reach the replication level at which they may be described, in Rosenberg's term (1978), as theoretical generalizations. These propositions have received repeated support from many research efforts. As these ideas are presented, I shall provide citations to the supportive literature. However, even these propositions must be open to modification as further empirical efforts direct. It is in this spirit of continuous evolution that the ideas in this book are shared.

The Client–System Interaction

EP 9b

A critical factor in the helping process is the way one views the client. In early attempts to conceptualize this process, the helping professions borrowed the medical model developed by physicians. The term *medical model* has also been used in recent years to characterize a view of the client that focuses on illness and pathology; however, I use it in another sense. The medical model is defined here as the four-step process of thinking about practice commonly described as study, diagnosis, treatment, and evaluation. In this framework, the knowing professional studies the client, attempts to make an accurate assessment or diagnosis, develops a treatment plan, and evaluates the outcome. The result of the evaluation, if not positive, may lead to a rethinking of the assessment or the specific treatment plan.

This is, at times, the approach taken in supervision and/or case conferences with other professionals. What this leaves out, in many cases, is a focus on the process—that is, the interaction between the social worker and the client. I don't believe this is a simple oversight but rather a result of the paradigm that has guided our thinking about social work practice since its inception with a focus on the case rather than on the process. The next section addresses both the medical model and the concept of paradigms and paradigm shifts.

The Medical Model and the Paradigm Shift

EP 9b

Before I discuss the medical model—or more accurately the medical model paradigm—I need to describe the concept of a paradigm and how a paradigm may *shift*. Cottone (2013), referring to counseling and psychotherapy, suggested that

> counseling paradigms are overarching philosophical, theoretical and political structures that act to categorize counseling theories accordingly. Paradigms are

> "super theories," so to speak. The paradigm framework represents a theory about theories of counseling. It is metatheoretical to the variation of theories within and across paradigm frameworks. It is the big picture. (p. 55)

Thomas Kuhn (1962), in his classic book *The Structure of Scientific Revolutions* describes a paradigm as a framework that guides theory building and research in scientific disciplines. As an example, he points to Ptolemy and his paradigm that viewed the earth as the center of the universe. This earth-centric paradigm guided astronomers for centuries. There were unexplained observations, for example, a star or our moon moving in the wrong direction; however, these anomalies were discounted when observed. The paradigm itself was not challenged.

When the telescope was invented, the paradigm shifted and suddenly our sun was seen by most astronomers, not all, as the center of our universe. Many of the observed anomalies associated with the views of Ptolemy were now explained by the shift. Kuhn suggests that this is how science works: not incrementally, study by study, but through powerful paradigm shifts in thinking.

I believe the medical model consisting of the four steps of study, diagnosis, treatment, and evaluation is itself a paradigm. It guides much of our practice as a super-arching model within which other theories are nested including evidenced-based practices. When practice is seen through this lens, it is hard to understand an alternative paradigm without making a profound shift in the way we think about practice.

The reader may remember the Gestalt psychology class where he or she was shown a line drawing of an old lady or a young lady, depending on how one shifted one's perspective. When I shared these in a class about half of the class could see the old lady and the other half, looking at the same drawing, saw the young lady. I would point out that one could not see both at the same time. You needed to mentally let go of one in order to see the other. Some of my students were stuck and could not make the switch. A practice paradigm, shared by many in the helping professions, is also powerful and difficult to let go.

To be clear, it is not the elements of the model (study, diagnosis, treatment, and evaluation) that I question here but rather the linear way in which the process is described. I believe that the helping process does not proceed in such an orderly manner and that an *interactional model* or *paradigm* in which both client and practitioner are affecting and being affected by each other almost moment by moment, provides a more accurate description of the helping process. The helping professional who works with an individual, a couple, a family, a group, a community, or other professionals will do a great deal of thinking and planning before and after the encounter, but his or her responses to the moment will be guided by a clear sense of purpose and role, instinct, affect, and the immediate behavior of the client. This way of thinking and responding, acting and reacting—affecting and being affected by the client—will be illustrated throughout this text (Shulman, 2016b).

One of several problems with the medical model has been the heavy emphasis on the study phase, in which the social worker attempts to obtain a great deal of information about the client (e.g., family history, work history, and medical history) to develop the psychosocial study on which the diagnosis and resulting treatment plan are based. Obtaining such information in the early stage is important and, in some settings, essential for reimbursement of the service, yet the question-and-answer format could lead workers to ignore the equally important processes required to engage the client and to begin to develop the working

relationship. We will return to issues of assessment and diagnosis, an essential part of current social work practice, in a later chapter. For now, the argument is that the social worker needs to at one and the same time be obtaining information needed for a proper assessment and eventual treatment plan while engaging the client through a skillful contracting process as illustrated in the following example.

First Interview With a Depressed Client

Practice Points: (Note that the term *Practice Points*, used throughout this book, at the start of a paragraph indicates the text is an explanation of the detailed example that follows.) The following example illustrates how a social work student begins to connect with her new client during their first session, loses the client as she switches to taking the family history, and then catches herself as she reconnects with her client on an emotional level. Also note that rather than responding defensively to the question about experience, the student/social worker answers the question directly and then inquires as to the reason for the visit.

Worker: Come on in and sit down. If you get too cold, just tell me and I'll close the window.

Client: No, that's fine, it's very nice outside. So, what is your experience, your specialization? They tell me this is an important question to ask.

Worker: Well, I'm a second-year graduate student at the School of Social Work. This is my second internship. My first one was at a child welfare office. I could tell you all of the theories I have learned and books I have read, but I think it is more important for you to see how comfortable you are with me.

Client: I never had therapy before, so I guess we'll make a good team.

Worker: What brought you here today?

Client: I felt like driving my car into the canal. I left my husband in Florida, and I came home. I feel like this is where I belong. Basically, I feel like I'm drowning. (Tears fill her eyes.)

Practice Points: It is important that the social worker respond to the expressed emotion using a skill of articulating the client's feelings (to be discussed in detail in a later chapter). The client has not said the word *painful*; however, the social worker senses the pain from her words and her facial expressions. By saying *painful*, rather than simply asking how the client is feeling, the social worker is already demonstrating her capacity for empathy and understanding. She is also giving the client permission to express her feelings and starting to develop the working relationship (therapeutic alliance).

Worker: Sounds like this is a very painful time for you. (Client is silent, head down.) When did you leave Florida?

Client: Two and a half weeks ago. I went to Florida a year ago to save my marriage. I gave up everything for him—my friends, family, job—and I realize the sacrifice is not worth it. I'm going through the empty nest syndrome without the children. I had to adjust to his family, his way of living. There was no communication between us. I got scared! I felt more like his roommate. I always have to take care of everyone!

Worker: You sound angry.

Client: Yes, and I'm tired of it!

Practice Points: Note that the social worker picked up the angry tone in the client's statement and even named it when she says: "You sound angry." However, at this moment, the social worker changes the tone, mood, and content of the conversation by switching to a *study* process and asking questions. In part, this is necessary to obtain the information needed by the agency, for example, for documentation in the file and/or for billing purposes. However, it is my sense that this student worker, who felt comfortable with expressions of pain, did not feel quite so comfortable with expressions of anger. Note that the client gets back to her emotions in response to the questions and for a time the worker drops the information gathering and responds once again to the feelings.

Worker: Because this is an intake, I need to ask you some questions in order to complete the paperwork portion of our meeting.
Client: Oh, I'm sorry. Go ahead.
Worker: Don't be sorry. I just wanted you to know we needed to shift gears for a while.
Client: Go ahead; that's fine.
Worker: Tell me about your family.
Client: I have five grown children: Pam, Jane, John, Cathy, and Tina. She's my baby. She recently had a baby and.... (Tears fill her eyes.) That's another subject.
Worker: Seems like babies are a tough subject for you to talk about.
Client: (Beginning to cry) It's OK. Go ahead, ask your questions.
Worker: They are not as important as your feelings are right now. We'll have plenty of time later to complete the forms.

Practice Summary: (The term *Practice Summary* will be used throughout this text to introduce summary comments about the prior described practice example.) When this example was discussed in class, the student worker recognized that she had switched to the questioning format just when the client expressed strong feelings of anger. Other students in the class acknowledged that having a structured first interview in which they could focus on asking a series of questions made them feel more comfortable, whereas it possibly made the client feel less comfortable. They could also see how important it was to stay close to the feelings of the client. Many of the questions would be answered in the course of the interview, and the social worker could always leave some time at the end to obtain the missing data.

Integrating Assessment and Engagement: Behavior as Communication

Because assessment and diagnosis is usually, and appropriately, integrated into the practices of social agencies, I try to help my students develop a workable approach even while recognizing the limitations of the medical model. We develop creative approaches for obtaining the required information and skillfully engaging the client during the first interview. Involving the client actively in the process, discussing the reasons for the information gathering, and making sure that the study phase does not substitute for contracting work are essential elements.

Students are also encouraged to find ways of relating to the team when discussing specific clients, such as in a case conference, which may effect a shift in

attitude toward clients from pathology to strengths. In later chapters, we will examine assessment models and work with other professionals and systems in more detail. To preview this discussion, I will be suggesting that the social worker always has two clients—the client in the interview and the agency or host setting (e.g., school, hospital). In fact, I will argue that one of the unique aspects of the social work professional role is attending to and attempting to skillfully impact this *second* client.

Another problem with the medical model is that it tends to present clients in static terms. The model encourages attributing descriptive characteristics to the client (e.g., resistant, hard to reach). In extreme cases, workers may refer to clients as diagnoses, as in "I'm working with a borderline" rather than "a client with a borderline diagnosis." Even the term *therapy*, often used by social workers to describe work with individuals, families, and groups (e.g., group or family therapy), implies that something is wrong with the client that requires fixing.

Dynamic Systems Theory: The VISA Center Example

For many years now, dynamic systems theory has profoundly influenced the way that helping professionals view their clients. One central idea has been the emphasis on viewing a client in interaction with others. Instead of seeing a client as the object of analysis, workers began to focus on the way in which the client and the client's important systems were interacting. In fact, according to this viewpoint, one can never understand the movements of the client except as affected by the movements of others. Clients are viewed in interaction with their immediate and larger social surrounding, each affecting and being affected by the other in a reciprocal manner. A client may be considered resistant, for example, until one looks closely at the way the social worker is attempting to engage the client. The resistance may be a direct result of the efforts of the worker, or past experiences with other workers, and not inherent to the client.

For example, consider the work I directed during a project to address the problem of school violence in a midsize, inner-city school district, in which a significant percentage of students suspended from school for violent acts against teachers or other students, drug possession, or weapon possession were students of color who were also economically disadvantaged and at least 1 year behind in school. The center we established on the university campus, Vision, Integrity, Structure, and Accountability, or VISA, provided a short-term, 2-week academic and behavioral intervention program as well as services for the students' families.[1]

From the perspective of the school system, the problem was with the student, and the diagnosis was often "learning disability," "oppositional behavior disorder," "borderline personality," or "emotionally disturbed." The usual treatment was to formally suspend the student and send him or her home for 2 weeks, to receive home instruction from a teacher for 1 hour a day, or to enroll the student in anger management programs at the school or through local agencies. The school district recidivism rate was high, and many of the students were resuspended soon after they returned to school.

From our perspective, the students' behavior was instead a call for help to deal with some life situation that these students faced. We started with the

1. For more information, see the VISA Center Report at http://www.socialwork.buffalo.edu/research/visa.asp.

assumption that the behavior was not the problem but the symptom of a maladaptive way of coping with interactional struggles that existed for them with their families, their peer groups, their schools, the community, and—on a larger social level—society.

The VISA Center was a voluntary alternative offered to the students and their parents at the time of the formal suspension hearing. In addition to academic instruction, the behavioral modules were all designed to focus on the issues and concerns that faced students from their perspective. For example, modules on substance abuse were not used as lectures on the physical damage done by drugs, these students were well aware of these, but instead focused on the damage done to the students' lives. These included, for example, substance abuse issues in their families, the difficulty they faced from peer pressure to use drugs, their own difficulty in attempting to deal with an addiction, the risks associated with drug abuse in terms of the criminal justice system, and friends who were heavy users and whom they worried about but did not know how to help.

Mutual-aid support groups focused on issues in their lives that ranged from physical or sexual abuse to involvement in fights for fear of "losing face," pressure to join gang activity in the neighborhood (if only for protection), posttraumatic stress as a result of witnessing family violence or drive-by shootings, depression because of the loss of family members to violence and prison, anger about perceived racism within the schools they attended and the larger community, and a sense of hopelessness about their futures. The latter issue was poignantly characterized by one 16-year-old who said, "Why do I need to finish school? I'm not going to live past 20 anyway!"

This interactional perspective led to interventions that were designed to work *with* the students rather than *on* the students. More detail on this program will be shared later in the book; for now the point is that, by avoiding seeing the student as the problem and instead focusing on the reciprocal interaction between the student and the immediate and larger environment, we were able to shift the conversation. By understanding that the student's behavior in the VISA Center was constantly affecting and being affected by the interaction with staff and other students (e.g., group dynamics), we were able to see the student in a more dynamic and individualized way.

An* Anger Management Group *for Angry 15- and 16-Year-Old Girls Another illustration of understanding behavior as communication would be work done with a group of 15- and 16-year-old African American girls on probation for criminal activity referred to an *anger management group* by a judge as an alternative to going to jail. Brief excerpts from a number of sessions illustrate the importance of dealing with the issues and feelings leading to the maladaptive behavior.

In the early sessions, the two young, Caucasian, female middle-class group leaders need to clarify the purpose of the group, clarify the members' reactions to being mandated to attend, explain their roles as group leaders, and address the intercultural issues of having middle-class, suburban living Caucasian workers with low income inner-city African American clients. After opening up the issue of their involuntary attendance, one member, Monica, responds:

> What is it gonna matter if we decide we want to stay or not? We have to be here. I really just think it's stupid that I have to sit here with people I don't know and learn from two old women how I'm supposed to act.

Practice Points: The group leaders, both in their early twenties, later disclosed in class that they particularly reacted to the *old women* part of the comment. Their immediate responses are defensive, and they quickly change the subject and introduce an exercise. In a later session, the leaders address the issues of race, age, and class directly:

> I opened the session by asking the girls to go around the room and say one thing about their week. The girls did this with no problems until it came to Monica, who stated, "Why do you care about my week? None of you would understand what I'm going through anyway." I responded by asking Monica if she was concerned that Kim and I wouldn't understand because we are white and much older than her. Monica said that was part of it and that we both come from places that are different than where she lives. At this point, we were right in the thick of the authority theme (once again). I said, "Monica, I realize that Kim and I may look different than you, and we are. And, to be completely honest with you, we probably won't understand all of the time what you or any of the other members are experiencing. The only thing that I can tell you is that we want to try and understand, but that we can only do that if you'll give us the chance."

Practice Points: This courageous and direct response to an otherwise taboo issue helps to build a more positive relationship between the leaders and the group members. It later becomes clear through discussion that these girls had experienced early sexual and physical abuse. They also described incidents in detention centers (and one in an adult jail) where they witnessed or heard about other inmates forced to provide "sexual favors" to guards. The group leaders decide to introduce the idea of "forgiveness" as a way of getting past their continued underlying anger. Monica, who has emerged as an internal leader in the group, once again responds:

> Monica started talking right away. She said, "I hope you don't think I'm ever going to forgive my f—in' father—when he's dead, I'll forgive him." I asked Monica if she was saying that because she was still angry with him for some of the things that he had done to her. Monica agreed. I then asked her if she would mind sharing a little bit about what happened. She began explaining a situation with her father. When she was very little, he had broken her arm in five different places because he was trying to keep his beer from rolling down the hill, and he slammed her arm in the car door. She went on to explain that, when she was 10 years old, her stepbrother had molested her; her father knew about it and didn't do anything.

Practice Summary: One can easily understand the anger carried around by these girls. Expressions of rage and escalation of negative behavior are often a call for help. They will continue until someone hears the hurt and begins to respond to the meaning of the behavior. These two group leaders are quickly learning that persistent and ongoing oppression and emotional and physical trauma can lead to expressions of anger that are then responded to by the systems (e.g., school, juvenile justice) as the problem, which misses the underlying message. It serves as a striking example of the need to understand all behavior as communication (Shulman, 2016a, 2016b).

Work With a Depressed, Middle-Aged Woman in a Psychiatric Ward In another, very different example, this shift in thinking is illustrated by the case of