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Human Behavior in the Social Environment

A Multidimensional Perspective

José B. Ashford
Craig Winston LeCroy
Lela Rankin

Seventh Edition

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Preface

We are pleased that our book on human behavior in the social environment ushered in a new generation of textbooks with a focus on including issues of assessment in foundation knowledge for social work. In this edition, we continued connecting our integrative multidimensional framework to assessments of developmental concerns. We also introduced new content from other supporting frameworks and perspectives in social work that advance social work's commitments to addressing structural sources of oppression and privilege associated with, ability, age, caste, class, culture, ethnicity, disability, gender, gender identity, immigration status, race, religion, sexual orientation, and spirituality.

In recent years, case formulations have reappeared as key competencies for licensure in counseling, psychology, and psychiatry. Formulations have regained this attention because instructors in a number of applied fields similar to social work have found that beginning practitioners lack the capacity to provide a concise formulation of a case. We recognize that there are different approaches to developing competencies in case formulations. In our textbook, we are introducing students to an integrative multidimensional framework for developing a biopsychosocial formulation of a case. This framework is consistent with ecological system principles in social work and in keeping with recommendations by the Institute of Medicine of the National Academies for the advancement of scientific knowledge. By doing so, we also believe that we are providing social work professionals with a bridge to the American Psychiatric Association's shift in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (*DSM-5*) from multiaxial assessments to biopsychosocial formulations.

The capacity to develop relevant **case** and **situation** formulations has important implications for developing holistic rather than reductionist prevention and intervention strategies. Although we introduced this important practice skill in prior editions, we received substantial interest from other instructors about continuing to foster the development of case formulations in each of our developmental chapters. For this reason, each of our developmental chapters still include cases for students to complete a case formulation, which relies on the Four Ps' as a guide for organizing relevant case information.

Clearly, the focus on biopsychosocial interactions in our integrative framework supports recent actions taken by the Council of Social Work Education and the Institute of Medicine of the National Academies to move professions out of their respective silos toward the adoption of more integrative and translational approaches to understanding the biopsychosocial contributions to human and community well-being. For this reason, we are very proud that our textbook is supportive of this current trend in science policy and practice, as well as in our profession's revised Educational Policy and Accreditation Standards (EPAS).

Every chapter in this edition continues to identify biopsychosocial competencies that can help students and instructors cross many of the disciplinary chasms that currently exist between the biological, the psychological, and the social sciences. This book also continues to be about people, how people change across the span of their lives, and how biopsychosocial factors play a role in the course of their lives, within current political, cultural, and historical contexts.

People today are facing choices in their lives that were not conceived of by past and present generations. The current rate of social change is challenging many of our society's cherished social institutions and how people perceive their sense of self and others. The upshot of these changes is people are experiencing pressures to modify their life course in response to many of the changes in social institutions, social relationships, and cultural practices that are characteristic of our current society. Some of these changes are due to advances in technology that are a by-product of our expanding sphere of human thought, or what is sometimes termed the noosphere. Others are due to changes in the political economy and in our climate. For these reasons, this edition continues to devote substantial attention to trying to fill gaps in our profession's

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literature about how change is affecting the life tasks, choices, challenges, and opportunities confronting people across the life span, including changes resulting from developments in our physical, political-economic, and technological environments.

Key Features

The authors' multidimensional framework for assessing the current and developmental components of a case helps social work students understand theory and its implications for assessment of human behavior and social work practice across the life span. The framework is introduced in the all-new Chapter 2. The following represents the key features presented in this edition:

Learning Objectives for each of the book's chapters are presented at the beginning of each chapter.

Developmental Themes open each of the developmental chapters, and help students understand the key concepts, organized by major discussions within the chapter.

Applying the Framework concludes each developmental chapter which includes a case study, and includes a case study and an activity requiring the application of the Four Ps' formulation for Integration of relevant biopsychosocial data.

Practice Guidelines highlight critical issues for social workers and link foundation knowledge to assessment, prevention, intervention, engagement, and policy issues.

The Lived Experience presents firsthand accounts of real-life experiences related to diversity issues such as racism, poverty, sexual orientation, and ageism. Through these different voices, students gain a real-world flavor of the material discussed.

Focus On sections introduce additional information on theory, diversity, life tasks, life course transitions, and research.

What's New in the Seventh Edition?

We have heard from reviewers, chapter consultants, instructors, and students about suggestions for inclusions in this edition. In keeping with these suggestions, we have added a number of new elements, besides the previously mentioned changes in focus and organization of this edition.

New EPAS competencies. This edition includes specific competencies and practice behaviors germane to the most recent Council of Social Work Education Accreditation Standards (EPAS). In addition to these outcomes for the education of professional social workers, each chapter also includes other competencies that focus on content that is specific to content addressed in chapters that can further enhance a student's efficacy in mastering knowledge of human behavior and the social environment. We assume that these additional competencies can also help students in summarizing the relevant substantive issues covered in each chapter.

New and Updated Coverage. The book has also completely revised its introductory chapter with a primary focus on covering content on other supporting frameworks in social work. This revision was designed to help students understand varying theoretical approaches to human development and their implications for prevention and intervention. It also includes new content on the *social functioning framework. anti-oppressive frameworks (critical theory, critical race theory, conflict theory) and conceptual developments involving intersectionality and inequalities*. The second chapter removed content on single causal approaches and models of human behavior to provide students with earlier exposure to principles and justifications for adopting an integrative multidimensional perspective for implementing social work's person-in-environment framework. As in prior editions, our seventh edition includes:

- Updated citations
- New research on biopsychosocial development

Chapter-Specific Revisions. In addition to prior overarching revisions, each chapter has undergone other specific changes. In particular, Chapters 1 and 2 were completely revised, including: New developmental and theoretical constructs, differential perspectives for understanding human development, and other supporting frameworks, theories, and perspectives on human behavior and the social environment. A description of the social functioning framework, characteristics, and concepts for understanding the social environment and relevant social forces. Intersectionality and its implications for understanding inequalities, capabilities, and freedom, including differentiating between inequalities of condition and inequalities of opportunity. A critical review of anti-oppressive frameworks with a detailed examination of critical theory, critical race theory, and conflict theories.

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New content on cohort effects with a specific focus on the effects of the pandemic on millennials, and generation Z. A new exercise on intersectionality and content on evolving and emerging gender identities. Other major changes across the chapters include: more focus on the impact of social media, technology, and structural changes taking place in society. Since the previous edition, significant events and spread of social movements have resulted in large cultural shifts, such as the COVID-19 pandemic, Black Lives Matter, #MeToo, the increase of school shootings and gun violence, the advancement of anti-LGBTQ+ and abortion policies, global climate change, and international conflict, putting macro-level forces at the forefront of understanding human behavior.

Instructor Supplements

Additional instructor resources for this product are available online. Instructor assets include an Instructor's Manual, PowerPoint® slides, and a test bank powered by Cognero®. Sign up or sign in at **www.cengage.com** to search for and access this product and its online resources.

Online Instructor's Manual. The Instructor's Manual contains a variety of resources to aid instructors in preparing and presenting text material in a manner that meets their personal preferences and course needs. It presents chapter-by-chapter suggestions and resources to enhance and facilitate learning.

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Online PowerPoint®. These vibrant Microsoft® PowerPoint® lecture slides for each chapter assist instructors with their lectures by providing concept coverage directly from the textbook.

Acknowledgments

The feedback that we've received from many of our colleagues and students has helped us focus on key developments in our field. We thank all of them.

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To Nancy, my soul mate and inspiration for appreciating life and its continued mysteries.
J.B.A.

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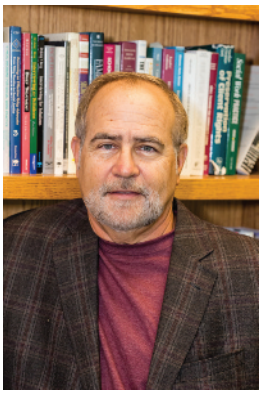

To my son, Skyler A. Milligan LeCroy
C.W.L.

Craig Winston Lecroy is the Communitas professor in the School of Social Work at Arizona State University at the Tucson campus. He also holds an appointment at the University of Arizona in the John and Doris Norton School of Human Ecology, Family Studies and Human Development division and in the University of Arizona School of Medicine, Department of Pediatrics. He has been a visiting professor at the University of Canterbury, New Zealand; the Zellerbach Visiting Professor at the University of California at Berkeley; and a senior Fulbright specialist. Professor LeCroy has published 14 previous books, including *First Person Accounts of Mental Illness and Recovery*, *Parenting Mentally Ill Children: Faith, Hope, Support, and Surviving the System*; *Handbook of Evidence-Based Treatment Manuals for Children and Adolescents*; *Handbook of Prevention and Intervention Program for Adolescent Girls*; *The Call to Social Work: Life Stories*; *Case Studies in Child, Adolescent, and Family Treatment*; *Case Studies in Social Work Practice*; *Empowering Adolescent Girls: Examining the Present and Building Skills for the Future with the "Go Girls" Program*; *Go Grrrls Workbook*; and *Social Skills Training for Children and youth*. Professor LeCroy has published over 100 articles and book chapters on a wide range of topics, including child and adolescent treatment, the social work profession, home visitation, and research methodology. He is the recipient of numerous grants, including (as principal investigator or coprincipal investigator) interventions for risk reduction and avoidance in youth (NIH), Go Grrrls Teen Pregnancy Prevention Program, evaluation of Healthy Families (a child-abuse prevention program), a mental health training grant for improving service delivery to severely emotionally disturbed children and adolescents (NIMH), and Youth Plus: Positive Socialization for Youth (CSAP).

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

The Council on Social Work Education's *Educational Policy and Accreditation Standards* (EPAS) 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. Multicolor helping hands icons 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, 2022)	Chapter where included
Competency 1	**Demonstrate Ethical and Professional Behavior:**	**1–10**
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 the context	**3–10**
b.	Demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication	**4**
c.	Manage personal and professional value conflicts and affective reactions	**3**
d.	Use technology ethically and appropriately to facilitate practice outcomes	**3**
e.	Use supervision and consultation to guide professional judgment and behavior	**3**
Competency 2	**Engage Anti-Racism, Diversity, Equity, and Inclusion in Practice:**	**1–10**
a.	Demonstrate anti-racist social work practice at the individual, family, group, organizational, community, research, and policy levels, informed by the theories and voices of those who have been marginalized	**1–10**
b.	Demonstrate cultural humility applying critical reflexivity, self-awareness, and self-regulation to manage the influence of bias, power, privilege, and values in working with clients and constituencies acknowledging them as experts of their own lived experiences	**2**
Competency 3	**Advance Human Rights and Social, Racial, Economic, and Environmental Justice:**	**3–10**
a.	Advocate for human rights at the individual and system levels;	**3–10**
b.	Engage in practices that advance social, racial, economic, and environmental justice for equal justice and the dismantling of structural racism and oppression	**3–10**
Competency 4	**Engage Practice-informed Research and Research-informed Practice:**	**1, 3–10**
a.	Apply research findings to inform and improve practice, policy, and programs	**1, 3–10**
b.	Identify strategies for use of quantitative and qualitative methods of research to advance the purposes of social work	**3–10**
Competency 5	**Engage in Policy Practice:**	**1–10**
a.	Assess how social welfare policies affect the delivery of and access to social services	**3–10**
b.	Apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, racial, economic, and environmental justice	**2–10**

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	The 9 Competencies and 31 Component Behaviors (EPAS, 2022)	Chapter where included
Competency 6	**Engage with Individuals, Families, Groups, Organizations, and Communities:**	**3–10**
a.	Apply knowledge of human behavior and person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies	**3–10**
b.	Use empathy, reflection, and interpersonal skills to effectively engage diverse clients and constituencies	**1–10**
Competency 7	**Assess Individuals, Families, Groups, Organizations, and Communities:**	**1–10**
a.	Apply knowledge of human behavior and person-in-environment and other culturally responsive multidisciplinary theoretical frameworks when assessing clients and constituencies	**1, 3–10**
b.	Demonstrate respect for client self-determination during the assessment process collaborating with clients and constituencies in developing mutually agreed-on goals	**3–10**
Competency 8	**Intervene with Individuals, Families, Groups, Organizations, and Communities:**	**1–10**
a.	Engage with clients and constituencies to critically choose and implement culturally responsive, evidenced-based interventions to achieve mutually agreed-on practice goals and enhance capacities of clients and constituencies	**3–10**
b.	Incorporate culturally responsive methods to negotiate, mediate, and advocate, with and on behalf of clients and constituencies	**3–10**
Competency 9	**Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities:**	**1–10**
a.	Select and use appropriate methods for evaluation of outcome	**3–10**
b.	Critically analyze outcomes and apply evaluation findings to improve practice effectiveness with individuals, families, groups, organizations, and communities	**1–10**

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Chapter 1

Introduction to Human Behavior in the Social Environment

Learning Objectives

1. Explain why social workers study human behavior and the social environment.
2. Understand the role of human development in social work.
3. Describe the role played by normative and nonnormative influences on developmental outcomes.
4. Contrasts the contributions of life stage, life span, life course, and strengths perspectives for understanding human development.
5. Describe the supporting frameworks and theories for understanding human development in social work.
6. Explain the effects of intersectionality on developmental outcomes.
7. Describe the role of anti-oppressive frameworks and theories for understanding power and inequalities.
8. Describe the defining elements of the ecological systems perspective in social work.

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Why Social Workers Study Human Behavior and the Social Environment

What most influences our behavior? Is it our biological makeup, our psychological characteristics, or our social setting? As you will learn in this book, human behavior takes place in a diverse array of geophysical, psychological, temporal (historical), and social contexts. In these contexts, people confront biological, psychological, and social demands that require effective adjustments. The ability to make effective adjustments to these demands on individuals, families, groups, communities, and organizations is an important form of social adaptation.

Understanding the process of adaptation is vital to practice in any human-service profession. In the field of social work, Human Behavior and the Social Environment (HBSE) is the curriculum area that provides the necessary foundation for understanding human adaptation. It is the area in education for social workers, which exposes students to theories of human behavior, the person-in-environment framework, and other multidisciplinary frameworks (Council of Social Work Education [CSWE], 2022). Additionally, HBSE courses help students critically evaluate how cultural, structural, and personal values can bias their assessments of individuals and the social contexts within which they live their lives (CSWE, 2022).

Social work, unlike many other human-service professions, sees social adaptation as one of its primary areas of expertise. People have to adjust in their lives to many different types of events, traumas, situations, or changes in their life situation. Some of these events and life changes involve normal levels of stress, whereas others involve excessive amounts of stress (traumatic stressors) for which it is difficult for some individuals to make positive adaptations. Persons who cannot make positive adaptations are vulnerable to experiencing negative developmental outcomes. However, some individuals are invulnerable to experiencing negative developmental outcomes. Developmental scientists consider these individuals **resilient** because of their positive social adaptations following exposure to significant adversity and risk (Gitterman, 2014). For this reason, social work educators recognize that students need to develop a fundamental understanding of the causes and the consequences of issues of risk and resilience and their connections to positive and negative developmental outcomes.

Social Work and Human Development

The curriculum in social work education relies on the developmental sciences for knowledge of change processes in people and their environments (Austrian, 2008; Butler, 1970; Hutchison & Charlesworth, 1998). Human development as an area of science focuses on the causes and consequences of biopsychosocial changes (Austrian, 2008; Davies, 2004). These changes contribute to positive and negative behavioral outcomes, as well as positive and negative directions in the course of a person's life. This book examines standards for assessing developmental outcomes over the course of a person's life. These standards provide important benchmarks for assessing the status of a client's behavior. They also help practitioners identify relevant developmental tasks at different phases of a person's life. These tasks "may vary from one culture to another to some degree, but these broad tasks presumably depend on human capabilities and societal goals that are widely shared across cultures" (Masten et al., 2009, p. 118). These tasks reflect changes in the physical, psychological, and the social development of persons in changing environments. They are also due to different types of systematic and non-systematic influences.

Age and Age-Graded Influences on Development

The predictable changes with ties to a person's age involve **normative age-graded influences**. Normative age-graded influences include the interactions of biological and environmental events that affect most people within a particular age category or age group. Examples of events due to biology that are representative of normative age-graded influences are the occurrence of menopause in women and puberty in adolescence. These age-related biological influences are normative because of their effects on a majority of the population (All Things Statistics, 2021). Age norms derived from social influences are as important as age-graded norms derived from maturational influences involving biologically based growth and development. They also affect the majority of individuals within relevant societal groups.

Age grades are an important form of social organization. Persons in the same age grade or age group have specific expectations or duties in common with other members of their group. These age grades vary from society to society and interact with other socially relevant

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Exhibit 1.1 Glossary of Key Terms

Adaptation refers to how a biological organism adjusts to changes in the environment.
Adjustment refers to the processes involved in how a person copes with the demands and challenges of everyday life, including changes in the social environment.
Age norms represent the socially and culturally defined expectations for how people should behave at a specific point in the life span.
Assets represent known internal or external resources with known probabilities of producing positive developmental or other relevant behavioral outcomes.
Cohort effects refer to influences on a group of individuals born around the same time who share common historical experiences, for example, Generation X.
Cumulative-risk hypothesis assumes that risk factors threaten development, and these negative effects will accumulate over time.
Developmental tasks are specific expectations for a person's development at a specific point in the life span.
Normative age-graded influences represent the predictable influences on behavior that are associated with a specific age grade or grouping of individuals that is associated with chronological age. It occurs for most of the people in that specific group, for example, children or adolescents.
Normative history-graded influences are factors associated with a group of people during a particular period of time that affects the lives of everyone growing up in that period. The Great Depression was a history influence that had differential effects on different age grades, adolescents, etc.
Nonnormative events are life experiences or events that are not shared by most individuals but have a significant influence on a person's developmental outcomes and behavior.
Protective Factor is any well-known event, experience, or circumstance that is associated with a positive developmental outcome.
Resilience refers to a person's ability to make positive adjustments under conditions of adversity.
Risk factor is any event or experience associated with an undesirable developmental outcome(s).

social statuses. The gender of a person is one of those statuses, which can represent a different age grade. For instance, age grades due to gender specify different ages (chronological age) when males and females mature or when they die. However, many people do not identify as male or female. For these individuals, we have less age-graded information about persons who identify as nonbinary or who identify with other emerging gender statuses (Baumeister & Bushman, 2021). This is an important gap in the current developmental literature.

Culture also affects variations in age grades across societies. Indeed, culture mediates age grades involving workforce participation. Most Americans assume that people ought to be able to work as long as they are able to do the work in a competent fashion. In fact, our society has specific laws that protect individuals from discriminatory employment practices based on age. However, women in some societies confront discriminatory employment practices based on age and on specific physical qualities. Indeed, it is common in many South American communities for women to be let go from a job when they reach 35 or 40 years of age. In addition, many job advertisements continue to ask for someone below a specific age and with specific physical characteristics. These practices are shocking for many North Americans because many individuals are just entering the labor market during their early 30s. The age structure and its influence on employment have important implications for the life chances of many women in Latin American cultures that differ from other cultural contexts.

Expectations about appropriate ages for retirement also vary from country to country. For instance, women are eligible for retirement in Mexico when they are 60 years old, whereas the expectation for retirement for women in Russia is around 55 years of age and men at around 65. Yet the life expectancy of men in Russia is 67 years of age, and that of Russian women is similar to that of women in the United States. These variations are due to conventions and cultural structures that often do not square with evidence about productivity or data on projected life spans. Instead, they involve the age grading of expectations in the course of a person's life supported by cultural institutions and practices. Clearly, women in Russia could work much longer than men, given their life

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expectancy, but other assumptions are influencing policy and other practices in Russia that are counterintuitive to individuals from other cultures.

Other predictable changes in developmental expectations are a consequence of other influences. These other influences involve social factors or other mechanisms of influence that operate during a particular historical era or period.

Cohort and Historical/Period Effects on Development

A **cohort** in the behavioral and social sciences consists of individuals who have birth years in the same generation. Individuals within a specific cohort can adhere to different norms concerning developmental tasks from individuals from other generations. A **generation** refers to a period of approximately 20 years. Adolescents in Generation Z encounter very different life tasks from prior generations. The pandemic illustrates this point. COVID-19 represents a significant event with distinct effects on the peer relationships and school experiences of Generation Zers from the experiences of other generations. Researchers are observing other significant differences between Millennials (1981–1996) and members of Generation Z (1997–2012). The Focus on Lived Experience: My journey teaching and supporting Millennials and Gen Zers describes the experiences of a teacher in teaching and supporting Millennial and Generation Z students. It is important to note that the experiences of a cohort at the beginning and at the ends of a generation can overlap in many ways with individuals in other generations.

While unlike other generations, Millenials and Generation Z grew up with computers, but they also grew up in different cultural, economic, and social contexts. Theses generations also witnessed different generation-defining

Focus on **The Lived Experience**

My Journey Teaching and Supporting Millennials and Gen Zers

As I begin to prepare for the coming school year, my 25th as a high school classroom teacher, it is not hard to look back over those years and see how much the educational landscape has changed. Pedagogical ideas seem to come and go as fast as the seasons and then come around again refocused and reformulated, but still just the same old ideas in new packaging. When I really look at what has changed teaching the most, I would say it is the students. The students who fill the seats in my classroom have made the most difference over the years in how I approach my teaching.

Generationally speaking, when I first began teaching full time, my students were in the beginning years of the Millennial Generation. That said, the bulk of my career has been with millennials, and gradually I have begun making the transition to teaching students from Generation Z. When I look at the factors that influenced how Gen Zers have behaved and responded in the classroom, I observed several differences between them and members of the Millennial generation. These differences made it necessary for me to change how I taught, presented, and assessed my students.

The most obvious difference between Millennials and Gen Zers were the changes in technology and in how they used technologies. Computers, laptops, cell phones, tablets, and smart boards were nonexistent when I started my teaching career with Millennials in the mid-1990s. Now technology has filled every corner of the educational landscape. The Millennials had experiences with computers as children, but not to the extent of Gen Zers.

My daughter was born in 1996. She was able at age 3 to play games like "Winnie the Pooh Math" or "Reader Rabbit" with a dexterity that at the time amazed me. As a Millennial parent, I had access to flip phones, Blackberries, early laptops, and other technologies. While this technology influenced aspects of some of my own development, it did not invade every aspect and every moment of my daily life or the lives of my Millennial students, which was not true of my Gen Z students.

When I began teaching 25 years ago, students in my classrooms might have had a Discman for listening to CDs and they were constantly searching for AA batteries to power their Discman. Flip phones also began showing up in my classrooms, and eventually my Millennial students had the ability to text messages. Smartphones also showed up and further complicated my classroom management. Unlike Millennials, however, Gen Z students have never known a world without Wi-Fi networks, smartphones,

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iPads, Chromebooks, and laptops. These technologies were available for everything they did. They not only had this technology but a new phenomenon that would come to be called social media emerged. My Space, YouTube, Facebook, Snapchat, Instagram, TikTok, Twitter, and a host of other media rapidly became a big part of daily life, where the focus quickly became putting your life, either real or imagined, on public display for others' approval in the form of clicks or "likes." Gen Zers in general have never known life in a world where they were not always potentially on display in video and in pictures posted on the platforms on the Internet that captured moment-to-moment aspects of their lives for everyone to consider. In fact, the term *social media* was not even in the lexicon of my Millennial students as it did not start gaining traction until the early 2000s. My Millennials still had far more in-person social relationships than is now true of my Gen Z students who are far more comfortable simply texting or posting to have any contact with friends. From a psychological point of view, we need to consider what this technology has done to the schemas and life experiences of the Gen Z student as compared to their Millennial predecessors.

Almost every student at my school has a smartphone; this extends down to the 7th and 8th graders, and even some of the older elementary school kids have them. These kids use them for everything. Smartphones are not what my Boomer generation viewed as a tool, because for these children and youths cell phones have become a way of life that Boomers and individuals from other generations may not be able fully to understand. I like to joke with my students and point out that each of them carries a device that makes all the information in the world accessible, and when I was their age, I had a stick, a rock, and maybe some string. They laugh, but it is a stark contrast, that I then follow up with by saying, "when I was your age and wondered about something, I just used to wonder…." I did not have a computer in my hand that could answer any of my factual and other questions.

I remember well a principal I work with who went to a conference in Washington, D.C., about changing technology and how to use it in the classroom. He is one of the first people I remember saying that technology, cell phones, computers, and so forth are the tools of the coming generations, and rather than banning them from our classrooms, we need to find ways to embrace them, incorporate them into our lesson planning, and use technology to help engage our students. What is even more interesting to me in looking at differences in dealing with technology and my students is how we as teachers have had to change what we do in the classroom involving the use of technology. It is no longer enough to be an expert in your field and have a good classroom presence. Technology is now essential to presentations and assessments. Presentations need to be not only verbal but also visual. All classrooms at my school are now equipped with interactive display boards to help with the presentation of class material and teachers are expected to use them daily. Each classroom has a Chromebook cart with 30 of the latest Chromebooks to access the Internet. Now we collect all assigned work through Google Classroom. There is no element in high school instruction that does not utilize technology.

Indeed, we can no longer expect Gen Zers to learn in the same ways as Baby Boomers or Gen Xers. They have very different schemas for learning from them. These challenges have forced educators to change how they ask the students to interact with the curriculum. We need to understand how they learn and apply those lessons to reach them both educationally and socially.

In my opinion, the attention span of Gen Zers is much shorter than other generations. In contrast to Millennials, Gen Zers prefer to work alone. That said, group work is more productive if they are allowed to collaborate online through chats and group messaging, which is easily facilitated through mediums such as Google Classroom. It is important to note that Gen Zers use their cell phones for everything, and it is one of the biggest differences between Millennials and Gen Zers. For this reason, Gen Zers, for the most part, have an extremely hard time being "unplugged" during class. Not a class period goes by when I will not catch someone using their cell phone and, more than likely, two or three students during lecture/discussion who have snuck a phone back out and are playing a game, watching a video, or texting, under their desk. It has become my biggest frustration as a teacher with this generation, managing cell phone use, and trying to find a balance in holding their attention without increasing their anxiety levels because of fears of what they are missing online. In one study I looked at briefly, a little over 40% of Gen Zers self-reported that they are more than likely "digital device addicts." In this same study, only 25% of Millennials reported the same. Through my years of teaching, I can corroborate that it has required more and more energy and time each year to manage cell phone use no matter what limits and expectations are set in place at the beginning of the school year. The high use

Continued

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of cell phones is also across every group of our students. It is as prevalent among honors students as for grade-level or at-risk students. Whenever I have my students put their cell phones away, I have found that my classroom teaching requires more and more use of other technologies to hold their attention.

With the use of laptops and Chromebooks in class, I can have my students access articles, curriculum-specific texts, blogs, and other class material that they can then write responses to, post comments about, and have a discussion without having to speak out in class. I find that for Gen Zers I get much better overall participation from them in this medium. Once they have had time to think of a response and write it down in a medium they are comfortable with, it is much easier to get them then to engage in any type of verbal discussion.

Social media is a powerful tool for use with Gen Zers in a way that Millennials did not appreciate. This leads me to another difference between Millennials and Gen Zers in how they acquire answers to what they are wondering or thinking about. Millennial students were much more likely to look up information from sources such as journal articles and websites. Social media sites such as Instagram, Snapchat, and YouTube provide the Gen Xer with the answers to many of their queries about the world. However, it is the TikTok app that is truly entrancing Generation Z into scrolling and staring at the little screen for hours on end. The phenomenon of TikTok, an app that originated in China and features short videos of 15 seconds to a minute, is mostly creative content about every imaginable topic. TikTok's largest demographic is 10- to 19-year-olds who make up just over 25% of the total user. When you add in the 20 to 29-year-olds, this boosts the numbers to just over 50% of users. TikTok's platform is so powerful that in July of 2022 Meta's COE Mark Zuckerberg announced plans to incorporate many of TikTok's features into redesigns of both Facebook and Instagram. Both of those platforms are more popular with Millennials and in many cases require a bit of reading in order to decipher a meaning. TikTok is purely visual and quick, and often taken as truth at face value. When pushed to do deeper research for academic purposes, the average Gen Z high school student most often uses answers from the first source that pops up in the results from their Google search. Most often this would be from Wikipedia, and they appear more than happy to accept this at face value without further research, or going beyond the first page of their search results.

In my classes, I have set up in Google Classroom a weekly journal for the students to complete. They can do this either on a computer, laptop, or cell phone. Before I converted this exercise to digital media, I had just slightly less than a 60% completion rate, by digitizing it several years ago, posting it in Google Classroom, and setting up a reminder for them with a due date weekly, I have had a completion rate of nearly 100%.

In closing, there is one way in which Millennials and Gen Zers are extremely similar in the classroom. I have found with both these groups of students that they need caring teachers who provide feedback and guidance designed to help them improve, as well as real-world lessons they can carry forward into life. As an educational professional, we may have been hired to teach a curriculum of a particular subject, grade papers, and take attendance, but our job is not totally encompassed in those menial duties. We need to be more than that. It is essential we give them honest, caring feedback on how they can improve. We need to care about their progress and be actively engaged in giving them positive feedback. We need to model appropriate responses and find ways to motivate them and push them to be more than they believe they can be. We need to be their advocates, their mentors, their champions. It is in that task that we find our true work as educators. Our ability to use a kind word to ease a student's worry, to gently encourage, make a student smile, to be the reason why a student continues on when they feel like giving up. I am a firm believer in a quote by Haim Ginott that I keep framed on my desk at school, that I look at weekly because it reminds me, even when I am tired, of what my responsibility and duties are.

"I've come to a frightening conclusion that I am the decisive element in the classroom. It's my personal approach that creates the climate. It's my daily mood that makes the weather. As a teacher, I possess a tremendous power to make a child's life miserable or joyous. I can be a tool of torture or an instrument of inspiration. I can humiliate or heal. In all situations, it is my response that decides whether a crisis will be escalated or de-escalated and a child humanized or dehumanized." —Haim Ginott

—By David Vitagliano

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Exhibit 1.2 Are You a Millennial?

The Pew Research Center created a fascinating quiz called "how millennial are you?" and the questions help identify the distinctive characteristics of Millennials. A sample of the questions are:

1. In the past 24 hours, did you watch more than an hour of television programming, or not?
   (a) Yes (b) No
2. In the past 24 hours, did you read a daily newspaper, or not?
   (a) Yes (b) No
3. In the past 24 hours, did you play video games, or not?
   (a) Yes (b) No
5. In the past 24 hours, about how many text messages, if any, did you send or receive on your cell phone?
   (a) 1–9 text messages (b) 10–49 text messages
   (c) 50 or more text messages
6. How important is being successful in a high-paying career or profession to you personally?
   (a) One of the most important things (b) Very important but not the most
   (c) Somewhat important (d) Not important
10. How important is living a very religious life to you personally?
    (a) One of the most important things (b) Very important but not the most
    (c) Somewhat important (d) Not important
12. Do you have a tattoo, or not?
    (a) Yes (b) No

Source: The Pew Research Center (2016). Your score depends on how you answer all the questions. To take the quiz and get your score go to the Pew website: http://www.pewresearch.org/quiz/how-millennial-are-you/

moments. Clearly, a defining moment for Generation Z is COVID-19; conversely, the attack on the World Trade Center (WTC) is a defining moment for most Millennials. Each of these generations experience significant changes in a historical period with important differential impacts on their behavior and development.

Some of the other generations that have been studied by developmental scientists include the GI generation, which consists of people born between 1901 and 1924; the Silent generation, people born between 1925 and 1945; the Baby Boomer generation, people born between 1946 and 1960; and Generation *X*, people born between 1961 and 1981. Clearly, the age of a person during COVID-19 has profound influences on the experience of this major historical event. Normative history-graded factors (wars, economic recessions, pandemics) have a shaping effect on the developmental trajectories of an entire population (Hiller & Barrow, 2015). However, these effects will differ across age groups. The economic recession of 2008, for instance, had significantly different effects on the trajectories of Millennials from Generation Zers.

Each of the prior generations had age norms based on distinctly different sociohistorical influences. **Age norms** are society's way of telling people the expectations for a person's behavior at a specific age or phase of development (Sigelman & Rider, 2015). Age norms derived from social influences are as important as age norms derived from maturational influences associated with biologically based growth and developmental processes. They influence how members of society judge a person's behavior and influence, what Bernice Neugarten (1968) termed the *social clock*—"a person's sense of when things should be done and when [a person} is ahead or behind the schedule dictated by age norms" (Sigelman & Rider, 2015, p. 7). Thus, age norms encompass predictable influences on human development due to maturational and sociocultural influences.

Nonnormative Influences on Development

Many changes observed in people and their environments are due to nonnormative events. **Nonnormative events** encompass all our chance encounters—things that do not happen to everyone and that do not follow any predictable timetable or systematic sequence. We lack knowledge of the sequencing of nonnormative events and their causes relative to issues of time and place e.g., the Focus on Lived Experiences that describes the experiences of a women who experience distinct life tasks for adjusting to becoming a stepparent.

Nonnormative events also do not involve assessments of either a person's age or cohort years. Examples of nonnormative events that can influence outcomes include

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Focus on **The Lived Experience**

The Life of a Stepfamily Member

Story 1

I loved my stepchildren before I met them. How could I not? They were Bruce's children. After spending the summer with them during their annual visit, my love felt deeper because they were both so much like their father. They were nice to me, and I had a fabulous time that summer before marrying their father, getting to know them. When it was time for them to leave, I sobbed like a baby at the airport and for days after.

When Bruce and I got married, I was thrilled to be their stepmother. I could not believe my luck at meeting a man who was a good father, with kids who liked me! However, things changed after we got married: the kids were not nice, or even respectful, to me. It seemed like they were deliberately trying to create conflict between their father and me. I hated how my husband catered to their every whim—to the point of serving them. When I suggested we have dinner together each evening, Bruce said the kids simply would not like it. I told my husband they do not have to like it, but that he could make them do it. I was angry and hurt, and my husband was unaware—entirely focused on doing anything his children wanted, even if it was unhealthy or extravagant. I was miserable and confused.

We went to Disneyland that summer. When I got hungry around noon our first day there, I suggested to my husband we get lunch. Bruce asked his oldest son whether he wanted to eat yet. When the 10-year-old replied that he wasn't hungry, Bruce told me to get a snack while he took the boys on another ride. I was furious, but my husband wouldn't budge. The boys watched my tantrum with a smile. Just as I was finishing my snack, about 10 minutes later, my stepson was suddenly famished. We went to lunch. This incident got us into therapy.

In therapy, my husband and I learned our problems were common to stepfamilies in formation. We learned that the boys' behavior toward me was, ultimately, the responsibility of my husband. The boys were reacting normally to their father's marriage, wanting assurance he still loved them. We learned that creating a healthy stepfamily takes a great deal of work and commitment. I don't think we would still be married had we not gotten help with our marriage and education about stepfamilies.

It's been more than 10 years now since I became a stepmother. It has simultaneously been the most difficult, rewarding, and thankless job I have ever had. My stepchildren are nearly grown, both in college. I don't love my stepchildren in the same way their biological parents love them, but I do love them as a parent—a stepparent. The love I feel for my stepchildren is so great it cannot be put into words. I would not be the person I am today without my husband or without my stepchildren, and I am grateful. (P.S. They love me, too!)

Story 2

As I grew older, I knew if I got married, it would probably be to someone who had children. When I married a man with two young boys, I was sure his previous marriage was simply a mismatch. My husband was so wonderful, and I didn't believe it could have been anything else.

As a new stepmother, I planned to include the boys' biological mother in everything. After all, how could I create a home for them if I did not include the person who was most important to them? She was not hostile, but she was cold, even impolite. She would write thank-you notes to my husband for personal gifts from me. I made excuses for her because I was confident I would win her over. I knew we were going to be one big, happy family.

Then, my younger stepson had a serious problem in school while he was with my husband and me. She blamed me for this problem, shouted at my husband over the phone, and told me she was going to do everything in her power to make sure her children never saw me again because I was "dangerous." I was devastated, and I didn't understand. It was hard enough trying to find help for my stepson without her accusations.

My stepson got the help he needed, and today he is okay. His problem was not my fault, or anyone else's. We communicate with the boys' biological mother through a facilitator only, and it has helped tremendously. I have managed to recover from the hurt and pain.

Sometimes I think about how naive I was, imagining we'd all be a happy family, and I feel stupid. I'm no longer naive, but I still consider the bio-mom of my stepchildren a member of my family. We're just not talking right now.

The thing I want people to know about stepparents is that, whether anyone likes it or not, we are in a parenting role. We are parents, not biological parents, but parents nonetheless.

—Anonymous Author

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exposure to various kinds of traumas, such as the loss of a child, involvement in a serious car accident, exposure to a natural disaster, contracting a serious illness, experiencing serious maltreatment during critical periods of development, and many other non-predictable events and experiences. They can also be associated with other kinds of chance experiences that are positive, such as meeting a mentor at school, a caring neighbor, or a supportive intimate partner or friend. These positive experiences can promote rather than threaten developmental outcomes. Researchers and practitioners are now classifying many of these nonnormative influences as either risks or protective factors.

Assessing Developmental Risks and Protective Factors

Social workers need knowledge of factors that place individuals at risk for developing negative outcomes, as well as factors for developing positive outcomes. Early research on human development focused primarily on identifying factors that increased the probability of a person having poor health and well-being. These well-established threats to human developmental and behavioral outcomes involve *risk factors.* However, everyone who experiences a risk factor will not necessarily experience negative developmental outcomes. People can have other personal strengths and supports in their social environment that can buffer the effects of these established risk factors.

Knowledge of exposure to extreme risks is important, but studies such as the one by Emmy Werner (1996, 2005) showed that most children exposed to a single risk factor during the first two years of their lives are able to adjust. Werner and her colleagues followed all of the children born on the island of Kauai in 1955 for 40 years. Thirty percent of this study's birth cohort had one or more of the following risks: prenatal or birth complications, poverty, exposure to family violence, divorce, parental psychopathology, and low parental education. Two-thirds of the 30% of children with four or more risk factors had the highest probability of developing "learning disabilities, behavior disorders, delinquency, or mental health problems before adulthood" (Kloos, Hill, Thomas, Wandersman, Elias, & Dalton, 2012, p. 295). These and other findings in the overall risk literature have contributed to the **cumulative-risk hypothesis** (Rutter et al., 2010).

The cumulative-risk hypothesis assumes that many individuals can handle one or two risk factors, but "when you get up to two-risk factors, the chances of a negative outcome increase exponentially. It is not the presence of a risk in a child's life that results in negative outcomes; it is the level of cumulative risks" (Kloos et al., 2012, p. 295). Indeed, risk factors are likely to co-occur, and when they pile up over time, we now know that they will increase the likelihood of negative developmental outcomes (Masten et al., 2009). In other words, there are very few single-risk factors after the prenatal phase of development that are associated with negative developmental outcomes germane to many human behavior concerns. Many problems in living commonly encountered by social workers occur after exposure to multiple risk factors. Figure 1.3 illustrates assessed differences between risk and protective factors.

It is important to note, however, that developmental scientists focus not only on understanding the relationship between risks and negative developmental outcomes but also on identifying factors that can promote resiliency under various conditions of adversity. This focus on understanding the relationship between risks and resilience has produced additional findings about the kinds of factors that can help to buffer or protect individuals from negative outcomes after exposure to known risk factors. These factors are **protective factors** in the risk and resilience literature (Mark & Fraser, 2015; Waller, 2001). The protective factors help practitioners explain and predict good forms of adaptation in situations of adversity.

The risk and resilience framework is one framework for assessing and understanding developmental concerns. The next section provides a brief overview of other perspectives in the developmental sciences for understanding human developmental processes and outcomes.

Perspectives on Human Development

Stage theories have played a significant role in understanding the changes in human development in the field of psychology. Compton and Hoffman (2013, p. 178) wrote:

> Stage or growth models postulate recognizable stages that need to be addressed, roughly at different ages. In contrast to stage theories, lifespan models do not postulate age-specific challenges but rather see personality development as a continuous process of adjustment to challenges. Often these adjustments are viewed in terms of various phases of life, such as adolescence, early adulthood, and middle adulthood. (2019, p. 236)

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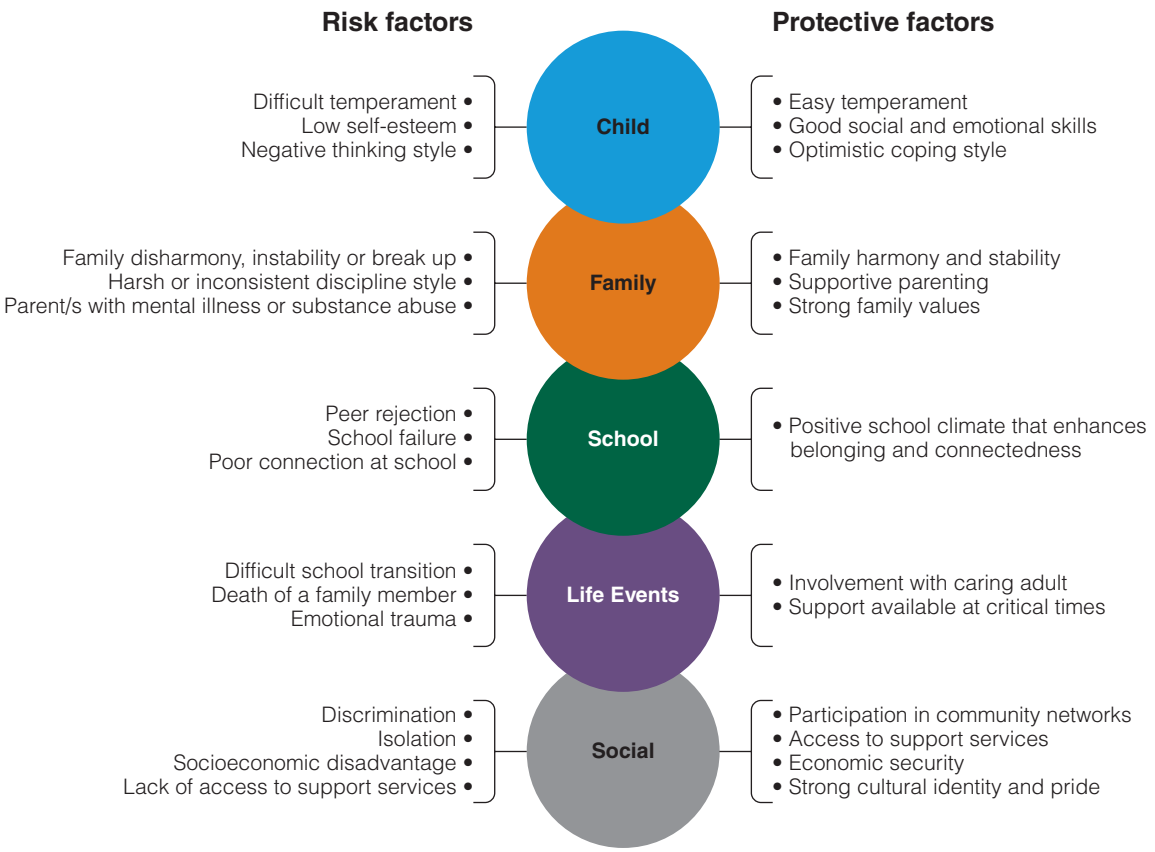
Exhibit 1.3 Assessing Risk and Protective Factors



An excellent example of a stage theory is Erik Erikson's eight stages of psychosocial development. For Erikson, each stage represents a specific psychosocial "crisis" that results from both biological forces and age-related social or cultural expectations. The biological forces follow an inborn plan that governs when and how aspects of the biological system arise. This plan represents an *epigenetic plan*, which means that it follows a biological blueprint that dictates how the organism grows and reaches maturity. This plan guiding the biological forces combines with changes in the social expectations of a society to structure the person's adaptation or adjustment to his or her environment.

Erikson identified eight psychosocial stages of human development, as shown in Exhibit 1.4. Each of these stages marks a specific crisis that encompasses "appropriate physical, emotional, and cognitive tasks that individuals must master in the struggle to adjust to the demands of the social environment" (Okun, 1984, p. 16). This patterned sequence of changes is not complete in adulthood, and it continues across the life span. For Erikson, a fundamental issue that individuals revisit across this sequence of changes is their identity.

Each of Erikson's eight stages of development refers to a psychosocial crisis or conflict. These conflicts involve bipolar tasks, such as trust versus mistrust. His focus on these bipolar tasks for specific stages of development is what differentiates his approach from the approach of life-span models of development. In our developmental chapters, we will refer to Erikson's psychosocial tasks, which continue to influence theory and research on human development. His approach is appealing to social workers, because of its sensitivity to the effects of social and cultural variables on processes of human development. However, the age grading associated with many of his identified stages is not without controversy. Many individuals do not adhere to the age grading implied in his stages of psychosocial development. In addition, his stages reflect a historical bias toward heterosexuality, marriage, dual-parent families, and other social formations that differ from many of our current psychosocial realities. Sociologists and other theorists who give increased

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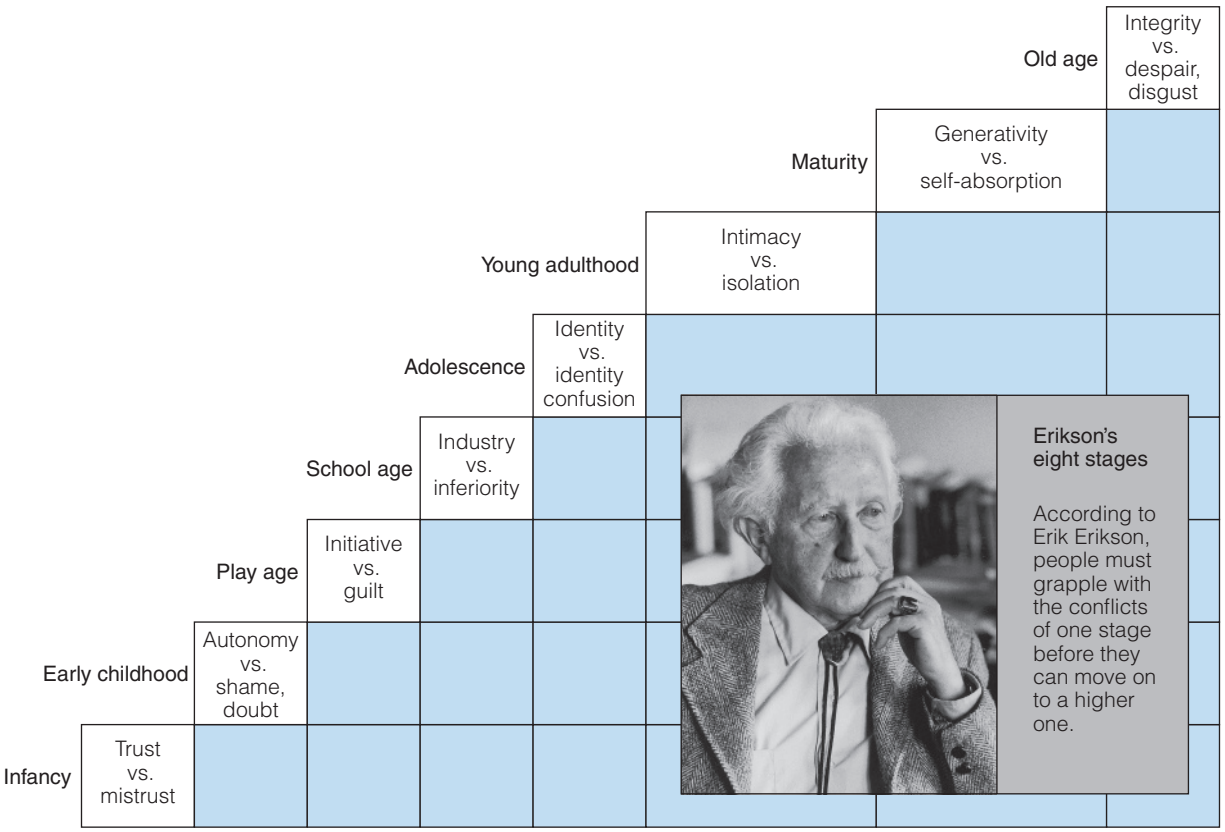
Exhibit 1.4 Erikson's Eight Psychosocial Stages



Source: Adapted from "Reflections on Dr. Borg's life cycle," by E. H. Erikson, in "Adulthood," Daedalus, 105(2), Spring 1976, p. 43. Copyright © 1976 American Academy of Arts and Sciences. Adapted with permission.

primacy to understanding the contributions of contextual factors identified many of the biases in Erikson's theory, and other stage theories.

Sociologists' research and theory construction, by contrast to stage approaches, has focused on understanding the contributions of *social forces* and *social changes* to the age-differentiated **life course** (Mortimer & Shanahan, 2006). Sociologists are also much more interested in studying changes in *patterns of life* or in *social-environmental pathways (life paths)*. Phyllis Moen (2003) wrote, "A life-course approach investigates people's life paths as they play out in historical context as well as in the situational circumstances and chance events shaping them" (p. 13). An important aim within this approach is to understand how time operates at both a social-historical and a personal level (Elder, Johnson, & Crosnoe, 2004). Different historical periods—the economic recession of 2008, the Gulf and Iraq Wars, the Great Depression, the 1918 and 2020 pandemics—will all contribute to important changes in the personal lives of individuals growing up in each of these distinct periods of history. Sociologists recognize that people will have common human needs associated with varying life tasks, but that these needs are not as universal as once assumed (Heinz & Marshall, 2003). "For instance, youths today do not confront the same life choices and tasks in coping with transitions from adolescence to adulthood as youths experienced in the early 1900s or 1950s" (Ashford, 2013, p. 83). The sociological perspective recognizes that tasks considered universal markers of adolescent development in previous generations changed because of changes in history (time) and changes in place (socio-geographical context) (Ashford, 2013).

Social workers need to place in proper perspective what each of the prior academic traditions and models of development will bring to our understanding of changes in people and environments. With this end in mind, we will incorporate each of the assumptions from these overlapping approaches to human development in

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our integrative multidimensional framework for understanding human behavior in Chapter 2. That people change over the course of their lives is not a particularly contentious issue. However, precisely how and why people change continues to be a topic of debate in the twenty-first century (Garcia Coll et al., 1996; Garcia Coll, Bearer & Lerner 2004; Lerner, 2015). Life-span development is an additional perspective and is a major theme in this book because of the value that it brings to our understanding of issues of continuity and discontinuity in change processes, and the age norming and grading of developmental tasks. We begin our description of the different perspectives or models of human development with the life-span perspective in psychology. Exhibit 1.5 provides important contrasts between life-span and life-course perspectives.

Exhibit 1.5 Differences Between Life Span and Life-course Perspectives

Life Span	Life Course
Individual (micro influences)	Group (macro influences)
Age norms	Age grades
Life stages	Age stratification
Continuity and discontinuity	Contextual variations
Individual trajectories	Social pathways or life paths
Coping behaviors	Life choices and life chances
Maturational effects	Cohort or period effects
Dispositions, behaviors, and traits over time	Roles or events (transitions) sequenced over time
Changes in behavior in social context	Changes in patterns of life within life domains
Age-norm expectations about what is expected biologically, psychologically, and socially at different points in the life span.	Age grades represent socially defined age groups such as infancy, adolescence, and emerging adulthood.
Individual difference is the component of life-span perspective that focuses on understanding what contributes to differences among individuals observed at different points in the life span.	Age stratification involves attributing qualities associated with social status to specific age groups. Different cultures, for instance, will have different perceptions of youth and old age.
The life-span perspective examines continuity and discontinuity of traits, dispositions, temperament, emotions, behaviors, and personality over the course of a person's life.	The issue of contextual contributions that results in expectations that are not as universal as once believed.
Individual trajectories represent changes in direction of specific traits such as changes in shyness over the course of a person's life.	Life paths are considered specific paths followed in a specific life domain toward a specific life destination such as marriage, career, or other life choice.
Individuals adopt different individual styles of coping with life demands and challenges.	There are different social pathways that can be followed in achieving life destinations.
Maturational effects are associated with biological processes within individuals that vary over the span of a person's life, regardless of specific external events such as growing older.	Life choices are shaped and constrained by inhibiting and promoting environments.
The life-span perspective studies the paths or the trajectories of a person's behaviors, personality, and traits over time.	Cohort and period effects involve influences on changes in behavior and development that are shared by individuals who were born around the same period of time, which is why they are also referred to as period effects. The life-course perspective studies the trajectories of roles or events (transitions) from one status to another in specific life domains and for specific life destinations (marriage, divorce, becoming a parent; becoming a delinquent).

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Life-Span Perspective: Assumptions and Issues

Most research and writing in the life-span tradition adheres to one of two styles. The first is the study of behaviors, dispositions, skills, and traits over a substantial period of the life span. For example, Terrie Moffitt and her colleagues have studied the traits of *emotionality*, *constraint*, and *intelligence* over time in birth cohorts in New Zealand and in the United States (Hagan, 1995). Their research specifically tracks the role of the continuity of individual differences in explaining deviant behaviors (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996).

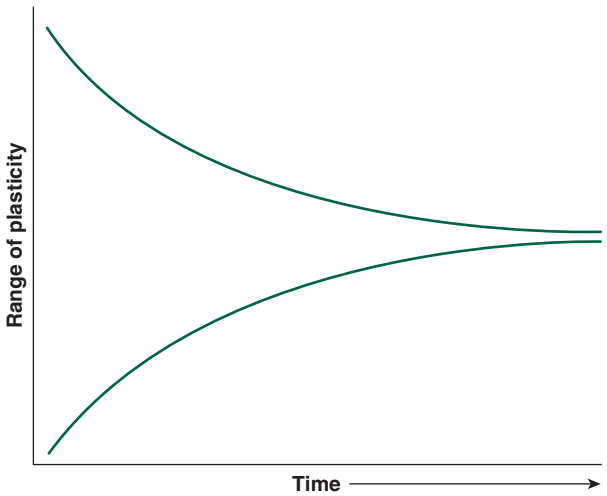
The second style of research in life-span studies focuses on clarifying how specific psychological functions, traits, and skills in one phase of development compared with other phases (Berk, 2022). That is, the life-span perspective provides a description of age-related biological, psychological, and behavioral changes from birth to death (Hutchison & Charlesworth, 1998). For instance, life-span theorists are interested in discerning what development is like in midlife and how it differs from other stages of development. We are now seeing this perspective applied to many other aspects of human behavior, including the development of positive social character and other personal strengths (Brown-Kirschman, Johnson, Bender, & Roberts, 2009; Compton & Hoffman, 2013, 2019).

Stability and Change Issues in Development

A dominant controversy in life-span research is whether traits or behavioral propensities are continuous or discontinuous. This controversy raises an important question about change. How hard is it for people to change? Some theories and theorists assume that once the formation of a person's self or personality occurs, change is very difficult (Mahoney, 2003). For example, Freud assumed that the bulk of personality happens by age seven and that minimal changes in personality occur after this age. From this perspective, once personality patterns occur, they are subject to modification, but the basic personality structure remains the same—because of processes of *cumulative continuity* or *self-selection*. "Cumulative continuity refers to the way in which behavior at one point in life influences opportunities and behavior later in life" (Benson, 2013, p. 15). For instance, early failure in school can generate stereotypes and other expectations that facilitate future failure in school. *Self-selection*, on the other hand, refers to a person's tendency to select contexts and experiences that are consistent with personality traits. The process of continuous change is not limited to personality. It is also applicable to many other traits, propensities, or dispositional characteristics addressed by developmental theorists, including developing positive social character (Peterson & Park, 2009).

One of the theoretical propositions advanced by life-span theory is that change occurs across the entire span of a person's life. In some contexts, this is referred to as *plasticity*, or "the human capacity for change" (Mahoney, 2003; Lerner, 2015). However, some earlier theories of development subscribe to a funnel theory. This hypothesis assumes that possibilities for change contract over time (Mahoney, 1991, 2003). Exhibit 1.6 provides a graphic depiction of this thesis. The possibilities for change decline because people have a declining capacity for change as they age. This assumption supports biological models that limit development to the first half of life and processes of aging and decline to the second half (Mahoney, 2003). Although early concepts of development support this thesis, recent research based on the life-span tradition disproves this assumption. We now know that human development does not involve the passive unfolding of prewired maturational programs or mechanistic reactions to environmental stimuli (Staudinger & Bluck, 2001). People are in constant transactions with their environments. They actively select contexts, change contexts, and the contexts change them as the contexts vary from one historical period to the next period (Staudinger & Bluck, 2001).

Exhibit 1.6 Funnel Theory



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The American Academy of Social Work and Social Welfare is championing social progress through the establishment of its Grand Challenges for Social Work (American Academy of Social Work and Social Welfare, 2022). This initiative focuses on addressing pressing social issues through science. One of its pressing social issues is mass incarceration. The United States incarcerates more individuals than any other nation in the world. The rates of incarceration in the United States often have little to do with public safety. The attendant non-safety rationales for incarcerating people for nonviolent offenses are an issue that disproportionately affects people of color. In response to this serious social issue, one of the academy's challenges for a just society is the promotion of smart decarceration (Academy of Social Work and Social Welfare, 2022). For this reason, we apply evidence from different developmental perspectives to the problem of delinquency and crime to clarify how and why understanding human development is an important foundation of knowledge for the practice of social work. Developmental perspectives apply to other issues like family violence and the development of psychological and behavioral health issues. This is why social work has always included content in education for social work on human growth and development (Ashford, 1997).

Implications for Practice

Delinquency is a major problem that social workers confront in many communities in which they currently practice. We have selected the problem of delinquency to illustrate how the life-span perspective can augment our understanding of this specific social problem. We selected this social problem because social work and other advocacy groups are becoming increasingly concerned about the over-representation of racial and ethnic minorities in the criminal justice system. The application of theory and theoretical frameworks in efforts to understand this and other social problems enables social workers to formulate and advocate for policies that advance the rights of individuals that they are sanctioned to serve.

In order to formulate appropriate strategies to reform society's response to issues of delinquency and crime, they need to identify relevant targets for change. Different theories of human behavior and different developmental perspectives will select different targets for change. Accurate life-span considerations are critical for understanding how the problem of delinquency, or any problem for that matter, develops in youth and how it can potentially change over the course of the youth's life. With these understandings about how the problem developed, practitioners should be in a better position to develop relevant prevention and intervention strategies.

Accordingly, what does the life-span perspective offer practitioners in trying to understand the social phenomena of juvenile delinquency? Does delinquency reflect a trait or propensity to crime that remains constant over time? Is there a critical period for the development of this propensity? Once this propensity is developed, how likely is the person to change? Note that each of these questions, if answered in the affirmative, is consistent with a general theory of crime and delinquency (Lahey & Waldman, 2003). This theory assumes that the behavior of delinquents is sufficiently homogeneous for a single or common set of causal factors in explaining criminal behavior (Ashford, Sales, & Reid, 2001a). An excellent example of this viewpoint is Gottfredson and Hirschi's (1990) *A General Theory of Crime*. Their theory identifies poor self-control as the key factor associated with all forms of crime. Exhibit 1.7 examines the critical assumptions associated with the general theory of crime.

If poor self-control causes delinquency, then preventive interventions must address personal and social factors that place individuals at risk of developing poor self-control. Research on the subject has identified differences in early parenting experiences, as well as neuropsychological processes that are associated with the development of poor self-restraint (Benson, 2002; Moffitt, 2003; Simons, Simons, & Wallace, 2004). If we do not modify these factors by age 10, then a propensity for crime will exists that remains relatively stable across the life span (Benson, 2002, 2022). This theory has a very pessimistic outlook on the potential effectiveness of treatment interventions after age 10. Clearly, in this viewpoint, variations in types of offender patterns are due to variations in the criminal propensity of the offender. According to this approach, treatment must target the individual's capacity for self-control, and this type of intervention would hold increased promise for success prior to age 10.

However, developmental criminologists contend that the General Theory of Crime is not a developmental theory (Benson, 2022). Other approaches in criminological theory, on the other hand, adopt a life-span perspective, which assume that the causes of delinquency and crime can change over the course of an offender's life. As in life-span theory, developmental criminologists do not assume

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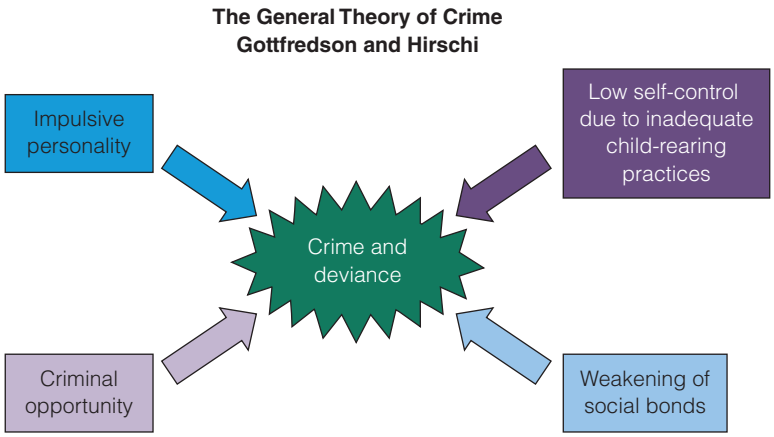
Exhibit 1.7 The General Theory of Crime



that the causes of crime are universal. These developmental theories assume that offenders are too **heterogeneous** to have a common set of causes. According to this viewpoint, there are distinct types or groupings of offenders with distinct causal processes (Ashford et al., 2001a; Benson, 2022).

As an example, Terrie Moffitt's theory of crime and delinquency has identified two types of offenders: life-course-persistent and adolescent-limited. "According to Moffitt, these two-types of offenders follow distinctly different trajectories in crime and antisocial behavior over the life course, and their differing trajectories are caused by fundamentally different factors" (Benson, 2002, p. 82). Research by Moffit and colleagues (1996) demonstrated that the age of onset of crime and conduct problems for life-course-persistent offenders begins earlier in life than the onset for the adolescent-limited type. Moffitt found that the life-course-persistent offender differs substantially from offenders with an onset of crime in adolescence. Moffitt (2003) identified neurodevelopmental and family risk correlates for the early-onset type (Hodgins & Janson, 2002). The participants in the second type, adolescent-limited, desisted from crime as they aged out of adolescence. Moffitt hypothesized that each of these types have different causal factors. Peer processes had more of an effect on adolescent-limited crime then life-course-persistent crime. Patterson, Reid, and Dishion (1992) have identified similar types, early starters and late starters, but attribute different causal processes to understanding them: family processes. Unlike Gottfredson and Hirschi (1990), most developmental criminologists assume that there are different crime pathways or trajectories caused by different causal processes.

Developmental theories of crime and delinquency also attempt to explain important societal-age crime patterns. When we compare rates of crime across age groups, we learn that adolescents and young adults are at the greatest risk of involvement in crime. "The calculation of age-adjusted arrest rates clearly shows that arrests occur much more frequently during the late teenage years than at any other time in the life course" (Benson, 2002, p. 71). Why is this true? This question is the type of substantive problem that life-span theory helps practitioners focus on, and its answer has important policy and practice implications. *Exhibit 1.8* shows the age-adjusted rates. These results demonstrate that youths have more arrests between 15 and 20 than adults between 35 and 40 do. What is the significance of this empirical fact? Does it mean that we should institute policies that prevent young offenders from engaging in crime by imprisoning them until they grow out of the risky age group? What are the problems with this type of thinking? How would developmental theories of delinquency help?

The data reported in *Exhibit 1.8* is cross-sectional information on crime rates. This information is important, but it tells us very little about individual types of offenders and the potential for change for specific types. In order to address the issue of individual change, we need longitudinal data, as well as data that help identify different types of offenders. *Exhibit 1.9* presents information on the age of onset of serious involvement in crime over time. This information provides different information of relevance to understanding types of offenders. We currently know that a small percentage of offenders commit the majority of crimes. In addition, a small percentage follows a life-course-persistent pattern. For this reason, some theorists

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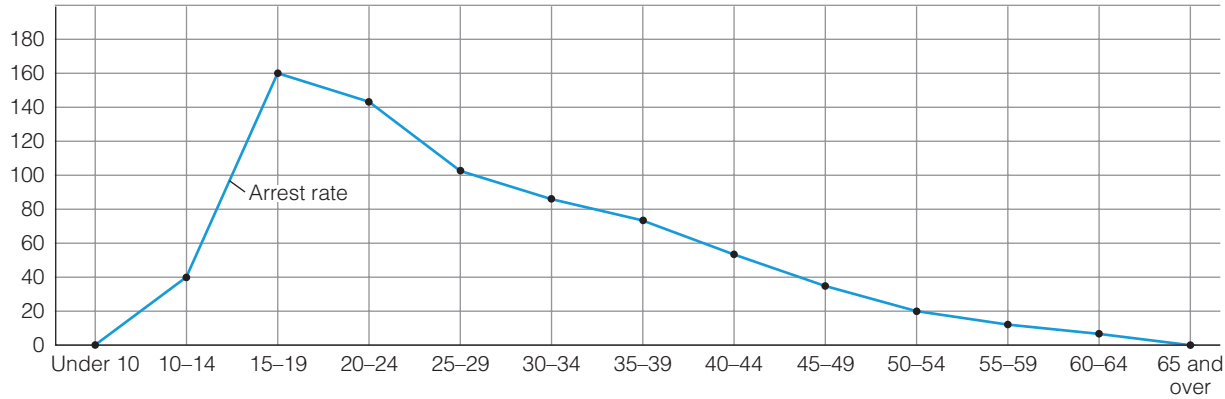
Exhibit 1.8 Arrests per 1000 by Age



would argue that we clearly do not want to subject individuals who are likely to grow out of crime to long periods of incarceration, and that the group that we need to target for long periods of incarceration would be the individuals who fit a life-course-persistent profile.

In this brief discussion, we have attempted to show how information about age and development can guide societal responses to delinquency. Clearly, different theories will provide different approaches for understanding many age-related considerations.

Exhibit 1.10 depicts the developmental trajectories of aggressive behavior for three 10-year-old children. These trajectories illustrate the types of traits studied by scholars from the life-span tradition. Child A has maintained a high rate of aggression over time. Child B's trajectory shows a constant rate of aggression over time, and child C's trajectory shows a pattern of accelerated growth of aggressive behaviors. In order to interpret these trajectories, the practitioner needs to consider not only the **current** intensity or level of the child's aggressive behavior but also the **developmental trajectory** of aggressive behavior and its relation with age norms for that type of behavior. Developmental research provides this type of information. We understand intra-individual changes best when we defer to longitudinal data. Life-span developmental theory provides excellent information about changes in specific traits over time and about the norms appropriate for evaluating these changes. Life-span information also helps us in isolating whether the changes observed in traits, skills; functions, strengths, and so forth are due to the age of the individual, the cohort group, or specific contextual factors in the person's immediate environment.

Life-Course Perspective: Assumptions and Issues

The life-course perspective originated in sociology and has many similarities with the life-span perspective. In some contexts, researchers use the terms describing these perspectives interchangeably, including some of their

Exhibit 1.9 Hazard Rate for Onset of Serious Offending

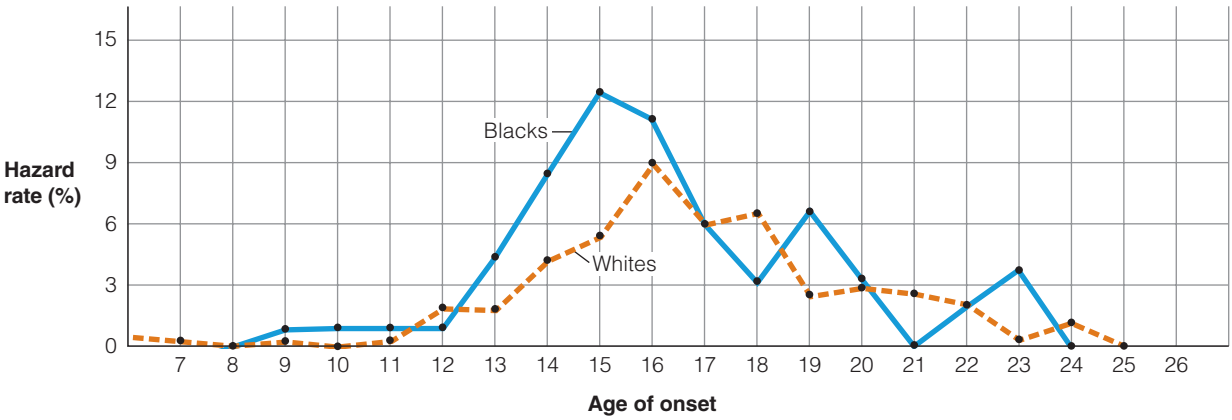


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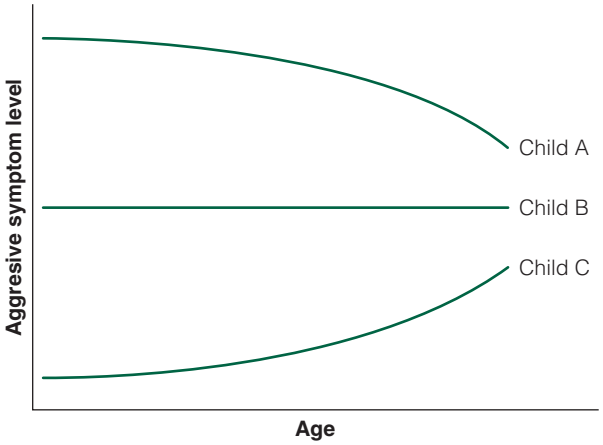
Exhibit 1.10 Developmental Trajectories for Aggressive Behavior



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A student addresses the demands associated with the transition to High School here.

concepts (e.g., transition and trajectory), but we will treat them as separate perspectives in order to clarify important differences.

The life *course* is both a concept and a distinct *theoretical perspective* (Bronfenbrenner, 1996, 1999; Clausen, 1986; Elder et al., 2004). The life course refers to *age-differentiated life patterns* embedded in social institutions that are subject to historical changes (Elder, 1991, 1996). This approach focuses on understanding changes in *patterns of life*, rather than on understanding changes in personality, traits, or behavior. The life-course perspective uses the concept of trajectory to understand the environmental paths or the social paths followed by people in key social domains of life: work, marriage, crime, and parenthood (Elder, 1996). What is the common pathway—the sequence of events or transitions—to having children? Does this pathway vary with socioeconomic status? Does the current pathway differ from known pathways at the turn of the eighteenth century?

Life-course theorists are also interested in understanding the causes of other life destinations or outcomes (Gotlib & Wheaton, 1997; Paternoster & Brame, 1997; Rutter et al., 2010). They want to describe and explain life destinations in terms of trajectories and transitions. A *trajectory* is defined by Gotlib and Wheaton (1997, p. 2) as "the stable component of a direction toward a life destination . . . characterized by a given probability of occurrence." *Trajectory* refers in this context to a specific path or line of development followed by a person to a specific life outcome, regardless of whether the outcome is positive or negative. What is the pathway to homelessness? Do marker events for this life destination differ from those for graduating from college? Do role paths or trajectories to graduate school in social work differ from role paths to medicine (Ashford, 2013)?

The life-course perspective assumes that role transitions exist within trajectories and that both the transitions and the trajectories allow for micro and macro levels of analysis. Many writings also describe role transitions as a series of linked states (Elder, 1996). A change from one of these states to another constitutes what is technically termed in the life-course literature as a *transition*. **Transitions** refer to short-term state changes that are marked by life events. Each life trajectory involves an ordered sequence of life events, roles, and transitions embedded within a specific life trajectory such as parenting, work, crime, or marriage (Elder, 1991; Paternoster & Brame, 1997). Some life-course theorists prefer to focus on the sequence of roles in a particular life domain, rather than on changes in life events. However, the goal for both of these approaches is to identify the **ordered sequence of role and event changes** in a person's life.

The **Focus on Lived Experience** presents a narrative that describes Daniel's college transition to illustrate the use of different methods for obtaining knowledge about life transitions. This narrative shows the kinds of challenges that youths encounter in making the transition to college. It involves multiple adjustments to this important milestone in Daniel's life. Personal narratives are an important source of knowledge. For instance, *Reflections: Narratives of Professional Helping* is a journal in social work that examines narratives of special interest to members of the social work profession. These narratives represent a different source of knowledge about human development.

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Qualitative researchers use narratives to capture the lived experiences of persons with different intersecting statuses or different events such as developing an illness or losing a baby. We use different narratives throughout our developmental chapters to capture variations in the lived experiences of persons at different phases of the life course.

Transitions are clearly an inevitable part of any person's life. "Until death stops it all, human lives are always in transition" (McAdams, Josselson, & Lieblich, 2001, xv). Although it is a cliché to say that the only constant in life is change, we often proceed as if our lives were simple, not complex and fleeting, as they really are. We subscribe to what has been termed the myth of arrival. Mahoney (2000, pp. 2–3) wrote, "This is the myth that someday after hard work and survived crises, life will be what we always wanted. We will have our 'self' and our 'life' together, living in the relationships for which we have longed, in the house of our dreams, in the job (and at the salary) we have wanted and so on." However, every inevitable transition involves meaning making and various forms of adaptation. Life-course theorists who work with narratives attempt to understand how people make

Focus on **The Lived Experience**

College Transition

Handling College's Freedoms

A teenager's transition into college life can be very exciting yet very stressful and confusing at the same time. After living at home for 18 years with the security provided by my parents, I was thrown into a whole new world with as little as a few weeks' time for making an adjustment. Time flew by so fast that I had to try very hard to get a firm grasp on my personal situation before everything passed me by.

In preparing for my first fall semester, I was really concerned about my future roommates. I was going to live in one room with three other guys. I considered this a double-edged sword. However, the positives proved to outweigh the anticipated negatives. Rather than the four of us constantly getting on each other's nerves, we got to know each other very quickly and were constantly together. This, of course, did not come without patience and the kinds of generosity that all roommates must put forth if they are to get along. When one roommate is playing the guitar, the second is talking on the phone, and the third is watching television, sacrifice is definitely needed.

Meeting new friends was the best thing about my first year at college. My friend Paul has a very zany personality, just as I do, so when we first met that fall, I thought that he was absolutely hilarious. We distinctly remember our first two months as friends because every time we saw each other, we simply laughed ourselves silly. Also, after having a girlfriend for most of my senior year, it was nice not having a "significant other" during my freshman year. I could go out and meet as many people as I could, and I made several female friends that I know I'll be close to for a long time. One of my roommates started dating a girl the first week of school, and when they broke up with each other after a couple of weeks, he hardly knew anyone. He spent all of his time with her, and probably missed getting to know many people.

Another change that naturally evolved pertained to my relationship with my parents. My mother was pretty open-minded about the "whole college thing." She actually expected me to start drinking, even though I did not. When I came home for breaks and the following summer,

Courtesy of Daniel Brosmer

Students experience transitions when they change from the home environment to the high school and college environment.

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my parents automatically gave me more responsibility, and the word "curfew" was never even mentioned. When one of my friends discovered the same thing, her response was, "What happened to my old parents?" Because of the family atmosphere of my dorm and the friends that I met, I felt very comfortable being an 11-hour drive away from home. I called home every Sunday night to keep in touch with the home front, and I often e-mailed my father to update him on little things, but I honestly never really missed my parents this past year. Although it sounds sort of insensitive, I think that it shows that I grew up as an individual. At college, I enjoyed the freedom that I received, and I believe that I used it in a responsible manner. It really made me more mature and more ready to handle the life ahead of me.

—Daniel Brosmer

meaning out of these life transitions. In their viewpoint, people make meaning out of their lives with storytelling—"the construction and the sharing of stories of the self" (McAdams et al., 2001, p. xv). The stories people tell help them position themselves in their social and cultural worlds. One key element of these stories is their location within the social clock prescribed by their culture and its age-grading institutions. We capitalize on narratives in the developmental sections of the book to sensitize readers to different forms of meaning making in different phases of the life course. These narratives are a way to represent what qualitative researchers refer to as the **lived experience** of phenomena.

Understanding the connections between the age and the timing of events or role transitions is a key principle of life-course theory. The timing of the event in relation to a person's chronological age can have significant implications for the consequence of the event (Lerner, Perkins, & Jacobson, 1993). For instance, Elder found in his research that younger children were more seriously impacted by the adversities of the Great Depression than were older children (Ashford, 2013). Similarly, when and for how long a child's abuse occurs has important implications. For this reason, a central concern in the life-course perspective is assessing the **timing** of a specific event and trying to determine its influence on a person's life trajectory. Some transitions under circumstances of adversity can lead to major turns in the direction of a person's life.

Considerable research in the life-course tradition has been devoted to studying individuals under conditions of maximum adversity, such as the Holocaust (Levav, 1998), natural or human disasters (Giel, 1998), and childhood victimization (Widom, 1998). Research using this perspective recognizes that the life course, as an institution of socialization, can be influenced by major processes of social change, including wars, economic depressions, natural disasters, and other macro-oriented events, such as 9/11 or the pandemic (Heinz, 1996). Elder's (1974) seminal work on the effects of the Great Depression on life patterns is an excellent example. (See also Clausen's 1993 research on children of the Great Depression.) What sets these researchers apart from other developmental scientists is their interest in period and history effects on developmental changes. Other examples of history effects include growing up during or after the Civil Rights Movement for African Americans; for Native American children growing up after or prior to Wounded Knee; going through adolescence during the 2020 pandemic; and changes in U.S. society pre- and post-9/11 and post-COVID-19. In the life-course perspective, issues of time and timing often shift from focusing on the characteristics of the person to features of the environment or context, including the historical period (Bronfenbrenner, 1999; Friedman & Wach, 1999; Shanahan & Elder, 2002). It is important for social workers to consider various historical events in examining many aspects of human development. Researchers are now trying to determine the differential effects of the COVID-19 pandemic on school and college aged and various age groups within the workforce.

Implications for Practice

Robert Sampson and John Laub (1990, 1993, 1997) are life-course criminologists who have developed an age-graded theory of informal social control for explaining crime and delinquency. Their theory relies on the fundamental assumption that delinquency and crime are natural occurrences. Consequently, society has to prevent people from following their natural inclinations; otherwise, they are at risk of engaging in antisocial or criminal behavior (Benson, 2022). It is Laub and Sampson's contention that there are different environmental pathways of informal social control that vary across a person's span of life that provide informal forms of social control (Laub & Sampson, 2003). In childhood, the key components of this environmental pathway are the

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family, school, and peer groups. In these groups, children experienced different types of informal controls of their behavior that determine whether they will engage in crime. As in other delinquency research, the family is an important contributor to delinquency (Simons et al., 2004). Children whose parents do not monitor them are at increased risk for delinquency. However, these environmental pathways to delinquency change in young adulthood. In this phase of development, work, marriage, and the military are key domains associated with crime prevention and informal social control. That is, when young adults experience relevant informal social control in their work or marriage, then they are less likely to engage in crime. In fact, Sampson and Laub found that marriage and work were key determinants of whether a youth with high propensities toward crime experienced a *turning point* in his or her crime trajectory (Sampson & Laub, 1993; Simons et al., 2004).

In essence, the life-course perspective from sociology offers a different view of the role of time and age in human change from that of life-span models of psychology. It focuses much more on the contributions of the context on observed changes in behavior. **Biographical time** (the life history) in the life-course perspective represents a socially constructed pathway of role transitions affected by the historical time and the place where the individual's life history unfolds. Researchers who use this approach focus on explaining how the biographical timing of events reflect changes in institutions or historical changes in socio-geographical contexts (Weymann & Heinz, 1996). Thus, a benefit of the life-course perspective is that it allows for an examination of the multiple dimensions of time—**biographical time, social time, and historical time**—in understanding human behavior (Weymann & Heinz, 1996).

In early life-span developmental theory, social structure was often taken-for-granted or treated as a given (Hagestad, 1991; Heinz, 1991). Dannefer (1984) and other sociologists challenged this limited approach for understanding development. They adopted approaches to development that assume that social policy and other sources of social change can influence institutions of training, employment, kinship, and socialization that have implications for the life course (Ashford, 2013; Laub & Sampson, 1993). This focus on policy assumes, of course, that the timing of change in the life course can be subject to the influences of social processes. In other words, developmental change in this theoretical approach is not limited to modifications in the organism's physical structure. Social changes can influence developmental patterns whether they are due to **social policy, macro events**, or **other environmental circumstances**.

Public policies can have significant implications for the life course of many people. Indeed, President Barack Obama's executive actions for dreamers resulted in major changes in the lives of a select group of immigrants that was not available for similarly situated immigrants from earlier generations from China, Central America, and Mexico. The president's policy enabled dreamers to participate in activities that were previously limited to documented citizens, which has significantly altered the lives and the life chances of the dreamers. **Life chances** refer to differences in opportunities for gaining power, respect, and well-being (Tipperman & Wilson, 1996, p. 31).

Redlining was another example of a policy that influenced the life chances of marginalized groups in our society. **Redlining** was a public policy that began in the 1930s, whereby government loans were unavailable to persons from neighborhoods deemed risky, which differentially affected the lives and life chances of persons of color (Rothstein, 2017). These policies were major contributors to racial segregation in the United States. Consequently, these policies had serious effects on the social mobility and accumulation of wealth for African and Mexican Americans. Another policy contributing to inequalities of access for African Americans occurred after World War II. Many nondominant, groups lacked access to GI benefits in some parts of the country available to other ethnic groups, for example, Italian and Irish Americans. The other White ethnic groups had different opportunities that contributed to improvements in their social mobility and corresponding capabilities for the increased accumulation of wealth because of their access to GI benefits not available to African and Mexican Americans in some communities.

The next section deals with an alternative approach to development from life-span and life-course perspectives. This perspective does not focus on risks or problems, but on understanding how strengths promote positive developmental outcomes.

Strengths Perspective: Promoting Strengths, Assets, and Good Lives

The prior discussion of delinquency illustrates how life-span and life-course perspectives offer different lenses for evaluating behaviors and the course of a person's life. However, developmental theory and principles are not limited to understanding problems or issues. They are

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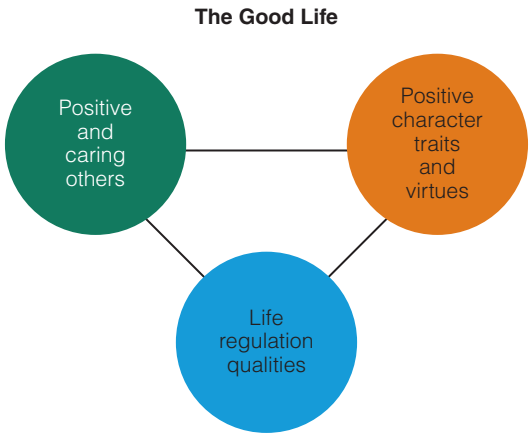
Exhibit 1.11 Characteristics of Positive Psychology and Strength Perspectives

- Every person has strengths.
- Every person is not a problem or considered "broken" but is considered instead a resource.
- Aligning resources in a person's environment with strengths can promote positive development.
- Human development is plastic.
- The strengths perspective does not focus on managing risks, but on promoting positive development.
- Positive psychological researchers are examining factors that constitute the good life.
- Character traits and virtues are considered strengths.

Exhibit 1.12 The Good Life



also useful for understanding the promotion of strengths, health, and subjective well-being. The strengths perspective in social work is consistent with other trends in psychology and other disciplines that recognize that every individual has strengths, "and their families, schools, faith institutions, and communities have resources that, when aligned with these strengths can promote positive development . . ." (Lerner, 2015, p. 149).

Positive psychology, and the strengths perspective in social work, assume that development is plastic and that people are resources to be developed. This viewpoint contrasts with approaches that focus primarily on managing risks. This shift in the orientation of researchers and practitioners, from focusing on problems, deficits, maladjustment, and pathology to focusing on strengths, recognizes the fact that values play an important role in the frameworks that practitioners rely on for guiding their intervention strategies (Tedeschi & Kilmer, 2005; Ward & Fortune, 2013). Approaches to development that focus on strengths are committed to the value of promoting good lives. A good life employs "your signature strengths every day to produce authentic happiness and abundant gratification" (Seligman, 2002, p. 13).

Defining good lives was previously beyond the reach of science. However, positive psychologists and social work professionals began in the late 1980s and early 1990s to apply scientific principles to the study of what constitutes the good life. Their investigations of good lives initially consisted of identifying factors that contributed to the greatest sense of subjective well-being, satisfaction, and personal fulfillment across the life span. The results of this research reinforced the importance of adopting frameworks that capitalized on assisting individuals to achieve goals that are meaningful, supportive of core values, and respectful of a person's sense of agency (Ward & Fortune, 2013). In keeping with these principles, Compton and Hoffman (2013, 2019) wrote that the good life consists of three key elements: (1) connection to positive and caring others; (2) positive character traits and virtues; and (3) life regulation qualities. The emphasis on connections, character, and specific capacities (life regulation qualities) is consistent with other scientific efforts toward measuring the factors associated with good lives. "[L]ife regulation qualities allow us to regulate our day-to-day behavior so that we can accomplish our goals while helping to enrich the people and institutions that we encounter along the way" (Compton & Hoffman, 2013, p. 3). In short, life regulation qualities rely on competencies, skills, or capabilities relevant for achieving the goals of "the good life." Exhibit 1.12 illustrates the dynamic relationships between elements in the Good Life Model.

Implications for Practice

Richard Lerner (2015) developed a strengths-based vision and vocabulary for examining the development of young persons that exemplifies the application of the strength's perspective to the applied developmental concern of juvenile delinquency. Lerner's positive youth development (PYD) framework grew out of advances in developmental systems theory, observations by community advocates, and longitudinal investigations of 4H-programs (Lerner et al., 2008; Lerner, 2015). The PYD framework does not consider youths as risks, as damaged, but considers them as

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resources to be developed (Lerner et al., 2008). To this end, this framework emphasizes understanding the interactions between youth and caring adults in varying social contexts, such as family, school, neighborhood, and community (Butts, Mayer, & Ruth, 2005). These social contexts consist of relationships between youths and adults that are capable of supporting the acquisition of what Learner and colleagues (2008) have termed the **Five Cs**: Competence, Confidence, Connection, Character, and Caring (see **Exhibit 1.13** for definition of the Five Cs). When a youth's life incorporates assets from a positive social environment that promotes the Five Cs, then this framework assumes that there is an increased probability that these youths will develop a Sixth C: "Contributions to self, family, community, and the institutions of a civil society" (Lerner et al., 2008, p. 7).

The Oregon Commission on Children and Families adopted positive youth development as a policy position for troubled and non-troubled youth. The Commission wrote: "Youth development is not a highly sophisticated prescription for 'fixing' troubled kids. Rather, it is about people, programs, institutions and systems who provide all youth, troubled or not, with the supports and opportunities they need to empower themselves. Youth development strategies focus on giving young people the chance to form relationships with caring adults, build skills, exercise leadership, and help their communities" (Oregon Commission on Children and Families, 2015).

Lerner and his colleagues identified specific features of youth services that reflect the principles of positive youth development. These features were (1) programs that promote positive and sustained relationships between youth and adults; (2) programs with activities that helped youth build important life skills; and (3) programs that afford youths opportunities to use these skills in valued community activities as participants and as leaders (Learner et al., 2008). These characteristics support the framework's Five Cs, as well as the three elements identified by Compton and Hoffman (2013) that are associated with their definition of the good life.

Principles from the strengths perspective have influenced policies and practices not only for youth service providers and programs but also for practitioners involved in the treatment of serious juvenile and adult offenders. Ward and Stewart (2003) introduced the Good Lives Model (GLM) as a strengths-based approach to correctional rehabilitation. "From the perspective of GLM, correctional programs should aim to increase individuals' awareness of their core values and assist them to translate this awareness into a concrete intervention plan" (Ward & Fortune, 2013, p. 29). A good life plan offers offenders alternative prosocial ways of achieving primary goods that support an offender's core values, which in this model represents an intervention plan. The GLM model "asserts that an effective way of reducing the risk of recidivism is by assisting offenders to formulate their personal priorities (primary goods or core values) within a good lives plan that translates these abstract values into lifestyles that bestow meaning and purpose to offenders while also lowering their potential for reoffending" (Ward & Fortune, 2013, pp. 31–32). In assisting offenders to achieve their life plans, the model directs practitioners to focus on two fundamental tasks:

1. help offenders think about what constitutes a good life and help them challenge distorted beliefs and attitudes
2. promote the development of internal and external resources, including the development of skills and other capabilities that offenders will need in order to implement their life plans (Purvis, Ward, & Willis, 2011; Ward & Fortune, 2013).

Exhibit 1.13 The 5Cs of Positive Youth Development

"C"	Definition
Competence	Positive sense of capabilities in various areas of life, for example, in academic, cognitive, health, emotional, and social areas of life.
Confidence	An internal sense of efficacy and self-worth.
Connection	Positive connections or bonds with people and pro-social institutions and involving peers, family, school, and community.
Character	A developed respect and application of sociocultural norms governing appropriate behavior and a fundamental sense of right and wrong.
Caring Compassion	A sense of sympathy and empathy for others.

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Other Supporting Frameworks, Theories, and Perspectives: A Brief Overview

In the remaining sections of this introductory chapter, we will review a number of other assumptions, frameworks, theories and perspectives on human behavior in the social environment that are important components of the multidimensional framework described in this book for examining developmental and other human behavior matters. We begin our review of this background information by examining the social functioning framework in education for social workers.

Social Functioning Framework

Werner Boehm (1958) made a significant contribution to social work's knowledge base by clarifying the profession's primary focus in responding to matters involving issues of positive adaptation. Boehm (1958, p. 14) wrote that the complexity of humans' "functioning and the increase of scientific specialization have made it necessary for each profession to take one aspect . . . as the primary focus of its activities." In Boehm's view, the physician focuses on enhancing a client's physical functioning and the social worker should focus on enhancing the social functioning of a client.

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Werner Boehm, the developer of the social functioning framework.

Social functioning is a technical term in social work that supports the profession's focus on person-in-environment transactions. It refers to the client's ability to accomplish the tasks necessary for daily living (such as obtaining food, shelter, and transportation) and to fulfill his or her major social roles, as defined by the client's community or subculture (Karls & O'Keefe, 2008). In responding to social functioning concerns, social workers address "common human needs that must be adequately met to enable individuals to achieve a reasonable degree of fulfillment and to function as productive and contributing members of society" (Hepworth, Rooney, Ronney, Strom-Gottfried, & Larsen, 2012, p. 6). This societally sanctioned mandate for the profession of social work assumes that social workers will have solid grounding in normative expectations about good forms of social adaptation.

Ruth M. Butler (1907–2007) was also an important figure in the development of social work's knowledge base (Ashford, 1997). She introduced educators to a framework on social functioning to advance Human Behavior and Social Environment (HBSE) curriculum in the education of social workers (Butler, 1970). Her framework reflected the profession's commitments to promoting effective social functioning and to considering person-in-environment transactions when assessing human behavior concerns.

The person-in-environment focus is a hallmark of the profession of social work (Akesson, Burns, & Hordyk, 2017). It places a person's experiences within their social and historical contexts, which allows for a wider understanding of a person's experiences. *Exhibit 1.14* presents an illustration of person-in-environment considerations that guide the assessments of social work professionals. This wider understanding is a potential guardrail against adopting simplistic solutions to human behavior concerns. Simplistic solutions do not recognize that any problem is part of a larger environment. To ignore this principle is to engage in the unfortunate fallacy of "ignoring the environment" in designing solutions to social system concerns (Churchman, 1978). Social work emphasizes considering a person's social environment when seeking solutions to their private troubles. For this reason, the feelings, thoughts, and behaviors of individuals require consideration of the social groups in which they occur and their larger social and cultural contexts. These groups constitute their *social environment*.

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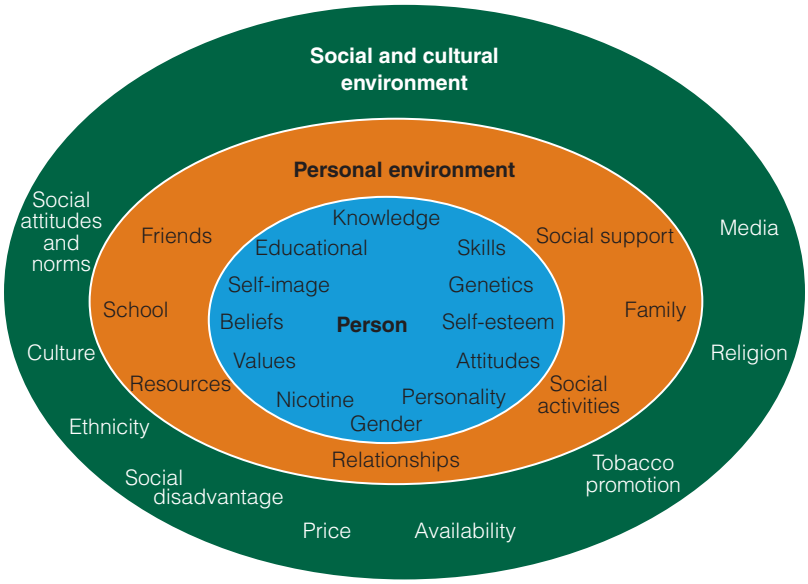
Exhibit 1.14 Person-in-Environment Model



A person's social environment also consists of *social forces* external to individuals that shape their behavior in different social contexts. Sociologists refer to these forces as social facts. **Social facts** refer to the norms, values, institutions, and social structures external to individuals that exercise control over their behavior. They are the properties of the collective worlds in which people live their lives. Consequently, they are independent of a person's private or personal expectations. Two social facts with important implications for understanding human behavior are **social norms** and **social stratification** (Crawford & Novak, 2018).

Social Norms

Social norms are what tells people how to behave in specific situations. For instance, can you urinate on the side of the road when you need to relieve a full bladder? We learn norms for guiding the answer to this question. The salience of specific norms for guiding this behavior can vary from society to society. Norms structure how people can and should address this important biological need. Indeed, it is common in many countries lacking public facilities for individuals to relieve their biological needs in the streets without sanction or disapproval. This behavior also varies from society to society and even within communities within a society. San Francisco is struggling, for instance, with how to respond to homeless people who do not use public facilities. This community has had higher levels of tolerance for this deviation from norms from other cities and communities in the past. However, the tolerance for this concern is starting to diminish in this community. Indeed, norms influence how societies react to deviations from normative expectations for various types of behavior. For this reason, norms play a major role in shaping human behavior and in shaping **societal reactions** to human behavior concerns.

Social norms are also a key component of social institutions. **Social institutions** consist of an "integrated set of social norms organized around the preservation of a basic society value "(Leslie, Larson, & Gorman, 173, p. 109). The sociologist Talcott Parsons (1902–1979) refers to five basic institutions that fulfill the basic functions of a society: the family, religion, education, economy, and government. Some of the functions that these institutions serve are now the responsibility of social welfare, health, and other social institutions. Social institutions maintain the social order by addressing key societal functions and other social needs. Consequently, they are important forces in shaping different kinds of behavior.

Social Stratification

Social stratification, on the other hand, "refers to the rank ordering of groups from low to high in terms of access to important resources such as money, power, and prestige" (Crawford & Novak, 2018, p. 6). This rank ordering applies to the differential positions or statuses that people

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occupy within different groups. In most societies, these statuses stratify persons in terms of their age, social class, ethnicity, gender, sexual orientation, race, and religion

Age and Ageism

Many of our judgments about people and places are age based (Macnicol, 2005). Most individuals on meeting a new person will guess the person's age. This guess will reflect differential assumptions about that person. We also select people for relationships or places for socializing that are age-based. People learn about age divisions and "their importance in the hierarchies of power that surround us" (Macnicol, 2005, p. 4). These age divisions can reflect stereotypes that contribute to social inequalities and age discrimination in employment and social relationships. **Ageism** involves the stereotypic ways we think, feel, and act toward other individuals based on their age (WHO, 2021). It is closely associated with age discrimination. "Like all discrimination, ageism can essentially be thought of as the application of assumed age-based group characteristic to an individual, regardless of that individual's actual personal characteristics" (Macnicol, p. 6).

Ageism limits the potential development of individuals based on age. It can oppress any age group whether young or old on grounds of immaturity or inexperience. Youth on grounds of inexperience and seniors because of their declining youthfulness, differences in educational attainment and differences in work experience from more recently educated youth (Hillier & Barrow, 2015).

Aging is a normal process. There are problems associated with aging that require individual adaptations. The need to adjust to a knee replacement is an example. However, these individual adaptations can diminish as an individual's capacity for such adjustments diminish with age (Hillier & Barrow, 2015). A person's frailties will increase as physical aging processes progress, which will require macro rather than personal solutions to the person's problems in living. The press of the person's environment (fixing meals, doing laundry, management of money) will require assistance from external resources (Hillier & Barrow, 2015). Indeed, "the causes and solutions to social problems relevant to aging might be at an individual, a group, a societal or even a global level" (Hillier & Barrow, 2015, p. 6). They will also vary during different phases and historical periods or peoples' lives.

Race and Racism

It is important to recognize that the characteristics used to define a racial group are fundamentally meaningless as a biological concept. Instead, race is a social rather than biological construct. This social construct offers different advantages and disadvantages to different groups of people. Clearly, race remains an important cornerstone of the social hierarchy that supports the longstanding infrastructure of White supremacy in the United States, an infrastructure that Isabel Wilkerson (2020) classifies as a caste system. "A caste system uses rigid, often arbitrary boundaries to keep the ranked groups apart, distinct from one another and in their assigned places" (Wilkerson, 2020, p. 17). The hierarchy in most caste systems exists to maintain the power of one group over other groups. The caste systems of India and the United States rely heavily on processes of stigmatization to justify the dehumanizing and unequal treatment of their lower-ranked classes. The lowest caste in India is the untouchables (Dalits) and African Americans are one of the lowest-ranked classes in the United States (Wilkerson, 2020). When Dr. Martin Luther King visited southern India with his wife, he visited a school in Kerala with students and families from the untouchable class. The teacher introduced him to the students as a "fellow untouchable from the United States" (Wilkerson, 2020, p. 22). This reference by the teacher shocked Dr. King, but after thinking about his life and the lives of his constituents, he concluded, "'Yes, I am an untouchable, and every Negro [sic] in the United States is an untouchable' "(Wilkerson, 2020, p. 22).

Racism refers to a system of power and privilege manifested in attitudes, actions, and institutional structures based on the color characteristics of people (Andersen & Collins, 2019, 2022). Stratification by skin shades continue to exist both across and within broadly defined ethnoracial groups in the United States. Consequently, it even affects politics within and across ethnoracial categories (Ostfeld & Yadon, 2022). This leads to previously unexamined assumptions about how within ethnoracial groups might vote and how their skin color affects their personal assessment of their own skin color. Research by Ostfeld and Yadon (2022) shows how overestimations of the lightness of skin color among Latinx individuals has closer links to conservative views on racialized political issues than Latinx individuals who conversely overestimate the darkness of their skin color. Indeed, stratification by skin color not only affects attitudes, but also differential access to wealth, education, and resources. Skin color also differentially contributes to discrimination in housing employment and pay. It also has differential effects on a person's interactions with the criminal justice system (Ostfeld & Yadon, 2022) and on the mass

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The unjust killing of George Floyd had a major impact on the Black Community and the world community.

incarceration of African Americans in the United States (Alexander, 2010).

Mass incarceration of African Americans represents a policy position that Michele Alexander (2010) refers to as *The New Jim Crow*. She characterizes it as the New Jim Crow because we did not end the racial caste system in the United States with the abolishment of the Jim Crow laws. The vestiges of Jim Crow law on segregation and unequal forms of social justice continue for African Americans and other non-dominant ethnic and racial groups.

Gender

Gender represents another socially constructed concept, which is not a fact of nature with specific biological imperatives. It differs from sex. Sex refers to the biological status assigned to female or male; whereas gender refers to the social definitions of male or female. Gender identity is another gender-related concept that emerged in the mid-1960s to describe a person's inner sense of being either male or female (Molerio & Pinto, 2015). Gender identity references the needs of people who do not identify as either male or female. It refers to a person's conceptualization of their gender that is independent of their biological sex. The umbrella term *transgender* currently refers to people "who are transsexual and intersex, but also those who identify outside the female/male binary and those whose expression and behavior differs from social expectations" (Moleiro & Pinto, 2015).

Englert and Dinkins (2016) contend that there are three distinct measures of a person's gender: their sex characteristics, gender identity, and their gender expression/presentation. Gender issues incorporate all the factors that structure the relationships between males and females and among cisgender and transgender, and nonbinary individuals. Cisgender individuals are individuals whose sense of self does not conflict with their sex assigned at birth (see Exhibit 1.15 for a brief list of some current gender identifications). Conversely, transgender and nonbinary individuals experience a conflicting sense of self from their sex assigned at birth. The social relations of women and transgender individuals in work and other contexts have different structures from men. In fact, in a gender-polarized society, every aspect of a person's life connects in some way to the person's gender. The pressure to conform to established sex and gender role stereotypes contribute to many psychological problems: depression, sexual dysfunctions, obesity, and other clinically relevant concerns. Indeed, gender has important influences on a person's self-esteem, psychological well-being, and physical health. It also structures how and with whom people establish friendships, and introduces barriers to many social opportunities and social relationships.

Social Class

The sociologist Max Weber (1864–1920) recognized the pervasive influence of social class on the lives of people (Gilbert, 2022). Class for Weber was similar to Karl Marx because they both recognized that class involves the ranking of groups of people according to their economic position in society. Their ranking reflects their strength in economic markets, whether it is in the job market or the securities market (Gilbert, 2022). Membership in their economic grouping shapes their life chances. The second major ordering besides a person's class is their **social status**, which refers to the socially assigned prestige to one's position in society. We integrate conceptions of class and status in what we now refer to as socioeconomic status (SES). Social class is a category in England that provides a sense of community for its members. Social class is also important in the United States, but provides less of a symbolic sense of identification for its members as in England (Gilbert, 2022).

Castells (2002) contends that any social construction of an identity occurs within a context of power

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Exhibit 1.15 List of Gender identities

1. Cisgender: Individuals whose gender identity aligns with their assigned sex at birth
2. Transgender: Individuals whose gender identity does not match their sex assigned at birth
3. Cis-hetero: Cisgender individuals who are sexually attracted to the opposite sex.
4. Nonbinary: Individuals who do not identify exclusively as male or female.
5. Intersex: Individuals born with both biological sex characteristics (hormones, sex organs, and chromosomes).
6. Genderqueer: Refers to people who do not identify as woman or man and makes a political statement for some individuals who are wanting to assert a third gender.
7. Gender fluid: Refers to a person's fluidity in physical attractions, as well as in their maleness and femaleness.
8. Gender outlaw: Refers to individuals who refuse to allow society's definition of maleness or femaleness to define them.
9. Two spirit: a general term for different sexualities and genders for people having both a masculine and feminine spirit within Indigenous communities.

relationships that produce different types of identity structures. They are:

- A legitimizing identity, a form of identity constructed by the dominant institutions of a society, which rationalizes the existing sources of its structural domination;
- A resistance identity, which is generally associated with people in contexts that are devalued or stigmatized by dominant factors, thus contributing to resistance to the domination;
- A project identity, which occurs when individuals use available cultural and social resources to transform or build a new identity.

Class, race, and gender are potential identification communities. **Community** refers here to the perceived relationships with groups that define a person's social location within the broader society. This type of community often becomes a major source of resistance and struggle against domination by dominant groups. This resistance is often in response to the negative social emotions resulting from membership in an identification community. Indeed, the social emotion of shame has close associations with experiences of rejection, disrespect, embarrassment, and related feelings (Scheff, 1999). Sennett and Cobb's (1972) seminal study of the hidden injuries of class shows how males from Italian and Jewish working-class backgrounds in Boston experience a lack of respect in various contexts because of their class and occupational position. The study's participants report experiencing a lack of respect in interactions with teachers, bosses, and even their children. Clearly, access to respect is a form of inequality with close links to class and other social statuses (Sennett, 2003).

Intersectionality and Inequalities

Intersectionality is a concept that alerts social workers to the fact that social statuses such as age, race, class, and gender do not operate independent of one another (Andersen & Collins, 2022; Crawford & Novak, 2018). They combine in synergistic ways to shape a person's experiences of advantage and disadvantage. "Being a woman for instance, has different consequences for African Americans and Whites, and the social experiences of working-class Black women are distinct from those of middle-class Black women (as well as from working-and middle-class Black or White men" (Crawford & Novak, 2018, p. 7). Dominant patriarchal ideologies justify the maintenance of male supremacy over women and their attendant inequalities (Abbott & Wallace, 1997). The experience of male dominance will have different consequences for women from different ethnic, racial, religious and socio-economic statuses. Focus on Research, reviews studies showing different intersectionality considerations relevant for understanding intimate partner violence (IPV).

Margaret Spencer (2017) identifies inequalities citizens from non-dominant and marginalized statuses experience. She wrote, "The point is that diverse citizens navigate environments and attempt access to socially constructed supports which are constitutionally promised but are, in fact, differentially provided or made accessible due to the intersectionality of unequitable conditions and impactful perceptions due to race, gender, skin color, and socioeconomic status influences and their interactions" (Spencer, 2017, pp. 287–288). These barriers in accessing supports and other *inequalities of opportunity* and

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Focus on **Research**

Applying an Intersectional Lens When Addressing Intimate Partner Violence: Implications for Practice

Both men and women report intimate partner violence (IPV); however, women are at higher risk of experiencing IPV, particularly severe forms of IPV (Smith et al., 2018). This risk is even higher for women with intersecting identities. For example, in the United States, African American women are at higher risk than White women of being strangled (attempted, completed, or multiple strangulations) by an intimate partner (Messing et al., 2018). Native American women experience higher lifetime and past-year IPV rates than women in any other racial/ethnic group (Smith et al., 2018). Women living with HIV (WLHIV) in Uganda are disproportionally affected by IPV, especially if they are young: 25% of WLHIV in Uganda aged 20 to 24 experienced sexual IPV during their lifetime (Kabwama et al., 2019). This rate is 14% higher than the Uganda national prevalence of lifetime sexual IPV among young women aged 20 to 24 (Uganda Bureau of Statistics and ICF, 2018).

Why are women with intersecting identities at increased risk of IPV? Among women diagnosed with HIV, IPV may be a negative outcome for women who disclose their HIV-positive status to their partners (Colombini et al., 2016; Maeri et al., 2016). Additionally, cultural norms may condone IPV and male controlling behaviors, making it difficult to leave abusive relationships. For example, a common theme found in qualitative research in Uganda showed that WLHIV who sought help for IPV were often advised to "endure" IPV for the sake of their children and maintaining their family (Bloom et al., 2021). These findings echo findings from another qualitative study involving married WLHIV in Uganda who experienced IPV. This study found that women expressed feeling "trapped" due to the exchange of bridewealth that, if broken, could bring shame to their family and mean losing custody of children and rights to maintain property and status within their relationship (Winchester, 2015).

Women of color are vulnerable to poverty and homelessness, increasing their IPV risk (Gillum, 2019; Roschelle, 2017). Due to economic deprivation, women may feel compelled to remain in violent relationships to gain necessary financial or tangible needs (Adams et al., 2013; Duvvury et al., 2013; Hess & Rosario, 2018). Additionally, IPV services are often limited in communities of color and may be culturally inappropriate, leading to the underutilization of IPV services and increasing IPV risk among women of color (Bent-Goodley, 2005; Hampton, Lataillade, Dacey, & Marghi, 2008; Waller et al., 2021). IPV services that are not community-based are less likely to be used, despite the need, because of such issues as transportation constraints, lack of money to get to appointments, and fear of entering perceived hostile environments (Bent-Goodley, 2004; Waller et al., 2021).

Several factors are associated with the underutilization of the legal resources among IPV survivors of color in the United States, including anti-immigration laws, the mass incarceration of Black/African American and Hispanic/Latinx men, racially biased police brutality, and racial and ethnic stereotyping by police (O'neal & Beckman, 2017; Richie, 2012; Sokoloff & Dupont, 2005). For instance, one qualitative study found that Black/African American women perceived nuisance property laws (a municipal-level law with legal consequences, including fines or an eviction, for calling the police (911) too many times within a certain period) as a barrier to contacting the police for IPV (Arnold, 2019). Further, survivors of color may be hesitant to report IPV to the police due to racial disparities in policing (Ogbonnaya et al., 2021). Instead, they may choose to sustain abuse to protect their partner, family, or community from racial injustices (Bent-Goodley, 2004). Knowing such barriers exist, social service providers can work to provide women of color with alternative resources and strategies for dealing with IPV. Informal support, such as help from family and friends, has been attributed to helping women of color achieve resilience in the face of IPV (Anyikwa, 2015; Cho, Shamrova, Han, & Levchenko, 2020).

While healthcare providers often recommend disclosing one's HIV status to their partner to help decrease the spread of HIV, HIV status disclosure could lead to increased IPV risk for WLHIV in abusive relationships. Therefore, healthcare providers serving WLHIV should continually assess for IPV and, if present, identify ways women can safely disclose their HIV status to their partners. The SHARE intervention, designed to help IPV survivors safely disclose their HIV status to their partners, may be useful for this population (King et al., 2017). Alternatives to HIV disclosure in the face of IPV included in SHARE are: (1) not disclosing; (2) deferring disclosure to a time when safety can be

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ensured; and (3) developing a plan to mediate disclosure, such as disclosing in the presence of a counselor or family member or friend. Similar interventions should be considered for WLHIV who report either current or past IPV. WLHIV with a past IPV experience may also find it difficult to disclose their HIV status to intimate partners due to fear of IPV related to having a history of IPV.

In summary, service providers working with clients who have experienced IPV must not ignore intersecting identities. Doing so might impede their client's ability to seek help for IPV and, in some cases, increase IPV risk. Service providers should inquire about their clients' race/ethnicity, culture, health, and socioeconomic status and implement IPV interventions accounting for these factors. Before implementing an IPV intervention, service providers may ask themselves the following questions: Would my client who is a woman of color feel comfortable reporting IPV to the police or legal system if she lives in a neighborhood with high rates of police brutality or lacks trust in the police system? Might disclosing my client's health status increase her risk of IPV? Is the IPV service I am recommending located in my client's community? Are the IPV services offered in my clients' preferred language? Can my client afford transportation to get to the counselor I am referring her to? Does the counselor I am referring my client to accept my client's insurance plan? Considering these factors may mean the difference between saving and further endangering a client's life.

—By Igeoma Ogbonnaya

inequalities of conditions diminish the formation of many desirable capabilities.

Tepperman and Wilson (1996) identify two categories of social inequality: **inequalities of condition** (disparities or differences in physical or material well-being) and **inequalities of opportunity** (differences in chances or likelihood of obtaining more wealth, power, and respect). These types of inequality contribute to differences in developmental, economic, health, welfare, and quality-of-life outcomes. Getting what one desires out of life depends on the configuration of the intersectionality of one's social statuses. The social locations of a person in social space increase the likelihood of some people getting what they want out life, which is not true of persons within other social positions. Indeed, "[r]esarch shows that some people are more 'socially mobile' than others—that is, they have a higher than average chance of improving their social position" (Tepperman & Wilson, 1996, p. 31). Exhibit 1.16 includes a brief exercise for exploring your own intersectionality.

Capabilities, Freedom, and Inequalities

Amarta Sen (1987) writes about the important role capabilities play in observed differences and disparities in human developmental outcomes. Capabilities afford people the freedom to do and be what they want. They give people the freedom to be able to make choices that will support the pursuit of goals" (Morgaine & Capous-Desyllas, 2015, p. 10). Some differences in functioning and life goals are due to the access individuals have to specific capabilities. If everyone had equal capabilities, then we could assume that differences in outcomes represent personal preferences, values, and choices (Melamed & Samman, 2013). However, this is not a realistic assumption. There are many different kinds of inequalities due to a lack of real access to relevant capabilities (Melamed & Samman, 2013; Sen, 1987). Differences in crime vulnerabilities, for instance, reflect different capabilities for safety not due to personal desires or preferences; whereas the differences in the career outcomes of well-trained classical guitarists are much more reflective of personal preferences than capacities for safety. The differences in outcomes for one group are due to access or opportunity considerations, and for the other group, increased access to capabilities allowing for increased freedoms to choose the directions of their lives (Morgaine & Capous-Desyllas, 2015, 2020). Indeed, the choices of persons with constricted capabilities for safety are less free than the choices of groups with capabilities to choose a specific career direction within a group with similar capabilities.

We live in a world with substantial inequalities. The choices people make in this world are never entirely free. Their environment limits their decisions and opportunities

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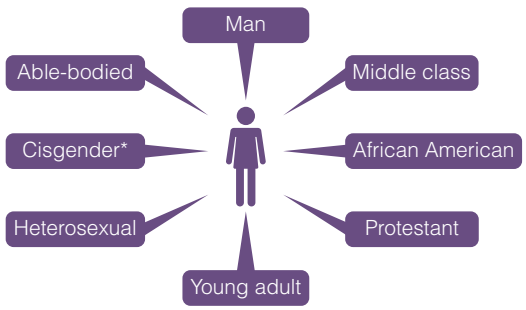
Exhibit 1.16 Brief Exercise for Exploring Intersectionality

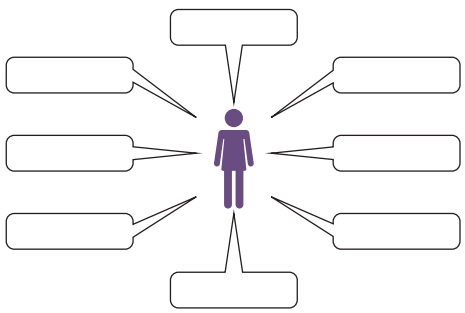
What Do You Think?

Intersectionality will differentially influence a person's experiences and directions in their life course.

Various social positions or statuses are associated with different forms of inequality (gender groups, class groups, religious groups, age groups, and other groups attributed positive and negative attributes). These socially constructed statuses affect access to respect, power, and resources. This exercise can help you examine how differential combinations of status characteristics in your life are influencing how you are perceived and treated in your social relationships. Some individuals are unaware of how their membership in specific status groups affords them various advantages. This is especially true of individuals from advantaged social positions (White, able-bodied, cisgender, heterosexual, youth, Christian).

Intersectionality Exercise





Fill in the empty bubbles in the figure above to consider the intersection of your status characteristics. (Put What do you think above the actual exercise with blank bubbles).

Adapted from: Lizabeth A. Crawford and Katherine B. Novak (2018) Individual and Society: Sociological Social Psychology. Routledge.

for developing a number of desirable capabilities. The sociologist Shils (1985, 805) writes:

Human actions are limited or determined by environment. Human beings become what they are at any given moment not by their own free decision, taken rationally and in full knowledge of the conditions, but under the pressure of circumstances which delimit their range of choice and which also fix their objectives and the standards by which they make choices.

The quotation by Shils recognizes the differences in freedom based on the intersectionality of their social statues. Their social and physical environment shapes and determines their functioning. Shil's quotation is also reminiscent of the often-quoted saying by Arthur Schopenhauer (1788–1860): "A man [sic.] can do what he wants, but not want what he wants." The extent to which our preferences reflect our actual choices is difficult to determine because of the limits our environment places on our attitudes, beliefs, feelings, motivations, and behavior (Robeyns, 2003). Our environment shapes the things we want out of life, even things members of marginalized groups internalize from their experiences of discrimination and institutional forms of oppression.

Indeed, our preferences and values are a function of our environment. Consequently, the intersectionality of different social statuses involves different environments with different implications for understanding developmental and social functioning concerns. For this reason, social work researchers and practitioners are adopting anti-oppressive and anti-racist frameworks to change environments fostering power structures that deny individuals access to relevant capabilities and opportunities for increased freedom in their choices.

Anti-Oppressive Frameworks

The International Federation of Social Workers (IFSW) considers social work research and theories distinct because of their *applied* and *emancipatory* qualities. The emancipatory qualities support one of the profession's core mandates.

The development of critical consciousness through reflecting on structural sources of oppression and/or privilege, on the basis of criteria such as race, class, language, religion, gender, disability, culture, and sexual orientation, and developing action strategies towards addressing structural and personal barriers are central to emancipatory practice where the goals are the empowerment and liberation of people. In solidarity with those who are disadvantaged, the profession strives to alleviate poverty, liberate the vulnerable and oppressed, and promote social inclusion and social cohesion. (Retrieved on June 12, 2022, at https//www.ifsw.org/what-is-social-work/global-definition of social work/)

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Focus on **Theories**

Conflict Theories

Conflict theories focus on issues involving conflict, coercion, and the role of power in social relationships. Conflict occurs when there are uneven distributions of resources, status and power in social relationships. The best-known conflict theorist is Karl Marx (1818–1883). He assumes that all of human history represents a struggle over material or monetary resources involving conflicts between the classes, and for this reason, he places significant emphasis on understanding the material structures of production.

In Marx's view, the first act in human history is the *production* of the necessary materials for survival. In doing so, humans enter relationships independent of their will. These relationships are also independent of their critical consciousness. "These are the relationships which surround the production process and which will vary according to the particular historical stage of development of the system of production—technically referred to as the *mode of production*" (Water, 1994, p. 101). These relations of production represent for Marx the economic base of the society. For Marx, the economic base during feudalism differed from the economic base in the capitalistic period of history. Consequently, these periods of history had different social formations and relations of production.

Marx assumes that the economic base determines the structure and development of social life. For this reason, the social organization of production (the economic substructure) plays a determining role not only in the productive processes of a society but also in the formation of the society's *superstructure*. The superstructure in Marxian theory includes all the idealists' structures in a society, such as religion, law and philosophy.

For Marx, social change occurs because of the contradictions between the material forces of production and the social relationships of production. This fundamental contradiction is the dialectical process that produces changes and it is why some characterize his theory as *dialectical materialism*. It is dialectical approach because of the dialectical contraction included in his theory of change. In Hegel's philosophical approach, he introduces the importance of reasoning involving a dialectic between a *thesis* and an *antithesis* that produces a new *synthesis* or change in thought. In effect, the mechanism of change is the contradiction of the thesis. Marx extends the Hegelian dialectical reasoning from ideas to analyzing the material conditions of production. Like other conflict theorists, Marx recognizes the central role of conflict in social life. However, other conflict theorists focus on other forms of conflict in social relationships. They include interest group conflicts, value conflicts, and conflicts in authority relationships.

Some basic assumptions in more modern approaches to conflict than Marx's approach are:

1. Interests are basic elements of social life.
2. Social life involves coercion.
3. Social life involves groups with different interests.
4. Social life generates opposition, exclusion, and hostility.
5. Social life generates conflict.
6. Social differences involve power.
7. Social systems are not united or harmonious.
8. Social systems tend to change. (Denisoff & Wahrman, 1979)

The list of prior assumptions illustrates that an important issue in conflict theory is who is benefiting from a particular social arrangement. Conflict theories invite social workers to ask questions such as whose interests are involved and who will benefit or suffer from the existing social conditions. For social workers, conflict theories are most helpful in examining issues of social inequality. Conflict theorists do not assume that inequality exists because it is functional for a society as a whole. Instead, they assume that these inequalities result from some group's ability to achieve power over another group.

In keeping with this mandate, social work practitioners and researchers adhere to anti-oppressive frameworks to realize the profession's mandates for changing oppressive processes and structures. Anti-oppressive practice requires an understanding of power and an understanding of strategies for changing institutions of oppression (Pollack, 2004; Potts & Brown, 2008). Oppression produces hardships and injustices that result from the dominance of one group over another (Tedam, 2021). Power plays an essential role in creating and maintaining dominant

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relationships responsible for these injustices. The exercise of power in relationships and the contesting of power that maintains social privilege and the dominance of one group over other groups is important for social workers to understand (Dominelli, 2017). The Focus on Theory describes conflict theory, a theoretical tradition that focuses on the nature of conflicts in power relationships.

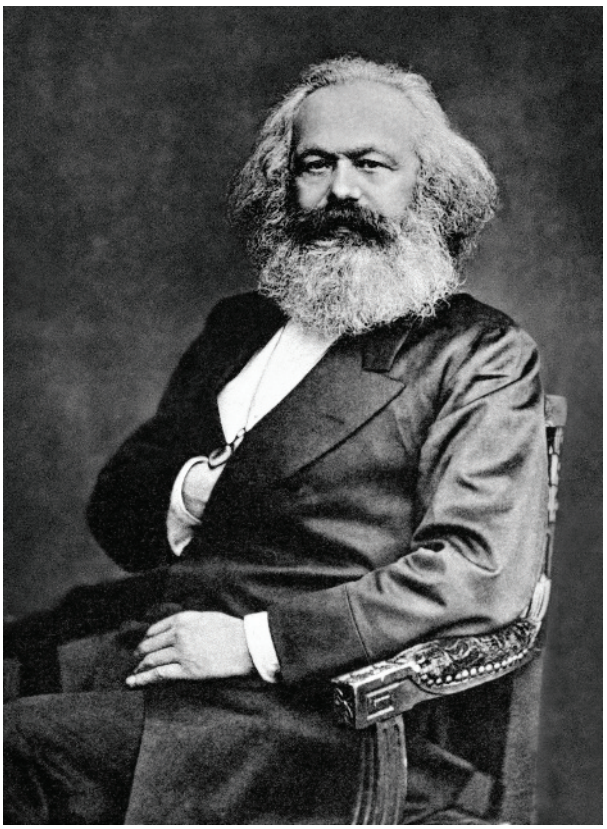
In their classic analysis, French and Raven (1959) identify five forms of power:

- Reward power: Based on the person's ability to reward others as a means for obtaining power.
- Coercive power: Based on the person's ability to apply sanctions such as punishments and threats toward others.
- Expert power: Based on the person's ability to demonstrate superior skills and abilities as a means of influencing others.
- Referent power: Based on the person's personal characteristics such as likeability and respect, that give the person influence over others.
- Legitimate power: Based on the person's perceived legitimate right to make demands of other people.

Power is a concept that is important for social workers at many different levels. It is not just relevant for addressing structural injustices in the broader environment. It also affects the interactions of social workers with their service users (Dominelli, 2017; Sakamoto & Pitner, 2005). Service users often do not define their problems and their outcomes in the same ways as professional social workers. For this reason, it is important for social workers to reflect on their own personal and professional biases in responding to observed inequalities. Social and behavioral scientists also need to reflect on how to rectify the extent to which the developmental experiences of non-dominant group members do not reflect the resilience of these group members. These researchers and practitioners need to approach developmental assessments with a critical consciousness. Exposure to critical theory in the social sciences is helpful in developing this critical consciousness. This includes critical assessments of life course successes and conditions that challenge the lives of service recipients (Spencer, 2017). The life course represents an important social institution that can impart negative messages about various social identities and social statuses with important implications for developmental outcomes and knowledge about these outcomes (Spencer, 2017).

When people benefit from dominance and other statuses, then these benefits reflect *privileges* by ascription and not by personal merit (Black & Stone, 2005). "Ironically privileged persons often believe that their personal qualities specifically warranted their inclusion in this group while simultaneously remaining unaware of the extent and impact of these privileges" (Black & Stone, 2005, p. 243). Many discussions of privilege previously reduced privilege to issues of race and gender, which diminishes our understanding of the intersections of privilege with other relevant identities and advantages (Black & Stone, 2005; Spencer, 2017). Indeed, "membership in multiple oppressed groups means that one experiences various kinds of oppression, at the same time, persons with conflicting identities (i.e., partly privileged and partly underprivileged, as in the case of a Black male, a rich woman, a gay White person) can feel confused, angry, and cynical about their standing in society" (Spencer, 2017, p. 295).

Integration of critical consciousness is important for reflecting on other theories and perspectives for understanding developmental outcomes and the life course. For this reason, we provide a brief description of the origins and the characteristics of critical theory.



IanDagnall Computing/Alamy Stock Photo

Karl Marx was a major social theorist who sought to liberate the masses from their oppressive material conditions.

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Critical Theory

The early writings of Karl Marx (1818–1883) had an emancipatory theme. This theme was also the cornerstone of most critical theory after Marx. The Frankfurt Institute for Social Research (1923), for instance, consisted of a group of interdisciplinary scholars in Germany with the goal of blending theory and action in emancipatory ways to overcome many of criticism of Marx's utopian visions of revolutionary change (Turner, 1998). The three central figures in the first generation of critical theorists were George Lukács, Max Horkheimer, and Theordor Adorno. They provided an important transition to contemporary critical theory by maintaining critique as a central tenet of their theory and research (Connerton, 1976). Karl Marx was a major social theorist who sought to liberate the masses from their oppressive material conditions.

The origins and methods of critical theory originated "within the intellectual crucible of Marxism" (Bonner, 2017, p. 2). However, historical events made members of the Frankfurt School skeptical of some of Marx's theoretical propositions. Some of these events were "The defeat of the left-wing working class-movements, the rise of fascism in the aftermath of World War I, and the degeneration of the Russian Revolution into Stalinism had, by the 1930s, made it clear that Marx's analysis needed revision" (Turner, 1991, p. 255). In response to the prior historical developments, members of the Frankfort School dismissed Marx's theory of economic determinism, and his belief in the inevitable triumph of socialism. They focused instead on the critique of *human consciousness* and a return to Marx's early approach to criticizing German ideology. Unlike Marx's later works, George Lukács from the Frankfurt School argued for the resurrection of the Hegelian dialectic, but with an explicit commitment to maintaining Marx's emancipatory project. He wanted his revised approach to analyze the historical processes that contributed to the *reification* of social relationships as objects. For instance, the treatment of a family or gender as a natural object are examples of processes of reification. In his view, reification led to subjection, manipulation, and treatment of people as commodities. The role of the critical theorist for Lukács was to expose processes of reification and alienation to critical methods of dialectical analysis. He proposed solving problems of domination among people by making people conscious of the situation in their lives. However, Adorno and Horkhemier rejected his revisions of Marxian criticism because they concluded that they would not lead to resistive actions against domination and power in social relationships (Turner, 1998). They sought other modifications that focused on improving the relationship between theory and action. Horkheimer, for instance, contended that critical theory needed to challenge ideological mystifications and their oppressive consequences with the end in mind of creating a better society (Felluga, 2015).

In time, critical theory evolves and finds a place in a number of different theoretical arenas. It becomes a central method for addressing *ideological forms of* oppression within cultural studies, feminism, gender studies, ethnic and racial studies, literature, and postmodernism (Felluga, 2015). The critical theorists in each of these areas of scholarship analyze the ways of thinking and thought that existed before the emergence of our current ways of thinking by placing current thought within a proper historical context (Felluga, 2015). They also focus on examining disparate discourses during earlier periods of history to understand what people today take for granted as *naturalized* forms of thinking about gender, sex, race, law, and other areas of social life. In the next section, we provide a brief description of critical race theory to demystify some of the misconceptions about the focus and purpose of critical race theory in current political discourse. Critical race theory relies heavily on many of the key tenets in critical theory.

Critical Race Theory

Kimberlé Crenshaw contended in an interview for the American Bar Association that critical race theory sought to prepare law students to interrogate the role of race in society (George, 2021). It is a theory that grew out of two intellectual movements of the 1970s: critical legal studies and radical feminism (Delgado & Stefancic, 2017). It reflected the views of legal scholars from Black, Indigenous, and People of Color (BIPOC) who were concerned about the emerging challenges to the legal remedies addressing racial inequities during the Civil Rights era. Many laws and policies during the Civil Rights era began using race as a consideration when pursuing equity-based remedies for the harmful legacy of racism. This legal approach represented an anti-racism strategy for achieving equity in promoting access to school and other valued societal resources (Kendi, 2019; Sawchuk, 2021). Yet it conflicted with cherished ideological justifications for the fundamental principle of equality under the law.

Critical race scholars reject popular assumptions about racism and about our society's liberal order, including theories of equality, and legal reasoning in our legal institution (Delgado & Stefancic, 2017). They

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introduced important critiques of color-blind approaches to the equal protection clause of the U.S. constitution for addressing racial discrimination (Turner, 2015). Delgado and Stefancic (2017, pp. 8–9) wrote:

> Color-blind, or "formal" conceptions of equality, expressed in rules that insists only on treatment that is the same across the board, can thus remedy only the most blatant forms of discrimination, such as mortgage redlining or an immigrant dragnet in a food-processing plant that targets Latino workers or the refusal to hire a black PhD rather than a white college dropout and attract attention.

Associate Justice Sotomayor also contest the color-blind approach that conservative justices adopted in the case *of Schuette v. Coalition to Defend Affirmative Action, Integration, and Fight for Equality by Any Means Necessary* (2014) in her dissenting opinion. She opined, "The way to stop discrimination on the basis of race is to speak openly and candidly on the subject of race, and to apply the Constitution with eyes open to the unfortunate effects of centuries of racial discrimination" ((134 S. Ct. 1623, 1676 (2014) Sotomayor, J. dissenting). Clearly, her dissent is critical of a highly regarded reified principle of equality under the law by adhering to a primary tenet of critical race theory, material determinism (Delgado & Stefancic, 2017). *Material determinism* connects the inequalities of racism to the use of conscious strategies for the overcoming racial inequalities, an approach that directly contradicts Chief Justice Robert's reasoning in the case of *Schools v. Seattle School District 1* (2007). He concluded, "The way to stop discrimination on the basis of race is to stop discriminating on the basis of race." Then Associate Justice Ruth Bader Ginsburg challenged this view during oral arguments in this same case. She said, "It is very hard for me to see how you can have a racial objective but a nonracial means to there" (Sawchuk, 2021).

Newscom/Alamy Stock Photo

A liberal justice who argued against legal precedents that eliminated consideration of the unfortunate effects of centuries of racial discrimination on current access to highly valued educational opportunities.

The reasoning in the prior cases illustrates different viewpoints about a taken-for-granted idea in legal jurisprudence that can perpetuate racial inequalities. Clearly, critical race theory in legal practice and education involves interrogating the role of law in facilitating racial inequities and not the promotion of the types of putative training on diversity and inclusion that conservative politicians are asserting (George, 2020). It adopts critical methods in challenging taken-for-granted ideas in legal institutions that perpetuate the harmful institutional consequences of racism. Clearly, the dissenting opinion of Justice Sotomayor is consistent with these tenets.

Social workers have adopted critical race theory as well as a framework for guiding education, policy, practice, and research (Daflarty, 2020; Quinn & Grumbach, 2015; Sulé, 2020). The multicultural approach and cultural competence have been hallmarks of social work education and training. They have pushed students and practitioners to be aware of the limits of their own perspectives and to develop important sensitivities to other cultural views (Constance-Huggins, 2012). Yet, they do not focus on addressing the persistent inequalities among many of the disadvantaged racial and cultural communities in our society (Sulé, 2020). For this reason, scholars in social work have begun to embrace the tenets of critical race theory in analyzing various ideas, theories, and institutions, including the life course as an institution. For this reason, it is an important perspective for reflecting on current developmental norms and their consequences for members of non-dominant and marginalized groups in our society.

Ecological Systems Theory

Ecology is the study of the interrelationships of organisms with one another and with the environment (Hanson, 1962). Ecological systems theory (Germain, 1991; Weiss & Lopez, 2013) recognizes that human beings, like all other living beings, are an important part of the systems in which they live. Critical to the ecological perspective is its holistic view of people. The ecological perspective functions as a metaphor that provides an understanding about the reciprocal transactions that take place between people and the social environment in which they function. A central

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Courtesy of Carol Germain's Estate

Carol Germain was a noted social-work theorist who developed the ecological perspective for the practice of social work and furthered the understanding of human behavior in multiple environments.

principle of all forms of systems theory is holism. **Holism** refers to the idea that the whole is more than the sum of its parts (Richardson, 2000); people and environments are part of a holistic system in which each shapes the other.

The scientific opposite of holism is **reductionism**. "Reductionism assumes that the whole is the sum of its parts, and attempts to understand problems by focusing on smaller and smaller units" (Oltmanns & Emery, 2004, p. 37). The central principle of reductionism is that ultimate explanations exist when we reduce issues to their smallest possible components. This form of thinking is pervasive in science and in everyday thinking about human behavior. For example, when scientists find that brain chemistry in people with depression differs from that of individuals without depression, they often assume that this means that the brain caused the depression. However, the change in brain chemistry is equally due to adverse life experiences that reduce explanations to constituent parts. Explanations that reduce the understanding of behavioral concerns to molecular variables are no better than approaches that reduce them to molar, or larger system variables. For this reason, we have adopted an integrated multidimensional approach (see Chapter 2) that relies on principles from systems theory. This approach assumes that each level of a system offers a different analysis of people, behaviors, problems, and strengths.

Following are some of the basic ideas of the ecological systems perspective (Germain, 1991; Weiss & Lopez, 2013):

- Social work practice has a dual focus.
- This focus includes the person and situation, and the system and its environment.
- Social work practice occurs at the interface between the human system and its environment, and the ways each influences the other.
- Social work practice is best when the transactions promote growth and development of the organism while being ameliorative to the environment, thus making it a better place for all systems that depend upon the environment for sustenance.

In examining any social context, the social system plays an important role. A **system** represents any set of elements that affect or influence one another. We cannot solve the problem of any system by engaging in the fallacy of ignoring that system's environment (Bronfenbrenner, 1999; Churchman, 1978). A **social system** is a system in which the components are people. These people participate in a number of social systems that influence their development—family, school, work setting, neighborhood, community, nation, and so forth. For this reason, we need to develop knowledge of the key dimensions of social systems, their interrelations, and their environment.

Brim (1975) and Bronfenbrenner (1999) identified four categories, or levels, of systems that are useful to social workers in conceptualizing person and environment transactions: microsystems, mesosystems, exosystems, and macrosystems. **Microsystems** involve face-to-face or direct contact among system participants. As social workers, we are interested in identifying categories from science that enable us to classify behavior that takes place in these systems. This type of analysis is limited, however, if it neglects the relations between the microsystem of primary attention and other key microsystems. If we understand the interconnection of multiple microsystems, we can have a more informed understanding of the behavior in a particular context. Mesosystems are the category systems theorists use to address this level of analysis. **Mesosystems** refer to the network of personal settings in which we spend our social lives. Each of our clients lives in a similar but different mesosystem. It is critical to understand the network of personal settings affecting a particular microsystem under investigation.

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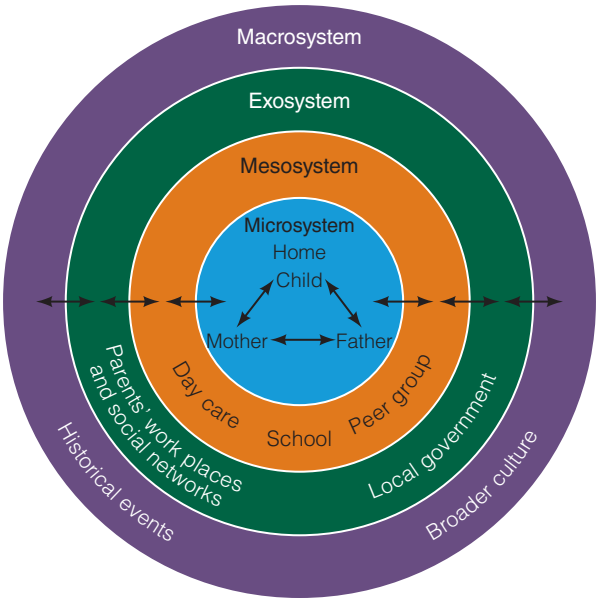
Individuals are members of a number of different microsystems. What happens to them in any one microsystem can influence their behavior in other settings. For example, if you are working with an adolescent, you should not ignore the fact that events in his or her peer group can influence the degree of conflict observed in his or her school or family setting. The makeup of the mesosystem is important when analyzing any other identified microsystem issue. Indeed, how well an adult at home functions must consider the adult's functioning in the workplace. Similarly, workplace performance must consider the adult's circumstances in the home. Some jobs make it very difficult for adults to play effective roles in the home environment (Berk, 2022).

Exosystems in Bronfenbrenner's scheme are the larger institutions of society that influence our personal systems. These include institutions such as government agencies, which, although we may not directly work in them, have profound effects on our lives. *Exosystems* refer to the systems in which an individual is not directly involved. For instance, parents' work settings can affect their children's lives in many ways, yet the children have no direct involvement in these work settings. An exosystem level of analysis stresses the need to consider clients' broader social environment by examining the influence of significant social institutions.

Last, **macrosystems** are the larger subcultural and cultural contexts in which microsystems, meso-systems, and exosystems are located. Macrosystems have the most pervasive level of influence on social activities. **Culture** is a system of meanings and values shared by a population and transmitted to future generations (Sigelman & Rider, 2017). It includes all the key artifacts developed during the history of a population—all its *material* and *non-material* (symbolic) products. Every sociocultural group has its own history, but in recent years, scholars of race, class, and gender studies clarify the silencing of many of history's voices. The voices metaphor comes from the efforts of scholars to break the silence of the experiences of many groups in our society. These scholars focus on ignored aspects of diversity in our society by "listening to the voices" of representatives of the silenced groups (Andersen & Collins, 2019, 2022). The goal of much of current multicultural scholarship is to help people think about the experiences of previously silenced groups (Andersen & Collins, 2004; Dominelli, 2002; Sakamoto & Pitner, 2005). The material and symbolic aspects of culture influence all facets of our behavior, and they demand significant attention in the analysis of social systems by most practice frameworks in social work.

Exhibit 1.17 Bronfenbreener's Ecological Model



Social work scholars have adopted system levels to conceptualize the environmental component of our person-in-environment framework. have adopted these same systems. Before the emergence of ecological-systems thinking in social work, there were many simplistic views of the environment in the profession. These views frustrated most practitioners' efforts to achieve any objectives involving "environmental modification" (Grinnell, Kyte, & Bostwick, 1981). Grinnell and colleagues pointed out that these early concepts of environment represented "(1) social structures (for example, social class system, ethnicity); (2) social conditions (for instance, unemployment, discrimination); 3) social systems (for example, economic, health, and educational networks); and (4) specific neighborhood or community resources (for instance, schools, churches, day-care centers, job training programs)" (p. 153). Many other dimensions and classifications existed in social work to categorize the environment. However, ecological-systems thinking, unlike the other approaches, enhanced our ability to look at the environment in a way that allowed for its modification. This perspective redirected attention to the transactions between people and environment, rather than focusing on either the person or the environment. *Focus on Theory:* Revisualizing Ecological Systems Frameworks offers a way of decentering the current implementation of systems principles in social work.

Ecological systems theory has not been the only conceptual approach to understanding human behavior in the social environment. Crisis theory has also provided social workers with useful concepts for practice that assist them

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Focus on **Theory**

Revisualizing Ecological System Frameworks

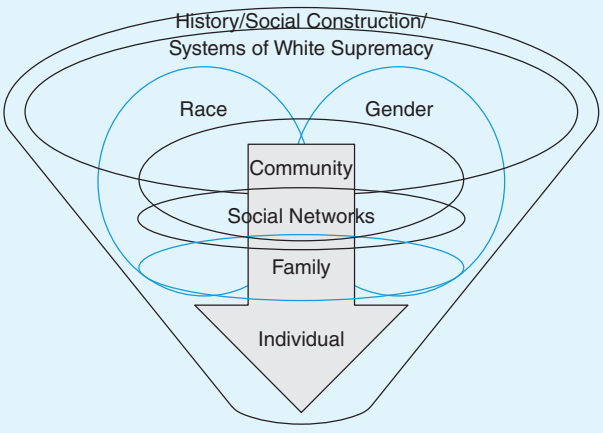
In 2014, I was doing research on Black female White male interracial marriage experiences and how they navigated race and identity in their relationship with three different generational cohorts through videography. I approached this study through the lens of ecological systems framework and social construction. The ecological systems framework had been successful in exploring fluidity in multiracial identity, and therefore had the potential to guide my understanding of interracial couple identity. Combining this theory with social construction for analysis, created guidance in exploring how each pair constructed a couple (racial) identity when experiencing encounters external and within their relationship.

The traditional image that had been taught to visualize ecological systems framework was in the back of my mind as I began my analysis. The participants race and gender were important variables to consider in how they navigated the world, but where were these visualized in the bullseye? How were the historical social constructions, policies and laws that influenced each generations experiences, shaping their current understanding of the world, depicted in the visual? There was no place to acknowledge how a few decades ago, these marriages were illegal. When considering social construction, I realized the ecological system images actually limited my understanding of the experiences of my participants. The participants were interacting with multiple systems with complicated histories, but how they uniquely interacted with them, both as individuals and as a couple, was not aligned with how the original image depicted the framework.

Each partner's race and gender influenced their experience within and outside of the relationship, shaping their relationship and how they constructed a couple identity. The bullseye left out how socially constructed aspects of identity, specifically race and gender, play a role in the functioning of systems and creates conditions for individuals based on how they identify and are viewed in the world (Crudup, Fike, McLoone, 2021). Race and gender were not visualized nor were the reciprocal relationships that the individuals, and couples were having with the environment and systems that they were living in. Capturing a wholistic view of people is a critical tenant of the ecological systems theory, yet the visual I had been taught to understand did not account for the totality of the lived experience of an individual interacting with the systems or the historical context that influenced many of their interactions. These questions, along with reflecting on how my own biases might be shaping my understanding, led me to revisualize the image in an attempt to capture a more complete understanding of the framework that could benefit the application of the theory in practice.

The image that emerged was specific to Black female and White male interracial couples, however I quickly realized that the main components of the image (the funnel) would be translatable in better understanding all individuals, couples, or families. The *Revised Ecological Systems Framework* emerged. Unlike the traditional bullseye image, the revisualized funnel captures the intersectionality of individuals lived experience and their relationship with systems/environments and community that have been shaped by historical context and social construction through the overlapping systems (Crudup, Fike, McLoone 2021).

As I began to operationalize the new visual, I found that the traditional image was void of a central component in understanding the impact of systems—the role or power. The bullseye lacked the influence of power systems have and how that power was established through a limited racial and gender lens over time to create systems that function in favor of specific populations. It centered the individual in a way that made them solely responsible for their circumstances, When in reality the systems were not created to support those not White and male. This perpetuates the myth that an individual could work hard and pull themselves up by their bootstraps to overcome challenges they were faced with. The traditional image is an example of how



Revised Ecological Systems Framework

Continued

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whiteness is centered in our understanding of systems and how people navigate them in a linear way (Crudup, Fike, McLoone 2021). Visualizing intersecting identities, understanding how they have been socially constructed over time, and acknowledging the power dynamics allows for not only a more comprehensive understanding of the client and the conditions they are encountering but brings into view potential strengths and challenges shedding light on potential supports and resources needed.

The *Revised Ecological Systems Framework* allows social workers to visualize the ecological systems framework for an individual, couple, or family through a lens of critical consciousness. Social workers are obligated to consider a client's complete circumstance. Social workers must understand the intersecting identities of a client to be able to support them at the micro level while also being able to advocate for systems change at the macro level. It is when we understand this full picture, we are able to support wholistic change that addresses not only the individual but the power dynamics imposed by systems built to center whiteness. Sustained change comes when the community and individual work together to support change. Race and gender implications must be considered when understanding a person in their environment. Of course, other intersecting identities are also important; however, race and gender must be considered as they are embedded in the history and construction of the systems. The *Revised Ecological Systems Framework* image is a tool to assist critical thinking and the process of decentering whiteness in our clients' experiences while deconstructing narratives of supremacy that are baked into the core of our profession.

—Chandra Crudup

in understanding how people cope with demands caused by stressful events, extremely stressful events (traumas), and other life circumstances. Crisis theory helps practitioners evaluate strategies taken by individuals in adjusting to life events, extremely stressful life events (trauma), and normative developmental processes. Thus, crisis theory helps identify levels of adjustment or maladjustment evident in a person's responses to stressful and other adverse circumstances.

What Is Crisis Theory?

Crisis theory originated with the work of Eric Lindemann (1944). His follow-up study of the relatives of victims of a tragic nightclub fire in Boston at the Coconut Grove

Boston Globe/Boston Globe/Getty Images

This nightclub fire killed 492 people in 1942.

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Dance Hall in 1941 introduced crisis as a relevant consideration for understanding processes of personal adjustment. Lindemann learned from his study of grief responses that the survivors had to change by detaching in some manner from their relationships with the deceased and forming new attachments. Those who did not adapt developed some form of disabling mental disorder. **Crisis** refers in this context to "any rapid change or encounter that provides an individual with a 'no exit' challenge, no choice but to alter his or her conduct in some manner" (Levine & Perkins, 1997, p. 207).

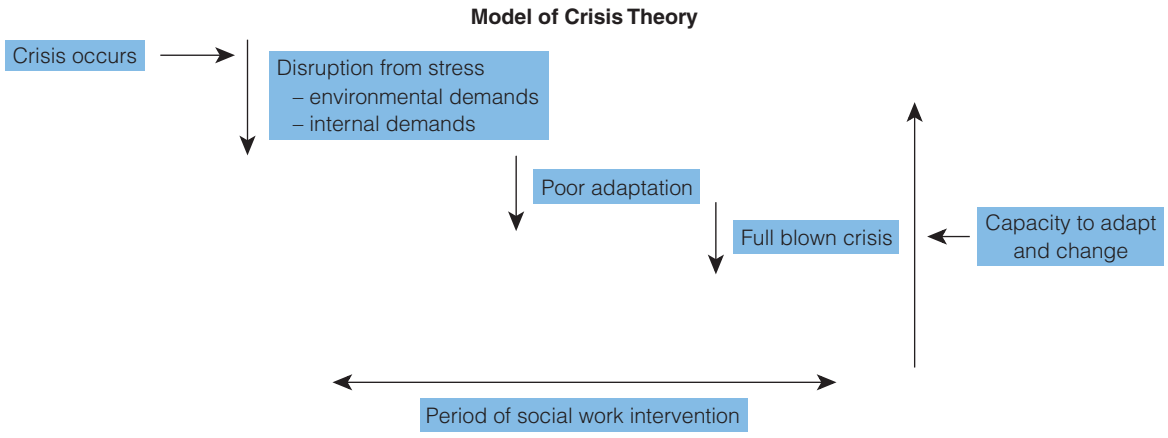
Gerald Caplan, Lindemann's colleague at the Harvard School of Public Health, recognized that other situations, not just loss events involving extreme stress (traumatic events), place people at risk for developing serious mental disorders. Stress represents "any event in which environmental demands, internal demands, or both tax or exceed the adaptive resources of an individual" (Monat & Lazarus, 1977, p. 3). Lindemann concluded from his research that normative life changes also are capable of the kinds of stress that produce symptoms of psychopathology and other forms of social maladjustment. That is, his definition of crisis includes any significant change in a person's life situation. Such a change becomes a crisis when internal adjustment or external adaptation is beyond the person's capacity. Caplan's research inspired a growing field of inquiry presently known as *life events research*. This field of research focuses on the relationships between life events, stress, and illness. As a result of this body of research in life events, we now know that change associated with non-extreme events in life also contributes to stress and can place people at risk for developing severe mental disturbances and other threats to a person's well-being (Dohrenwend, 1998; Gotlib & Wheaton, 1997).

The word *crisis* comes from a Greek root word meaning, "to decide." In some contexts, it refers to a point in a disease or disorder process that is "decisive" for recovery or death (Levine & Perkins, 1997). In a more general sense, it refers to a critical turning point (just prior to the need for a decision) in a process in which a decisive change for better or worse is approaching. To some extent, this is the meaning adopted by Erik Erikson in his theory of psychosocial crisis. For Erikson, a crisis is a challenge or turning point at which there are opportunities for individuals to choose between polarities associated with key developmental tasks, such as trust or mistrust. (We will review each of Erikson's polarities and relevant themes associated with these polarities at the start of each of our developmental chapters that follow.)

In crisis theory, winning the lottery represents a challenge to a person's previous state of adaptation. Accepting a new job or becoming the boss also involves changes, which require new adaptations that tax personal and social resources. To understand these challenges, social workers require a theoretical and an empirical understanding of crisis theory, as well as an understanding of normative changes in the life course that can contribute to ill health or a lack of personal well-being when adaptations are beyond a person's capacities.

Making the transition from straight to gay offers challenges to prior patterns of adaptation that are described in the Focus on Lived Experiences titled "From Straight to Gay." This narrative illustrates the kinds of challenges people confront in having to adjust to the circumstances of everyday life that differ from circumstances associated with having to adjust to a traumatic event.

Exhibit 1.18 Model of Crisis Theory



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Focus on **The Lived Experience**

From Straight to Gay

It's a sunny August afternoon in the mountains near Flagstaff, Arizona. Robin and Tracy have rented a log cabin and invited a group of friends to celebrate Robin's 40th birthday. I'm sitting on the porch with my laptop, working on this piece about being a single lesbian mother. Tracy asks what I'm writing, and next thing I know, all of us are sitting on the porch, talking for hours about our experiences as lesbian mothers and partners of mothers. Although lesbian families are as varied as heterosexual families, our group of friends has in common the experience of transitioning from heterosexual to lesbian families, or, for those of us without kids, from being single to being a stepparent. Three themes emerge from our stories: coming out to our children, reshaping our families to include our partners, and becoming stepparents.

TRACY: It was really hard for Robin. She moved in when my kids, David and Trisha, were 12 and 16. They had to deal with my coming out and with a new adult in the house. Sometimes she was in the middle, like, "Why can't they (the kids) turn the TV off?" "Why can't they turn the lights off?" "Why do they talk back to you?"

The parent has to educate her partner about the family norms. The partner sees a different view of what's going on between the mother and the kids. And it's frustrating to be the partner and not have authority with the kids. David was so angry. It was so hard because Robin would see how much he was hurting me.

ROBIN: It took me till the last three to four years before I could even be in the same room with David—because he was so mean to her.

TRACY: I've always had an easier time with my daughter, Trisha. Now she has a fiancé, and she just told him, "Well, my brother's gay and my mom's gay, so you have to deal with it." Trisha tells me, "What difference does it make? Everybody's gay anymore." I just could not even imagine not having my two children in my life. I just got to meet his [her fiancé's] family last summer, and we found out we have horses in common and we got along just fine.

Sylvia and I have six boys. I was married twice and widowed twice. My kids were 11–23 when their father died of pancreatic cancer. He was the best father. But there was always some dissatisfied part of me that could not get satisfied. Then, where I was working, I met some gay women and we would go off for weekends. Pretty soon I realized I was gay, but I couldn't stand the thought of disrupting my kids' lives. What I didn't know until after my husband died was that he was gay also. After he died, I sat my kids down in two groups—the younger group and the older group. I told them that their father had been gay and that I had recently realized that I was gay, as well. Out of all of them, Tim, the 11-year-old, was the only one who had a hard time—his father died and came out at the same time, and then his mother came out. At the time, he was going to a conservative church with his friends and so when he found out I was gay, he was sure I was going to hell. Until he was fifteen he would never let his friends come in the house.

But then I met Sylvia—she's in Atlanta, and I'm in Phoenix for the next year till I finish school. Right away Sylvia started sending Tim notes about this and that. Then I wanted to send her a CD of photos and Tim showed me how. And then my other son has been struggling with alcohol and Susan's a recovering alcoholic, and she helped me understand some of the things he was going through.

DE: My children were 19 and 24 when Georgie and I got together five years ago.

GEORGIE: I thought the kids would be gone.

DE: My stepdaughter, Heather, is 29 now. She decided she couldn't be part of my life as a lesbian. When she got married, she said that if Georgie was going to come to the wedding, I shouldn't go. She wanted it at the swank golf club where Georgie works, but she didn't want Georgie there. I finally did go, but I was way in the back, far from the head table. When she got pregnant, I wasn't invited to the baby shower. I raised her from the age of two. Now I have a grandchild who is going to be two whom I've never seen. Heather has sort of adopted my younger sister, and she's the one who does the mother things, like arranging all the occasions that I'm not invited to.

But then, at another family wedding, my nephew's partner, who's very flamboyant, saw me and Georgie walk in and

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said, "The lesbians are here!" And this was a tiptop Texas wedding with hundreds of people and everything just so.

My son, Chris, is completely different from my stepdaughter. He's 24 now, living in Tucson. A few months ago, Chris, in front of his five roommates—and the other seven or so who wander in and out—said, "This is my mom, and this is my other mom." Right there in the kitchen with all his friends around.

As we sipped cool drinks and exchanged stories on that refreshing autumn afternoon in the mountains, I realized that our difficulties were not limited to gay families. These challenges—new loves and divided loyalties, old hierarchies and new management, the exhilaration and resentment related to changing roles, relief and discomfort, ambivalence and hope—are the challenges typical to any blended family. Even the added stress of living in a hostile social climate that invalidates and pathologizes your family was typical for stepfamilies until recently. Realizing this parallel, I am heartened. U.S. society *has* become less hostile to stepfamilies. We're waiting.

—Margaret Ann Waller, Ph.d.

Summary

We describe in this first chapter the theoretical and conceptual themes that we include in our multidimensional framework for assessing human behavior and developmental concerns (see Chapter 2). The chapter begins with a description of social work's expertise and why it focuses on promoting effective adaptation. This description includes a detailed discussion of factors contributing to *social adaptation* and positive developmental outcomes of interest to social work professionals. We also describe distinctions between risk and resiliency and risk and protective factors with a special focus on understanding the kinds of factors that are potential threats and supports of developmental outcomes. This information is relevant for understanding why social work has consistently included in education for social workers' information about human growth and development.

Next, it clarifies the important role knowledge of human development plays in social work education and practice. It also introduces readers to a distinction in developmental knowledge between systematic (developmental) influences and chance (nonnormative) influences on changes in human behavior. This discussion includes a review of key developmental concepts for understanding and assessing risks and protective factors.

After introducing the risk and resilience perspectives on human development, the chapter describes and contrasts other perspectives on development: life span, life course, and strengths. Then, we apply these perspectives to the problem of juvenile delinquency to help readers understand the utility in policy and practice of having knowledge of life span, life course, and strength perspectives. These perspectives offer different lens for examining different client concerns at different phases of a person's life.

The chapter then provides a brief overview of other supporting perspectives and frameworks for understanding human development in social work. It begins this overview with a description of the *social functioning framework* and its compatibility with social work's person-in-environment framework. Additionally, this section introduces readers to the important concept in social work assessment processes of the *social environment*. The *social environment* is the context within which the lives of people unfold—neighborhoods, families, schools, communities, organizations, and macro institutions. People learn in the social environment the expectations, motives, and incentives from the individuals, members of their family, groups, organizations, and communities where they live their lives. Indeed, social workers have the professional obligation

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of assessing how the social environment influences and constrains a person's *life choices* and *life chances*. For this reason, we also review *social forces* in the social environment that help in shaping a person's behavior. This includes a description of norms and social stratification involving positive statuses in social space (e.g., age, class, gender, race, social orientation, and so forth). We examine how the *intersectionality* of these statues contribute to inequalities in the life chances and choices of people and how the capabilities for making life choices involve *inequalities of condition* and *inequalities of opportunity*.

Many inequalities are due to oppressive societal practices and structures. For this reason, we also provide a brief description of the important role anti-oppressive frameworks can play in examining developmental norms. The chapter also introduces theories and content for understanding the role of power in social relationships because of the close associations between oppression and power. This includes a brief description of *conflict theories, critical theories, and critical race theory*.

Next, the chapter reviews the widely adopted theory in social work of ecological systems theory. This includes a description of its utility in maintaining the profession's dual focus on the person and environment. It also introduces the levels and elements of *Bronfenbrenner's ecological model*. This conception of the social environment addresses different levels of social organization: microsystems, mesosystems, exosystems, and macrosystems. The chapter concludes with a brief description of crisis theory, which is another theory that continues to play a significant role in understanding coping response to trauma and loss, as well as the transitions of people from different life worlds, social circumstances, and intersecting social statuses.

Thus, a fundamental aim of this chapter was to introduce you to how and why social workers need to understand human development and how it affects strategies of intervention and prevention in promoting positive human development. It also introduced you to key assumptions, developmental concepts, theoretical perspectives, and accepted theories consistent with the integrative *multidimensional framework* described in Chapter 2.

The integrative multidimensional framework recognizes that no single perspective or theoretical framework is sufficient for understanding the complexity of human behavior and its development. Consequently, social work practitioners need to be able to integrate diverse perspectives valued in social work and in the developmental sciences in their assessments of human behavior concerns. They also need to know how to describe current problems and how those problems develop and change over the course of a person's life. These are the primary aims of Chapter 2, which is the chapter in the book that provides relevant background information for the translation of our framework to practice relevant considerations.

Reviewing Your Competencies:

You should be able to:

1. Explain why social workers study human behavior and the social environment.
2. Understand the role of human development in social work.
3. Describe the role played by normative and nonnormative influences on developmental outcomes.
4. Contrast the life stage, life span, life course, and strengths perspectives for understanding human development.
5. Describe supporting frameworks and theories for understanding human development in social work.
6. Explain the effects of intersectionality on developmental outcomes.
7. Describe the role of anti-oppressive frameworks and theories for understanding power and inequalities.
8. Explain the defining elements of the ecological systems perspective in social work.

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Key Terms

adaptation
adolescent-limited delinquency
age grading
age norms
animism
anti-oppressive frameworks
biographical time
cohort (period) effects
crisis
crisis theory
cumulative continuity
cumulative-risk hypothesis
current perspective
developmental perspective
economic inequalities
environmental paths
epigenetic plan
Five Cs
funnel theory
human plasticity
inhibiting and promoting environments
intersectionality
life course
life-course-persistent delinquency
life paths
lived experience
myth of arrival
nonnormative events
normative age-graded influences
normative history-graded influences
opportunity inequalities
power
privileges
protective factors
reification
risk factors
self-selection
social environment
social facts
social functioning
stratification
strengths perspective
the good life
trajectory
transitions
turning points

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Chapter 2

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An Integrative Multidimensional Framework

Learning Objectives

1. Describe the limits of one-dimensional approaches to assessing human behavior in the social environment.
2. Understand the five assumptions underlying the biopsychosocial framework employed in this book.
3. Explain the role of case conceptualizations/case formulations in social work assessment processes.
4. Describe how to apply the critical inquiry process when testing hypotheses for each dimension of the integrative multidimensional framework.
5. Explain how to organize case information by identifying precipitating, predisposing, perpetuating, and protective factors (the 4 Ps) when assessing client concerns.

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Case: Mrs. Morgan

Monica Morgan is an 82-year-old African American mother of six children and a grandmother of eight children. She recently moved to Brooklyn, New York, to live with her daughter and son-in-law because of health difficulties. She has a longstanding history of high blood pressure and other physical complications associated with the normal aging process. Mrs. Morgan resents that her children made her leave her home in Alabama. Prior to the move, Mrs. Morgan was spending long hours in bed and her children could not tell what was causing this noteworthy change in her behavior. They sent an older friend of the family to visit and to determine what was causing her to stay in bed. The 80-year-old friend reported that the mother was just feeling sorry for herself. Because the problem continued, Mrs. Morgan's oldest son traveled from Atlanta to visit her; when he arrived, she was able to get out of bed, but she passed out shortly after they had lunch. They rushed her to the hospital, and the doctors determined that she was bleeding in her stomach and had been doing so for quite some time. She probably would have died in bed during the night had she not passed out and was taken to the hospital. The doctor thinks that Mrs. Morgan was not taking one of her medications correctly and that it caused her stomach to start bleeding.

After the emergency hospitalization, Mrs. Morgan's oldest daughter insisted that she come and live with her because her mother was not able to manage her medications. While the daughter thought her mother would be grateful for this action, the mother had the opposite reaction. Mrs. Morgan became very oppositional shortly after moving to Brooklyn and began verbally attacking her daughter and son-in-law for moving her out of her home. Mrs. Morgan questions her daughter's motives because her daughter and son-in-law both work and she is alone in their home while they are at work.

Colorblind Images LLC/Getty Images

Mrs. Morgan believes that she could have stayed in her own home in Alabama because she is equally at risk in Brooklyn while her daughter is at work. Mrs. Morgan valued her independence while living in Alabama and is starting to regress.

The daughter has presented at a social service agency seeking assistance because her mother is constantly angry and is not open to making any efforts at adjusting to life in Brooklyn. She complains about the food, does not eat much, and refuses attempts to link with services for seniors and other available social support activities in the community. The mother is also refusing to do some care duties that she was previously able to do, such as making breakfast and doing minor personal daily-living activities.

Assessment Considerations

The case of Mrs. Morgan has many different intersecting dimensions (developmental, biophysical, psychological, and social). When a social worker receives Mrs. Morgan's case, the social worker will need to make an assessment before formulating a description of her case, which technically involves constructing a *case formulation*. The primary objective of the case formulation is to identify and then describe the factors influencing Mrs. Moran's current situation.

What combination of factors could be contributing to her current difficulties? Is she experiencing common *developmental* issues associated with aging or associated with her prior developmental history (prior life events, risks, or other predisposing factors)? Are there physical factors, such as current medicines or the onset of other illnesses contributing to her current difficulties (biophysical considerations)? Are there *psychological considerations*, such as the presence of depression, feelings of powerlessness or loss, cognitive declines, or other psychological considerations contributing to her anger and changes in behavior? Are there *social considerations*, such as prior relational conflicts with her daughter or son-in-law, loss of friends, loss of home, and a sense of community? Does she find it difficult adapting to the cultural practices, language styles, spiritual practices, and material culture of the North (*multicultural considerations*). What specific strengths exist in her history that could serve as protective forces for facilitating a positive adjustment to the changes in her life? What support services are available in Brooklyn that could address some of her needs while her daughter and son-in-law are at work? If Mrs. Morgan's social worker

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ignores these different considerations, then the intervention might ignore important targets for change that are reinforcing or perpetuating Mrs. Morgan's current difficulties. For this reason, we assume that practitioners need to formulate a multidimensional conceptualization of *current* and *developmental* concerns.

Conceptualizing Human Behavior and Its Development

This book takes the issue with adopting a single theory to understand human behavior and human developmental processes whether they are *person centered* or *environment* centered. We assume that you cannot understand human behavior and its development by isolating the internal variables of people from the external variables of their environments. For this reason, this book uses an integrative multidimensional approach to guide our examination of human developmental processes and for helping students learn how to formulate or construct biopsychosocial descriptions of their cases.

Social work professionals must be clear about how they will systematically assess, measure, or describe the characteristics of their clients and their problems-in-living. **Problems-in-living** refers to the difficulties people experience in everyday life: loss of a job, fear of rejection, having bills that one cannot pay, undergoing a divorce, and not being able to manage one's children or household. Any assessments by social workers of these life difficulties will depend on their perspectives. As Carter (2017) concludes, any viewpoint is relative to one's own perspective of the system one is describing and that system's environment. Social work professionals seek a perspective on human behavior that is consistent with the principles of their professional code of ethics, their commitments to respecting individual uniqueness, the strengths and empowerment perspectives, ecological systems theory, anti-oppressive frameworks, and principles from general systems theory.

Our **multidimensional framework** is a perspective and not a theory. "A *theory* is an orderly, integrated set of statements that describes, explains and predicts behavior" [emphasis added] (Berk, 2022). *Perspectives*, on the other hand, do not offer explicit predictions or observations about human behavior. In other words, our framework offers practitioners a way to consider various points of view and integrate them into their assessments of human behavior and its development.

Our multidimensional framework relies heavily on principles from systems thinking, which assume that "[e]ach person is composed of molecules, cells, and organs, each person is also a member of a family, community, culture, nation and world" (Eisendrath, 1988, p. 36). The other key assumptions are:

- There are three basic dimensions for assessing human behavior and its development: biophysical, psychological, and social.
- These three dimensions are conceptualized as a system of biopsychosocial functioning.
- This system involves multiple systems organized in a hierarchy of levels from smallest (cellular) to largest (social).
- The social system exists within cultural, historical, political, spiritual, and religious institutions, and other macro system contributions.
- The ascending hierarchy of systems is in a constant state of interaction with other living systems and with other nonliving components of the system's physical environment.

Considering the three dimensions of the multidimensional framework does not mean that one cannot integrate other formulations within the assessment process that has concepts from psychodynamic theories, cognitive theories, and other grand theories. Many components of a complete treatment plan can include other relevant formulations. Exhibit 2.1 illustrates concepts from theory-guided

Exhibit 2.1 Components of Psychological Theoretical Formulations

Psychodynamic components
Difficulties with trust or having to depend on others
Difficulties with control
Difficulties with self-esteem
Difficulties with relationships
Cognitive components
Automatic dysfunctional thoughts
Negative core beliefs
Cognitive distortions (errors in logic)
Behavioral components
Is there behavioral reinforcement of a maladaptive behavior?
Is there something that extinguishes a desired behavior?
Is there a paired association between a behavior and an environmental cue that initiates the behavior?

Source: Derived from Campbell & Rohrbaugh, 2006.

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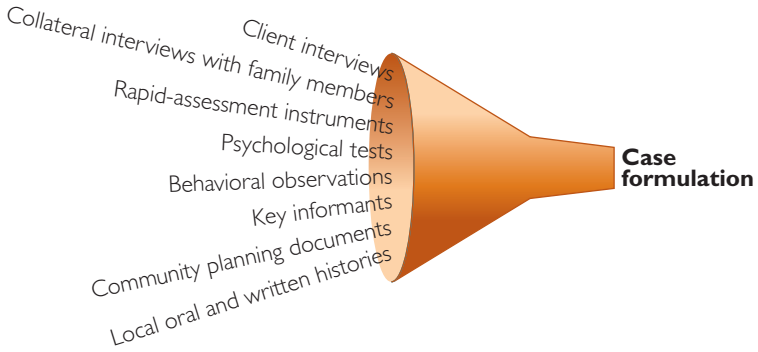
Exhibit 2.2 Illustration of Data Gathering in a Case Formulation Process



formulations that practitioners can incorporate, when appropriate, within their multidimensional assessments.

An important value of an integrative framework is the emphasis it places on *not* reducing explanations or descriptions to single causes, theories, or concepts. The primary objective of our framework is to assist practitioners in integrating information necessary for describing the unique characteristics of individuals in their social elements, including client system vulnerabilities, resources, and strengths. Practitioners all too often focus on presenting problems and fail to zero in on areas of strength in facilitating changes in a person's situation (Saleebey, 2001).

The biopsychosocial system contains information for understanding human behavior concerns that serve as a basis for various kinds of intervention strategies. They also allow social workers to maintain their commitment to considering strengths and relevant competencies in person-in-environment transactions when designing their intervention strategies.

In completing a case formulation, practitioners need to obtain information from many different sources. Some common sources of information social workers rely on in their case formulations are:

- Client interviews
- Collateral interviews with family members, friends, neighbors, teachers, or other significant others
- Complete rapid-assessment instruments
- Review of psychological or neurological test results
- Review of relevant medical reports
- Behavioral observations
- Interviews with key community informants
- Review of existing community planning documents
- Review of local oral and written histories

The prior list is not appropriate for every case. The sources depend on the nature of the case and specific client concerns/needs. Exhibit 2.2 provides an illustration of how the data gathering in a case formulation begins with large amounts of information and narrows to include the factors relevant for describing the contributions to the client's current issues. The sources of information that social workers examine focus on the dimensions of our integrative multidimensional framework.

In the next section, we describe the characteristics of the formal dimensions making up our integrative multidimensional framework.

Integrative Multidimensional Framework and Its Dimensions

Biophysical Dimension

The *biophysical dimension* of the multidimensional framework consists of the biochemical systems, cell systems, organ systems, and physiological systems. This dimension helps in the assessment of an individual's physical growth and development. The functioning of this system involves the balanced exchange of energy among its biophysical components. This dimension relies on biological theory and seeks to identify and explain the relationship between biological and physiological mechanisms that influence human behavior. Any change in this dimension will have corresponding changes in the other dimensions inside and outside this system. Social workers must examine how a person's biological heritage (genetics) and their health status place limits on a person's behavior and development.

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Regardless of your innate qualities, physical factors affecting your health status, such as extreme sleep deprivation, can place limits on your performance. For this reason, it is important in any assessment to identify *physical strengths* (factors that can enhance physical performance) and ***physical hazards*** (factors that can impede physical performance). The *biophysical dimension* helps us look at the person as a physical organism or as a biological entity. Structural mechanisms and undefined impulses associated with these mechanisms are the physiological foundations for the roles people play. The physical foundations in some social role contexts are more essential to behavioral outcomes than are social or psychological foundations (Gerth & Mills, 1953).

Physical hazards refer to factors in the external or internal environment of a person that can cause adverse or harmful health effect. For example, exposure to specific substances such as lead in the environment can threaten important physical developmental processes. This concern is very prominent in the minds of many Americans following the problems with lead identified in Flint, Michigan's water system.

Other naturally occurring substances in a person's physical environment can also be a hazard to that person's health and welfare. These external and internal hazards (like genetic abnormalities) differ from risks. *Risks* refer to the chances of a harmful consequence occurring after exposure to adverse experiences. In other words, hazards are not necessarily synonymous with risks. Many risk factors in and of themselves are not hazardous. For instance, salt is a nontoxic or nonhazardous substance, but it can be a risk for some adverse physical conditions. Social workers must identify whether clients have been exposed to hazardous physical factors and risk factors because of the role they play in health and welfare concerns.

Psychological Dimension

The *psychological dimension* represents the systems that contribute to the organization or integration of the individual's mental processes. This dimension involves several functions designed to help the person satisfy their needs. These psychological functions involve the systems of information processing and cognitive development; communication; social cognition and emotions; and psychological strengths, hazards, and risk factors. We will define each of these psychological systems in a review of the key dimensions of our multidimensional framework in the section of this chapter focusing on the critical inquiry process.

Social Dimension

The *social dimension* refers to the systems of social relationships that a person interacts with individually or in a group. The social groups and relationships included in this system are families, communities, and other support systems; gay and lesbian relationships; cultural and ethnic groups; and social institutions such as churches, political

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Playing and growing up close to landfills and dumps is a physical risk for children. Identifying physical hazards and strengths is an important aspect of social work.

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Cigarettes can be a risk to a person's health. They differ from physical hazards like exposure to toxic hazards.

parties, schools, healthcare networks, and welfare service systems. These groups, institutions, and relationships contribute to the organization and integration of social life.

This dimension contains categories that help practitioners locate the conduct of individuals in various social systems and institutions. This dimension includes social forces and social facts in a person's social environment involving both social position and social stratification constructs. By focusing on these concepts and constructs, we place issues of age, social class, culture, ethnicity, gender, and sexual orientation at the core of our assessment process, rather than at the periphery (Johnson et al., 2003; Garcia Coll et al., 1996). In addition, we can examine how these positional, institutional, and cultural system variables serve as strengths, hazards, or risks to social functioning. They also allow for a critical assessment of factors that can promote anti-oppressive practices and structures.

This book adopts the assumptions stressed in this new synthesis by emphasizing that we cannot understand development without considering biopsychosocial interactions across multiple levels of system organization.

The Biopsychosocial Interaction

Individuals and their environments represent multiple systems that extend from the biochemical to the psychosocial realm. The biological realm of an individual extends from the molecular to the molar, or structural, level; the psychological realm extends from the emotional to the behavioral. The social realm of an individual includes the family and other groups, the neighborhood, the cultural setting, and the context of society. We can conceive of these multiple sources of influence as a person within a body, within a family, within a state, within a country, within the world, within the solar system, within the galaxy, and within the universe.

A *person* refers to who they are individually (genetic makeup, past learning, role combinations, role history, and so forth) and socially or environmentally (the social forces and people in the person's environment). Behavior is the result of interactions between the person and the environment. No single factor can be solely responsible for causing a behavioral response. Within a complex system, multiple factors interact to produce specific behaviors. When we think of the biopsychosocial interaction, we recognize that certain biological processes, cognitive processes, and environments can increase the likelihood that a particular behavioral response will develop.

Clearly, biology is not destiny. We must also consider psychological and social variables in accounting for human behavior. For example, attention-deficit hyperactivity disorder (ADHD) in some children does not appear to have a genetic basis. In addition, some children with a

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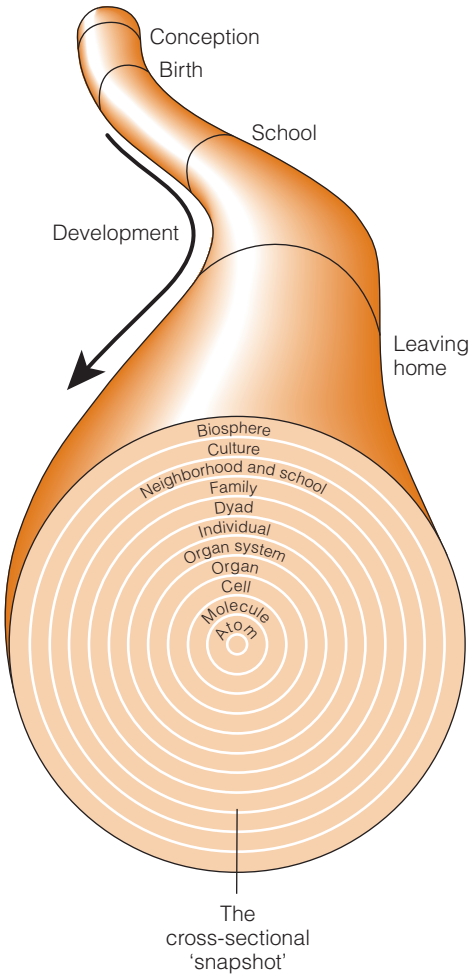
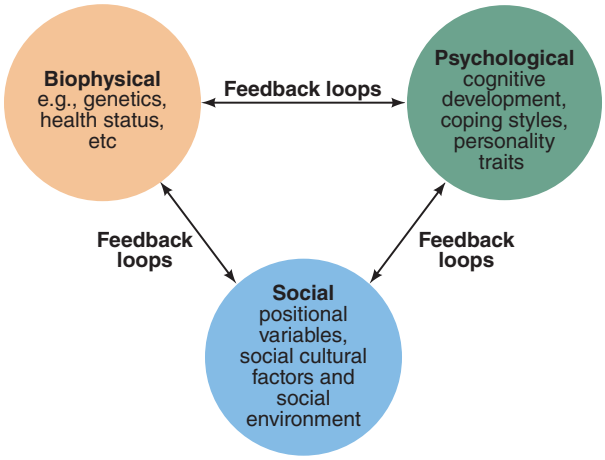
Exhibit 2.3 Illustration of the Interactions that are Considered in the Biopsychosocial Approach



genetic predisposition will not develop ADHD, indicating that biological factors alone do not account for the disorder. A child with a small propensity toward hyperactivity can have a parent reinforce and promote more hyperactive behavior. Conversely, a child exposed to high amounts of lead—through lead-based paint—might develop symptoms of ADHD, yet the symptoms are subject to moderation by appropriate environmental responses. The influence of environment on ADHD illustrates an important developmental concept—*human plasticity*. Human physical and psychosocial structures are subject to changes introduced by variations in the environment. A number of studies show that an environmental setting has a definite influence on personality and on social and intellectual functioning, independent of a person's genetic makeup (Exhibit 2.4 presents a multilevel concept of human development.)

Exhibit 2.4 Multilevel Concept of Human Development



Caspi and his colleagues (2003) capture the environment's influence on gene expression in their seminal research on depression. They systematically collected data for more than two decades on a group of individuals who were administered multiple forms of measurement from age 3. This data set has helped the authors isolate highly specific forms of genetic and environmental interactions that illustrate that some people exposed to environmental stressors do not develop depression. The authors identified through their research that a specific gene associated with depression (5-HTT) has two types of alleles—either two long alleles (LL) or two short alleles (SS). Using this information about the two types of alleles, the authors examined how exposure to stressful life events was associated with the development of depression in the study's participants. They found that people with two short alleles (SS) for the 5-HTT gene were at increased risk for the development of depression (63%) when compared with individuals with two long alleles (30%). Advancements in technology and our understanding of biological data provide social workers with the opportunity to better understand when and for whom prevention programs will have the most impact (i.e., Gene × Intervention studies).

Exhibit 2.5 displays the rates of depression for participants with no history of maltreatment, probable maltreatment, and severe maltreatment as children. These results show that depression in the LL allele groups is not due to stress or exposure to childhood maltreatment. These results are "by far the most important yet in demonstrating very clearly that neither genes nor life experiences (environmental events) can explain the onset of a disorder such as depression" (Barlow & Durand, 2005, p. 7). Depression, like most conditions encountered by social workers, is a

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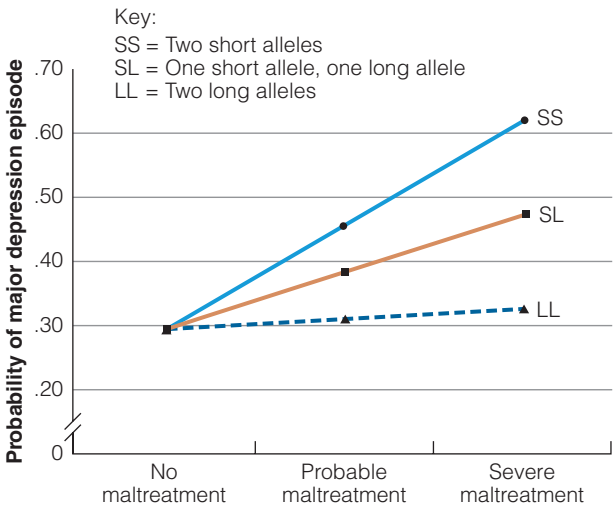
Exhibit 2.5 Interaction of Genes and Early Environment in Producing Adult Major Depression



condition not caused by a single factor. Most problems in living, diseases, disorders, and positive developmental outcomes are due to multiple factors or influences. Our integrative multidimensional framework allows for multifactorial assessments of *current* and *developmental* concerns.

When implementing our framing in completing assessment, we recommend engaging in a process of **critical inquiry**.

The Critical Inquiry Process

The testing of hypotheses is a practice that is consistent with the methods of science and with principles of critical inquiry. "Critical inquiry is a process in which theories are relentlessly criticized—and only those that withstand the process are retained" (Dilts, Jr., 2001, p. 16). The testing of hypotheses cannot all occur in a lab, which is especially true of practice in social work and in many other professions. However, science is not just about testing hypotheses in laboratories. It is also about exposing hypotheses to criticism that results in the self-correction of a practitioner's actions.

Hypotheses are not accurate without supporting evidence. Hypotheses are also not accepted simply on the basis of tradition or professional dogmatism, but because they have proved themselves in research and in practice (Dilts, Jr., 2001). For this reason, social work practitioners should always consider their hypotheses as tentative. If the hypothesis is not working, then we must discard it. Indeed, after generating a hypothesis, we need to test the hypothesis with evidence indicating that the assumption is correct. For instance, if the assumption is that the person is suffering from a depression that would benefit from antidepressant medications, then the individual should respond to the medication in an expected direction. We would not expect the person on such medication to become agitated or manic in response to receiving an appropriate antidepressant medication, which would suggest to a practitioner that the assessment (initial hypothesis) might not be correct.

In summary, hypotheses should help you think about the various determinants of human behavior within a specific dimension. We encourage you to think about human behavior in terms of different hypotheses. In this way, you will become more skilled in assessment. In addition, the better you are in assessment, the more effective you will be in providing services. Social workers, as professionals, are typically responsible for assessing issues involving social functioning in the implementation of most multidimensional assessment processes. In the next section, we provide some guidelines for doing so that are consistent with how we also organize our presentation of the information in our developmental chapters.

Practice Guidelines for Implementing the Critical Inquiry Process

The following outline suggests specific considerations for developing hypotheses in completing assessments for each of the dimensions contained in the multidimensional framework.

1. Biophysical hypotheses:
   a. Biophysical growth and developmental factors (genetics, health status, use of medications or other substances)
   b. Biophysical strengths, hazards, and risk factors—for example, exposure to teratogens in intrauterine stages of development (hazards); perinatal complications (risks); good nutrition (strength)
2. Psychological hypotheses:
   a. Relevant cognitive-developmental, information-processing capacities; personality development; and coping behavior (abstraction, attention, concentration, comprehension, judgment, problem solving, personality traits, and styles of coping)
   b. Attitudes, emotions, and regulation (conceptions of self and others, impulse control, and self-regulation)

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   c. Psychological strengths, hazards, and risk factors (character strengths, virtues, distorted cognitions, and values)

3. Social and cultural hypotheses:
   a. Groups and family factors (group structure, peer groups, social position, social status roles, norms, family structure, and stratification (power) considerations.
   b. Communities and support systems (neighborhoods and civil organizations)
   c. Organizations and social institutions (schools, healthcare institutions, welfare institutions, multinational corporations)
   d. Multicultural, gender, spiritual, and structural considerations (positional variables such as age, class, ethnicity, gender, sexual orientation, religion, and spirituality)
   e. Social strengths, hazards, and risk factors (socially connected/disconnected, marginalization, poverty, discrimination, institutional racism, social isolation, maltreatment, and various forms of oppression)

We expand on this outline in the next section by providing definitions and examples of relevant considerations when implementing the practice guidelines for testing hypotheses in a critical inquiry process.

Biophysical Growth and Development

Prenatal Growth and Development

Assessment considerations include mother's nutritional status during pregnancy, mother's health status, father's health status, length of gestation, prenatal substance exposure to infant by mother, pregnancy complications, family genetic history, genetic abnormalities, chromosomal abnormalities, and physical birth defects (cleft palate, heart defects, etc.).

Client's History of Attaining Developmental Milestones

Assessment considerations include when client took first steps, fed self, dressed self, achieved toilet training, had first menses or first nocturnal emission, and developed secondary sex characteristics.

Client's General Health Status

Assessment considerations include stability of weight; regularity of menstrual periods; regularity of sleep-wake cycle; level of physical activity and level of nutrition; presence of biochemical imbalances; presence of physically handicapping conditions; use of substances such as tobacco, alcohol, and drugs; assessment of client's general appearance (does client look their stated age?); and client's ability to perform activities of daily living (ADLs). The client's present use of antidepressants or antipsychotics, and use of other prescription drugs.

Biophysical Strengths

An easy temperament, high energy levels, good sleep patterns, and overall physical vitality can be important elements to capitalize on in designing effective interventions. Good genetic history is an important asset for a variety of developmental and health outcomes. Good physical appearance, a history that is free of physical disabilities, and other physical characteristics are also important resources. Early physical maturation can be another example of a physical resource with implications for treatment planning and other intervention strategies.

Biophysical Hazards and Risk Factors

Assessment considerations include family history of heart disease, respiratory problems, cancer, diabetes, health status of close relatives, causes of death of close relatives and their age at death, client's current and past health status, and presence of symptoms related to a major illness. Porzelius (2002, p. 8) wrote, "People who are unattractive, disfigured, in a wheelchair, or overweight are often exposed to serious discrimination and prejudice, which could contribute to psychological problems. Sometimes, in a misguided attempt to deny any personal prejudice, therapists may simply ignore an undesirable characteristic, such as overweight." By ignoring physical characteristics, the practitioner may miss important information about how peers respond to the person, a factor that could be a significant target of potential change.

Other physical hazards include homelessness or exposure to toxins in a person's environment that can influence prenatal and postnatal development. In addition, it is important to identify whether others in the person's physical habitat have had prevalence rates of particular types of physical abnormalities that are higher than in other locales, as well as exposure to distinct types of substances in a person's physical environment that may perpetuate

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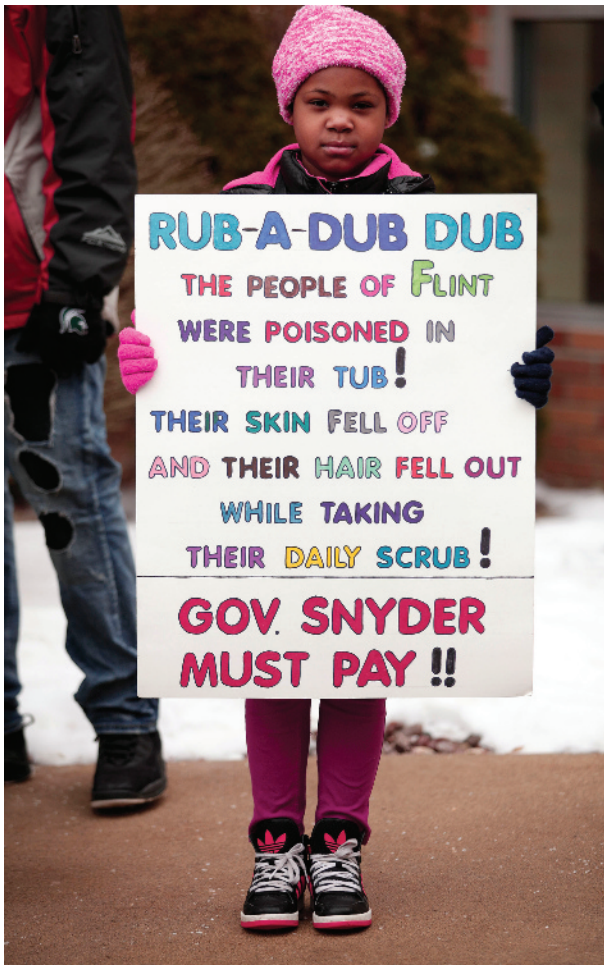

Bill Pugliano/Getty Images News/Getty Images

Lead pipes are a serious hazard.

specific types of health or other problems. It is also important to determine whether the person has characteristics that match specific risk populations for identified health problems or other adverse health consequences.

Psychological Considerations

The social worker must consider many relevant psychological hypotheses when assessing a client's psychological status. Most relevant to the social worker is the individual or family interview. In addition to the traditional psychosocial interview, social workers are making use of semi-structured interviews as well as results from psychological tests, behavioral observations, personality tests, and results from rapid-assessment instruments.

A client's problem may either be related to or a direct result of some of the key components of the psychological dimension. These components can change at different phases of a person's life, which is described for each of the age grades described in our developmental chapters.

Cognitive Development and Information Processing

Client's Attention Span, Memory, Concentration, and Capacity for Abstract Thought

Assessment considerations include ability to focus attention, ability to complete tasks appropriate to age, and capacity for memory.

Client's Reality Base

Assessment considerations include client's cognitive functioning, client's ability to discern reality, and content of client's thoughts and perceptions.

Client's Learning Abilities and Performance

Assessment considerations include school performance, problem-solving abilities, and capacity for insight and reflection.

Client's Language Ability and Vocabulary

Assessment considerations include bilingual expectations, use of language, comprehension of language, and general verbal and nonverbal abilities in self-expression.

Client's Self-Perception

Assessment considerations include negative and positive perceptions of self, view of self with others, comparison of self with expectations of others, and perception of what others think about the person.

Client's Emotional Responses

Assessment considerations include full range of emotions evident and excessive emotions such as anger, sadness, and frustration.

Client's Self-Statements

Assessment considerations include content of self-talk, amount of irrational ideas present, and relationship between self-talk and problem behavior (e.g., fear and hopelessness).

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Social Cognition and Emotional Regulation

Client's Social Knowledge about Others

Assessment considerations include client's understanding of social interactions, client's view of friendship, and client's expectations of others.

Client's Capacity for Empathy

Assessment considerations include client's capacity for perspective taking, client's sense of morality, and client's interpersonal understanding of others.

Client's Capacity for Impulse Control

Assessment considerations include stability in jobs, relationships, play activities, and other interpersonal relationships.

Client's Capacity for Emotional Regulation

Assessment considerations include assessment of affect and mood changes, whether the affect is appropriate to the situation, and the duration and intensity of moods.

Client's Social Skills

Assessment considerations include appropriateness of client's social interactions, client's knowledge of social skills, and client's ability to communicate effectively.

Client's Social Problem-Solving Skills

Assessment considerations include client's ability to generate solutions to problems, client's ability to think of consequences, and client's means–ends thinking (cognition of steps needed to solve problems).

Client's Maladaptive Behavior Patterns

Assessment considerations include client's behavioral responses to problem situations; client's patterns of behavior that lead to difficulties for self, others, or society; and client's desired behavior changes and patterns.

Client's Coping Skills

Assessment of how clients have handled stress; exposure to trauma and poor social conditions; threats; and environmental, biological, or other concerns.

Psychological Strengths

Strengths may include a good regulation of emotions, a high intelligence quotient, good emotional intelligence, an extroverted personality, a sense of mastery, a belief in changeable social traits, and other psychological qualities. Also included is a positive history of experience with parents, authority figures, and significant others. In addition, if a client has had experiences of value with others, subjected to positive discipline in critical life stages, and other positive life experiences, these represent psychological strengths.

Psychological Hazards and Risks

Client's Experience of Past Life Events

Assessment considerations include client's description of significant events in childhood, experience with parents and other adult figures (especially whether any physical or sexual abuse occurred), experience with emotional abuse, experience with peers, psychosocial living environment, history of mental disorders, and history of use of antidepressants or antipsychotic medications.

Client's Experience with Recent Life Events

Assessment considerations include client's description of significant life events in recent years, recent experiences with adult and peer figures (especially involving events such as divorce or parents' divorce or death of a loved one).

Social Considerations

The social worker's assessment extends beyond the biological and psychological dimensions to include the social dimension. Social factors include the family, community, and other social support systems; access to resources; and the impinging social environment. What is the client's social relationships? Additionally, what is the environmental context of the client's social relationships? For example, does the client live in poverty? Does the client face racism on a daily basis? The social worker must assess how society perceives and treats the client, how the client interacts with people in the client's social environment, including family members, schoolmates, work colleagues, and friends.

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Intimate contact helps in establishing interpersonal bonds

A client's problem can be a direct result of people within their social environment.

The client's problem may be related to or a direct result of the following social categories or classifications of people:

Groups and Families

Role Systems and Subsystems, Family Boundaries, and Client Membership Groups. Assessment considerations include patterns of interaction in peer and work groups, influence of group norms, and other group dynamics on the individual's behavior.

Assessment considerations include open or closed family systems, family structure (e.g., enmeshed or disengaged), and how the family defines itself.

Patterns of Communication within the Family. Assessment considerations include content and processes of interaction, patterns of conflict, and verbal and nonverbal expressions of affect.

Family Roles. Assessment considerations include role assignments within the family, satisfaction with roles, expectations and definitions of roles, allocation of power, role strain and role support? Is there evidence of parentification in the family? That is, do parents engage in role reversals whereby the children assume responsibilities for key family needs typically associated with the expectations of parents?

Communities and Support Systems

Communities of Which the Client Is a Member. Assessment considerations include the degree of attachment the client has toward the place where they live, attachment to ethnic communities and the significance of ethnic location for the client's identity, the unique values adopted by the person's community, the supports and strengths identified within the person's community, and whether the community is inhibiting or promoting normative developmental outcomes.

Support Systems Available to the Client. Assessment considerations include social supports (family, friends, extended family, social-support groups, and self-help groups); institutional supports (child support, welfare, health benefits); access to resources (day care, recreational facilities, police protection); barriers to support systems; and need for new resources and support systems.

Institutional Contributions to Client's Problem. Assessment considerations include whether the structural aspects of the person's environment are constraining or

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promoting certain behavior choices, whether the institutions are in conflict, and whether the institutions fit with existing social conditions. This should include effects of *globalization* on relevant client institutions and other trends on client and system behaviors, as well as the effects of macro and local economic system influences. The extent to which the institutions in a person's life maintain and promote various types of oppression.

Organizational Contributions. Assessments should include informal norms, formal organization rules, lines of communication, span of control, and styles of leadership.

Multicultural Gender and Spiritual Considerations

Assessment considerations include ethnic or gender identity; degree of acculturation; sexual orientation; language barriers; amount of interaction within and outside the ethnic group; and expectations influenced by cultural, gender, or sexual-orientation considerations. Regarding cultural, gender, or sexual-orientation considerations, we recommend considering the positional variables identified by Garcia Coll and her colleagues (1996) for assessing people from BIPOC backgrounds. Their conceptual model focuses the assessment on the unique ecological or social environmental circumstances faced by BIPOC individuals. The intersectionality of other relevant positional variables also require consideration such as age, social class, and disabilities. *Positional variables* are the attributes of a person that societies use in processes of *stratification* (race, social class, ethnicity, and gender (Johnson et al., 2003). "These positional factors represent social addresses that influence or create alternative developmental pathways" (Garcia Coll et al., 1996, p. 1895).

Practitioners need to understand how these factors affect human behavior. In most instances, they do not directly influence outcomes. These positional variables mediate the pervasive social processes of racism, prejudice, discrimination, and oppression (Johnson et al., 2003). The model developed by Garcia Coll and her colleagues (1996) demonstrates how the positional variable of race operates through the creation of segregated contexts. *Segregation* in this model is a multifaceted concept. It combines residential, economic, social, and psychological dimensions influenced by processes of segregation. Because segregation leads to nonshared experiences and distinct conditions those children of color face daily, these processes impact what Garcia Coll and her colleagues have termed *inhibiting and promoting environments*. Examples

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Prior social institutions constrained specific opportunities for members of LGBTQI community.

of these environments include schools, neighborhoods, and other central social institutions. Children from BIPOC backgrounds develop in these environments, which directly influence their personal and family development.

A person's culture affects the meanings associated with each of the positional variables described by Garcia Coll and her colleagues. Culture also influences a person's inhibiting and promoting environments, as well as a person's spirituality and religion. Generating hypotheses about a person's culture and its effects on the meanings and values of clients is an important component of any assessment process. The practitioner needs to determine how culture is influencing a person's definition of a problem and potential strategies for change, as well as the client's notions of identity and spirituality. While the need for employing cultural formulations is widely accepted by most practitioners, many practitioners are less familiar with and comfortable with assessing issues of spirituality. What does a spiritual assessment entail?

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Different religious institutions promote different forms of spirituality.

A spiritual assessment involves analyzing and synthesizing information about spirituality into a framework that provides the basis for practice decisions (Hodge, 2001a). **Spirituality** involves a process, as is true of religion, with associations with health and well-being (Hodge, 2001a; Koenig, McCullough, & Larson, 2001). For this reason, practitioners need to integrate information about spirituality within their integrative multidimensional assessments.

The spiritual assessment must understand how spirituality shapes the person's functioning (Canda & Furman, 2010). Will the person's spiritual beliefs have any implications for service provision? That is, the process is not to determine the correctness of clients' beliefs, but rather to understand how spiritual beliefs are influencing client functioning, including functioning related to service provision (Crisp, 2010). A two-stage process for assessing spirituality is contained in the Focus on Practice. This two-stage process developed by Professor Hodge offers practitioners useful guidelines for developing spiritual hypotheses.

Social Strengths

A person's life experiences, language, cultural traditions, cultural continuity, family supports, and other resources need an assessment. Resources from friends, neighbors, and other informal supports are key strengths that can augment intervention plans.

Social Hazard and Risk Factors

Assessment considerations include high rates of unemployment, divorce, poverty, discrimination, inadequate social institutions, corrupt governmental and other institutions, and impoverished neighborhoods.

Guidelines for Organizing Relevant Case Information

The framework can direct practitioners toward specific strategies for intervention when the client's presentation is organized into predisposing, precipitating, perpetuating, and protective factors for each of the dimensions of the multidimensional framework—otherwise known as the 4 **Ps** (see Exhibit 2.6).

1. **P**recipitants or activating situation(s) for a client's concern(s)
2. **P**redisposing factors (includes any risk factors in a client's developmental history)
3. **P**erpetuating factors (factors that are reinforcing or maintaining a problem)
4. **P**rotective factors refer to a client's assets, strengths, and resources.

Henderson and Martin (2014) observed that the **4 Ps** connect chronological, developmental, and etiological considerations to the biopsychosocial model in ways that

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Focus on **Practice**

Spirituality Assessment in Practice Settings

Assessment: A Two-Stage Process

Due to ever-present time limitations, spiritual assessment is commonly through a two-stage process: a brief preliminary assessment followed, if warranted, by an extensive comprehensive assessment (Pargament & Krumrei, 2009). The purpose of the preliminary assessment is twofold: (1) to determine the relevance of spirituality to service provision and (2) to ascertain whether a comprehensive assessment is needed (Hodge, 2006). In many cases, spirituality plays a limited role in clients' lives or is peripheral to service provision. In such instances, a brief assessment may be all that is required. In other cases, a more comprehensive assessment is warranted.

Table 2.1.1 presents one set of questions that practitioners may find useful in conducting a brief assessment with many clients (Hodge, 2004). These questions are designed to assess the self-ascribed importance of spirituality, spiritual affiliation, how spirituality functions as a resource of strength, and the presence of any spiritual needs or concerns that may intersect service provision.

Tentative language is typically helpful in creating a neutral environment that allows clients the freedom to respond in diverse ways. Prompts and follow-up questions are commonly used to flesh out responses (Sperry, Shafranske, 2005). Initially, it is often helpful to use common terms to aid understanding (e.g., church) followed with a broader term to ensure as much inclusivity as possible (e.g., spiritual community). It is important, however, to tailor the language to fit the client's spiritual narrative as soon as possible, so the assessment is conducted in a culturally appropriate manner. If the assessment reveals the client is affiliated with a specific spiritual tradition (e.g., Islam), then language that reflects the norms within that tradition should typically be used (Richards & Bergin, 2000; Van Hook, Hugen, & Aguilar, 2001).

Table 2.1.1 Brief Spiritual Assessment Questions

Aim	Question to operationalize aim
Importance	I was wondering if spirituality or religion is important to you.
Affiliation	Do you happen to attend a church or some other type of spiritual community?
Assets	Are there certain spiritual beliefs or practices that help you cope with problems?
Needs	I was also wondering if there are any needs or concerns I can help you address.

If the results of the brief assessment suggest that spirituality may be related to service provision, a comprehensive assessment is typically warranted. Before proceeding with a comprehensive assessment, four factors should typically be considered (Hodge, 2006). First, given the personal, sensitive nature of spirituality, it is important to ensure clients are comfortable with a more in-depth exploration of their spirituality. Second, practitioners should contemplate their ability to work within the context of the client's spiritual value system in a culturally competent manner in light of the information obtained in the preliminary assessment (Husain & Ross-Sheriff, 2011). Third, if the initial assessment suggests that spirituality functions as an important organizing principle in the client's life, a more extensive assessment is likely appropriate. Finally, the degree to which clients' spiritual values are related to service provision should be considered. If the services or presenting problem intersect the normative values in the clients' spiritual tradition, then a comprehensive assessment might be administered.

Stage 2: Comprehensive Assessment

The goal of a comprehensive spiritual assessment is to obtain a more detailed understanding of clients' spiritual beliefs, practices, and experiences as they intersect service provision (Hathaway & Ripley, 2009). Toward this end, a number of conceptually unique comprehensive spiritual assessment approaches or tools have been developed. Both clients and practitioners have a variety of needs and interests in any given practice setting. The amount of time available for assessment, the nature of the services provided, communication styles, cultural backgrounds, and similar factors vary from case to case. Ideally, therapists should select the approach that provides the best fit to optimize service provision.

Spiritual histories: Conducting a spiritual history is perhaps the most popular assessment approach. In a manner analogous to administering a family history, a series of questions are used to unpack clients' spiritual stories (Hodge, 2001a). The questions help clients relate their spiritual narratives while concurrently eliciting clinically salient information.

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Spiritual life maps: This approach represents a diagrammatic alternative to verbally based spiritual histories (Hodge, 2005c). A spiritual life map is a pictorial delineation of a client's spiritual journey, an illustrated account of the client's relationship with God or the Transcendent. As is the case with the other diagrammatic instruments discussed below, drawing pencils and other media are used to depict spiritually significant life events on a large sheet of paper.

Spiritual genograms: Much like traditional genograms, **spiritual genograms** provide a graphic blueprint of intergenerational spiritual interactions (Hodge, 2001). The concrete depiction of spiritual information across at least three generations helps both clients and practitioners understand the flow of historically rooted patterns through time. Spiritual genograms are often particularly helpful when working with couples or family of origin issues.

Spiritual eco-maps: While the above approaches focus on clients' spiritual stories as they exist through time, spiritual eco-maps focus on that portion of clients' spiritual stories that exist in present space (Hodge, 2001; Hodge & Williams, 2002). In other words, spiritual eco-maps focus on clients' current relationships to important spiritual variables in their here-and-now environments. They tend to be quick and easy to construct and can be readily incorporated into a boarder assessment of biopsychosocial functioning.

Spiritual ecograms: This approach combines the strengths of spiritual eco-maps and genograms in a single tool (Hodge, 2005). Spiritual ecograms depict historical information across three generations, as well as present relationships with current spiritual variables. Although somewhat time intensive to administer, they offer the advantage of illustrating connections between past and present functioning. On a single piece of paper, historical influences on current spiritual variables can be seen as well as the relationship between current variables and historical influences.

Conclusion

Understanding the respective strengths and limitations of each comprehensive assessment tool aids in selecting the most appropriate approach (Hodge, 2005). Developing an assessment "toolbox" allows practitioners to provide more client-centered, optimally effective services. However, the most important variable in the assessment process is the relational context in which the assessment occurs. The relationship between the practitioner and the client must be characterized by mutual trust and respect for clients to enter into a discussion of their personal spiritual narratives. Attending to these relational dynamics will help ensure a successful assessment that, in turn, lays a foundation for practice decisions that promote clients' health and wellness.

Source: By David Hodge, Professor of Social Work.

can help practitioners identify where interventions can take place. Macneil and colleagues (2012) have added a fifth P to the equation for clinical practitioners: the presenting problem or concern. Exhibit 2.7 illustrates questions that underlie each of the 5 Ps for completing an effective case formulation. These **5 Ps** incorporate concerns relevant to completing both a current and a developmental assessment. The predisposing P factor in this case formulation model focuses on conceptualizing developmental or life history factors that contribute to client concerns at different phases of their development. The completion of this component of the model requires knowledge of the kinds of content covered in the remaining chapters of this book. The protective factors require the practitioner to consider the significant role strengths and resources should play in designing effective interventions. This knowledge will help you understand factors that *predispose, precipitate, perpetuate*, and *protect* individuals in adapting to their life

Exhibit 2.6 Description of 4 Ps in Biopsychosocial Model

Ps and Questions	Biophysical	Psychological	Social
Predisposing factors *Why me?*	Genetic loading Family history	Immature defense mechanisms	Poverty and social isolation
Precipitating factors *Why now?*	Temperament	Recent loss	Stressors at school
Perpetuating factors *Why does it continue?*	Poor response to medication	Distorted self-concept	Not able to attend counseling because of transportation issues
Protective factors *What can I rely on?*	Family history of response to treatment	Insightful	Faith as a social support and church is a resource

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Exhibit 2.7 The 5 P's of a Clinical Case Formulation

5Ps	Questions
■ Presenting problem	What is the client's problem(s)? Provide a list
■ Predisposing factors	What factors over the course of the person's life contributed to the development of the problem(s)?
■ Precipitants	Why seeking help now? Are there any triggers for problem(s)?
■ Perpetuating factors	What factors are reinforcing or maintaining the problem(s)?
■ Protective or positive factors	What strengths can the client draw on? Are there social supports and/or community resources or assets?

challenges. They also allow the practitioner to organize the contributions of biopsychosocial factors from a current or a developmental perspective. The *current perspective* involves assessing how biological, psychological, and social system factors influence current states of affairs, whereas the *developmental perspective* focuses on how these system factors interact leading up to the current state of affairs.

Selecting Interventions

The considerations described in the prior hypotheses testing guidelines will help you identify information necessary for the organization of relevant case information into the 4 Ps. In completing this important task, you will need to adhere to the following steps:

1. Establish hypotheses for the 4 Ps in each dimension of the multidimensional framework. For example, biophysical, psychological, and sociocultural. (This hypothesis should explain why the person has the problem or concern.)
2. Provide a succinct summary of your analysis and this analysis should include evidence that backs up or supports your stated hypotheses. (Provide evidence in support of the hypotheses that you are offering as explanations of the biopsychosocial factors influencing client concerns.)
3. Determine how your case formulation is informing your intervention plans.

When you select a hypothesis for a specific P within each of the framework's dimensions, the hypothesis should help you select an appropriate intervention. For example, a client suffering from a severe psychosis such as schizophrenia needs interventions directed at multiple levels. Biological concepts from neurobiology suggest the need for psychopharmacological interventions to address the psychotic symptoms, psychological concepts to deal with the client's expectations regarding their psychotic condition, and social concepts to address the supportiveness of the individual's environment. While Mrs. Morgan's case at the beginning of the chapter suggests a number of adjustment difficulties, one could strictly focus on hypotheses germane to precipitants to her difficulties and ignore relevant protective or predisposing factors contributing to her current situation. In her case and other cases, social workers do not have the luxury of limiting their description of current problems to a single dimension or a single theoretical construct.

After completing the case formulation, the practitioner needs to develop a written summary of the case formulation. In developing a written summary of the case formulation, Ginter has provided a useful format (see Exhibit 2.8). Remember, the formulation should answer the important question of why a person has a specific concern or problem.

Our multidimensional framework is not comprehensive. Other dimensions can offer useful considerations in addressing social-functioning concerns. However, we will review only those dimensions that have received the profession's sanction and have the support of the scientific community. This does not mean that you should ignore other dimensions in your evaluations of client functioning. In fact, careful evaluation of information from these specified dimensions will sensitize you to additional issues and questions requiring future scientific inquiry.

Exhibit 2.8 Format for Developing a Written Summary of a Case Formulation

Step 1: Client presents with …
Step 2: The client's concern was precipitated by …
Step 3: The factors which we assume predisposed him/her to this concern include…
Step 4: The protective and positive factors include…

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Summary

Social workers need a multidimensional framework for integrating the knowledge and theories from biological, psychological, and social perspectives on human development. No single theory or approach to intervention can account for the whole range of forces influencing social functioning and other concerns. Our multidimensional framework includes the following assumptions: (1) There are three dimensions for assessing human behavior—biophysical, psychological, and social; (2) these dimensions constitute a system of biopsychosocial functioning; (3) systems are organized in a hierarchy of levels from smallest to largest; and (4) each system is in constant interaction with other systems.

System explanations are useful in alerting us to the multidimensional nature of human behavior. When combined with a hypotheses approach, a multidimensional perspective allows us to evaluate the effects that different dimensions and their attendant levels of complexity have on client functioning. This perspective also ensures that practitioners focus their attention on the client's whole situation, including the client's personal and environmental hazards, risks, and strengths. The multidimensional framework includes the following components Biophysical, Psychological and Social Dimensions.

The implementation of the multidimensional framework involves a specific process. First, establish hypotheses for each dimension of the multidimensional framework. This procedure clarifies in a concise fashion the main concerns in the case situation whether one uses a current or developmental perspective. Second, provide a detailed case analysis including evidence that backs up the statements contained in the initial hypotheses. Additionally, the analysis should include a comprehensive study of strengths (strong points, positive features, successes, coping strategies, skills, factors and other considerations that can augment change efforts) and weaknesses (concerns, issues, problems, symptoms, intervention barriers, and so forth) based on the questions systematically covered in your critical inquiry process. Finally, organize the information gathered in the critical inquiry process into 4 Ps for each of the dimensions of the framework.

Review Your Competencies

You should be able to:

1. Describe the limits of one-dimensional approaches to assessing human behavior in the social environment.
2. Understand the four assumptions underlying the biopsychosocial framework employed in this book.
3. Explain the role of case conceptualizations/case formulations in social work assessment processes.
4. Describe how to apply the critical inquiry process when testing hypotheses for each dimension of our integrative multidimensional framework.
5. Explain how to organize case information by identifying precipitating, predisposing, perpetuating, and protective factors (the 4 Ps) when assessing client concerns.

Key Terms

Biophysical dimension
Case conceptualization
Case formulation
Critical inquiry
Current perspective
Developmental perspective
Physical hazards
Inhibiting environments
Life maps
Multicultural considerations
Multidimensional framework
Person
Perspective
Positional variables
Problems-in-living

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Promoting environment
Psychological dimension
Risks
Segregation
Spiritual genograms
Spirituality
Social dimension
Theory
4 Ps
5 Ps

Case Formulation Example

Reason for Referral and Presenting Concerns

Lanesha, a 45-year-old African American single woman, was referred to the mental health social worker at her inner-city "free clinic" because of her doctor's concern about chronic pain and depressed appearance during a routine follow-up visit for arthritis and high cholesterol. Lanesha identified her primary concerns as chronic knee pain, her impending loss of her methadone program, and relationship issues with her partner.

Developmental History

Lanesha is the fourth of five children born to parents with a high-conflict relationship notable for chronic alcohol abuse and intermittent domestic violence. Her parents offered her beer sips, and she snuck more when they were not looking. She recalls that her mother had been raised a Baptist, but her father had not identified any religious affiliations. Her family did not attend church, nor does she recall any spiritual instruction. Her anecdotes and vignettes from elementary school suggest she was inattentive but intelligent. She occasionally had physical altercations with peers, sometimes related to teasing her for her tall height and bulky build; other times, she was defending her younger sister in their high-crime, low-income neighborhood. By age 11, Lanesha was very motivated to earn money to buy brand-name shoes and clothes, so she assertively "bugged" nearby shopkeepers to hire her. She especially liked the Latina/Latinx women who owned a hair salon; they paid her to sweep, take out trash, clean the break room, and so on. They also taught her Spanish. She felt comfortable in this all-female setting although she disdained makeup and hairdo primping and was just beginning to recognize her own attraction to females and gradually identifying as a lesbian. Lanesha became interested in soccer, which one owner—Alma—had blaring from the break room TV on the Spanish station. Alma encouraged Lanesha, bought her soccer gear, and drove her to practices. Lanesha was avoiding her own home and spending all her after-school hours at the salon. She was frightened and upset by her parents' fights, the unstable food situation, and the filthy conditions at home. By age 14, she was routinely drinking a beer before school and often cutting classes. Several times she ran away from home overnight and slept next to the dumpster behind the shop. Alma and Leticia, who by now had come out to Lanesha as a lesbian couple, were extremely concerned about Lanesha but intimidated at the prospect of talking directly with her parents. Gradually, Lanesha started staying at the couple's apartment and benefiting from their supportive supervision and insistence that she attend school. By 10th grade, despite low grades, a Catholic girls' high school accepted her on a soccer scholarship where Alma was an active alumna. Lanesha never returned home, and no one came looking for her, though her peers in the neighborhood—as well as two of her siblings—knew where she was living. In high school, she struggled with attention and homework completion as well as a quick temper, but she ran away from provocation rather than fighting. She smoked cannabis several times a week and drank beer occasionally at parties. She graduated with a B average and high marks in Spanish and auto repair; she immediately earned her commercial drivers' license.

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Lanesha

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Adult History

From age 19–25, Lanesha's life centered on "sex, drugs, and rock 'n' roll." She was earning good money as a truck driver; she drove a pricey vintage sports car; she had many girlfriends, often more than one at a time; and she started dabbling in gambling at after-hours clubs where she drank large amounts of alcohol at night. She spent all her income on her sharp car and gifts for her partners: expensive clothes, jewelry, and restaurant meals. At some point, she started using cocaine, snorting it, and then moved on to smoking crack. Since heroin was cheaper and more available, she tried it and discovered she preferred that high and kept using. She continued alcohol and cannabis use. Within a couple of years, she could no longer manage her daily life while heavily addicted; she received an eviction from her apartment for nonpayment of rent and began sleeping in her car. She then lost her job after flunking a random employer drug screening, and apparently was unable to complete her employer's rehabilitation plan along with multiple attempts to help her. Some months later, the city towed her car and she took to sleeping in the Greyhound station, under the highway overpass, or in the bushes of a shallow canyon. Her lifestyle quickly degraded; she stopped using the homeless drop-in services, such as showers and laundry; she lived a "hand-to-mouth" existence for over 10 years. She was frequently harassed for her sexual orientation and masculine-type appearance. She was also ostracized by many African American peers because she felt more comfortable speaking and hanging out with her Latinx clique. Around this time, she met Catalina, who also had addiction struggles. For a long time, they used together.

A clinical outreach worker had urged Lanesha to come by for an HIV test and a restaurant coupon. Lanesha tried that and was gradually drawn in to other clinic services and especially by the kindness of a warm and caring doctor who helped her get into a 30-day drug rehab program, followed by outpatient methadone intervention. Catalina also started accessing clinic services, and they supported each other in their recovery attempts. By the time Lanesha met the social worker, she had been clean five years, adherent with methadone, and recently housed in her own studio apartment in a supported living program near the clinic. She needed housing sooner, but she only recently got a medical letter certifying her dog as an assistance animal, so she would not have to give up her dog to move indoors. She felt that her relationship with Catalina had deteriorated since they had housing, with frequent disagreements and arguments.

Mental Status

Appearance—client is a tall (just over six feet tall) African American female with broad shoulders; muscular; stooped posture; furrowed brow; frowning while in the waiting room; eyes downcast toward her lap over the course of the interview; graying black hair in a short cut; dressed casually in clean T-shirt and loose khaki pants; slip-on canvas shoes; large scar over her right eye, going up to her forehead.

Communication—initially laconic (very few words), just answering questions briefly without elaboration, no obvious speech or language issues, good vocabulary, and sentence structure.

Cognition—some attentional or concentration issues in completing serial 7s and short-term memory difficulties with three-word recall at five minutes (only one recalled); she complains of difficulty concentrating and completing tasks at home; her focus of attention in sessions is adequate in terms of topic maintenance, although she is prone to auditory distractions from the streets (yelling, sirens, and horns honking).

Psychosis—no evidence of hallucinations or delusions on interview; client denies auditory hallucinations, visual hallucinations, or tactile hallucinations; thought processes appear linear and coherent without loose associations or an inability to speak to the point because of tangential or circumstantial thought processes.

Social Relating—Lanesha has a serious demeanor, not speaking unless spoken to; she does show a subtle sarcastic sense of humor in ongoing relationships; client reports having a history of anger management problems, which currently manifest as her leaving the conflict situation or "shutting down (her words) if she can't get away.

Mood—described as "pretty down" with chronic initial insomnia, moderate anhedonia, excessive guilt, brooding about the past, decreased energy, irritability; denies appetite changes, these depressive symptoms come and go but don't seem to cluster together for more than a few days at a time; and never prevent her from getting out of bed and carrying on with basic role functions.

Affect—consistent with mildly depressed mood; somewhat blunted in range.

Danger Assessment—client discloses occasional, fleeting suicidal thoughts without plan; no history of suicide attempt; she denies any homicidal ideation and notes that she has not had physical altercations since about 15/16; she denies domestic violence victimization or perpetration; she has no ongoing contact with minor children.

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5 Ps Data Integration Exercise

Problems

- Chronic knee pain
- Depression (persistent depressive disorder—dysthymia)
- Relationship distress with intimate partner Z63.0
- Substance use disorders in sustained remission (longer than 12 months)

	Biological	Psychological	Social
Predisposing Why me?	■ poor nutrition/alcohol exposure prenatally? ■ genetic predisposition to addiction? (and, possibly, to depression) ■ prepubertal, ongoing alcohol ingestion ■ attention deficit disorder? ■ addiction	■ chaotic, insecurely attached family relationships; neglect; possible posttraumatic stress disorder (PTSD)? ■ (+) high-quality high school education with success experience ■ early experiences of feeling different in her sexual orientation, her body type ■ behavioral habit of escaping and numbing	■ social modeling of her parents' aggressive behaviors ■ stigmatized group status (race, sexual orientation) ■ (+) strength: stable, supportive attention of two nonfamily adults in childhood
Precipitating Why now?	■ knee pain has recently escalated → more disclosing to her doctor, more open to mental health services	■ (+) sobriety has opened her heart and mind to difficult emotions such as guilt, regret, hopelessness about the future ■ life stage self-reflection	■ (+) recently housed after 10+ years homeless allows her to address some higher-order needs ■ loss of Medicaid funding for methadone program
Perpetuating Why does it continue?	■ residual brain damage from polysubstance exposure? e.g., memory problems from etOH endorphin suppression from opiates, etc.	■ many years of running away from emotionally distressing situations (long-term habit practice) ■ a history of behaviors she regrets, multiple losses ■ ongoing vulnerability to addiction (impulses, habits, triggers)	■ SSI regulations limit ability to work → loss of primary adult role identity and distraction from brooding → demoralization ■ ethnically divided urban neighborhood with inter-group tensions (AA – Lat.)
Protective What can I rely on?	■ physically robust and strong, generally healthy (HIV negative, no hepatitis) ■ good nutrition and hygiene ■ offer of PT and pain management treatments ■ ongoing availability of methadone program	■ has successfully managed aggressive impulses, but has substituted fleeing instead of verbal processing with partner ■ strong work ethic and work history; open to some kind of work, even volunteer, in her future ■ has dog whom she loves and who eases her feelings of loneliness	■ stable HUD-subsidized housing with SSI income ■ caring, long-term partner willing to work on issues ■ Alma and Leticia want to have more contact with her ■ possibility of reconciling with sibling(s), parent ■ availability of individual and couples' therapy, substance abuse groups, service advocacy, etc., in a setting she trusts

? = hypothesized risk factors, possibly subject to confirmation with more data collection
(+) = protective or strengths-based factors from history that we hypothesize are helpful in client moving forward

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Summary and Formulation

Lanesha is a 45-year-old gay female in a committed relationship with recent increase in conflict, referred to the clinic psychiatric social worker by her primary care doctor for chronic knee pain and depression. Her motivation for therapeutic help at this time appears precipitated by her worsening pain, her recent transition into stable housing after more than a decade of homelessness, and the looming threat of loss of methadone treatment after a multidecade severe polysubstance addiction. Factors that seem to have predisposed her to mood, substance use, and relationship problems include her early exposure to alcohol abuse by both parents, witnessing domestic violence, and very early onset of alcohol consumption and probable childhood onset ADD. Her problems were exacerbated by social stigma and rejection/alienation from larger social groups based on her sexual orientation and bicultural identification with Latinx culture. She coped with these challenges primarily by blunting emotions with drugs, which ended her successful career as a commercial truck driver. Addiction perpetuated her poor coping, leading to severe deterioration in self-care as well as degradation of her sense of self-worth and hope for the future. However, Lanesha's history is notable for protective factors that include the loving support of a lesbian couple who provided more structure, supervision, and a private school education. She also benefits from a caring, involved partner; a devotion to her dog; and active therapeutic alliance with a willingness to engage in services. Her goals for the future include volunteer work and reconnecting with her "mamitas."

Diagnostically, she meets the criteria for persistent depressive disorder (dysthymia). Substance use disorder(s): stimulant, opioid (on maintenance therapy), alcohol, cannabis, in sustained remission. Chronic knee pain secondary to arthritis (per medical reports); high cholesterol (per medical reports); relationship distress with intimate partner.

The existing formulation is subject to change based on any new information. Assessments are always subject to revision based on new findings and changes in the client's condition. You may have additional questions not addressed in this example, or you may have other hypotheses about the causes of this case that would need to be tested. However, they must be supported by your case formulation and an examination of whether the case proceeds in a direction consistent with your initial assessments. For instance, her intervention or treatment plan would need to be modified to address continued discrimination or persecution from others about her sexual orientation or any problems associated with adjusting to her new living situation or loss of her methadone maintenance.

At the end of each of the developmental chapters of this book, you are exposed to information about a case that will allow you to practice applying the 4 Ps. These cases will also help you practice providing a summary of your biopsychosocial formulation of these cases. Most beginning practitioners have a hard time summarizing the information that they collected during the completion of a complex assessment process. For this reason, it is important to learn how to use the 4 and 5 Ps in guiding the integration of the biological, psychological, and social information in completing a biopsychosocial formulation of a case. The chapters will also request you to apply the information to other relevant curriculum competencies, for example:

1. **Describe an appropriate biopsychosocial intervention based on the findings from the completion of the prior Ps exercise.**
2. **Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial data that you identified in your formulation of the 5 Ps.**
3. **Describe how you would evaluate your intervention based on the data captured in your 5 Ps.**

The completion of the prior questions requires knowledge of intervention strategies learned in other courses. However, you need to begin thinking about the connection between constructions of client presenting concerns and relevant preventive and intervention strategies.

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Chapter 3

Pregnancy, Birth, and the Newborn

Learning Objectives

1. Critically evaluate ethical dilemmas faced by parents in learning they are pregnant.
2. Identify the biological hazards, risks, and complications of pregnancy.
3. Describe relevant environmental effects on prenatal development, including parent nutrition, substance use, and emotional states.
4. Describe the challenges associated with newborns (e.g., premature birth, infants with Neonatal Abstinence Syndrome, infants with disabilities) and social strengths (e.g., community resources) that can support successful family adaptation.
5. Describe the key developmental tasks in the newborn period (e.g., sensitive period for bonding/attachment, using the BNAS for understanding the response patterns of neonates).

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Developmental Themes	Key Concepts
	■ Accepting the reality of the pregnancy ■ Adjusting to the role of parenthood ■ Work and parenting ■ Making decisions about pregnancy
Biophysical Dimension	
Biophysical Growth and Development	■ Physical development of the fetus: germinal period (rapid cell division); embryonic period (internal organs develop); fetal period (growth and weight gain); birth ■ Prepared childbirth ■ Newborn evaluations: Apgar score
Biophysical Strengths, Hazards, and Risks	■ Complications of pregnancy: vaginal bleeding, placenta previa, toxemia, preeclampsia, gestational diabetes, and IUGR ■ Environmental effects on prenatal development: maternal age, multiple gestations, maternal nutrition, illness, alcohol use, stress, depression, and maternal anxiety ■ Prenatal testing ■ Complications of birth; Cesarean births; neonatal complications: prematurity, birth defects, and developmental disorders ■ Strengths: walking in pregnancy, good nutrition, and adequate sleep
Psychological Dimension	
Cognitive Development and Information Processing	■ Fetal responses to pain, light, touch, and taste
Communication	■ Fetal response to sound: habituation to sound ■ Fetal learning: newborn response to maternal voice
Attitudes, Emotions, and Regulation	■ Effect of mother's emotional state on fetus ■ Parental interactions with fetus and newborn emotional health ■ Newborn states and newborn reflexes ■ The Brazelton Neonatal Assessment Scale
Psychological Strengths, Hazards, and Risks	■ Newborn attachment: question of a "sensitive period" ■ Multiple-gestation births
Social Dimension	
Groups, Families, Communities, and Support Systems	■ Prenatal intervention programs and postpartum early intervention programs
Multicultural, Gender, and Spiritual Considerations	■ Infant mortality: the Black/White disparity ■ Cultural differences among newborns ■ Circumcision
Social Strengths, Hazards, and Risks	■ Poverty's effect on prenatal development ■ Intimate partner violence ■ Babywearing

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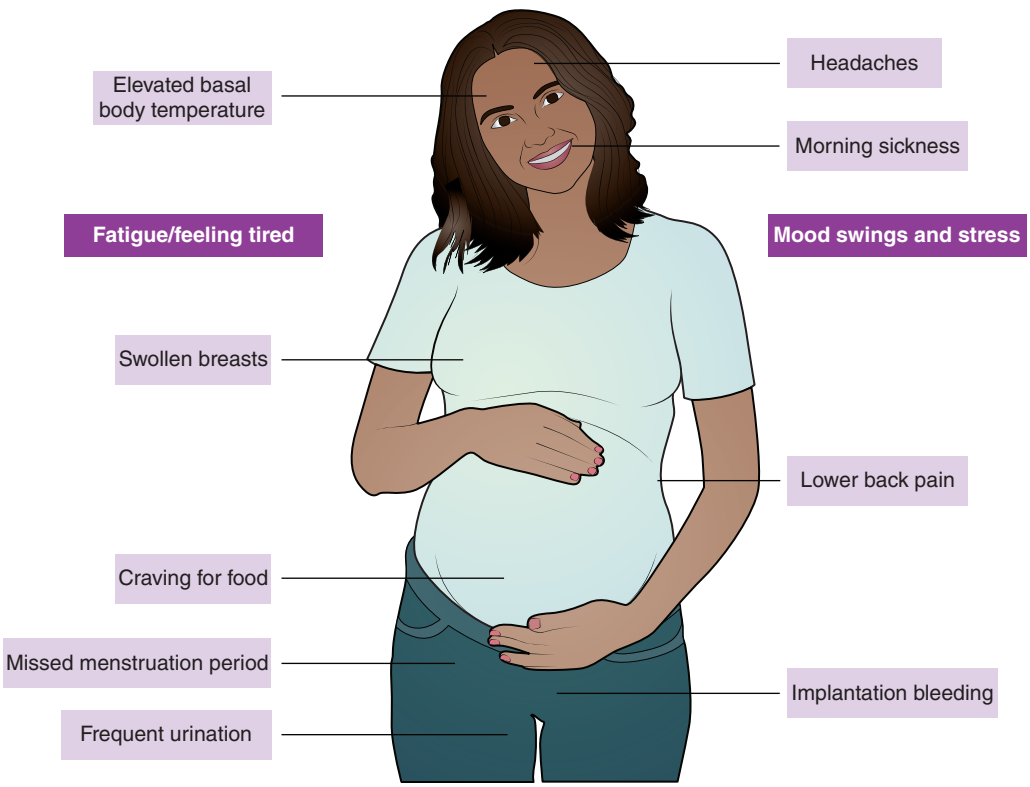
Developmental Themes

Whether planned or unplanned, confirmation of pregnancy is often a shock. The first task for the expectant parents is to accept that the pregnancy is real and involves the growth of a real fetus. Even if a pregnancy is planned, the woman or couple may question their readiness for the new stage. The pregnancy may spur mixed emotions; biological parents may be excited and happy and yet also be fearful, anxious, and doubtful. The woman may have specific fears about the birthing process and wonder, "How is this baby going to get out, and how much will it hurt?" Unplanned pregnancies can be particularly stressful as it may involve additional decisions, such as whether or not to terminate the pregnancy or whether or not to consider adoption. The stress associated with making these types of decisions can in some cases leave the pregnant woman feeling trapped and unable to take action. Young, unmarried women may face social stigma that can make reaching out for social support during these tumultuous stages of early pregnancy even more challenging.

A young, single woman may ignore the reality of the pregnancy for months, refusing to admit even to herself that she is expecting. Many issues are further compounded when the mother is an adolescent (see Exhibit 3.1).

Social workers must learn how to assess parents' level of preparation for this important role change. Gorski (1999) has identified five subject areas to examine when meeting with expectant parents: (1) attachments and commitments, (2) how they are mentally representing the fetal infant, (3) history of social and professional support, (4) history of loss, and (5) sense of security. Lots of cultural expectations surround feelings about pregnancy and birth as well. The Childbirth Readiness Scale (Mengmei et al., 2022) was developed in the context of the Chinese culture, and it assesses women's readiness for childbirth across four dimensions: (1) self-management (the participation in preventative or therapeutic healthcare activities), (2) information literacy (knowledge about pregnancy and childbirth), (3) birth confidence (belief in her ability to have a natural childbirth), and (4) birth plan (ability to express her needs and expectations around the birth, even if the plan is not fully implemented). In China, all of these factors are associated with greater physical and mental states during pregnancy, more positive birth outcomes, and an increased ability to cope in the postpartum period. Pregnancy is also

Exhibit 3.1 Top Pregnancy Symptoms



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an adjustment for the father (Tulman & Fawcett, 2003). He has many worries about his ability to parent, to provide for a family, and to live up to his partner's expectations. The pregnancy is even less real for him, and his task often is to assimilate to the fact that the fetus is real and is his without the benefit of the biological processes associated with pregnancy. The same can be said of a lesbian co-parent or adoptive parents. Feeling fetal movement, hearing the heartbeat, attending childbirth preparation classes, and being present at the birth all help to include the other parent in the pregnancy and birth process. Some fathers wish to explore every aspect of pregnancy, childbirth, and parenting, whereas others are more task oriented and view themselves as managers. Regardless of how fathers are included, father involvement during the pregnancy has a positive impact on the family and is more likely to occur when there is support from the mother (Widarsson, Engström, Tydén, Lundberg, & Hammar, 2015).

© Naked Eye Photography

Expectant parents Kerrick and Rae are excitedly expecting their first child.

Through the nine months of pregnancy, then, the couple faces the tasks involved in becoming parents. When the baby is born, both must give up the fantasy baby each has dreamed of for nine months and accept the very real baby that has been born. The postdelivery process includes an additional set of adaptations that are heavily determined by the health status of the mother and the availability of appropriate supports. Low-income immigrant mothers are especially vulnerable to not having access to good support and parenting services (Takanishi, 2004).

In addition to role changes, mothers confront many postpartum physical changes, including, "discomfort from an episiotomy or cesarean section incision, uterine cramps, breast-engorgement or infection, nipple irritation, poor appetite, fatigue, anemia, thyroid disorders, hot flashes, increased sweating, dizziness, acne, sleep disturbances, carpal tunnel syndrome, hand numbness, or tingling, excessive vaginal bleeding . . . and sexual concerns" (Tulman & Fawcett, 2003, p. 74). Women also expect to lose weight after the pregnancy. They typically lose between 19 and 24 pounds in the first few weeks. Twelve to 13 of these pounds are accounted for by the fetus, the placenta, amniotic fluid, blood loss, water loss, and other factors. Most women gain more than recommended amounts during pregnancy, and for women who are overweight prior to pregnancy, additional weight gained during pregnancy can be particularly difficult to lose (Neville, McKinley, Holmes, Spence, & Woodside, 2014). For this reason, it takes a year on average for women to gradually lose pregnancy weight in a healthy manner. In addition, they must adapt to a number of psychological and social changes in adjusting to the new member of the family (Tulman & Fawcett, 2003).

Mothers also confront the key issue of work. The United States is the only high-resource country to provide zero paid maternity, paternity, and parental leave. The Family and Medical Leave Act (FMLA) allows eligible employees to take 12 weeks of unpaid leave to care for the birth or adoption of a child, or placement of a child in foster care, within one year of delivery/placement. In February 2015, the definition of spouse was amended to include same-sex marriages so that partners could qualify for FMLA and take care of family members regardless of the state they live in. However, not all families can afford to take unpaid leave and are forced to return to work, disrupting parent-infant bonding as well as the breastfeeding relationship. Some form of maternal leave is associated with reduced role strain and financial stress, as well as maternal health benefits (Aitken et al., 2015). The

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dual-earner family is the most common form of two-parent families with children in the United States. Dual-earner families have increased dramatically since the 1960s, but the increase is even more dramatic for women with children under three years of age (Altucher & Williams, 2003; Winkler, 1998). In the past, husbands' careers were primary and took precedence over the careers of women, but "[t]he question of who works, who takes care of the children and how whoever this is will manage to fulfill these tasks, is still contested and in flux as shifting cultural expectations come into conflict" (Altucher & Williams, 2003, p. 49). While on average, mothers work less outside the home than fathers, and childless women (approximately two hours less per day) mothers are spending twice as much time on housework compared to fathers. Time spent working outside the home and housework did not differ between fathers and childless men (Clarkberg & Merola, 2003). There's been interest at the policy level on childcare costs for several decades. However, it has yet to gain much traction. In other high-resource countries, such as in Canada, there is federal funding available to offset out-of-pocket day care expenses for parents. Their current goal is that by the end of 2026, total cost to parents would be $10 for children under six years of age (https://www.canada.ca/en/early-learning-child-care-agreement.html). Support in the United States for a federal policy is mixed. President Richard Nixon vetoed the comprehensive child development act of 1971 because it was a "family weakening" bill and in 2021, one U.S. state representative declared that he would not vote for a federal bill to support childhood education as it would make it "more convenient for mothers to come out of the home and let others raise their child." Many women decide to forgo having children because of career and work demands. Fertility rates have been declining in the United States, reaching another record low of 55.8 births per 1,000 women aged 15–44, down 4% from 2019 (Centers for Disease Control and Prevention, 2022). In addition to fewer babies born each year, mothers are having babies later in life. The mean age of first birth is 26.3 years, a current record high.

Unintended Pregnancy

According to a report by the United Nations' sexual and reproductive health agency (UNFPA, 2022), half of pregnancies are unintended worldwide. That means that approximately 121 million women are facing a significant life change that they did not plan. This has been deemed a global failure to uphold basic human rights for women and girls. The rate of untended pregnancies is expected to increase over other the next few years, in part because of the war in Ukraine and other global conflicts that result in disruption to birth control and increased incidence of sexual violence. Further, many women feel pushed into pregnancy. Societies across the globe place significant pressure on women and girls to become mothers. Nearly a quarter of all women feel unable to say no to demands for sex. A lack of health care, harmful societal norms around women controlling their own bodies, sexual violence and reproductive coercion, and shaming in health

Focus on **The Lived Experience**

Navajo Taboos in Pregnancy

When I was pregnant, I remember my grandmother yelling at me for standing in front of the stove. She said that the placenta would stick to my back or some other birth complication would happen. In the Navajo culture, there are certain events or activities that pregnant women and expecting fathers cannot do, such as attend funerals, see dead animals, sew, or crotchet. The Navajo believe that doing these activities causes babies to have health problems. If you do any of these things, the baby requires a specific ceremony to prevent those health problems. If the baby develops health or behavioral problems later in childhood because of their parents' participation in these taboos, the child will need another traditional ceremony to get rid of the health or behavioral problem. This can take up to four days and means the child could be absent from school for up to four days. .

If social workers are unaware of the cultural significance of specific behavioral issues a Navajo child has, they may not be empathetic toward missing so many days of school. Also, understanding these taboos can help expecting Navajo parents navigate potentially difficult situations, such as losing a loved one while pregnant and being unable to grieve with their family at the funeral.

—Lee Zohaunnie-Russell

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services all contribute to unintended pregnancies. In situations of conflict, women lose agency at multiple levels, placing them at increased risk of unintended pregnancy. Social workers should be mindful that after the onset of a crisis it is imperative that girls and women have access to sexual and reproductive health and protection services. It is as vital as the need for food, water, and shelter. Studies report that over 20% of refugee women and children will experience sexual violence.

The COVID-19 pandemic influenced birth rates. Referred to as a "baby bust," there were 62,000 fewer conceptions in the first few months of the pandemic, resulting in a baby bust six to nine months later; however, that trend reversed, resulting in 51,000 more conceptions than usual in the fall of 2020 (Kearney & Levine, 2022). This drop in births was disproportionately among women in older age groups and those with greater education and resources; most of the babies born during late 2021 and early 2021 were born to younger people with fewer resources. And looking at it from a global perspective, an estimated 12 million women in low- and middle-income countries experienced contraceptive service disruptions, resulting in 1.4 million unintended pregnancies during the pandemic. Women in the poorest countries are nearly three times more likely to experience unintended pregnancy than women in the wealthiest countries. Misinformation, cultural barriers, low levels of female autonomy, difference in fertility preferences between partners, and stigma all play a role in who can access modern contraception. Clearly, we need to think about making the healthcare system more equitable and not just changing individual women's behaviors.

Abortion

For a woman of any age, the decision to have an abortion can be one of the most difficult and distressing choices she will make in her life. Abortion is complicated and controversial. Some individuals believe that termination of a pregnancy at any point for any reason is murder and is morally wrong. Other individuals believe that a woman has the right to control her own reproductive process and determine her own fate. Regardless, it is a significant global issue that impacts women. According to the UNFPA 2022 report, over 60% of unintended pregnancies result in abortion and just under half of those abortions (45%) are unsafe, accounting for 5 to 13% of all maternal deaths recorded. A scoping review of research across the globe indicated a strong association between abortion stigma and quality in abortion care (Sorhaindo & Lavelanet, 2022).

The abortion question has a long history. In 1973, the Supreme Court decided in *Roe v. Wade* that states could not deny a woman her right to have an abortion. For nearly 50 years, the federal constitutional right to abortion was protected. However, in June 2022, the U.S. Supreme Court overturned *Roe v. Wade*, which opened the door for some states to ban abortion outright. Abortion policies are now at the discretion of each state and are currently in flux (see the Center for Reproductive Rights for a real-time tool to understand the laws and constitutions for each state: https://reproductiverights.org/maps/abortion-laws-by-state/). Many states repealed abortion bans they had in place before 1973 (i.e., pre-*Roe* bans) or abortion bans that were created in the event that *Roe* was turned (i.e., trigger bans). Other bans included pre-viability gestational bans, method bans, reason bans, criminalization of self-managed abortion, and SB-8 Copycats. Additionally, there are restrictions on abortion. For instance, most states require girls under 18 years of age to notify or get permission from their parents to obtain an abortion—in some states, permission is required even from a noncustodial parent. Mandatory counseling or requiring an ultrasound prior to receiving an abortion, is typically in place to dissuade people from having an abortion, rather than to improve their mental health and wellness. And fewer and fewer doctors are available to perform abortions. Some simply are untrained in the procedure, whereas others become discouraged by the violence associated with abortion protests. However, as of this writing, many women still have a choice.

A social worker can play an important role in helping a woman make the abortion decision. But this is one instance in which it is vital to be able to separate personal from professional values. The most important consideration is that the woman needs to make the decision herself; no one can make it for her. In this situation, a social worker's role is a supportive one. Though many women feel some guilt and depression after an abortion, most women have less regret and fewer emotional problems when the choice has not been forced on them by other people. In fact, fewer than 10% of women experience psychological problems after an abortion. Women who had a high incidence of emotional problems following abortion were more ambivalent before the procedure, felt coerced, or already had symptoms of personality problems (Cameron, 2010).

It is important to be aware of and address both mothers' and fathers' concerns and opinions when assisting with the abortion process. Social workers should ensure

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that both parents are apprised of all relevant information regarding abortions, most notably that fathers have no legal rights during the abortion process but will be responsible for the child upon birth. That being said, many women cite the absence of a willing father to provide emotional, physical, and financial support as their primary reason for terminating their pregnancy. It also bears mentioning that fathers often experience postabortion distress that can negatively impact and/or terminate relationships, as fathers have reported increased arguments with jealously and substance use, and feelings of grief, anxiety, guilt, helplessness, and anger up to one year following an abortion (Coleman, Rue, & Coyle, 2009; Coyle, 2007). These feelings can be further exacerbated and more likely to occur in fathers than mothers, as repression of emotions may prevent men from resolving their grief, and ". . . because the decision to abort is ultimately the female's and the final decision opted for may not be congruent with the male's choice" (Coleman & Nelson, 1998, p. 428; Coyle, 2007). There have also been significant findings in relationship failures following abortions, yielding emotional withdrawal, sexual and interpersonal conflicts, regret, relationship failure, a loss of trust, and many other psychological challenges (Coyle, 2006). Taken together, it is important that social workers work with mothers and fathers when discussing and planning for abortions, and let them know the risks with not weighing both parents' opinions, and what both may experience if they opt to terminate their pregnancy.

Even after a parent decides to have a child, many factors can contribute to the ending of a pregnancy. Technically, the ending of a pregnancy before the fetus is viable is considered an abortion. Most people use the term **miscarriage** to refer to the spontaneous loss of a fetus before the 20th week of pregnancy, though medical providers may use the term **spontaneous abortion**. Pregnancy losses after the 20th week are called **stillbirth**. In the next section, we introduce the growth and developmental processes associated with pregnancy and the birth process, which will be covered in our biophysical level of analysis.

Practice Guidelines:
Preparing for Parenthood

- Help parents prepare for parenthood by discussing attachments and commitments, their feelings about the fetal infant, social and professional support systems, history of losses, and their sense of security.
- Encourage parents to reflect on what their relationship to their parents were like. What did they like about their childhood? What would they like to do differently?
- Create a safe environment to discuss parents work desires and plans to return to work.
- Ask families to outline what expectations they have regarding division of household chores. What adaptations will need to occur after the arrival of the baby?
- Allow time to reflect on the multiple identities they hold. What does it mean to be a mother? What does it mean to be a father?
- Discuss each parents' concerns about role losses. This may involve grief work.
- Help mothers who are considering an abortion explore all alternatives, such as putting the baby up for adoption, raising the child herself, or allowing a family member to raise the child. Allow her space without judgment to think through what each choice means for her now and in the future. Offer support for the mother's decision.
- Advocate for paid family leave systems. Access to paid family leave and sick day benefits support parent-Infant bonding, breastfeeding, and on-time routine childhood vaccinations, as well as improved maternal health outcomes, such as reduced depressive symptoms.

Study Table Developmental Themes in Pregnancy, Birth, and the Newborn

Developmental Themes	■ Accepting the reality of pregnancy ■ Resolving multiple identities ■ Preparing for birth ■ Reconciling fantasy baby with real baby ■ Terminating the pregnancy

Biophysical Dimension

Biophysical Growth and Development

What will eventually become a baby begins as a single cell. About midway through her menstrual cycle, a woman

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produces a mature ovum, or egg, in a fluid-filled sac on one of her ovaries. At ovulation, the sac bursts and the mature ovum is swept into the fallopian tube to begin the journey to the uterus.

When the ovum enters the fallopian tube, it continues along toward the lower one-third of the tube. Sperm deposited in the vagina during intercourse swim up through the cervix, into the uterus, and then into the fallopian tube, where one sperm fertilizes the ovum.

The fertilized ovum is known as a zygote. After a brief rest of 24 to 36 hours, the zygote begins the process of regular cell division. It then takes three days for the zygote to travel down the fallopian tube and into the uterus. By then, it has developed into a fluid-filled sphere of about 150 cells. The inner layer of cells develops into the embryo, and the outer layer of cells forms the chorionic villi—fingerlike tendrils that give the zygote a shaggy appearance. These chorionic villi burrow into the uterine lining (implant) and provide early nutrients. This process of implantation of the zygote, known as the germinal period, takes about two weeks. After implantation, the zygote, now known as an embryo, begins to secrete human chorionic gonadotrophin (HCG) to maintain the pregnancy. HCG can be detected in the mother's blood six to eight days after conception, and presence of this substance is the basis for early pregnancy testing. An at-home early pregnancy test can detect HCG in the mother's urine as soon as one day after the missed menstrual cycle. The next few weeks after conception, from two to eight weeks, is the embryonic period (see Exhibit 3.2).

Physical Development of the Fetus

After eight weeks, the embryo is 90% formed, with most of the basic structures, including a face, arms, legs, feet, and hands. From this point on, the embryo is referred to as a *fetus*. Between 8 and 12 weeks, the chorionic villi develop into a functioning placenta attached to the mother's uterus, and the fetus is connected to the placenta by the umbilical cord. For the remainder of the pregnancy, the placenta acts as the fetus's lungs, digestive tract, kidneys, and liver. Oxygen and nutrients from the mother pass through this semipermeable membrane to the fetus, and carbon dioxide and other wastes pass from the fetus to the mother. It was once thought that the placenta acted as a barrier and protected the fetus from any harmful substances ingested by the mother. Now, however, we know that what the mother eats, drinks, sniffs, or inhales is passed on to the developing baby, including informing the baby's food preferences (Ventura, Phelan, & Garcia, 2021). The effects of these substances on the fetus will be discussed in a later section.

The fetus floats in amniotic fluid inside the amniotic sac, or bag of waters. This fluid regulates the temperature, cushions the fetus from injury, and allows freedom of movement. After 12 weeks, the fetus begins to move in this fluid, drink it, and urinate into it.

By 20 weeks, the mother can feel the first fetal movements, commonly described as "butterflies" fluttering in her lower abdomen. Often this is the time when the expectant parents first see the fetus by ultrasound.

By 24 weeks, the fetus resembles a tiny baby. This baby appears to be rather red and wrinkled, though, because it has not put on much fat. At this time, the fetus is covered with a substance called vernix, which looks a lot like shortening and protects the skin from prolonged exposure to the amniotic fluid. Babies at term are sometimes born with some of this vernix still covering their skin. A fetus at 24 weeks makes breathing motions, hiccoughs (sometimes felt by the mother), responds to sound, and sleeps and wakes in noticeable cycles. With the advanced technology now available in high-level neonatal intensive care units (NICU), babies born at 22 weeks have a chance for survival (with active treatment, about 28% survive). This increases to 55% chance of survival at 23 weeks (Bell et al., 2022). Babies born before 37 weeks are considered preterm. In the United States, preterm births have declined and represent 10.1% of births in 2020, although this rate is 50% higher among African American women (Centers for Disease Control and Prevention, 2022).

During the last two months of pregnancy, the fetus stores fat and gains weight. The fetal lungs undergo important development, and each week the fetus remains in the uterus increases its chances of survival and reduced long-term problems. Although today a premature baby has greater chances of survival at earlier and earlier stages of pregnancy, problems related to low birth weight and prematurity remain (see Exhibit 3.3).

The fetus is ready for life outside the uterine environment between 37 and 41 weeks. Full-term pregnancy is now considered at 39 weeks because research shows that babies do best when they are born during weeks 39 and 40 (Spong, 2013). Early-term deliveries (37 weeks 0 days to 38 weeks 6 days) means that babies are more at risk for problems with breathing, feeding, and controlling their temperature and developing a learning disability later in childhood. Babies that are delivered late

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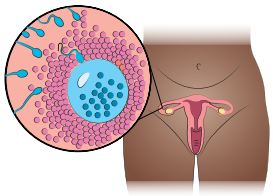
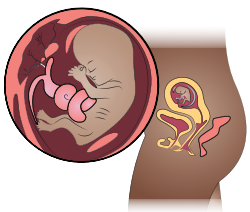
Exhibit 3.2 Fetal Development

Fertilization



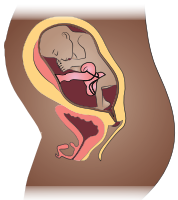
One sperm reaches the ovum and fertilizes it.
Milosis of fertilizes ovum creatign and undifferentiated cells
The undifferentiated cells are forming the embryo

First tri-mester



Within the first tri-mester, parts of the baby's brian are beginning to grow. Baby's heart begins in beat Webbed fingers and toes start to form The baby can strat to bend his/her elbows and knees. Eyelids now cover the baby's eys baby's

Second Tri-mester



In the second tri-mester, fingerprints are formed, They baby's gender can be differentiated now. The baby's heart pumps 25 quarts of blood a day. Baby's bones are hardening, Ears are beginning to stand out from his hand and he may be able to hear you now. Tooth buds for baby and adult teeth are in place and baby's usle buds may be working now.

Third Tri-mester

Third tri-mester, is the final development stage for the baby, Most physical development is completed in this state. Baby's hair has color and texture. Fat is building up under the baby's skin. Hiccup is common at this time. The baby can open his eyes and blink new. Billiors of recurens are developing in the baby's brain Nails new cover the tip of baby's toes and fingers, Baby' lungs are fully developed.

Before Birth

Right before birth, weight gain is the baby's top priority. Baby gains approximately an ounce a day. At 37 weeks, the baby is in full term. The average baby weighs about seven pounds now. Baby's skull is flexible so it can squeeze through the birth canal

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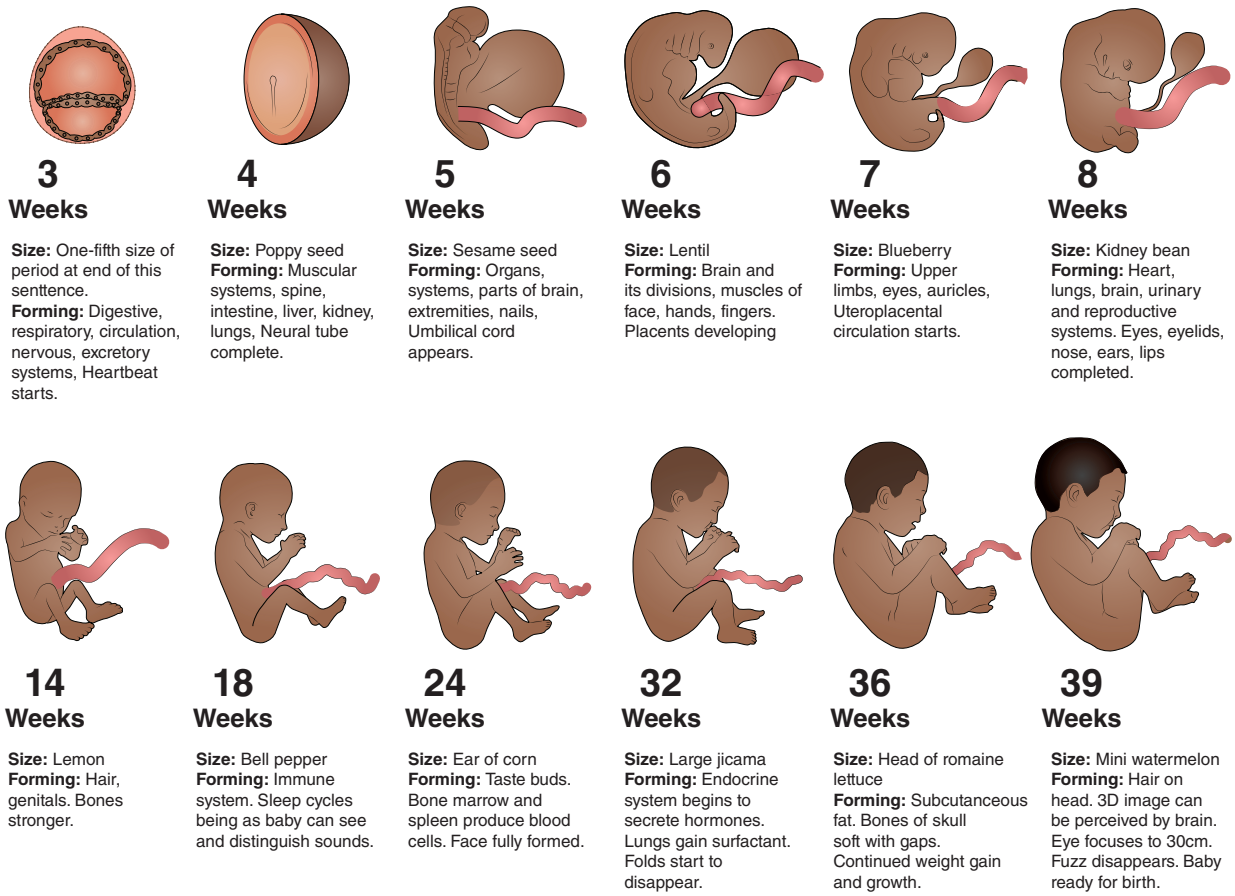
Exhibit 3.3 Embryo Development



term (41 weeks 0 days to 41 weeks 6 days) and post-term (42 weeks and beyond) present risks to the baby and to the mother. Most practices in the United States will not allow a mother to go beyond 42 weeks without intervention, as there is no benefit to the infant and the likelihood of complications increases, including prolonged labor, birth trauma, and infant mortality. How is the "due date" determined? If pregnancy is defined as beginning at the time of conception, then birth occurs after 266 days, or 38 weeks. The mother's due date, however, is usually calculated according to Nagele's rule. To determine a woman's due date, count back three months from the first day of her last menstrual period and add seven days. According to this procedure, pregnancy begins on the first day of the last menstrual period and lasts 280 days, or 40 weeks. In most clinical situations, pregnancy is calculated in this way, so, for our discussion of prenatal development, pregnancy is based on menstrual dates and lasts 40 weeks.

The Birth Process

Doesn't it seem that depictions of birth in the popular media always show labor beginning with the woman doubling over in sudden, intense pain? This is followed by a frantic rush to get to the hospital in time for the birth. Although some cab and ride-share drivers have delivered babies, in reality most women find that labor begins more slowly, allowing ample time to make it to the hospital.

Labor is divided into three stages (see Exhibit 3.4). During the first stage, the cervix opens up, or dilates, to 10 centimeters to allow the passage of the baby's head. The average length of the first stage of labor is 12 to 14 hours. In early labor, contractions can be up to 20 minutes apart and usually last less than 1 minute. Most women are pretty comfortable in the early part of labor and are excited about having the baby at last, though a little anxious over the process. As labor progresses, toward the end of the first

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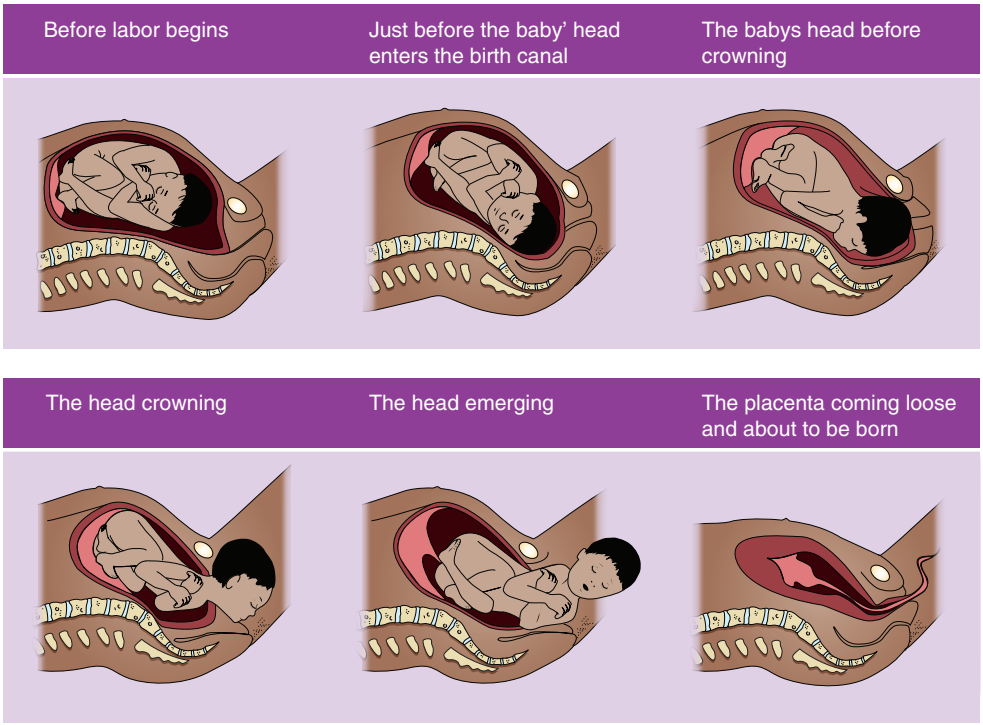
Exhibit 3.4 Birth Process



Source: Adapted by the authors from *Before We Are Born: Basic Embryology and Birth Defects*, 3rd ed., by K. L. Moore, copyright © 1989, with permission from Elsevier.

stage, the contractions may come one right after another and last up to two minutes. During this phase, a laboring woman needs a lot of support and encouragement. And if she has not gone to the hospital or birthing center yet, now is the time to rush or hope the driver knows what he or she is doing.

At birth, babies leave the comfort of the uterine environment and must immediately adapt to the outside environment.

When the cervix has fully dilated to 10 centimeters, the second stage of labor begins. During this stage, the baby is born. A woman can now actively participate in the birth process by pushing the baby down the birth canal. This process can take from 10 minutes to more than 3 hours, depending on how many previous births the woman has had and how much medication she has been given.

During the third stage of labor, the placenta is delivered, which usually takes from 5 to 30 minutes. At this time, the mother and her partner or support person are busy marveling over the baby. A fourth stage of labor is the recovery time, one to two hours after birth, referred to as the "golden hour." During this time, the mother is watched for excessive bleeding or other recovery problems. Research has shown that uninterrupted skin-to-skin contact between mother and child during the first 60 minutes of the baby's life maximizes bonding, promotes release of oxytocin (the love and bonding hormone), and is critical to the growth and development of the baby.

In the next section, we will review the child birthing process and the preparations for delivery. Child

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A striking comparison of the baby at birth and at four weeks. The newborn's head is elongated, and the baby's face shows the pressures that occurred during the birth process.

preparation practices vary from country to country and from generation to generation.

Practice Guidelines:

Promoting Attachment

The American Association of Pediatricians has developed the following guidelines for healthcare providers to encourage healthy attachment:

- Healthy newborns have "skin-to-skin" contact with the mother until breastfeeding occurs
- The first physical assessments of baby occur while on the mother's chest
- Conventional newborn care (measuring, injections, blood tests, bathing, and weighing) does not occur until after the first breastfeeding session
- Baby and mother are allowed to remain together for the entire recovery period

Prepared Childbirth

Having a baby involves some degree of pain, which is caused by cervical dilation and the sensation of the baby's head pushing through the pelvis. Through the years, different methods have been used to help ease this pain.

Many of the early drugs given to relieve the pain of childbirth rendered most women unconscious during delivery. Because the mother was not awake and could not help push the baby out, the baby was usually delivered with a high degree of medical intervention. The mother's partner would wait in the fathers' waiting room. After birth, the baby was kept in the hospital nursery and brought to the mother only at scheduled feeding times. Understandably, women began to want more control over and participation in their birth experiences. Also, such a heavy reliance on drugs for pain relief during birth had major side effects for the baby. In response, other methods of pain relief, without drugs, were developed.

Exercising during pregnancy has a variety of benefits to the mother and infant. In a randomized control trial (Shojaei et al., 2021), mothers who started walking consistently in the 34th week of pregnancy (about four times a week for 40 minutes each time) were more likely to go into labor naturally, decrease their chance of a cesarean or other interventions at delivery, and their infants had higher Apgar scores (discussed in the next section). Across at least 17 different countries (Bohren et al., 2017), studies have also shown that the presence of a supportive female birth attendant, or doula, during labor results in less medication, less medical intervention, fewer birth complications, a shorter labor, better Apgar scores, and more positive feelings about their childbirth experience.

Over the years, hospitals have attempted to make birth more family centered. Many hospitals have special birthing rooms, which resemble a regular bedroom. The mother is allowed to have any number of attendants present for the birth; even siblings may be included. Birthing centers, outside the hospital setting, allow for homelike birth with the possibility of medical intervention if necessary. Some women choose to have their babies at home; in 2020 home births represented 1.26% of all births, an increase of 22% from 2019 (Gregory et al., 2021). From March through December 2020, home births peaked to 1.49% which coincided with the initial surge of COVID-19 cases in the United States. Prior to the pandemic (i.e., between 2018 and 2019), however, the percentage of home births showed little change. The midwifery model of care, however, is

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gaining popularity, particularly among Millennials. Embedded in midwifery care is empowering mothers to take ownership of their health and pregnancy, by having a collaborative model of shared decision making, and viewing pregnancy and labor as a normal life process rather than a condition to be managed. There are four types of midwives: certified nurse midwives, certified midwives, certified professional midwives, and traditional/unlicensed midwives. Each has a different degree of medical training and ability to practice in a hospital, birth center, or home setting. Certified nurse midwives can work in all 50 states and in all settings, write prescriptions, and provide other health care, whereas traditional/unlicensed midwives typically serve families in home settings and often in specific communities, such as Indigenous communities or religious populations like the Amish. Though only 8% of U.S. births are attended by midwives, in the United Kingdom and other countries, that rate is over two-thirds and those births are associated with more positive outcomes for infant and maternal health, such as fewer cesarean births and greater rates of breastfeeding (Attanasio & Kozhimannil, 2017). Unfortunately, there are many barriers to midwifery care, particularly for women of color. This is significant because African American mothers are three to four times more likely to die in the perinatal period compared to white women, and are almost half as likely to give birth prematurely (Centers for Disease Control and Prevention, 2022). Part of this disparity may be a result of providers dismissing the symptoms or pain of African American mothers. For example, in 2017, Serena Williams had to demand her doctors check for blood clots after having a cesarean delivery of her daughter. Though midwifery care could have a remarkable difference in birth experiences for African American women, it is near impossible to find midwives who look like them. According to 2021 data (Zippia, 2022), only 6.7% of certified nurse midwives are African American, and these rates have remained unchanged in the past 10 years. African American certified nurse midwives have the lowest average salary compared to other ethnicities. There is a gender wage gap as well; 6% of certified midwives in the United States are men and, on average, are paid approximately $10,777 more per year.

Newborn Evaluations

One of the first questions asked by new parents at delivery is, "Is my baby okay?" One objective measure of newborn health is the Apgar score (see Exhibit 3.5). In 1953, Virginia Apgar developed a scale that looks at the infant's adaptation to life outside the womb. A newborn is given an **Apgar score** at one minute and at five minutes after birth. At these times, the physician evaluates the baby on skin color, heart rate, response to stimulation, muscle tone, and breathing effort. In each area, the physician gives the baby a score of 0, 1, or 2. Normal newborns usually lose a point or two for skin color, because the hands and feet remain somewhat blue for a time after birth. (There is an old joke that only fellow obstetricians' babies receive a perfect score of 10.) Most infants with low Apgar scores at one minute will have normal scores by five minutes. At the five-minute mark, a score of 7–10 is considered good and represents about 90% of infants in the United States. A score of 5–7 is poor, and the baby may need some medical intervention. A score of 0–4 is very poor, and the baby very likely requires resuscitation and has increased risk of mortality and neurological defects (Simon, Hashmi, & Bragg, 2022).

Exhibit 3.5 The Apgar Score

	Score		
Sign	**0**	**1**	**2**
Heart rate	No heartbeat	Fewer than 100 beats per minute	100–140 beats per minute
Breathing	No breathing	Irregular shallow breathing	Strong breathing and crying
Reflex	No response	Weak reflexive response	Strong reflexive response (sneezing, coughing, grimacing)
Muscle tone	Limp	Weak flexion of arms and legs	Strong flexion of arms and legs
Color	Blue body	Body pink, blue extremities	Body and extremities pink

Source: Zigler & Stevenson (1993).

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Focus on **The Lived Experience**

Childbirth and Labor during COVID-19

I was in labor for 39 hours with my first child, Eddie Archie. My water broke at 5:30 a.m. on Wednesday, March 9, 2022, and he was born, sick and not breathing at 9:08 p.m. on Thursday, March 10. I later found out that his Apgar score was a 2. I went to the hospital four times over a 20-hour span and was sent home the first three times because my cervix wasn't dilated. The fourth time, I refused to leave, saying the pain was too much and I had no way of knowing at home how far along things were.

In my prenatal appointments, my doctor told me that there was a risk of infection if the baby wasn't born within 24 hours of my water breaking, but I wasn't induced until 26 hours later. I did develop an infection around the 30-hour mark which caused me to have a fever and Eddie Archie to have an elevated heart rate.

I knew things were very wrong when he was born and there was no crying. He was immediately taken away and my husband went with him to the NICU. I required more care to deal with the infection and didn't get to see Eddie Archie until four hours later. I didn't get to hold him until two hours after that. And I didn't have an opportunity to try breastfeeding him until the next day. This resulted in significant challenges with breastfeeding.

We spent five more days in the hospital and the entire time I was focused on Eddie Archie's health. It wasn't until we were sent home that I wondered why things went so poorly. Why I was left to labor so long, knowing there would be a risk of infection. When I asked my doctor, she said the hospital couldn't admit me when I came earlier. Staffing challenges.

Nova Scotia, Canada, was in the depths of dealing with the worst wave of the COVID-19 pandemic yet with the omicron variant. I had heard that our hospitals were struggling with staffing challenges as a result but didn't expect it to impact me to the level that it did.

Eddie Archie's birth was far from what I had wished for us. It left me feeling disappointed, jealous of others who had better experiences, and anxious for what this meant for Eddie Archie's future health. A friend recommended a social worker that specialized in birth trauma and I began seeing her weekly when Eddie Archie was three months old. Through my sessions with her I am slowly finding peace and closure. Though I came to her because of traumatic birth experience, I'm coming through the other side with a new perspective and tools that are not only helping me heal from the past, but grow and become a better parent and person.

—Carole Rankin, Halifax, Nova Scotia, Canada

Eddie Archie laying in a bassinet while admitted to the NICU

Carole practicing skin-to-skin contact with her son, Eddie Archie, while in the NICU.

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Practice Guidelines:
Preparing for Birth

- Encourage mothers to consider all available birth options in order to have an optimal birth experience. Touring the facilities, such as birthing centers or hospitals, offers opportunities to ask questions about each health-provider practice. Parents may also want to interview midwives and physicians to understand the level of prenatal and postpartum care.
- Classes on birth preparation, breastfeeding, and newborn care are usually offered at hospitals and are often available for free or reduced cost. Ongoing support groups are often available for after the baby arrives.
- Encourage providers to offer group prenatal care, as participation provides health benefits to both mothers and babies, such as fewer instances of preterm birth.
- Knowledge about the birth process reduces fear and the experience of pain. A support person during labor and delivery promotes positive outcomes for mother and baby. Conversely, it is important for the mother to consider who she would like present in the delivery room, as relationships that cause stress or anxiety may prolong labor and lead to poorer outcomes for mother and baby.
- Advocate for doula care to be covered by health insurance providers in order to help close the gap in birth outcomes between African Americans and other mothers.
- Advocate for coverage of telehealth services for pregnant women and alignment of telehealth reimbursement approaches across payers.

Biophysical Strengths, Hazards, and Risks

Birth is as safe as life gets.

—Harriette Hartigan

As discussed in the previous chapter, when a social worker is gathering developmental data about a client for a psychosocial history, it may be helpful to obtain prenatal information about the client, including any problems or complications that occurred during the pregnancy or birth. These complications may have an effect on the individual's postnatal development. For instance, some early research (Colletti, 1979) suggested that children with learning disabilities had a significantly higher incidence of pregnancy and birth complications than other children. Other more recent evidence suggests a link between attention deficit disorder and adverse pregnancy and perinatal outcomes, regardless of if they were taking medication (Poulton, **Armstrong**, & Nanan, 2018). In the next sections, we will discuss some of the possible complications of pregnancy and birth.

Complications of Pregnancy

Many women experience nausea, or morning sickness, during early pregnancy. This nausea and occasional vomiting usually clear up by the fourth month of gestation.

A complication that can have serious consequences is **vaginal bleeding**. In early pregnancy, this bleeding can be a symptom of a miscarriage; 80% of miscarriages occur in the first 12 weeks of pregnancy. Not all incidences of first-trimester bleeding end in loss of the pregnancy, though. Sometimes the bleeding abates and the pregnancy is carried to term. In fact, most women who have vaginal spotting or bleeding in the first trimester go on to have successful pregnancies. Because many miscarriages are the result of fetal abnormalities, it may be helpful to note instances of early pregnancy bleeding.

Vaginal bleeding in later pregnancy may indicate placental problems. This bleeding is usually the result of a placenta located low in the uterus and covering the cervix (**placenta previa**) or a placenta that begins to separate from the wall of the uterus (abruptio placentae). Significant bleeding in late pregnancy due to these conditions can be very serious and threaten the survival of the mother and the baby.

Toxemia and *eclampsia* also can be serious complications of pregnancy. Toxemia of pregnancy refers to an abnormal condition of pregnancy involving the toxic substance of proteinuria (protein in the urine). Early stages of toxemia are referred to as preeclampsia. In the United States, preeclampsia is the cause of 15% of premature births (March of Dimes, 2021). First pregnancy, obesity, fertility treatment, older maternal age (35+ years), and being African American are all risks associated with preeclampsia. In **preeclampsia**, the pregnant woman exhibits elevated blood pressure, swelling (especially of the hands and face), weight gain, and protein in her urine. These symptoms are not always easily noticed by the mother and are often caught at a prenatal visit. This is one reason that regular, consistent prenatal visits are so important to the pregnancy outcome. If these early signs are not detected and treated, the condition can advance to eclampsia and serious complications, including maternal death, fetal death, and fetal brain damage.

Diabetes is one of the most common metabolic abnormalities of pregnancy. **Gestational diabetes**, defined as

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carbohydrate intolerance with onset or first recognition during pregnancy, makes up 80% of cases of diabetes in pregnancy. A woman diagnosed with diabetes before pregnancy is at an increased risk of both maternal and fetal complications and may require intensive medical management before, during, and after her pregnancy. A woman who develops gestational diabetes must monitor her blood glucose levels, controlling them through diet and possibly insulin injections. Women experiencing gestational diabetes should be routinely monitored by a physician postpartum, because the majority of these women develop diabetes after pregnancy (Kim & Ferrara, 2010).

A good example of a complication of pregnancy that can be caused by factors in the maternal environment is **intrauterine growth restriction (IUGR)**. This condition occurs when the fetal weight falls below the 10th percentile for gestational age. Many factors can affect the quality of the maternal uterine environment and result in this growth slowdown, including the mother's nutrition, weight gain, age, number and spacing of previous pregnancies, health status, level of environmental stress, and ingestion of substances such as cigarettes, alcohol, and drugs. IUGR increases the risk of fetal death and the risk of problems for the infant after birth.

Getting adequate sleep during pregnancy is a biophysical strength that helps reduce the risk of many pregnancy complications we have just described, including preeclampsia, gestational diabetes, longer labors, and cesarean section (The Johns Hopkins University, 2022). Having trouble sleeping is common during pregnancy, starting in the first trimester, because of the spike in progesterone. Although this may subside in the second trimester, the third trimester brings the challenge of getting in a comfortable sleeping position, and sometimes the increase in estrogen causes swelling of the nasal tissue, which is associated with snoring. It is recommended that pregnant women get at least six hours of sleep a night to buffer these risks.

A Centers for Disease Control and Prevention (CDC) report released in 2022 determined that four out of five pregnancy-related deaths in the United States are preventable. Further, mental health conditions are the most frequent cause of death (including deaths due to suicide, homicide, and overdose/poisoning related to substance use disorder). This highlights the need for state-level initiatives to improve care for pregnant and postpartum people. Many states have implemented the expansion of postpartum care coverage but social workers need to continue to examine if this is enough. These statistics are a sobering reminder to continue statewide advocacy, particularly for Native American/Alaska Native people, of which 93% of pregnancy-related deaths are deemed preventable.

© Birdie Fyffe Photography

This mother is babywearing her newborn twins. Multiple gestations are now more common as a result of assisted reproductive technology.

Environmental Effects on Prenatal Development

The child is born into a family environment that will shape and influence his or her lifelong development. Even before birth, however, human development occurs in an "environment" that exerts significant influence on the growing fetus.

Maternal Age

Problems in pregnancy attributable to maternal age arise in mothers under 18 and over 35. Older mothers have an increased risk for illness and for pregnancy complications. Specifically, the incidence of chromosomal abnormalities such as Down syndrome goes up significantly for older women. The risk of having an infant born with Down syndrome is 1:1,200 for a 25-year-old woman, whereas the risk is 1:100 for a woman at age 40.

Teenage mothers also can have problems with pregnancy, including increased risk of infant death and infant cognitive deficits. One contributing problem for teenage mothers may be that they are less likely to obtain prenatal care than are older women (Haeri, Guichard, & Saddlemire, 2009). For either end of the age spectrum, good medical management of the pregnancy through prenatal visits increases the likelihood of a successful outcome.

At the other end of the age spectrum, more women in their 30s are giving birth. Multiple-gestation births are more common in this age group generally, and because fertility

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levels for women over 30 are lower, fertility interventions are used. These also may lead to multiple-gestation births. As the following section discusses, these births carry special risks.

Multiple Gestations

A pregnancy involving more than one fetus increases the risk of complications of pregnancy, especially for IUGR and premature labor. Whereas the average gestational age for single fetuses is 39 weeks, for twins it is 35 weeks, triplets 33, and quadruplets 29. Multiple gestations are twice as likely to have birth defects (Feinbloom, 2000).

Over the last 40 years, rates of twin births have nearly doubled. Assisted reproductive technology (ART), such as in-vitro fertilization, has been a contributing factor to the increase in multiple-gestation births. More than one-third of twins, and more than three-quarters of triplets are a result of ART-associated conception (Kulkarni et al., 2013). Though ART practices are improving and fewer embryos are being transferred, women and couples interested in ART should receive information and counseling regarding the procedure because of the increased risk of multiple gestations.

It has been observed that women who have several closely spaced pregnancies have increased problems with fetal and child health. In a meta-analysis of 58 observational studies attempting to identify the causal mechanism that explains this phenomenon, Conde-Agudelo, Rosas-Bermudez, Castaño, and Norton (2012) found a variety of hypotheses, including maternal nutritional depletion, suboptimal lactation related to breastfeeding–pregnancy overlap, transmission of infectious diseases among siblings, and incomplete healing of uterine scar from previous cesarean delivery. For this reason, birth spacing is an outcome of interest for home visiting programs and early intervention programs (Chang et al., 2013; de Bocanegra, Chang, Howell, & Darney, 2014).

Maternal Nutrition

A pregnant woman needs an extra 300 calories a day of high-quality food for good nutrition. Physicians used to advise pregnant women to limit their weight gain to 15–18 pounds. Physicians now advise their patients to "eat to appetite" and to gain 25–30 pounds. Poor nutrition can result in IUGR and low birth weight. Lack of certain vitamins and minerals can cause problems; for example, lack of folic acid has been linked to neural-tube defects. Severe malnutrition increases the likelihood of congenital defects and fetal death. A good diet adequate in protein is most important during the last three months of pregnancy, when the baby is gaining weight and developing brain cells.

To help ensure adequate nutrition for low-income women during pregnancy, the government developed the Supplemental Food Program for Women, Infants and Children (referred to as WIC). This program provides vouchers to pregnant women and new mothers with children to age five for high-protein, iron-fortified food. The program also provides nutritional education and counseling.

Maternal Illness

Several illnesses can cause serious problems with a pregnancy or for the fetus at birth.

Sexually transmitted infections, such as syphilis, gonorrhea, and HIV, can have a profound effect on the fetus. Syphilis can be passed to the fetus through the placenta, and fetal infection with syphilis can result in miscarriage or eye, ear, bone, or brain damage. A woman with gonorrhea can pass the infection to her newborn during birth, resulting in blindness in the infant. As a safeguard, most hospitals treat a newborn's eyes with erythromycin ointment or silver nitrate. Without treatment, about 14 to 20% of mothers in European countries, and up to 43% of mothers in African countries, infected with HIV transmit the virus to their babies. However, with effective treatment and a managed delivery, the risk is 0.3% or less.

Diabetic mothers have increased risk of pregnancy and birth complications. Uncontrolled diabetes can result in miscarriage, fetal death, and birth defects. Also, babies born to diabetic mothers tend to be larger, with an increased risk of birth injury because of their size. For this reason, infants of diabetic mothers are often delivered early, resulting in problems associated with prematurity.

Maternal Drug Use

Substances that cause birth defects are known as **teratogens**. The serious effects of drugs acting as teratogens can be illustrated with the story of thalidomide, a mild tranquilizer sold over the counter in the early 1960s for symptoms of morning sickness. The drug had been tested on pregnant laboratory rats and deemed safe for use by pregnant women. Although thalidomide was widely used in West Germany and Britain, the Food and Drug Administration (FDA) never approved its use in the United States, "pending further study." Unfortunately, thousands of women who used the drug in early pregnancy gave birth to babies with birth defects. The most striking defect was short or missing limbs so that hands and feet were attached to the torso. A pregnant woman is now advised not to take any over-the-counter (OTC) medications without consulting her physician. Other drugs that have been identified as teratogens include alcohol, amphetamines, certain antibiotics, aspirin, Dilantin (seizure medication),

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barbiturates, hallucinogens, lithium cocaine, heroin (methadone), certain hormones, tranquilizers, tobacco, vitamin A (Accutane), antihistamines, and corticosteroids.

Though the long-term effects of illegal substances on development are still uncertain, mothers with substance use disorders can give birth to infants diagnosed with **Neonatal Abstinence Syndrome (NAS)** or Neonatal Opioid Withdrawal Syndrome (NOWS) (a new term that is used describe withdrawal symptoms associated with only opioids). Every 15 minutes, an infant in the United States is diagnosed with NAS (Winkelman et al., 2018). Most cases of NAS are a result of opioids. Opioids are a class of drugs used to manage pain, including prescribed (e.g., codeine, morphine, Fentanyl) and street (e.g., heroin) opioids. As a result of exposure to drugs prenatally, these infants are fussier, more irritable, and have greater difficulty adapting to different environments. Diagnosis of NAS typically happens within three days of birth. Withdrawal symptoms include high-pitched crying, jitteriness, seizures, vomiting, tremors, poor feeding, and sleep disturbances. The duration of symptoms can vary from one week to months after birth and standard treatment typically includes initiating and then tapering a course of medication, such as morphine or methadone, until the infant shows minimal signs of withdrawal.

Prenatal drug use can increase the incidence of miscarriage, fetal death, hemorrhage, and low birth weight. It is recommended that alongside counseling and behavioral therapy, pregnant women have access to medication-assisted treatment (e.g., buprenorphine, methadone, naltrexone), not only to facilitate her recovery but stopping "cold turkey" can be lethal to the developing fetus. Because of the dangers associated with drug usage during pregnancy, a number of controversial policies are generating significant debate (see Exhibit 3.6).

Exhibit 3.6 Drugs that may Affect Prenatal Development

Alcohol: Prenatal/postnatal growth retardation; developmental delays; facial anomalies; microcephaly (small head); heart defects; hyperactivity; behavioral problems; developmental disabilities
Amphetamines: Premature birth; stillbirth; neonatal irritability; poor feeding in newborn
Antibiotics
Streptomycin: Hearing loss
Tetracycline: Premature birth; stained teeth; short arms or legs; webbed hands; inhibited bone growth
Aspirin: Bleeding problems in mother or infant
Dilantin (seizure medicine): Head and facial abnormalities; heart defects; cleft palate; developmental disabilities
Barbiturates: Fetal addiction with subsequent withdrawal symptoms, including seizures, vomiting, agitation; also can cause neurological problems
Hallucinogens (LSD, mescaline): Possible chromosomal damage; miscarriage; possible behavioral abnormalities
Lithium: Heart defects; lethargic newborn
Cocaine: Low birth weight; seizures; microcephaly; SIDS; premature birth; IUGR; miscarriage
Heroin (methadone): Toxemia; IUGR; miscarriage; premature birth; low birth weight; stillbirth; SIDS; neonatal addiction with withdrawal symptoms, including restlessness, vomiting, tremors
Hormones
DES: Reproductive-system anomalies; cancer of reproductive system
Estrogens: Feminization of males
Androgens: Masculinization of females
Tranquilizers (valium): In first trimester, can cause cleft palate, respiratory distress, poor muscle tone, lethargy in newborn
Tobacco: IUGR; premature birth; stillbirth; low birth weight; miscarriage; SIDS; possible hyperactivity; possible learning problems
Vitamin A: Cleft palate; heart defects
Accutane (acne medicine): Microcephaly; blindness; heart defects; miscarriage; fetal death
Caffeine: Low birth weight; IUGR; premature birth
Antihistamines: Anomalies; fetal death
Corticosteroids: Anomalies; cleft palate; IUGR

Source: Johnson, J., "Developmental Assessment in Clinical Child Psychology," p. 39. Prentice Hall, 1992. Used by permission of the author.

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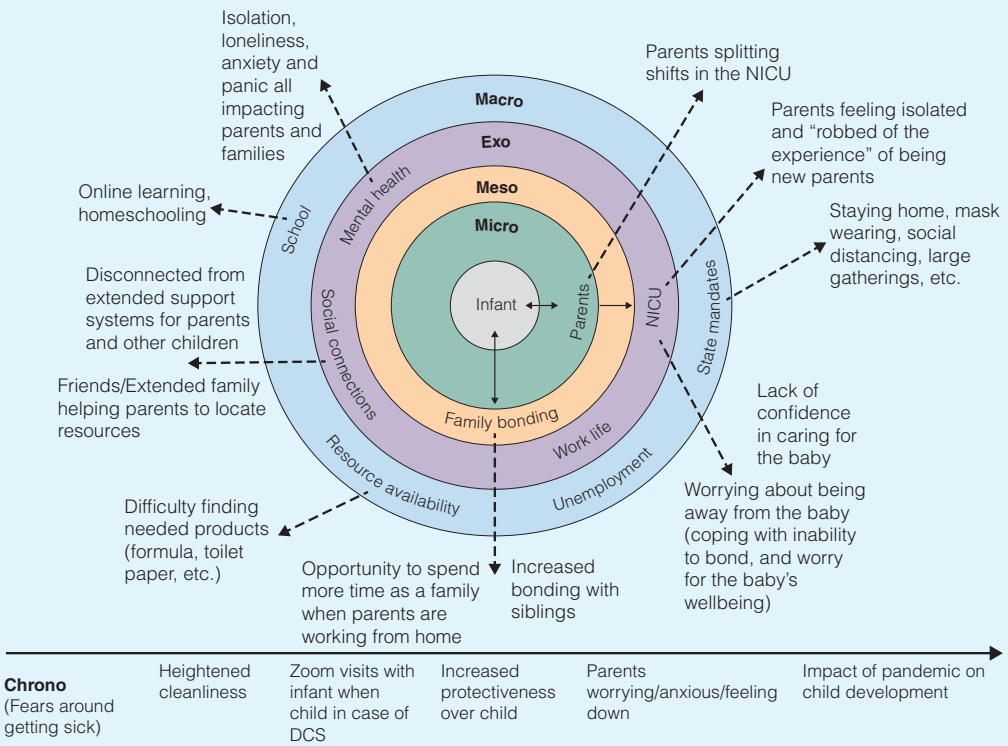
Focus on **The Lived Experience**

The Impact of COVID-19 While in the NICU

In the immediate weeks of the COVID-19 pandemic, many parents faced sudden and stringent restrictions in the NICU. Though the World Health Organization (WHO) released guidelines in March 2020 that recommended skin-to-skin contact, initiating breastfeeding within an hour of birth, and mom and baby to remain in the same room at all times, many hospitals adopted policies that separated the mother and the baby and discouraged breastfeeding in mothers who were suspected of having the virus. Some hospitals even required the mother and baby to sleep a certain distance apart (six feet) and avoid skin-to-skin contact. People with substance use disorders (SUDs) were disproportionately affected. In addition to the added emotional distress for all parents in the NICU, mothers with SUDs faced additional barriers including access to opioid antagonist treatments (e.g., methadone) or their assigned healthcare providers. One of these mothers shared her experience in the NICU around visitor restrictions. "My husband was the only one allowed there. They made an exception because it was supposed to only be one person in the NICU but they let both of us like rotate. My other kids weren't allowed though and we weren't allowed any other visitors in the room period." Another mother worried about the virus itself, when there was very little known about the virus. "I'm scared for it 'cause I do have heart disease myself so anytime I get like sick with respiratory infections I get really, really sick. Like it lasts a long time. It's hard to heal from it. So I feel like it would be a death sentence for me and I really want to see my kids grow up." Researchers qualitatively analyzed these mothers' experiences from one NICU in Tucson, AZ (Williams, Gebler-Wolfe, Safyer, & Grisham, 2021). By applying the ecological systems theory, we gained a better understanding of how parents with SUDs were impacted from the micro to macro level. Parents had to quickly adapt in concrete ways (e.g., establishing employment, housing, and food security), which manifested in feelings of protection, anxiety, and increased reliance on—or detachment from—community, and shifts in time spent with children. We learned from this study, that in times of crisis, it is helpful for parents to establish new routines with their children, which will foster children's internalized beliefs that their parents will be there in times of stress. Parents who are able to respond to their infants' needs, particularly in times of stress, will support the long-term development of trust and security.



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Laura arrived at the hospital emergency room in early labor. On questioning, Laura admitted that she had received no prenatal care. When the nurses requested a urine sample, Laura left. Three days later Laura returned, hemorrhaging, and an emergency cesarean section was performed. Because of the lack of prenatal care, Laura was screened for drug use, and her lab results were positive for methamphetamines. Laura's baby was born lethargic, with low muscle tone, and an irregular heartbeat. He was immediately transferred to the neonatal intensive care unit for further evaluation. The hospital notified the Department of Child Safety.

Often, even when the mother agrees to drug treatment, the treatment options are inadequate or not available. In fact, the number of pregnant women who receive treatment for substance abuse is quite low. Just under 5% of substance abuse treatment admissions are women who were pregnant between the years 2000 and 2010 (The TEDS Report, 2013). Many treatment programs have a long waiting list, many do not take pregnant women, and those that do often do not allow the woman to keep her other children with her during treatment. For mothers with substance use disorders, residential treatment, when available, can mean up to a year's separation from her family. Sometimes her children are placed in foster care. If the woman's partner is also using drugs, treatment for them is even more difficult to find. Programs that consider the needs of whole families are rare. Even in communities that do not criminalize pregnant mothers with substance use disorders, women often experience stigma and neglect from the healthcare and service delivery systems.

Maternal Alcohol Abuse

There is no known safe amount or safe time to use alcohol during pregnancy. Alcohol passes to the infant through the mother's blood through the umbilical cord. The leading known preventable cause of irreversible developmental disabilities in the Western world is a common legal drug: alcohol. Developmental disabilities refer to a group of conditions that result in impairments in physical learning, language, or behavior areas, which last throughout the life span (e.g., attention deficit hyperactivity disorder, cerebral palsy, autism spectrum disorder; Rubin & Crocker, 1989). Infants exposed to alcohol prenatally may develop **fetal alcohol spectrum disorders (FASDs)**.

FASD birth defects have lasting consequences. Fetal alcohol syndrome (FAS) represents the most severe end of the FASD spectrum. The physical signs include facial abnormalities such as a small head, small eyes or short eye openings, a poorly developed philtrum (that part of the face between the nose and upper lip), a thin upper lip, a short nose, and a flattened mid-facial area (Hannigan & Armant, 2000). Children with FAS can have problems with learning, attention, memory, and problem solving, along with lack of coordination, impulsiveness, and speech and hearing impairments. Adolescents and adults with FAS exhibit impulsiveness, lack of inhibitions, poor judgment, and a lack of understanding of socially appropriate sexual behavior (Mattson & Riley, 1998). These behavioral characteristics make it difficult for these individuals to hold a job or establish successful peer relationships. There is no cure for FASD. However, early recognition, particularly before age six, and intervention (e.g., medication, behavioral and education therapy, parent training) in loving and stable homes are known protective factors associated with improved developmental outcomes.

Exhibit 3.7 provides an overview of the type of prenatal information to collect in making assessments.

Exhibit 3.7 Prenatal Information to Obtain in Making an Assessment

Gestation
Duration of pregnancy—was baby full term or premature?
History of maternal substance abuse
Medications taken by mother during pregnancy
Mother's nutritional status
Maternal illness during pregnancy
Maternal exposure to radiation and toxic wastes
Other maternal factors during pregnancy: fever, accidents, diabetes, toxemia, threatened abortion (vaginal bleeding), and previous stillbirths
Birth
Presentation of infant—was baby breech or normal?
Type of delivery—Cesarean or vaginal?
Birth weight
Multiple or single birth
Complications—prolonged labor, fetal anoxia (fetal distress)
Newborn
Problems with newborn—hyperbilirubinemia (jaundice), hypoglycemia (low blood sugar), cerebral hemorrhage, infections
Duration of hospitalization (more than 48 hours, or less)

Government of Western Australia

Source: Johnson, J., "Developmental Assessment in Clinical Child Psychology," p. 39. Prentice Hall, 1992. Used by permission of the author.

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Maternal Smoking

Inhaling cigarette smoke increases the level of carbon monoxide in the blood, and in a pregnant woman, this in turn decreases oxygen to the fetus. Smoking increases the risk of prematurity, infant death, miscarriage, and other complications of pregnancy and birth. Women who smoke during pregnancy risk slowing the growth and development of their fetus, often resulting in low-birth-weight infants (Agrawal, Scherrer, Grant, Sartor, & Pergadia, 2010). Smoking also has been suspected of causing a higher risk of sudden infant death syndrome (SIDS). SIDS is the sudden and unexplained death of a baby who is younger than one year old (usually while the baby was asleep in their crib, which is why it originally was called "crib death") and will be described in more detail in the following chapter. Children of smokers are more likely to be smaller and show problems with cognitive development and educational achievement; Agrawal et al. (2010) have suggested that smoking during pregnancy increases the risk of developmental disabilities by 50% compared with nonsmoking mothers. Infants of smokers show differences in responsiveness by one week of age.

Maternal Depression and Anxiety

A third of women experience clinical depression or an anxiety disorder during pregnancy, and this may have consequences for the developing fetus and newborn. Accurate diagnosis of a mood disorder is difficult as many symptoms overlap with normative symptoms of pregnancy (e.g., changes in appetite, energy, concentration, or sleep). Untreated anxiety and depression may result in risks to the newborn: premature births or low-birth-weight babies, a low Apgar score and poor adaptation outside the womb. They show less organized sleep; lower vagal tone, or the ability to inhibit their heart rate; lower dopamine and serotonin levels; and biochemical characteristics that mimic their mothers' profile during pregnancy (Dieter, Emory, Johnson, & Raynor, 2008). Pregnant women with lower incomes are more likely to experience symptoms of depression. One correlate of low income and mental health is material hardship, also known as financial hardship or social deprivation (Katz et al., 2018). Material hardship includes difficulties in meeting basic daily needs such as food, housing, or transportation, which may be particularly devastating for pregnant women who require access to adequate nutrition, transportation to medical appointments, a safe place to sleep, and a phone to access providers and social support.

Prenatal anxiety is also associated with negative consequences for pregnancy and various child development outcomes. A review of the effects on infants of mothers with high anxiety include several biological effects, such as miscarriage, slowed growth, and small head circumference, as well as prolonged crying and irritability, difficulty bonding, impaired cognitive development such as language and attention regulation, and later in development, medical conditions such as asthma and endocrine disorders (Shahhosseini et al., 2015). Considering the high incidence and potentially serious complications resulting from anxiety during pregnancy, screening during routine prenatal care is critical so that the contexts and influencing factors can be addressed early (see Exhibit 3.8).

Maternal Instinct

Are mothers born with an innate ability, passed down from our ancestors, of knowing just what to do? Does this ability turn on at the moment their child is born? Or is it the environment, attending to the child through repeated interactions, that fosters a maternal instinct, in which parents become specifically attuned to the needs of their child? The idea of a maternal instinct has been discussed for centuries. In the 1800s, the myth of women's inborn maternal proclivity was used to justify why women were excluded from higher education and work positions and later was used for sociopolitical change, resulting in it being widely accepted as part of women's innate need to have children (Badinter, 1981). The idea of a maternal instinct has continued to pervade Western thought, leading to important, enduring consequences for women's role in society. These consequences are particularly focused on attitudes and views of women's ability to manage the time and energetic trade-off between employment or influence outside the home, and their dedication to their family life. The belief in an automatic or innate understanding to take of a baby, undermines women's request for help and may prohibit fathers from freely embracing a parenting role. It is important to sometimes challenge factors which we consider biological, to be a by-product of the social environment, which are shaped by political and cultural contexts. For example, the maternal instinct, long-believed as biologically driven and innate, is being called out as a myth created by patriarchic society (Conaboy, 2022).

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Exhibit 3.8 Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression. *N. Engl. J. Med.* vol. 347, No 3, July 18, 2002, 194-199.

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Exhibit 3.8 Edinburgh Postnatal Depression Scale (EPDS) *(Continued)*

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression. *N. Engl. J. Med.* vol. 347, No 3, July 18, 2002, 194-199

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Focus on **The Lived Experience**

Postpartum Depression and Depression during Pregnancy

During my pregnancy with my second child, a friend of mine from college, and one of the most positive people I knew, stepped in front of a train and took her own life. She was a relatively new mother and had undiagnosed PPD. Her husband shared, with her friends and family after she passed, that she was privately morose while she maintained her cheery disposition in public spaces. The hormonal changes during pregnancy are so intense for me it makes me feel like a different person. When I heard the news of my friend, I realized that I was struggling badly and not being transparent with anyone, not even my partner and the father of my children. When I am struggling, I feel small, insignificant, and like my feelings aren't worth sharing. When my friend died, I realized she probably felt the same, I wished she'd told someone. I vowed to be transparent going forward. After my first child was born I felt I was finally free from pregnancy, my baby cuddled right up and nursed, I had my body back (though not exactly the same shape at least it was no longer doubly occupied!) and I was euphorically happy. I nursed her through my second pregnancy and our bond was so strong. After my second was born all of the hormonal fluctuations I knew in both pregnancies continued. I felt completely overwhelmed and sometimes, like I was submerged in deep dark water. I could swim up to the surface but I couldn't get out. I couldn't meet all of my older child's needs and the beautiful bonding with the new baby only made me feel guilt. I started to feel smaller and smaller, like I wasn't enough for everyone around me and like I never ever could be. Every single thing felt like a failure. I recognized myself recoiling, and reminded by the recent loss of my friend, I kicked myself to tell my husband and then kicked myself to tell my midwife, my doula, and my closest friends. People very often have no idea the struggles of those around them and we are each internally struggling with things. What is the person next to you struggling with right now? What are you struggling with? I could not get out of my depression without telling people I was struggling. It was harder than I can explain to reach out but the consequences of not reaching out would've been so much worse.

—Francie

Practice Guidelines:

Reducing Risks

- The CDC recommends that state and local outreach to pregnant women be intensified to further reduce the mother-to-child transmission rate of sexually transmitted infections (STIs). To assist with this task, the Ryan White CARE Act provides resources for care and services to HIV-infected individuals and also requires states to examine their perinatal HIV prevention programs.
- Many people favor laws that allow a pregnant woman to be tested and treated for substance use without her consent and that if the pregnant woman does not comply with treatment, she should be jailed. Although there can be little dispute over protecting unborn children from maternal drug use, mandatory testing and threats of jail time may not be an effective preventive measure. In addition to raising ethical concerns, such practices undermine the relationship of healthcare providers with drug-using families. Such families often mistrust medical workers and fear that these workers are trying to take their children away. Testing a woman without her consent, with the intent of jailing her, only further reinforces this fear and may lead these women to become more distrustful and ultimately to avoid contact with healthcare providers.
- Individuals who work with mothers with substance use disorders should provide counseling and education, medication-assisted treatment, and assistance in general living skills.
- Prevention of FASD involves teaching pregnant women about nutrition and the harmful effects of drinking during pregnancy. Practitioners should screen for alcohol problems at the first prenatal visit and work with women through support groups and classes to promote healthy pregnancy outcomes.
- Stress can impact the mother's coping responses. Pregnant women may cope with environmental stress by engaging in health-compromising behaviors such as smoking, drinking, and using drugs—activities that have all been shown to increase the risk of premature birth and low birth weight (Brooks-Gunn, McCormick, & Heagarty, 1988).

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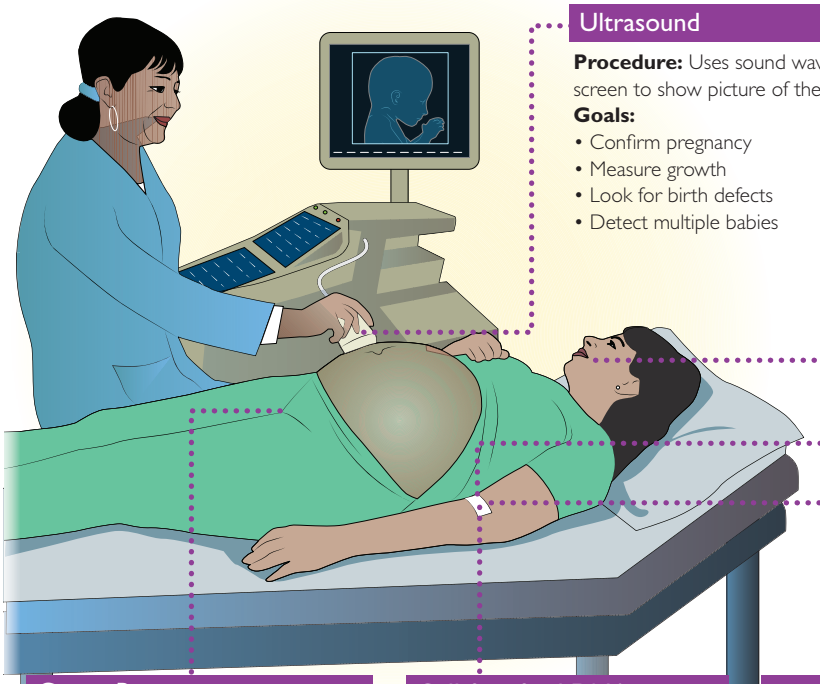
- Stigma results in lost opportunities for mothers to seek services and improve health outcomes. Social workers should be cognizant of the organizational culture and if it is one that is stigmatizing.

Several prenatal tests developed in recent years allow genetic screening during pregnancy. It is now possible to determine the sex of the fetus and whether the fetus has a specific genetic anomaly. There are two main types of prenatal testing: (1) screening tests, which can identify whether your baby is more or less likely to have certain birth defects or genetic disorders, and (2) diagnostic tests, which are done to confirm a diagnosis (e.g., chorionic villus sampling or amniocentesis, which carry a slight risk of miscarriage). The **ultrasound** is a screening procedure that uses high-frequency sound waves to form a picture of the developing pregnancy to determine the gestational age of the fetus, location of the placenta, whether there are multiple pregnancies, and to assess the growth and development of the fetus. Another noninvasive procedure is **alpha-fetoprotein blood screening**. This procedure examines the mother's blood and is used to detect congenital conditions and defects, including malformations of the fetus's skull or spinal cord such as spina bifida, an opening in the spinal column. Other noninvasive prenatal testing services are based on cell-free DNA analyses. Pregnant women contain fragments of the fetus's DNA in their blood. Now a simple blood test can be done to predict the baby's sex as well as many genetic conditions, including trisomy 21, trisomy 18, and trisomy 13. These tests have greater accuracy, can be done as early as nine weeks, and are often free to mothers identified at higher risk for chromosomal abnormalities (e.g., mother's age over 35) (see Exhibit 3.9).

The ability to obtain information about the sex and health of the fetus before birth brings up several ethical issues. Many parents choose to terminate when they learn they are carrying a fetus with a major birth defect. Does this practice of elective abortion mean that living with a disabling condition is now unacceptable? How do these practices reflect our society's attitude toward people with disabilities? Similarly, what if parents selected against fetuses predisposed to obesity or low IQ?

Exhibit 3.9 Prenatal Testing



Ultrasound

Procedure: Uses sound waves and a computer screen to show picture of the baby inside the womb.
Goals:
- Confirm pregnancy
- Measure growth
- Look for birth defects
- Detect multiple babies

Cystic fibrosis carrier screening

Also called: CF testing
Procedure: Testing genes of both mother and partner by blood draw or swabbing cells inside mouth
Goal: Looking for gene that causes cystic fibrosis

Glucose screening

Procedure: Consumption of glucose drink followed by blood samples at set intervals
Goal: Test for gestational diabetes, which some women get during pregnancy

Group B strep

Also called: GBS
Procedure: Swab of vagina and rectum
Goal: Test for strep infection that could be passed to baby during birth

Cell-free fetal DNA testing

Also called: Noninvasive prenatal screening or testing
Procedure: Blood sample
Goal: Tests for certain genetic conditions, like Down syndrome.

Maternal blood screening

Also called: Quad screen
Procedure: Blood sample
Goal: Measures four substances in blood looking for birth defects

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Complications of Birth

One birth complication that has an effect on development is **anoxia**, or insufficient oxygen to the fetus during delivery. Oxygen loss to the fetus can be caused by such problems as maternal blood loss, maternal overmedication, or umbilical cord compression. Lack of oxygen to the fetus during labor can cause fetal distress. When the baby is in distress, the heart rate drops or fluctuates. Lack of oxygen can cause brain damage or, in some instances, death. One consequence of anoxia is **cerebral palsy**—a condition that can result in movement and speech problems. Even mild reduction in oxygen to the fetus during delivery has been shown to produce problems with early development.

Cesarean Section

Jane and Gary expected that their first child's birth would be an uncomplicated vaginal delivery. Gary had actively participated with Jane in childbirth classes. As a graduation present, she had given him a dark blue T-shirt with "Coach" printed on the front. Jane's labor was long and slow. She spent most of her labor in bed, with an epidural for pain relief. She never dilated beyond six centimeters. After 18 hours of labor, the baby was delivered by **cesarean section**. Now, six weeks after the birth of a beautiful baby girl, Jane is tired and weepy. In addition, she feels guilty about her sadness because she thinks she should be happy just to have a normal, healthy baby.

In the past, some of the complications of birth could result in fetal death or injury. Today, however, many babies are saved through birth by cesarean section. A cesarean birth occurs through an incision in the abdominal wall and uterus rather than through the vagina. Though a C-section can be a lifesaving solution to a birth complication, the procedure itself carries increased risks for the mother and the baby. A cesarean birth increases the mother's risk of pain, trauma, and surgical complications and has an increased risk of maternal mortality. There has been a steady increase in cesarean births in the United States such that nearly a third of babies are delivered this way (Osterman et al., 2022). It's important to note that mothers who deliver by C-section are more likely to have difficulties with breastfeeding and bonding. Some advocates have tried to implement changes in the hospital that would allow for skin-to-skin contact in the operating room, immediately following a C-section (Grassley & Jones, 2014). However, this would require extra nurse support or the use of a carrier to prevent a possible fall-related injury as the mothers recover from major surgery.

Because of the increased incidence of surgical births, cesarean delivery has been trivialized. This attitude may overlook the fact that surgery is one of life's most frightening experiences.

Neonatal Complications: The High-Risk Infant

One of the major risk factors for the newborn infant is low birth weight. A low-birth-weight infant is one born weighing less than 2,500 grams, or 5½ pounds. A low birth weight can be the result of **prematurity** (being born before the 37th week of gestation) or IUGR (having some sort of prenatal deprivation that slows growth). In the past, all babies born weighing less than 5½ pounds were considered premature. However, a baby born before 37 weeks to a diabetic mother can weigh 5½ pounds or more but still be premature and encounter problems associated with early birth. A baby born at 40 weeks weighing less than 5½ pounds is mature but will encounter the problems associated with slowed fetal growth and development.

Intrauterine Growth Restriction

Growth restriction can occur at any point in the pregnancy. A fetus is considered small for gestational age (SGA) if its weight is less than the 10th percentile of the normal weight of an infant at that particular stage of gestational development. A premature baby whose weight is normal for gestational age has low birth weight because of being born too early; but a small-for-gestational-age baby is low birth weight because of abnormal growth. There is evidence that these babies are at risk for perinatal asphyxia, often requiring resuscitation after delivery (Nieto, Matorras, Villar, & Serra, 1998). As we have already seen, this abnormal prenatal growth can be caused by factors such as maternal illness, poor nutrition, and drug and alcohol use.

The problem for SGA infants is not just that they are born small; they are small because some sort of prenatal deprivation affected their growth and development. However, with appropriate medical care, most of these infants catch up in their growth during the first three months of life and tend to follow normal growth curves by one year of age (Vandenbosche & Kirchner, 1998).

Prematurity

Premature births are those that occur before the end of the 37th week of pregnancy; almost 10% of births are classified as premature. The rates of premature births in the United States are among the worst compared to other high-resourced countries. Currently, premature birth and its implications are the leading cause of death of infants

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in the United States (March of Dimes, 2021). Though premature babies may be growing and developing at a normal rate, they face the problems associated with low birth weight as the result of being born too early, such as respiratory difficulties, feeding problems, and jaundice. The lower the birth weight and the earlier the gestational age, the more likely it is that these problems will occur.

Problems Associated with Premature Birth

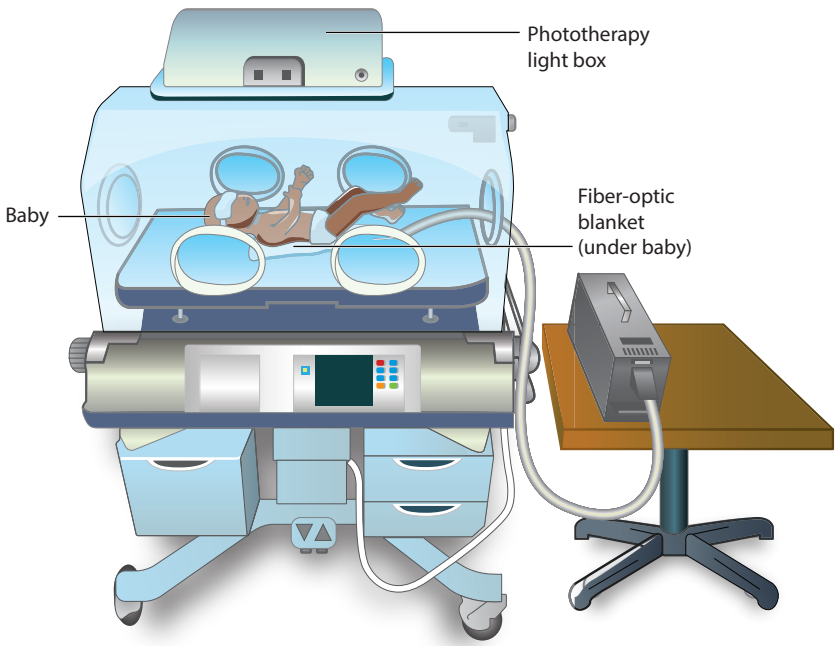
During the last month of pregnancy, the fetal lungs mature in preparation for birth. A baby born before the lungs are fully mature can suffer from respiratory distress syndrome. The baby may need supplemental oxygen, which needs to be carefully monitored, because it has been discovered that high oxygen levels can cause blindness (retinopathy of prematurity).

The reflexes of a premature infant are often weak or lacking. In particular, the sucking reflex is not well established until 34 weeks' gestation. A baby born before 34 weeks, then, may have feeding problems and be unable to nurse or take a bottle. These babies must be fed through a tube passed through their noses, down their throats, and into their stomachs (gavage feeding). The baby then has to learn to suck in order to feed from a bottle or the breast.

Preterm infants have more problems with jaundice than do full-term infants. Before birth, the fetus has extra red blood cells circulating in the blood. After birth, when the baby begins to breathe, these extra red blood cells are not necessary and are broken down in the baby's body. As these cells break down, they produce a by-product known as *bilirubin*. In a normal newborn, this bilirubin is broken down by the liver and excreted. A preterm infant's immature liver cannot effectively break down the excess bilirubin, so the substance builds up in the baby's system. Because bilirubin is orange-colored, this buildup results in a yellowish orange tint to the baby's skin called jaundice (also known as hyperbilirubinemia). High levels of bilirubin deposited in the infant's brain can lead to a form of brain damage that can result in developmental disabilities. However, jaundice is usually easily treatable through frequent feedings and exposure to indirect sunlight at home or through phototherapy. Phototherapy is a special light treatment in which babies lie naked under a lamp called a bili-light or with a bili-blanket to help break down the bilirubin (see Exhibit 3.10).

Developmentally, premature babies need to be assessed according to their expected due date instead of their actual birth date. Therefore, babies born two months early will have the capabilities of newborns when they are

Exhibit 3.10 Phototherapy Light Box Used to Treat Infants with Jaundice



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two months old. With good care, many of the problems of premature infants discussed up to this point resolve in the first few years after birth, allowing the children to develop normally. But the smaller and more immature the infant, the greater the risk of long-range problems. With the high technology now available in NICU, smaller and smaller babies are surviving. However, what are the long-term developmental consequences of being born so small?

These very small babies run a high risk of central nervous system bleeding or infection, which can result in lifelong consequences, including chronic lung disease, blindness, hearing loss, seizure disorders, and cerebral palsy (Bourke et al., 2019). The probability of disability-free survival to age 25 for infants born at 22 weeks is 4.1%. This increases to 53.0% for those born at 25 weeks, and 78.3% for those born at 28 weeks. Sometimes parents and practitioners face the very difficult decision of whether or not to use high-technology procedures and knowledge to save a very small infant who may later have severe disabilities and challenges.

Implications for Practice:
The Premature Infant

A premature birth can be a difficult adjustment for new parents. Depending on gestational age and weight, the baby may spend several weeks or months in an *isolette*, an enclosed infant bed that helps regulate temperature and guard against infection. New parents may feel intimidated by the high-technological and medical atmosphere of the NICU. They may hesitate to interact with a small, fragile infant hooked up to an intravenous line, a feeding tube, and a ventilator. When the parents do interact with the baby, they may experience frustration. It may be hard to attract and keep the baby's attention. Yet, too much stimulation can cause the baby to withdraw. The combination of an immature nervous system and a lengthy stay in an overstimulating hospital environment may make the baby irritable and difficult to parent. Many parents of infants admitted to the NIC experience significant psychological distress, the loss of the parenting role, and disruptions to parent-infant bonding (Lean et al., 2018).

In addition, many premature infants are born to young, uneducated, and single mothers living in poverty. In fact, low-birth-weight births "are often associated with poverty and its cofactors (e.g., low maternal education, high unemployment, and teenage motherhood), which are themselves associated with decreases in child well-being" (Fongruey & Brooks-Gunn, 1994). For these infants, it is hard to separate the effects of deficits in the home environment from those of problems caused by prematurity. The low-birth-weight infant benefits from a home where parents are sensitive and attentive and provide a rich array of objects and people for the child to interact with (Bradley, Caldwell, Rock, Casey, & Nelson, 1987).

Birth Defects and Developmental Disorders

In spite of all of the possible things that can go wrong in the prenatal period and during the birth process, most infants are born normal and healthy. About three babies out of 100, however, have some kind of anomaly or malformation at birth. Many of these congenital disorders or anomalies can affect development.

Congenital heart defects include hearts with openings between the chambers and hearts that are malformed. Sometimes heart disease is associated with other genetic anomalies, such as Down syndrome. If the heart defect is severe, it can interfere with growth and development. The baby may need corrective surgery at some point.

Neural-tube defects occur in 1 out of 1,000 births. A common neural-tube defect is spina bifida, a condition in which one or more vertebrae do not close over the spinal cord, leaving the cord uncovered in a portion of the spinal column. When the cord bulges through the opening, this increases the risk of fetal death and paralysis.

Several congenital conditions can affect an infant's brain. Hydrocephalus is a condition in which there is excess fluid in the baby's head. Because of the pressure of this increased fluid, hydrocephalus can result in intellectual disabilities, paralysis, lack of coordination, and seizures. A shunt can be placed in the head to drain off the excess fluid. Infants with microcephaly have a much smaller-than-normal head. In anencephaly, the baby lacks all or part of its brain, and the life expectancy of these infants is very short. The question has arisen regarding the ethics of using these infants as donors for organ transplants. Should an infant with no brain who will die in a matter of days or weeks be sacrificed to save the life of another child?

Several chromosomal abnormalities can affect development. The most common is Down syndrome, or trisomy 21, which results from an extra chromosome. Infants born with this disorder are at higher risk of heart defects and increased infant mortality. Babies with Down syndrome

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also have some degree of developmental disabilities, but the severity varies with each child. Early intervention programs can help these children reach their full potential. Many learn to read, hold jobs, and live in group housing. Babies born with other problems involving extra chromosomes, such as trisomy 13 and trisomy 18, usually do not live beyond 6 to 12 months.

Metabolic problems include phenylketonuria (PKU). A baby with this condition cannot metabolize a substance known as phenylalanine, found in protein. This substance builds up and can cause intellectual disabilities. For this reason, babies are tested for PKU at birth. Children with this condition must eat a restricted diet and avoid foods containing phenylalanine.

Babies who acquire brain damage from lack of oxygen or intracranial bleeding, either before or during birth, can develop cerebral palsy. The major problems with this condition are paralysis, muscle weakness, and lack of coordination. Some children with cerebral palsy also have developmental disabilities. Many of them, 70 to 80%, have some combination of speech and hearing problems, visual problems, learning problems, and seizures.

When the Baby Isn't Perfect

The birth of an infant with a disability can initiate a time of grief and loss for new parents. These parents have lost the perfect fantasy baby they dreamed of throughout the pregnancy and must now adjust to the reality of a less-than-perfect infant.

Parents of a child with a disability often go through an initial phase of grief, shock, and denial. Though faced with indisputable medical evidence of their child's condition, many parents attempt to minimize the seriousness of the disability (Jackson, 1985). One mother remembers thinking as the nurse checked her wristband before handing the baby over at discharge, "Please God, let her tell me I have the wrong baby."

As the parents develop a sense of awareness of the problem, they are often overcome by a sense of guilt and failure. They may feel they are being punished for past indiscretions or for wanting the baby to be of a particular sex instead of just a healthy baby. They may agonize over what they could have done to cause the disability. They may feel that they are biological failures for not being able to make a baby "right" (Jackson, 1985).

The sorrow and grief that accompany the birth of a child with a disability are chronic and pervasive (McCoyd, Akincigil, & Kwang Paek, 2010). Parents of a child with a disability are faced with their loss every day. Each new crisis renews the feelings of intense sadness and guilt.

Such a situation increases stress for the family at a time when the family is also faced with added financial burdens. Families can feel lonely and isolated, cut off from former friends and acquaintances. The divorce rate in families having children with developmental disabilities is three times the national average (McCoyd et al., 2010). Investigators have found that families with children with developmental disabilities experience problems with adjustment, poor health, and family relations (Schilling, Gilchrist, & Schinke, 1984).

Practice Guidelines:
Supporting Families

- Genetic counseling may be useful for parents considering prenatal testing. Accessibility to more expensive testing may be an issue. Create an open environment for parents to carefully consider the use of prenatal tests before deciding what to do with the results of the tests.
- Educate parents of premature babies about differences in their baby's regulatory system and how that impacts their needs. Provide them with extra support and help in learning to read their baby's cues. Increased confidence will help parents to know when to interact with their baby and when to back off.
- Premature babies often spit up after eating. Ensure that parents are able to assess that their baby is getting enough to eat (approximately 8–10 feedings a day) and gaining sufficient weight (approximately 0.5 to 1 oz a day). Solid foods may need to be introduced later than full-term babies.
- The home environment of premature babies is critical to their long-term functioning. Encourage parents of premature babies to have stimulating toys and materials available and to be responsive and accept the baby's behavior, including creating a safe space for play and exploration.
- Car seats should be installed in the back seat. Make sure that the baby fits the manufacturing recommendations and that the head and body aren't slumped, particularly for premature babies. Babies should never be left alone in vehicles, even for a few minutes.
- Provide interventions for families having children with developmental disabilities that enhance

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personal coping skills. Personal coping skills include problem-solving abilities, relaxation techniques, and self-praise.

- Help to develop sustainable positive support networks for families having children with developmental disabilities. Adequate social support includes physical assistance, information, and emotional support. Supportive social networks are associated with increased personal well-being for the parents and enhanced development for the child.
- Advocate for increased access to quality prenatal care in underserved and rural communities.
- Advocate for comprehensive healthcare coverage for pregnant mothers.

Psychological Dimension

Cognitive Development and Information Processing

True or False?

- Psychosocial development is a continuous process from about the 12th week of intrauterine life through the preschool years.
- There is a high correlation between intrauterine fetal activity and a newborn's level of activity.
- Babies of stressed mothers have higher levels of fetal activity and experience more challenges after birth than babies of non-stressed mothers.

Study Table Biophysical Dimension in Pregnancy, Birth, and the Newborn

Biophysical Growth and Development

- Conception occurs with the union of sperm and egg in the fallopian tube.
- Zygote: < 2 weeks; conception to implantation of the fertilized egg.
- Embryo: 2–8 weeks; most major organs and features are formed.
- Fetus: 8 weeks; the fetus grows and puts on weight.
- The birth process:
  - Stage 1: 12–14 hours; the cervix (opening to the womb) becomes fully dilated (opened).
  - Stage 2: minutes to 3 hours; pushing baby down the birth canal and actual birth.
  - Stage 3: Delivery of the placenta.
  - Many births involve some form of pain-relieving medication, but long-term effects of these medications are still unknown.
  - A newborn usually weighs between 5½ and 9½ pounds. Full-term pregnancy lasts 37–41 weeks (term pregnancy is 39–40 weeks). The Apgar score is an objective exam of the newborn's adjustment to life.

Biophysical Strengths, Hazards, and Risks

- Expectant mothers who are in good health and aware of potential biological risks in the family are less likely to experience complications.
- Parents with good health practices make easier transitions to the changes, such as in eating and sleep, needed to support health during pregnancy.
- In early phases of adulthood, women tend to be more fertile and have more physical resources to handle the stress associated with the pregnancy process.
- Complications of pregnancy may affect child development. These complications may include persistent vomiting, vaginal bleeding, toxemia or preeclampsia, and IUGR.
- Several environmental factors may affect pregnancy outcome, including maternal age (mothers under 18 or over 35), multiple births, poor nutrition, illness, drug use, alcohol use, cigarette use, and stress.
- Several tests screen for fetal problems, including ultrasound, alpha-fetoprotein blood screening, amniocentesis, and CVS.
- Birth complications may affect later development.
- Birth complications can necessitate birth by cesarean section.
- A major risk factor for newborns is low birth weight, either from IUGR (prenatal deprivation) or prematurity (birth before 37 weeks).
- Premature babies may face problems with breathing, feeding, and jaundice.
- Birth defects that may affect development include heart defects, neural-tube defects, chromosomal abnormalities, phenylketonuria, and cerebral palsy.

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- Mothers with a fetus who becomes very active at bedtime should place a flashlight under the covers and turn it on.
- A newborn responds to its mother's voice.

Surprisingly enough, recent research indicates that all the preceding statements are true. It was once thought that before birth the fetus could not experience sensation, emotion, learning, personality, or thought. New ways of studying fetal behavior, however, have revolutionized understanding of the prenatal period. Advancements in ultrasound, intrauterine photography, and measurement of fetal movement and heart rate, as well as the survival of infants at earlier and earlier stages of development in neonatal intensive care nurseries, have provided valuable insight into prenatal behavior. Information is gained through ultrasound; by recording changes in fetal movement, heart rate, and breathing motions; and by noting changes in swallowing and sucking behaviors in response to stimulation. Noting the responses of infants as early as 24 weeks' gestation in an NICU has provided information on the behavior of the fetus during the last 16 weeks of intrauterine development.

Because of this new information, psychosocial development is considered to be a continuous process from the 12th week of intrauterine life through the preschool years. And enough research now exists to allow us to look at the unborn child's various responses and capabilities.

There is much evidence that a fetus responds to various types of stimulation. For instance, the fetus has been observed to react to invasive obstetrical procedures. The fetus also responds to light. Shining a bright light on a pregnant woman's abdomen causes an increase in fetal heart rate. In fact, it is now believed that the fetus may see light through the abdomen as a rosy glow. The fetus seems to respond to touch. By the 17th week of gestation, almost all parts of the fetal body will react to being stroked by a hair. Many fetuses will kick back at a spot on a pregnant woman's abdomen when it is pressed.

In addition, babies in the womb show a preference for certain tastes. Fetuses will increase their swallowing of amniotic fluid when drops of a sweet-tasting substance are introduced into the womb, and they will stop swallowing when a bitter substance is introduced (Chamberlain, 1994).

Communication

Much anecdotal evidence suggests that a fetus responds to sound. When a pregnant woman laughs or coughs, fetal movement increases. Many women report that the fetus is startled by noises such as a door slamming. Women at loud concerts or viewing violent movies report increased fetal activity. Researchers have found that fetuses seem to become more active in response to loud rock music, whereas classical music has an apparently calming effect (St. James, 1987). Research has shown that at 26 weeks' **gestation**, a fetus will respond to a sound vibration. After several repeats of the sound stimulus, the fetus will stop responding. This failure to respond after repeated stimulation is evidence of the ability of the fetus to habituate—a form of learning (Morokuma, Doria, Kinukawa, & Fukushima, 2008).

Fetal learning ability is also evidenced by the fact that a newborn responds to the mother's voice over another woman's voice and to music heard in the womb. Newborns not only prefer to hear their native language but their cry melodies vary by their native language (Mampe, Friederici, Christophe, & Wermke, 2009). The fetus hears these familiar sounds, learns to distinguish them from others, and prefers them after birth. In fact, studies by DeCasper and Fifer (1980) found that newborns who in utero had heard their mothers read *The Cat in the Hat* twice a day preferred that story over *The King, the Mice, and the Cheese*, which they had not heard. Infants also communicate their needs in nonverbal ways before resorting to crying (see Exhibit 3.11).

Attitudes, Emotions, and Regulation

The mother's emotional state also seems to affect the fetus. Excessive crying and inconsolability of newborns has been linked to the mother's score on a depression scale during pregnancy (Zuckerman, cited in Chamberlain, 1994).

Colic is a term used to describe an infant with excessive crying, irritability, or fussiness (Roberts, Ostapchuk, & O'Brien, 2004). Colic typically includes prolonged bouts of crying in the late afternoon and evening. It lasts from approximately two weeks to four months of age, peaking around six weeks of age. Physicians have used the "rule of three" to diagnose colic in otherwise healthy and well-nourished babies that crying occurs for more than three hours per day, for more than three days per week, and for more than three weeks. Behaviors associated with colic includes a flushed face, furrowed brow, clenched fists, legs pulled up to the

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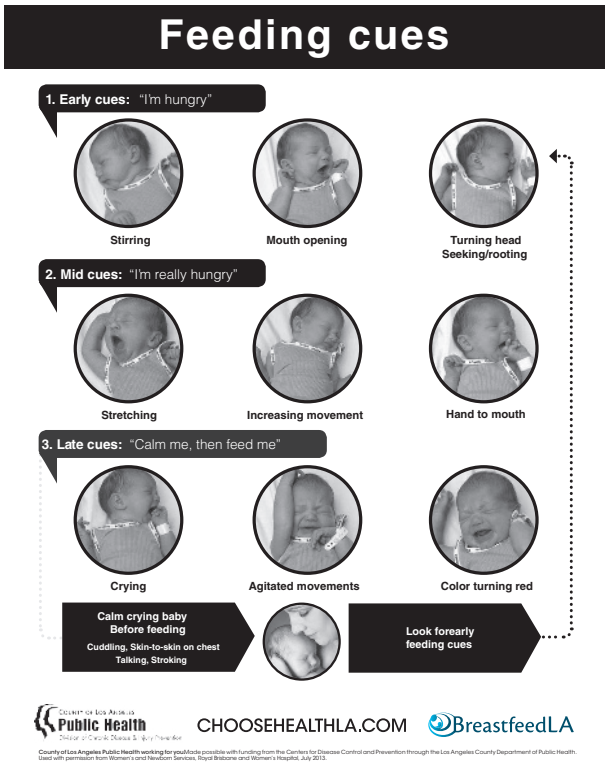
Exhibit 3.11 Infant Feeding Cues



Source: Government of Western Australia

abdomen and piercing, and high-pitched screams that cannot be soothed, even by feeding. Organic causes of colic account for less than 5% of cases (e.g., constipation, lactose intolerance, meningitis, and abuse). Primarily, the causes of colic are gastrointestinal, psychosocial, or neurodevelopmental.

There is no difference in the incidence of colic between breastfed and formula-fed babies. It is recommended that mothers continue to breastfeed if they are breastfeeding, but they may consider eliminating milk products, eggs, wheat, and nuts from their diet and monitor improvement. There is conflicting evidence for using fiber-enriched formula, medications, or car-ride simulators to reduce colic. There is little evidence for long-lasting effects of colic on infant temperament, asthma, or allergic disease or on maternal anxiety or depression. However, colic may be harmful within families where there are poor communication skills.

A small but growing number of parents and mental health professionals now believe that a child's emotional health begins at conception. These parents and professionals believe that meditation and communication with the fetus increase bonding and result in the child's better emotional well-being (Creno, 1994). Some researchers believe that this early attachment may help prevent later child abuse.

Practice Guidelines:
Promoting a Healthy Start

- The practitioner can encourage the parents to talk, play music, read, and sing to their unborn child. Parents may also want to eat a variety of foods. Babies prefer sounds and flavors they were exposed to during pregnancy.
- Attachment and bonding start in pregnancy. Parents who see that the baby will kick back at a spot pressed on the mother's abdomen can experience the fetus as a real, interactive being. These activities can help the parents relate to the baby and increase attachment. Parents who find out they are pregnant late in pregnancy need support in catching up.
- Symptoms of colic may be relieved from eliminating milk products, eggs, wheat, and nuts from the diet of breastfeeding mothers. Fiber-enriched formula does not have any evidence of improving crying over other types of formula.
- Practitioners are advised to look for signs of family distress in families dealing with infant colic. It is recommended that communication skills and coping resources be strengthened within these families.

Newborn States

At birth, a newborn infant is sensitive and responsive. During the first hour after delivery, the baby is usually in a state of quiet alertness and spends most of this time quietly listening and looking around with eyes wide open. A newborn can focus on objects about 8 to 12 inches away—the distance from a mother's arms, cradling the infant against her, to her face. In fact, studies have shown that newborns prefer looking at contrasting, complex patterns with curves—especially faces. Newborns will orient toward a sound, and they prefer high-pitched sounds, such as a female voice. They recognize their mother's voice and prefer it to that of another woman. Newborns can discriminate tastes and prefer

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sweet over salty, acidic, or bitter. A six-day-old baby knows the mother's smell and can distinguish her breast pad from another woman's.

Infants interact with their environment and begin learning from birth, and perhaps even earlier, as we have discussed. Research shows that a fetus is capable of basic types of learning. Infant preferences such as those mentioned above (mother's voice and specific foods) may develop in utero (Azar, 1997; Gross, 2010). In studies, one-day-old infants were trained to turn their heads to the right upon hearing a bell to receive a reward of sugar water. They learned to discriminate the bell from a buzzer and not to turn at the sound of the buzzer. They were then trained to turn for the buzzer and not the bell (Gross, 2010; Klaus & Klaus, 1985). Although researchers do not suggest that parents should begin teaching their babies prenatally (or to train them to respond to bells or buzzers), they do point out the importance of prenatal care for the baby's physical and cognitive developments.

Newborn infants can imitate facial expressions such as sticking out the tongue. They also move in response to speech in a sort of rhythmic dance. The brain cells that are activated in this social exchange are referred to as **mirror neurons**. These neurons respond to actions that we observe in others. Some of the greatest recent advancements in neuroscience has resulted from the discovery of mirror neurons, as we now know that infants are not just imitating, this is early learning. And they are learning much earlier than we thought. Mirror neurons support the development of speech, emotions, and empathy, and abnormalities in mirror neurons has been linked to autism (Acharya & Shukla, 2012).

A newborn infant spends most of their time in one of six states. Ten percent of the time, the infant is in a quiet alert state, listening and looking around, which provides a good opportunity for making eye contact and interacting with them. The infant also may be in an active alert state—moving, looking around, and making small sounds. This state occurs when the infant begins to get hungry or fussy. When really hungry or uncomfortable, the infant enters the crying state—not at all hard to recognize. After feeding and before falling asleep, the infant is in the drowsiness state—relaxed and moving a little, with eyes half-closed and unfocused. Then the newborn has two periods of sleep, which alternate every 30 minutes. In quiet sleep, the baby is relaxed, moves little, and breathes regularly. During active sleep, the baby's eyes move under the eyelids and may even flutter open; the baby moves around, making faces and breathing rapidly. This state of sleep is also referred to as rapid-eye movement (REM)

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From birth, infants learn to mimic facial expressions. This infant is mirroring his father's expression—sticking out his tongue.

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and is comparable to adult REM sleep, in which dreaming occurs, although it is not known whether infants dream.

An infant spends most of their time in sleep states, though sometimes it does not seem that way to tired new parents. Infants also use sleep to control their environment. When overstressed or overstimulated, they cope by going to sleep.

Newborn Reflexes

Babies at birth are equipped with many reflexes and survival skills. When placed face down, they will turn their head to the side or will turn away from something obstructing their breathing. If a scarf is placed over their face, infants will swipe at it with their hands and arms in an effort to remove it. If you touch the side of a baby's face, the baby will turn toward the touch and open their mouth, displaying the rooting reflex. By touching the appropriate side of an infant's face, a breastfeeding mother can get the baby to turn toward her breast and open their mouth in preparation for feeding. Infants also have sucking and swallowing reflexes.

When pricked on the foot, babies will withdraw the limb to avoid the prick. When placed in an upright position with feet touching a hard surface, infants will place one foot in front of the other in a walking pattern. The crawling reflex is similar: When placed on their stomach, infants will push against something placed next to their feet. Babies also have a palmar grasp reflex and so will grasp hold of a finger or an object placed against their palm. When pulled to a sitting position, babies will open their eyes. This is a good way to wake a sleepy baby for a feeding. When startled, babies exhibit the Moro reflex—arching their back, throwing out their arms, and grasping with their fingers. When stroked on the bottom of the foot, babies exhibit the Babinski reflex, fanning out their toes. The tonic neck reflex, or fencing reflex, occurs in the following way. To help prevent the baby's head from falling, babies' neck muscles are linked to the babies' arms. So, when babies turn their head to the side, as happens when they lie on their back, they extend the arm and leg on that side while flexing the arm and leg on the opposite side. If you look closely at babies in this position, you will see that one hand is now directly in their line of sight. In fact, one of the first moving objects babies study closely is their hand. So regardless of the evolutionary significance of this reflex, by turning their head to the side and extending their arm, a baby has something interesting to look at.

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Newborn infants typically have rooting, sucking, and swallowing reflexes that are essential aspects of breastfeeding. This mother is learning how to breastfed her newborn shortly after birth in the hospital.

Assessment Tools: The Brazelton Neonatal Assessment Scale

The **Brazelton Neonatal Assessment Scale (BNAS)** examines newborn's responses to their new environment and can be used with infants up to one month of age. BNAS assesses such items as the newborn's muscle tone and reflexes, as well as response to and control of stimulation (see Exhibit 3.12). For instance, the practitioner pulls the baby to a sitting position and notes whether she holds her head steady or lets it fall back; or the practitioner holds the baby upright on a table to elicit the walking reflex. In another test, the practitioner rings a bell to see whether the baby will turn toward the sound. Then the practitioner rings the bell to see how long it takes the baby to habituate and stop turning toward the bell. In all, the baby is evaluated on 37 behavioral items and 18 neurological reflexes.

The exam is especially helpful in looking at how babies use different responses and states of consciousness to control their reactions to environmental stimulation. A baby who has had too much stimulation may respond by averting their gaze, falling asleep, or crying. The practitioner can help the parents understand their infant by pointing out the baby's needs and preferences in interactions. The practitioner can frame the baby's response in a positive light: "Look at how she is telling you she has had enough; that's amazing." The parents can learn to

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Exhibit 3.12 Brazelton Neonatal Assessment Scale

Items Assessed	Examples	Scoring
Neurological		
Elicited reflexes and movements	Plantar grasp Hand grasp Ankle clonus Babinski Standing Automatic walking Crawling Tonic neck reflex Moro Rooting Sucking Passive movements of both legs and both arms	These neurological items are rated on a three-point scale for low, medium, and high intensity of response; asymmetry and absence are also noted.
Behavioral		
Specific behaviors observed or elicited	Focusing and following an object Reaction to an auditory stimulus Reaction to persons Reaction to a voice Reaction to a person's face and voice	These behavioral items are rated on a nine-point scale. The midpoint of the scale denotes the expected behavior of a three-day-old normal baby.
General behaviors observed	Degree of alertness Motor maturity Cuddliness Consolability with intervention Peak of excitement Irritability Number of startles Self-quieting activity Hand-to-mouth facility Number of smiles	

look for signs that the baby is stressed or that the baby is ready for more interaction, and they can learn to vary the level of stimulation to make the interaction pleasant for both parents and baby.

Implications for Practice:
Using the BNAS

Several studies have highlighted the benefits of using the BNAS with new parents. After participating in the BNAS, mothers of high-risk infants show more responsiveness to their babies (Nugent, 2013). A meta-analysis across 13 studies has shown that use of the assessment increases parents' confidence in their caregiving abilities, increases the effectiveness of parent–child interactions, and increases the parents' understanding of their newborn's behavior (Das Eiden & Reifman, 1996).

The assessment is inexpensive, and parents seem to enjoy participating. Some hospitals use the BNAS as part of their discharge teaching for new parents. It is a good way to introduce new parents to the individuality of their baby and to help them appreciate their newborn as a unique human being with strengths and resources.

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Practice Guidelines:

Responding to Infant Cues

- Demonstrate newborn reflexes with new parents. For the first-time parent, it may appear that babies cannot do much. Showing parents how babies learn and respond to the environment can help increase parent–child engagement.
- Practitioners can use the BNAS to support and enhance parent–infant engagement in the first few weeks of life. The BNAS is useful in helping parents to recognize, understand, and respond to the behavioral cues of their infants.
- The BNAS is effective at promoting bonding and attachment for mothers and fathers. The BNAS can be used in hospital care settings or by home visitors.

Psychological Strengths, Hazards, and Risks

In the past, the hospital routine was to separate mother and infant at birth. During the hospital stay, they were reunited every four hours for a feeding. Then, in 1976, pediatricians John Kennell and Marshall Klaus published a study indicating that mothers who received extra contact with their infants beginning immediately after birth exhibited better mothering skills than did mothers who received the routine hospital mother–infant contact. These pediatricians concluded that human mothers experienced a **sensitive period** just after birth for bonding with their infants in the same way that other species, such as goats, cows, and sheep, do.

Over the years, many articles have been published on the importance of early mother–infant contact. These findings have been important in changing hospital birthing practices to allow more contact between mothers and babies. In most hospitals now, healthy, full-term infants are handed to their mothers at birth for skin-to-skin contact. Face-to-face contact and breastfeeding are encouraged immediately after delivery. Many clinicians involve new parents in newborn examinations such as the BNAS in an effort to enhance parent–child interactions by introducing the parents to their baby's characteristics. Nurses in the NICU are trained to encourage interactions with premature and sick infants and their families. Some believe that early bonding can reduce child abuse and neglect.

These ideas of early contact helped change the way women give birth, but have these ideas set up unrealistic expectations for new families? What implications does this bonding issue have for the woman who has an emergency c-section and is not conscious immediately after birth? Or for the woman who lives in a remote area of a Native American reservation and has no transportation to go to the NICU for regular visits with her infant? Or for the woman who adopts a much-wanted infant when the baby is several months old?

Some practitioners now believe that the importance of early bonding should not be overemphasized to the exclusion of other social and emotional factors that can affect the mother–infant relationship (Bennington, 2010). In some cultures, other female family members assume the major care of the newborn while the new mother recovers from giving birth. In some Native American/Alaska Native and Hispanic cultures, women do not attempt breastfeeding for the first two to three days' postpartum, until their mature breast milk "comes in." And, for cultural reasons, some mothers may not engage in extended eye contact with their newborns.

Forming an attachment is an ongoing process; the immediate postpartum period is not the only opportunity for establishing lifelong ties. Mothers of premature infants or adopted babies can and do love and care for their infants. And although evidence exists that early interventions such as introducing the baby to the mother by doing the BNAS improves subsequent mother–infant interactions, this immediate postpartum period does not represent the only opportunity to enhance family relationships. Also, early bonding is not the magical answer to child abuse and neglect. Bonding should not be overemphasized at the cost of dealing with the complex social and emotional problems of the family, such as poverty and social isolation (Eyer, 1994, p. 90).

Following the birth of their child, 15 to 20% of women will experience debilitating symptoms of anxiety, insomnia, anorexic behavior, feelings of inadequacy and worthlessness, guilt, emotional disconnect from their child, and difficulty with self-care. Mothers who feel like this may be experiencing postpartum depression (PPD) or postpartum anxiety (PPA). PPD and PPA are not just bad days, or experiencing symptoms such as the following some of the times, women with PPD or PPA have symptoms such as these most of the time and for a period of at least two weeks.

PPD can have impact on the newborn infant as well. Studies show that infants of depressed mothers have

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increased heart rates, decreased muscle tone, and more sleeping and eating disturbances than infants of nondepressed mothers (Leonard, 1998).

Implications for Practice:

Babywearing as a Therapeutic Intervention for Postpartum Depression and Perinatal Mood and Anxiety Disorders

Babywearing refers to the practice of holding or wearing a baby in body-to-body contact through the use of a sling or in another form of carrier, and has been practiced for centuries around the world. The practice of babywearing supports parents and caregivers in a variety of ways including a significant reduction in infant crying, increased parent-infant bonding, breastfeeding rates, the ability to attend to the needs of siblings or daily tasks while safely holding their baby, increased confidence in their own ability to care for their baby, and in circumstances such as caring for a special needs infant, and it can help parents cope with the associated stress of caring for their child (Anisfeld et al., 1990; Piscane et al., 2012; Williams & Turner, 2020a, 2020b).

As many as 15 to 20% of parents (including mothers, fathers, and adoptive parents) may experience a perinatal mood or anxiety disorder (PMAD) during the first year of an infant's life (in some cases even before birth during the third trimester of pregnancy; Brett, Barfield, & Williams, 2008). It is important to note that while PPD is one of the more commonly known disorders, symptoms of PMAD may extend beyond depression and can include feelings of anger, fear, anxiety, distraction, forgetfulness, irrational thoughts, a traumatic childbirth experience, a significant medical diagnosis, or NICU admission for their newborn. Babywearing would be an effective recommendation by healthcare providers and counselors that have identified a client(s) at risk for, or currently experiencing, symptoms of PPD and/or PMAD. Many parents experiencing PPD or PMAD who engage in the practice of babywearing express feelings of closeness and responsiveness to their child that might otherwise be missed or neglected due to their disconnected or depressive symptoms. It has been empirically documented that infants benefit from the practice of "skin-to-skin" care and/or Kangaroo Care; babywearing is an ideal means to foster the benefits of human touch between infant and parent while still allowing freedom to move about and have their hands free. Parents are able to easily accomplish daily tasks such as housework, errands, or walks outside while safely wearing their baby, decreasing feelings of being overwhelmed or isolated while caring for their child.

Babywearing as a therapeutic intervention and/or a compliment to therapy has a strong propensity to be beneficial to both parents/caregivers and their children. Raising awareness of the benefits of babywearing in the field of health care and social work is significant as those providers will be the most likely to promote or suggest babywearing to parents or caregivers having difficulties in caring for, or bonding with, their child as a result of PPD and/or PMAD symptoms.

Changes in the NICU

NICUs now allow more parent–infant interaction. During the COVID-19 pandemic, many NICUs restricted visitation to only one parent at a time. However, NICU staff are encouraged to promote parental involvement in the baby's care and to utilize volunteers (i.e., cuddlers) to hold or babywear infants when the parent is not available. The importance of human touch is increasingly being recognized as important to their medical well-being as well as their long-term psychological and social development (e.g., improves the baby's temperature regulation, heart rate, breathing patterns, weight gain and growth, behavioral states, emotional states, interactions with parents and secure attachment). The baby can often be in skin-to-skin contact with the parent's chest while receiving NICU care.

A concept for reducing the high levels of stress and stimulation in preterm infant care is individualized developmental care (Als et al., 1994). In this approach, nurses are specially trained to recognize signs of stress (changes in skin color, pauses in breathing, finger splaying, arching, averting gaze) in premature babies and to help the infant with self-calming techniques. For instance, babies are placed in a flexed position for sleep to promote restfulness, and they are comforted before and after taxing or painful procedures. Babies should be allowed to sleep, wake, and feed on their own individual schedules. The neonatal unit should also be kept relatively dark and quiet. New technology can help facilitate this. For example, Sonicu uses digital sensors to measure sound pressure to give real-time feedback (i.e., a light indicator) when the sound levels are too high. NICUs using this technology report improved patient outcomes as well as a more positive and calmer working environment. Special equipment, such as a hammock, a soft nipple on a terrycloth strip, and terrycloth bunting, are also used to help soothe the infant. Researchers find that these measures result in calmer infants with better medical and developmental outcomes than routine care.

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Focus on **The Lived Experience**

Babywearing

I had a predicament. I was expecting my fourth child and my husband accepted a 12-month assignment as a military contractor overseas. I would be left with the task of caring for my four children on my own: a newborn, a two-year-old, a 10-year-old, and an 11-year-old. While the older children could certainly take care of many of their needs, they did have school, daily activities, sports, etc. that they participated in. My greatest difficulty would be managing a household on my own, while meeting the unique needs of a baby and a toddler, along with my older children and their activities. My solution: babywearing.

I had discovered babywearing when my oldest was born through my readings from Dr. Sears and his philosophies on attachment parenting. What I didn't know at the time was that this simple parenting tool would benefit three more children and would carry me through years of meeting my children's needs through touch and connection. Although I had experience in wearing my children as infants, I came to value the practice with a newfound appreciation with my fourth child.

My situation of "single parenting" while my husband was deployed made babywearing not just a helpful tool, but a necessity. In addition to the many benefits that babywearing provides for a parent/child dyad (reduced crying, healthier and more content babies, confident parents, etc.), I found it to be a critical component in daily life. I was able to breastfeed my infant while wearing him in a baby carrier and prepare a snack for my toddler. Babywearing allowed me to safely hold the baby while simultaneously giving my toddler a bath. Making a trip to the grocery store was easily accomplished with the baby in a baby carrier and my toddler also worn in a carrier on my back, or riding in the shopping cart—no strollers to push or car seat to lug around while also trying to keep my toddler nearby and safe. When it came time to attend school plays or sporting events, my baby was able to sleep contently on me while in the carrier. I was able to get myself and all four of my children through everyday life on my own with reduced stress and minimal difficulty.

At times, I found the tasks of caring for four children and a household on my own to be isolating and overwhelming. Babywearing allowed me to have more freedom to easily leave the house with all of my children. It allowed me to meet my infant's needs while providing self-care for myself. Many caregivers in this type of situation will experience being "touched out"—the daily physical and emotional demands of caring for young children that leaves one with the feeling of not wanting to be touched any more. When I reached this point at any given time, babywearing actually helped alleviate these feelings. It was a calming ritual for both me and the child I was wearing. It served as a "reset" button and helped me cope with my distress in a healthy way for both me and my children.

—By Candace Treiber, Salt Lake City, Utah

Practice Guidelines:

Helping Babies in the NICU

- Advocate for more parent–infant interaction while in hospital care. Particularly if the infant is in the NICU, encourage staff to promote parental involvement in the baby's care.
- Kangaroo Care is particularly beneficial to premature infants. Instead of spending most of the time in an isolette, the baby lies in skin-to-skin contact with the mother's or father's chest while receiving NICU care. Kangaroo Care improves the baby's temperature regulation, heart rate, breathing patterns, weight gain and growth, behavioral states, emotional states, and interactions with parents.
- Advocate for babywearing in the NICU, particularly for instances where skin-to-skin contact is not possible. In some hospitals, nurses (or volunteers) are able to babywear while charting and when the parent is not available or needs a break (Williams et al., 2021).
- Advocate for changes in NICUs that reduce stress and stimulation (e.g., more individual beds rather that large rooms with multiple isolettes, light sensors).

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Study Table Psychological Dimension in Pregnancy, Birth, and the Newborn

Cognitive Development and Information Processing

- Research indicates that the fetus responds to stimulation.
- The fetus can see, hear, taste, and respond to touch.

Communication

- Newborns recognize their mother's voice, indicating fetal learning in utero.

Attitudes and Emotions

- A woman's emotional state affects the fetus.
- A child's emotional health begins at conception and that prenatal experiences affect emotional development.

Social Cognition and Regulation

- Newborns interact with, and respond to, their environment.
- They recognize their mother's voice and her smell. They imitate facial expressions, and they can learn.
- Newborns experience several states, ranging from quiet alertness to fussiness to sleep.
- Babies are born with innate critical reflexes.
- The Brazelton Neonatal Assessment Scale measures a baby's responses to stimuli and ability to regulate those responses.

Psychological Strengths, Hazards, and Risks

- Attachment and bonding are an ongoing process.
- Parent-infant interaction and developmental care procedures are now encouraged in hospital settings.

Social Dimension

Groups, Families, Communities, and Support Systems

Each child is born into a family environment. What effect does that environment have on development? What is necessary for optimal development? Research by Bradley (1987) indicated that stimulation and support are the most important requirements in the home. New babies need parents who respond to them and talk to them. They need a structured, safe home with stimulating play and interesting toys. And new babies especially need a small group of adults who are warm and nurturing and eager to meet the infants' needs. (The next chapter will explore infants and families in more detail.)

Prenatal Intervention Programs: Every Birth a Healthy One

Adequate prenatal care is vital in ensuring the best pregnancy outcome. Yet in many poor communities, access to health care is still a problem (Rosenthal, Brownstein, Rush, Hirsch, & Willaert, 2010). Barriers to health care in poor neighborhoods include the large number of pregnant adolescents, the high number of non-English-speaking clients, and the prevalence of inadequate literacy skills. In addition, cultural ideas about healthcare practices may be hard to overcome so that even when health care is available, pregnant women may not understand the need for early and regular prenatal care.

How, then, do we encourage pregnant women to seek care? One answer is to set up programs that use Indigenous layworkers to recruit pregnant women into prenatal care. The idea behind such programs is that community members can have more influence on the health practices of their neighbors than can a healthcare professional. An example of this type of prenatal outreach program is Woman to Woman, in Tucson, Arizona. This program uses trained lay healthcare workers in disadvantaged neighborhoods to locate and educate expectant mothers. These layworkers, or *promotoras*, are volunteers who receive 40 hours of training. Outreach workers recruit clients in the community. After a woman is enrolled in the program, other workers visit her in her home to offer emotional support; help her get to medical and agency appointments; offer prenatal education and information; help her make contact with community resources; and help her obtain services and information on problem-solving skills. Ideally, outreach workers in these programs can overcome some of the barriers to prenatal care in poor communities and help get better care for their neighbors.

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Postpartum Early Intervention Programs

Many new families may be facing less-than-ideal conditions, and few programs exist to help them. After an uncomplicated vaginal birth, if the mother isn't bleeding and the baby is stable, both are discharged from the hospital to home within 24 and 48 hours of giving birth, whether or not they actually have a home. These new families might be dealing with problems such as being unhoused, intimate partner violence, stress, poverty, and unemployment. A two-day hospital stay does not allow much time to deal with these problems and, unfortunately, taking a baby home to such an environment increases the risk of abuse and neglect (Grietens, Geeraert, & Hellinckx, 2004).

Some researchers believe that early intervention programs that include home visitation can greatly benefit new families at risk for abuse and neglect. Evidence suggests that these programs improve poor children's cognitive development and school performance and reduce the incidence of delinquent behavior and conduct disorder (Frerrer-Wreder, Stattin, Lorente, Tubman, & Adamson, 2004).

An example of a program that includes home visitation is Healthy Families Arizona (LeCroy & Davis, 2017). The Arizona program is a volunteer program that screens families at the time of an infant's birth for risk factors that can cause high stress levels. Families at risk for abuse and neglect are then visited weekly by paraprofessional workers. The workers attempt to reduce each family's stress level by providing support, assisting parents in identifying needs and solving problems, and coordinating with community services appropriate to the family's needs. Practical assistance is provided for obtaining food, housing, diapers, utilities, childcare, and transportation.

The workers also seek to strengthen family functioning. They provide information and activities designed to improve the parent–child relationship and enhance parents' understanding of child development and appropriate discipline techniques. The worker encourages parents to provide the child with adequate nurturance and stimulation and helps parents find appropriate toys and other play materials.

The family support worker assists parents in developing social supports, managing stress and anger, and developing skills to avoid and resolve crises. The worker maintains contact with the family until the target child is five years old and ready to attend school. Other interventions address specific target groups with high-risk characteristics, such as adolescent mothers.

Practice Guidelines:

Early Intervention

- Help to ensure a safe and stimulating home for the newborns to return to at the end of their hospital stay. Stimulation and support are the most important requirements in the home. Encourage parents to talk to their baby. Parents may be more responsive to their baby's needs through babywearing.
- Train lay healthcare workers in disadvantaged neighborhoods to locate and educate expectant mothers. These workers can help educate mothers, and also mothers develop support networks and access formal services.
- Home visitation programs are effective at reducing the incidence of child abuse and neglect. Assessment tools are readily available to identify the risk level of an infant.

Multicultural, Gender, and Spiritual Considerations

Up to this point, we have looked thoroughly at the biological birth of the infant. But many cultures include another aspect of birth—the social birth of the child as a new member of the community. In fact, many cultural and ethnic groups have specific rites or ceremonies that welcome the child into the group. For instance, in many cultures, during a special ceremony, someone other than the parents receives the child into the society and expresses the desire to help raise him or her. In some cultures, godparents accept responsibility for the child. During a baptismal ceremony, an entire church congregation welcomes the child and vows to oversee the teaching and nurturing of the infant. In some cultures, circumcision is used as a birth ceremony. Removal of the foreskin of the penis is a symbolic act that establishes the child as a member of a particular culture or religion. Other cultures may have naming ceremonies to welcome the child into the community. In some Native American/Alaska Native naming ceremonies, the new infant is held up to the rising sun,

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as described in the following passage by Byrd Baylor (1977/1978):

And high on a mesa edge in Arizona they were holding a baby toward the sun. They were speaking the child's new name so the sun would hear and know that child. It had to be sunrise. And it had to be that first sudden moment. That's when all the power of life is in the sky. (p. 8)

Mika's Head-Shaving Ceremony

On the eve of her first birthday, we left our family home in Chennai at 4:30 in the morning to drive to a little village temple an hour or two outside of Pondicherry in the middle of paddy and coconut trees. This is the temple that has been the place of worship of Santoash's family for generations, and for generations, the babies of the family are brought here for their tonsure (head-shaving) and ear piercing around their first, third, fifth, or seventh birthday. The entire extended family on Santoash's dad's side came to bear witness and celebrate with us.

We were nervous—I had images of her crying and thrashing about as the barber held a straight blade to her scalp. But thanks to babywearing (and her being allowed to play with the forbidden phone), she was perfectly content wrapped on her nana and was all smiles the whole time. The barber was shocked—he never had an infant tonsure without tears. Afterwards, once she was bathed, she fell asleep wrapped on me and took a nap while we continued with the ceremony.

Andalusian Amethyst is the name of the wrap we chose for the head-shaving. It will always remind me of this sacred moment in time where our baby experienced her first tonsure, surrounded by her Indian family, in the middle of the paddy fields.

Infant Mortality: The African American–White Disparity

Although medical advances have reduced the overall infant mortality rate in the United States, the current rate is still higher than that in many other developed nations; 5.4 out of every 1,000 babies died at birth or in the first year of life in the United States in 2020, which was triple the rate of Japan or Norway. The primary reason is the high rate of low-birth-weight babies and preterm births and the powerful economic and racial disparities that exist in the United States. Stress is associated with preterm birth, and women in underserved communities are subjected to daily stress in their communities. Black women had the highest infant mortality rate at 10.6 per 1,000 births. What factors are causing this alarming disparity? Within the United States, obesity, poor access to health care, and teen birth rates are all high in the states with the highest infant mortality rates.

Interestingly, several studies have found that the Hispanic infant mortality rate is as low as or, in some instances, lower than Caucasian infant mortality, even though Hispanics tend to have a lower SES, have less education, and encounter language and cultural barriers that make them three times less likely to receive prenatal care than non-Hispanics. Referred to as the **Hispanic Mortality Paradox** (i.e., a longer life expectancy at birth and better health outcomes than similar socioeconomic groups) and the **Latina Birth Outcomes Paradox** (i.e., birth outcomes similar to those of women with higher socioeconomic status and access to health services; Velasco-Mondragon et al., 2016). So even though some Hispanic women have to deal with poverty and lack of prenatal care, their infant mortality rate is significantly lower than that of African American women. Why?

Mika's *tonsure*, or head-shaving ceremony.

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It has been suggested that Hispanic women have favorable birth weight distributions in part because of their low rates of smoking and drinking and their strong familial, cultural, and social ties (Rogers, 1989). In other words, Hispanic women have a strong social support network, which seems to mediate the effects of poverty and lack of prenatal care (Mason, 1991). If socioeconomic factors and lack of prenatal care fail to account for the infant mortality disparity, what, then, is the cause?

More than 90% of the excess risk of low birth weight among African American infants is related to the mothers' increased risk for high blood pressure, placental problems, or premature labor (Davidson, 1992). These factors can all be seen as related to maternal health and behavioral practices that can be affected by stress, and this increased stress can lead to poor health through using substances to cope and failing to obtain adequate health care. Further, Black mothers may be harmed by service providers that have a lack of cultural understanding and negative stereotypes (Parker, 2021).

To reduce the infant mortality of African American infants, the United States may need to focus more on social problems than medical ones. This implies taking measures to disrupt institutional racism, including reframing the narrative around Black maternal mental health and supports for mental health and build upon the strengths of Black mothers (Parker, 2021).

Circumcision

Circumcision of newborn males is a controversial issue. The American Academy of Pediatrics (AAP) states that circumcision has potential medical benefits and advantages, as well as risks. Evaluation of the evidence from 1995 through 2010 indicates that the health benefits outweigh the risks of the procedure (e.g., prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections including HIV). Currently, routine or universal circumcision is not recommended because the procedure is not essential to a child's well-being and many of the risks of not being circumcised are avoidable with proper care of the penis. Circumcision does not affect fertility nor is there evidence to support that it enhances or detracts from sexual pleasure for men or their partners. The decision to circumcise is best made by parents together with their healthcare professional, taking into account medical, religious, cultural, and ethnic traditions. The procedure is well tolerated by newborns when performed by trained professionals with appropriate pain management (American Academy of Pediatrics, 2012).

Practice Guidelines:

Providing Support to Families of Newborns

- Work to increase the social support system of pregnant women, particularly those that may be at highest risk for infant mortality.
- Help women to self-identify environmental stressors in their lives and enhance their coping skills to eliminate or challenge these stressors.
- Advocate to reduce institutional racism. Inform parents about the risks and benefits associated with circumcision. If parents wish for their newborn to be circumcised, help ensure that they have access to this procedure, without judgment.

Social Strengths, Hazards, and Risks

In this chapter, we have focused mainly on the biological risk factors that can affect prenatal and perinatal development: gestational age, prenatal environment, genetic anomalies, and so on. Throughout the discussion, though, you may have noticed a strong undercurrent of associated risk—the social factors that can have a negative effect on developmental outcomes. Social risk factors include unemployment, lack of maternal education, parental mental illness, a large family, an absent father, an adverse neighborhood, economic recession, institutional racism, and inadequate healthcare systems (Nair & Radhakrishnan, 2004). Many of these risk factors have a common denominator: poverty.

Children born into poverty have an increased risk of health and developmental problems (Nair & Radhakrishnan, 2004). Poverty is a factor in lack of prenatal care, low birth weight, prematurity, and poor maternal health habits. In particular, low income is strongly associated with child maltreatment (McGuinness & Schneider, 2007), and children who are abused and neglected have a higher risk of developmental problems (Goldson, 1991). Of course, this does not mean that poor families love their children any less than affluent families do. The high levels of environmental stress associated with poverty can inhibit good parenting and prevent parents from providing a stimulating and nurturing environment (Bradley et al., 1994). In later chapters, we will continue to explore the effects of poverty on development.

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The Social Vulnerability Index (SVI) is used as a way of examining the impact of social determinants of health at a county level. When a public emergency happens, such as the COVID-19 pandemic, socially vulnerable people are at greater risk of experiencing poor health outcomes. The same factors in this index, also contribute to poor maternal and infant health outcomes, including inadequate access to maternity care. Fifteen social factors were derived from the American Community Survey (ACS) 2014–2018, and were categorized into four areas: socioeconomic (e.g., poverty, unemployment, income, level of high school completion), household composition and disability, minority status and language, housing type and transportation (e.g., crowding, group quarters, no vehicle).

Intimate Partner Violence

Teri arrived in the hospital in premature labor brought on by cocaine use. Teri is 33 weeks pregnant and has had no prenatal care. After further questioning by the social worker, Teri disclosed that, although she has been abusing cocaine during the pregnancy, her contractions started shortly after her husband shoved her against the refrigerator. She claims that he often becomes violent after drinking and sometimes pushes or shoves her. Teri and her husband live in the desert in a pop-up trailer with no heat, no running water, and no indoor toilet. They have no car. Teri's husband makes it to his $6-an-hour job during the week and often helps at night with the kids. But after work on Fridays, he starts drinking and by the end of the weekend usually ends up pushing Teri around some. Teri copes by using cocaine.

Intimate partner violence (IPV) is a risk factor for a pregnant woman and her fetus. For many women, violence starts or becomes worse during pregnancy. The transition to parenthood can be a time marked by excitement and anticipation but can also be a period of heightened couple distress (Petch, Halford, Creedy, & Gamble, 2012). Studies indicate that up to one in four women are physically abused at some point during pregnancy. This abuse increases the risk of miscarriage, preterm labor, and low birth weight (Shah & Shah, 2010). Rates of IPV

Focus on **The Lived Experience**

Cultural Differences of Newborns

How much of the cultural difference in temperament is learned, and how much is inherited? Daniel Freedman tested infants from different cultures on their "defense reaction," measured by the following:

- The babies' reaction to a cloth pressed over their noses
- How quickly the babies stopped crying when picked up
- How long it took the babies to adapt to a light shined in their eyes
- How they reacted to a sudden loss of support of the head and neck

In response to the cloth pressed over their noses, the white and African American babies fought the cloth by turning away and swiping at the cloth with their hands. In contrast, Chinese and Navajo babies did not try to remove the cloth, but lay on their backs and breathed through their mouths. Also, crying Chinese and Navajo babies quieted immediately upon being picked up, whereas white babies cried for longer periods. Puerto Rican babies were also easier to console and were less likely to be startled in response to stress than white and African American babies. In response to the light shined in their eyes, white babies took longer to adapt than Chinese babies. In response to having head and neck support withdrawn, white babies became agitated and began crying, whereas Navajo babies remained calm and unconcerned.

Freedman concluded that what we consider cultural conditioning may in fact have a biological basis. Take, for example, the use of the cradleboard by Navajo mothers. Navajo babies are generally introduced to the cradleboard in the first month of life, but it is not forced on them—if the baby starts to fuss, he is released. However, most Navajo babies accept the cradleboard and do not begin protesting until after they are six months old, and most give up the cradleboard by the time they are one year old. In contrast, a study by Chisholm of Caucasian infants raised on cradleboards found that these babies fussed and protested more than the Navajo infants. All the Caucasian babies were completely off the board before they were six months old. Although we have assumed that Asian and Native American/Alaska Native mothers conditioned their children to be quiet and compliant, these children may actually have just been born that way.

—Adapted from Freedman & DeBoer (1979)

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increased during the COVID-19 pandemic among marginalized groups, including pregnant women (Peitzmeier et al., 2021). In addition to the social isolation caused by the pandemic, women who are being abused experience greater social isolation, and therefore have less access to prenatal care. In addition, because of the increased stress experienced in a violent relationship, there is a higher incidence of poor health habits, such as cigarette, drug, and alcohol use, all of which can have adverse effects on a developing fetus.

Women do not usually volunteer information about abuse; they need to be asked. During the interview, the woman should be separated from her partner. A woman is more likely to disclose abuse to the practitioner offering empathy, help, and support. With a hesitant client, the interviewer should use open-ended questions, such as, "When I see injuries like yours, often it is because someone has done it on purpose. I'm wondering if that's what happened to you."

The home situation also needs to be assessed. What is the level of violence? Are there any weapons in the home? Is the woman afraid of her partner? Is she afraid for her children? What previous experiences has she had with the police and courts?

The woman needs to develop a safety plan. Whom can she call? Where can she go? Can she put some money away? Does she have copies of identification for herself and her children (e.g., birth certificates, Social Security cards, legal documents)? Information about shelters and emergency housing, as well as referrals to legal and medical care and to counseling and support groups are needed. Most of all, the pregnant woman needs to be reassured that no one deserves to be hurt by someone she loves.

Study Table Social Dimension in Pregnancy, Birth, and the Newborn

Groups, Families, Communities, and Support Systems

- Babies need adequate stimulation and loving, caring adults in a safe home with opportunities for stimulating play.
- Indigenous workers can be helpful in recruiting women into prenatal care.
- Home visitation programs often work with women on prenatal care and provide support and guidance after the baby is born.

Multicultural, Gender, and Spiritual Considerations

- Many societies and cultures have rituals that welcome the baby as a new member.
- The mortality rate in the United States, and particularly for African Americans, remains quite high.
- Infant mortality is influenced by environmental stress.
- The majority of male infants in this country are circumcised at birth but it is no longer routinely done.

Social Strengths, Hazards, and Risks

- Mothers with good support systems are less likely to have birth complications.
- Prevention programs in low-income areas are effective at preventing prenatal difficulties.
- Drug-exposed infants are disorganized and may have a low sensory threshold. They are difficult to care for and may be at risk of abuse and neglect. Parents who continue to abuse drugs and alcohol after the baby's birth may not provide an adequate environment for development.
- Poverty is a risk factor for poor infant development.

Summary

In this chapter, we examined prenatal and perinatal factors that can affect lifelong development of an individual. Complications of pregnancy and birth, hazards in the prenatal environment, maternal habits, prematurity, genetic abnormalities, and social influences are all risk factors for developmental problems. An adequate assessment of prenatal and perinatal risk factors may sometimes provide a clue to possible contributions to an individual's problem.

Prevention is crucial. Early prenatal care, identification and treatment of substance abuse, parent education, promotion of good health practices, and

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adequate social support can go a long way in optimizing development.

For high-risk infants and families, early intervention programs that are "intensive, comprehensive, well integrated into other community services and flexible in responding to a family's unique needs produce the most consistent and impressive outcomes" (Daro, 1991).

Given all the hazards and complications, and all that can possibly go wrong, the birth of a healthy infant truly is a miracle.

Applying the Framework

The Family of a Premature Infant*

Jessica and Travis asked to see the hospital social worker to discuss their concerns about their two-week-old infant, who was in the hospital NICU. The baby had been born nine weeks premature. The couple was displaying some fear and apprehension in interacting with their baby during his stay in the NICU. They were apprehensive about their ability to parent their infant and worried about how they would ever be able to care for the baby on their own at home. They also were concerned about future developmental problems for their child.

Developmental History

Travis and Jessica had been attempting to have a baby for several years. Two previous pregnancies had ended in miscarriage. Fifteen months after her last miscarriage, Jessica became pregnant for the third time. She did not use alcohol or drugs during the pregnancy, but she did continue to smoke. After learning she was pregnant, though, she had managed to cut down to four or five cigarettes per day. Preterm labor began for Jessica in week 26 of her pregnancy, and she was placed on bed rest and medications at home to stop her labor. Several weeks later, her cervix started to dilate, and she was hospitalized in the high-risk obstetrics unit for the duration of the pregnancy. Eric was born at 31 weeks' gestation and weighed 1,134 grams (2 lbs 8 oz). The Apgar scores were 6 at one minute and 7 at five minutes. Immediately after birth, Eric began to experience respiratory distress. After a brief viewing by his parents, he was transferred to the NICU.

Biophysical Considerations

On admission to NICU, Eric was placed under an oxygen hood. He required cardiac and respiratory monitoring. Because he was too small to maintain his own body temperature, he was placed in an incubator. He required intravenous lines for maintaining fluids and administering medications. Eric's very low birth weight and gestational age placed him at potential risk for continued respiratory difficulty, anemia, infection, intraventricular hemorrhage, jaundice, and retinopathy of prematurity.

Fortunately, Eric's condition improved quickly. His lungs were mature enough for his need for supplemental oxygen to end when he was removed from the oxygen hood three days after birth. He then developed jaundice (hyperbilirubinemia), which was successfully treated with phototherapy (being placed under lights). Because he was born before his sucking reflex was well established, he required oral gavage feedings. Eight days after birth, he was transferred to the area of the NICU for "growing preemies," where he would remain until he had developed coordination to nipple- or breastfeed and had gained enough weight for discharge home.

Psychological Considerations

Jessica and Travis reported that, on entering the NICU for the first time, they found themselves totally unprepared for the sight of their baby. Alongside the machines and other technology, he appeared weak and vulnerable. Travis described his thoughts on that day: "We had lost control of the situation and felt completely intimidated. There were machines everywhere, and he just looked so small." Travis and Jessica began to worry about possible complications for their baby. As do many families faced with high-risk perinatal situations, Jessica and Travis became focused on possible medical outcomes instead of on their new baby.

Worry and uncertainty over their child's fate began to interfere with parental attachment and bonding. Jessica and Travis found it difficult to bond with a baby they feared

*The cases in this book are loosely based on several actual cases. Names and other identifying details included in the cases in this book are fictitious.

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might die or be severely handicapped. Jessica described her bonding process with Eric as a roller-coaster ride. "I loved him, but it felt like a risk."

Jessica felt that she did not know her infant—that she had lost control of the baby to the NICU staff. She felt inadequate and incompetent in her ability to care for her very ill child. Jessica remembered those early moments following Eric's birth. "He was taken away so quickly, and we had no idea where they were taking him. I looked at Travis and started crying. It wasn't what we expected." Just minutes after finally becoming a new mother, Jessica had relinquished her role of primary caregiver to the nurses and medical staff. This feeling was further reinforced when Jessica attempted to hold her baby. He slept most of the time, and when he was awake he was irritable. When Jessica held him, he would cry, put up his hands, and turn away from her. Jessica felt that the baby was rejecting her.

Social Considerations

Family Situation

Jessica and Travis were in their mid-20s and had been married for six years. Travis worked as a manager in a supermarket. Jessica worked as a medical transcriber in a hospital. They recently had purchased their first home. Jessica had planned to take three months off from work to care for her new baby, but because she was on bed rest for five weeks before the birth and had been visiting her baby in NICU daily since his birth, Jessica already had used up half of her maternity leave. She was afraid of losing her job, but she did not see how she could return to work full time with such a small baby to care for. Yet the couple did not believe they could make their mortgage payments on just Travis's salary. They had little savings. There was a possibility that Jessica could work part-time and perhaps do some transcription at home.

Jessica's parents lived in town, and she reported having a warm and close relationship with them. Her mother had expressed a desire to help with the baby's care, but because of back problems her participation would be limited. But her mother stated she might be able to come and watch the baby while Jessica worked at home.

Groups, Communities, and Social Support Systems

Travis and Jessica attended a Methodist church in their neighborhood. Many church friends and neighbors had offered support and prepared meals for them throughout the past six weeks. Jessica's friends from work had also helped out by throwing a baby shower a few days after the baby's birth and providing her with needed baby items.

The community in which the couple lived provided an early intervention program for low-birth-weight babies. The program offered weekly in-home visits, as well as regular developmental follow-up in a clinic.

Summary and Impressions

The assessment showed that this family had the following problems:

1. Low-birth-weight infant because of prematurity
2. Medical complications of hyperbilirubinemia and respiratory distress with need for supplemental oxygen
3. Problems with parent–infant interactions
4. Unknown long-term prognosis for the infant
5. Family financial problems

Looking at the couple's strengths and resources showed that they had a stable home life with an adequate environment for a low-birth-weight baby. They had family and friends who were supportive and caring. The parents were interested in, and willing to be involved in, learning to care for and interact with their infant. The hospital staff was very supportive of the new parents and willing to be involved in enhancing positive parent–infant interactions. The community provided an early intervention program for parents of low-birth-weight infants.

After meeting with the social worker, Jessica spent time every day with Eric, initially just observing others caring for him. His primary nurse explained his capacity for interaction, "time-out" signals, proper handling, and positioning. The nurse showed Jessica how to swaddle Eric and hold him quietly for a feeding. She taught Jessica to wait until the baby began to look around searchingly before trying to make eye contact and talk to him. The nurse explained that when Eric held up his hand and spread his fingers, he was signaling that he was tired and needed some time alone. Given information and support from the nurses and from the social worker, Jessica was able to interact positively with her infant.

As time went by, both parents learned about and participated in Eric's care. Their involvement helped establish and enhance their bond to the baby. They kept a calendar

Continued

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The Family of a Premature Infant (continued)

of events and took photos of Eric's days in the NICU—the transition from incubator to open crib, first tub bath, and first attempts at feeding. Thus, they were able to share their tiny son's struggles and accomplishments with friends and family.

After five weeks in the hospital, Eric weighed 1,843 grams (4 lbs 1 oz), was breastfeeding well, and was ready to go home. Jessica and Travis were ready to accept the responsibility for him at home, but the excitement of discharge was still tempered with apprehension about the transition. The long-term effects of the baby's prematurity were still unknown. And though they were now independent in their caring for Eric, they still felt "dependent on the NICU staff for backup." They admitted to still feeling a bit incompetent and unsure of their ability to adequately care for their small son. Travis recalls that "leaving the hospital was almost as stressful as being there, but we were glad to be taking our baby home. Finally!"

Cathy Jaworski, R.N., provided information for this case.

Four Ps' Formulation for Integration of the Data

Practice Exercise:

Fill in each of the four Ps for the case that apply the biopsychosocial framework for this chapter.

Use the results of the four Ps' formulation to:

1. Identify relevant problems, diagnoses, or other relevant judgments about the case described in the Applying the Framework section of the chapter.
2. Describe an appropriate biopsychosocial intervention based on the findings in your four Ps' formulation of the case.
3. Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial integrative data that you identified in your formulation of the four Ps
4. Describe how you would evaluate your invention based on the data captured in your four Ps' assessment.

	Biological	**Psychological**	**Social**
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

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Reviewing Your Competencies

You should be able to:

1. Critically evaluate ethical dilemmas faced by parents in learning they are pregnant.
2. Identify the biological hazards, risks, and complications of pregnancy.
3. Describe relevant environmental effects on prenatal development, Iing parent nutrition, substance use, and emotional states.
4. Describe the challenges associated with newborns (e.g., premature birth, infants with Neonatal Abstinence Syndrome, infants with disabilities) and social strengths (e.g., community resources) that can support successful family adaptation.
5. Describe the key developmental tasks in the newborn period (e.g., sensitive period for bonding/attachment, using the BNAS for understanding the response patterns of neonates).

Key Terms

alpha-fetoprotein blood screening
anoxia
Apgar score
babywearing
Brazelton Neonatal Assessment Scale (BNAS)
cerebral palsy
cesarean section
fetal alcohol spectrum disorders (FASDs)
gestation
gestational diabetes
Hispanic mortality paradox
intrauterine growth restriction (IUGR)
Latina birth outcomes paradox
mirror neurons
miscarriage
Neonatal Abstinence Syndrome (NAS)
neural-tube defects
placenta previa
preeclampsia
prematurity
sensitive period
spontaneous abortion
still birth
teratogens
toxemia
ultrasound
vaginal bleeding

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Chapter 4

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Infancy

Learning Objectives

1. Describe the key developmental themes present in infancy.
2. Understand the key aspects of biophysical growth and development (breastfeeding, SUIDS).
3. Describe the key themes in the psychological dimension for infancy (infant mental health, information processing, attention, learning, failure to thrive, social referencing, attachment).
4. Describe the key themes in the social dimension for infancy (adoptive families, HOME inventory, infant injuries).

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Developmental Themes	Key Concepts
	■ Stage: trust versus mistrust ■ Childcare practices: history and caregiving environment ■ Formation of attachments ■ Acquisition of knowledge ■ Development of a sense of self
Biophysical Dimension	
Biophysical Growth and Development	■ Physical growth ■ Brain development ■ Normal development: rapid growth and normal motor development ■ Developmental delay: early intervention
Biophysical Strengths, Hazards, and Risks	■ Accidents and childhood illness and disease ■ Immunizations ■ Breastfeeding ■ sudden unexpected infant death (SUID) and sudden infant death syndrome (SIDS) ■ Temperament
Psychological Dimension	
Cognitive Development and Information Processing	■ Piaget's sensorimotor stage ■ Information-processing ■ Judgments about right and wrong ■ Teaching infants
Communication	■ Infants' acquisition of language: crying and cooing, babbling, holophrastic speech and telegraphic speech ■ Recognizing speech problems ■ Adults' infant-directed speech
Attitudes, Emotions, and Regulation	■ Development of emotions ■ Stranger anxiety and separation anxiety ■ Temperamentally differences and goodness of fit ■ Attachment patterns; strange situation procedure; attachment risks and problems ■ Development of a sense of self ■ Learning to say no ■ Understanding standards of right and wrong ■ Terrible twos ■ Separation and loss
Psychological Strengths, Hazards, and Risks	■ Disorders of attachment; fostering a secure attachment ■ Failure to thrive ■ Infant mental health

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Social Dimension	
Groups and Families	■ Interactions between infants and their families ■ Playing with baby ■ Adoption
Communities and Support Systems	■ Day care; quality of childcare
Multicultural, Gender, and Spiritual Considerations	■ Developmental assessment for infants of color ■ Gender differences and sex stereotyping
Social Strengths, Hazards, and Risks	■ Poverty; environmental context ■ Infant abuse ■ Foster care ■ Parents with mental illness; parents with a history of developmental delay ■ Importance of social support

Developmental Themes

Before modern times, the major developmental task of infancy was simply to survive it. In premodern Europe, 40% of all children died before they were five years old. And babies who did survive were not exactly treated like cherished little bundles of joy. Many families, hesitant to invest in someone with such a high probability of dying, sent their babies to be raised by wet nurses (women hired to breastfeed babies) for the first two years of life—until the babies had survived infancy. This practice continued in France until around World War I (Mercer, 1998). With improved nutrition and control of infection and childhood disease, the infant mortality rate improved dramatically. This important social change had an impact on childcare practices in many developed countries. Over the years, there has been an accompanying increase in interest in babies and their development. Ideas of infant development changed during the 20th century, from the early belief that babies were "blobs" that could not see, hear, think, or feel to the more recent belief that babies are highly sensitive creatures whose experiences in early infancy affect personality and other characteristics for the rest of life. The first three years of life are now regarded as a special time of growth and development. We now know that the experiences of infants in the early years of development influence intellectual, emotional, and social development.

In the United States, major interest in infant development emerged in the early 1960s, when people began to recognize that "poor development in early life had multiple and expensive consequences, including the need for special education and, potentially, a lifetime on welfare or in prison" (Mercer, 1998, p. 3). Programs such as Head Start were developed to address problems of early life that placed children at a distinct disadvantage in making effective transitions to school. The success of this early intervention program suggested to researchers and policy advocates that even earlier interventions were probably needed, such as Healthy Families America, a home visitation program.

"Beliefs about infants are important because to raise a baby is to plant a seed in the garden of a culture" (Fogel, 2010, p. 4). A number of important social changes occurred in the second half of the 20th century that affected current beliefs and childcare practices. Many of these changes are tied closely to employment considerations, including both parents working, parents having to go back to work sooner after their babies are born, increased numbers of unmarried women, and increased numbers of teenaged mothers. Clearly, these changes have increased the role played by day care in the lives of infants. In the 1980s and 1990s, economic pressures influenced demands for changes in the age at which day-care placement began. This trend has been institutionalized and has been playing a major role in the lives of mothers in poverty since the passage of welfare reform legislation signed by President Bill Clinton in 1996.

The caregiving environment is a central theme in the study of infant development (Davies, 2004), and research recognizes the important role of the caregiving environment in the early years of a child's life (Jackson, 2003). A substantial body of research is developing on the effects of day care during infancy. The seminal study by Brooks-Gunn, Han, and Waldgogel (2002) showed that there is a link between the mother's employment in the

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first year of life and cognitive developmental outcomes, and more recently, early childhood obesity (McDonnell & Doyle, 2019). These findings point to the importance of critically examining institutional factors, such as subsidized or universal high-quality childcare, in infancy.

According to Erikson, infancy is the stage of trust. Infants are born totally dependent on their caregivers. They must receive appropriate and consistent care in order to develop a sense of security. Infants whose needs are met consistently in a warm and nurturing manner learn that the world is a safe place and that people are dependable. They learn trust. This trust allows babies to develop positive emotional bonds or social attachments to their caregivers. Babies who are neglected, rejected, and inconsistently cared for learn to be suspicious and fearful of the world around them. These babies develop mistrust, which can prevent or delay cognitive development and hinder movement into other stages. A baby also must develop a sense of self, form an attachment to caregivers, and acquire knowledge. These tasks will be explored in depth in this chapter as we consider the physical, cognitive, emotional, and social development of a child from birth to age two.

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Mother and her sleeping two-week-old newborn. Attachment to a caregiver is an important aspect of a child's social development. Children without this attachment may develop social and emotional problems later in life.

Study Table Developmental Themes of Infancy

Developmental Themes	■ Development of trust, sense of self, attachment to a caregiver, and knowledge about the world and how it works

Biophysical Dimension

Biophysical Growth and Development

At birth, the newborn weighs a little more than 7 pounds (less than a gallon of milk) and is about 20 inches long (Berger, 2005). Here's how to have some fun with a two-year-old: Measure her and predict her future size. At the age of two, a child has already grown to half her adult height. During the first two years, she quadrupled her birth weight and now weighs between 27 and 30 pounds. As you can see, the first two years of life are a time of rapid growth and development. Several processes occur to take the child from being a sedentary infant to a busy, active toddler.

At birth, an infant's bones are soft and pliable. During infancy, the bones harden, or ossify, to allow the child to stand and walk. The infant's skull comprises several bones that are not fused together, to allow molding of the head for a vaginal birth. Fontanelles, or soft spots, mark the spots where the skull bones do not join. By the age of two, these soft spots fill in and harden. Many cultures have developed traditions about the fontanelles. For example, mothers in traditional Mexican communities are taught about the condition known as *caida de mollera*. This condition involves fallen fontanelles and is associated with dehydration and other life-threatening physical symptoms. Many U.S. doctors and midwives also examine the fontanelles in assessing the hydration of infants. Mexican folk traditions also have introduced proscriptions against touching the spots, to protect the infant before they harden.

No aspect is more critical to the biophysical development of humans than the rapid growth of the brain, which

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is considered one of the most complex structures in the universe (Berger, 2005; Thompson, 2000). An infant's brain grows to more than half its adult size by the end of the first year. "By age 2, the brain is about 75% of adult weight, while the body is only about 20%" (Berger, 2005, p. 125). It grows so rapidly that, between the seventh month of gestation and the age of 1, the brain gains 1.7 grams per day (Shaffer, 1993). Diet during this period of rapid brain growth is crucial. It takes a substantial amount of high-quality protein to sustain this rate of growth. Inadequate nutrition in infancy can have a detrimental effect on brain development. The social environment is critical to infant brain development as well. One longitudinal research study showed that higher-quality mother-infant interactions at five months predicted higher frontal resting EEG power through 24 months of age (Bernier, Calkins, & Bell, 2016). Increases in EEG power are regarded as a key indicator of positive brain development, as it is the region associated with cognitive functioning (e.g., performance on executive function tasks such as paying attention, organizing, understanding different points of view, regulating emotions).

Most of the infant's brain neurons are created before birth. At birth, the human infant's brain has billions of neurons (Kalat, 2009). Of these neurons, 70% make up the cortex (the brain's outer layer, also known as the neocortex). This portion of the brain mediates a sizable proportion of our thoughts, feelings, and other sensations, and it includes the auditory, visual, and frontal cortexes. The frontal cortex plays a pivotal role in assisting humans in planning, self-control, self-regulation, and other executive functions. Besides humans, mammals are the only other class of animals that have a cortex (Berger, 2005; Kalat, 2009). Experience plays an important role in how the brain grows during this period (Davies, 2004).

During the first two years of an infant's life, major spurts of growth and refinement take place in the cortex. **Myelinization**, which begins in the prenatal period and continues after birth, is when a substance called myelin forms around neurons and acts as insulation, allowing faster and more efficient transmission of nerve impulses. A baby's development is referred to as **cephalocaudal** (from the head to the feet) and **proximodistal** (from the spine to the extremities). For example, first the baby gains control of her head and neck and can lift her head up. Then she gains control of her trunk and can roll over. Likewise, a baby can grasp an object in her palm before she can pick up an object with thumb and forefinger.

Motor development follows this sequence: hold up head, roll over, sit, roll from back or stomach to sit, crawl or creep, move from sit to crawl and back again, pull to stand, stand alone, cruise (walk holding on to furniture), and walk. Exhibit 4.1 presents milestones for infant gross motor skills.

Exhibit 4.1 Gross Motor Milestones across Infancy

What Are Gross-Motor Skills?
■ Large movements coordinated by the brain and large muscle groups
■ Crawling, walking, running, jumping
■ Allow us to explore our environment
Gross-Motor Skills: Birth to 1 Year
■ Raises head and trunk during tummy time for 10 seconds: 1–3 months
■ Rolls from stomach to back: 4 months
■ Rolls from back to stomach: 5 months
■ Independent prop sitting: 5 months
■ Independent upright sitting: 6 months
■ Crawls on belly: 8–9 months
■ Crawls on hands and knees: 9–10 months
■ Stands at stable surface and walks along furniture: 10 months
■ Independent walking: 10 months
Gross-Motor Skills: 1 to 2 Years
■ Crawls upstairs: 14–15 months
■ Crawls downstairs: 15–16 months
■ Walks upstairs with one-hand support: 15–16 months
■ Walks backward: 18 months
■ Walks downstairs with one-hand support: 18–20 months
■ Runs: 18–24 months
■ Walks sideways: 21–22 months
■ Walks upstairs independently: 23–24 months
■ Jumps on two feet forward 4 inches, up 2 inches, down from a height of 6 inches: 19–24 months
■ Kicks a ball: 19–24 months
■ Places one foot in front of the other (tandem stance)

Source: www.grossmotorskills.info.

Although age norms for motor development vary culturally, infants all over the world achieve these motor milestones in the same sequence. This is evidence of a maturational theory of development—that developmental achievements are genetically programmed to occur in a particular sequence as the baby grows.

The Learn the Signs Act Early program was created in 2004 in an attempt to identify infants with a developmental delay earlier so that learning interventions could be

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implemented earlier. Parents, early childhood education providers, and any other caregiver can use the free materials, including the Centers for Disease Control and Prevention's (CDC's) Milestone Tracker App, to monitor infants' development. After nearly two decades of new research, these guidelines were finally updated by the CDC and the AAP, partly in response to concerns regarding the developmental effects of the COVID-19 pandemic (Zubler, Wiggins, Macias, et al., 2022). These updates included reducing medical jargon and reducing the number of milestones into 10 checklists across four main categories: social-emotional, language and speech, cognition, and motor. New benchmarks help to identify potential developmental delays, including signs of autism, earlier. However, many of the motor milestones have been pushed to older ages, and may have implications for catching infants early in a developmental delay. A controversial change was the removal of crawling as a developmental milestone. Crawling indicates an ability to integrate reflexes, as well as a demonstration of strength and muscle tone. Exhibit 4.2 highlights the changes associated with the newly revised criteria for developmental milestones and surveillance tools.

The sleep–wake states provide useful information for assessing the integrity of the newborn infant's nervous system. Wolff (1966) made an intensive observation of infants and differentiated between **active sleep** (periods with eye movement) and **quiet sleep** (periods with no eye movements; Thoman, 2001). A number of early electrophysiological studies identified the specific sleep characteristics associated with various forms of atypical brain development. For example, children with a diagnosis of autism showed a delay in the development of sleep patterns, and unstable sleep patterns have also been observed in premature infants and infants with developmental disorders.

Exhibit 4.2 Newly Revised Criteria for Developmental Milestones and Surveillance Tools

1. Milestones are included at the age most (75%) children would be expected to demonstrate the milestone rather than half (50%).
2. Eliminates "warning signs" to reduce confusion on when to be concerned
3. Easy for diverse families of different social, cultural, and ethnic backgrounds to observe and use
4. Response format is yes, not yet, or not sure
5. Uses plain language and avoids unclear terms like *may*, *can*, and *begins*
6. Is organized into four developmental domains
7. Shows progression of skills with age, when possible
8. Reduces repetition of milestones across checklists
9. Includes open-ended questions
10. Includes information for developmental promotion
11. Includes information on how to act early when there are concerns

Implications for Practice:
Recognizing Developmental Delay

How can you tell whether a baby is developmentally delayed? This is where knowledge of developmental norms becomes important. To make an accurate assessment of developmental problems, you need to be able to contrast a child's current level of functioning with what is expected of typical children of his age (Johnson & Goldman, 1990). Basically, infants need a developmental assessment if they fail to demonstrate a skill at an age when 75% of babies can perform that skill.

The Ages & Stages Questionnaires, Third Edition (ASQ, Squires & Bricker, 2009), are used by many social workers and physicians because it is a highly valid and reliable screening tool that is cost-effective and easy to complete and score. The ASQ is used to assess developmental milestones from birth through 5.5 years in order to identify developmental and social-emotional delays early in development. An example item from the six-month gross-motor skills assessment includes the following: Does your baby roll from his back to his tummy, getting both arms out from under him? An example from the 12-month gross-motor skills assessment includes the following: While holding onto furniture, does your baby lower herself with control (without falling or flopping down)? Items are summed and scores for each area of development are identified as on schedule, close to the cutoff, and below the cutoff.

However, recently there has been an increased incidence of delay in babies learning to roll over and gain head and neck control. This delay is the result of a trend to place babies on their backs or sides to sleep instead of on their stomachs, as was the old norm. Parents used to be encouraged to place babies on their stomachs in case they spat up while asleep. However, studies have suggested that babies who sleep on their stomachs run a higher risk of dying from sudden infant death syndrome (SIDS, discussed in more detail in the next section; American Academy of Pediatrics, 1992, 1996). Now pediatricians recommend that parents put babies to sleep on their backs, and a decrease in SIDS deaths has been observed. However, because infants spend less time on their stomachs, they do not strengthen the arms, head, neck, and trunk by rolling

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over or pushing themselves up. Early intervention programs now recommend that parents allow babies to have some "tummy time," or special time to play on their stomachs, while awake. Tummy time may also prevent the formation of flat spots on the back of babies' skulls, which may be a result from sleeping on their back or spending increased time in car seats and bouncers/swings. Further, the first pandemic babies (born in March 2020) are showing significantly reduced verbal, motor, and cognitive performance compared to infants born pre-pandemic (Deoni, Beauchemin, Volpe, D'Sa, et al., 2021). These delays are attributed to disrupted educational experiences, limited explorative play, isolation, and lack of interaction with other children.

The National Center for Infants, Toddlers, and Families has promoted a different system for classifying mental and developmental disorders for infants from birth to three years of age. The Zero to Three Diagnostic Classification Task Force (1994) focused on ways of assessing infants that promoted treatment of the very young in the context of the family. Social work practitioners are now developing substantial expertise in this burgeoning field, known as infant mental health. This field promotes healthy social and emotional development for children from birth through three years of age. *Infant mental health* was defined by the Zero to Three Task Force (1994) as "the developing capacity of the child from birth to age three" to accomplish the following: "(1) experience, regulate, and express emotions; (2) form close and secure interpersonal relationships; (3) explore the environment and learn all in the context of the family, community and cultural expectations for young children" (National Center for Infant Mental Health, 2004). The development of *DC:0-5™ Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood* (Zero to Three, 2016) was created in order to better address early childhood psychopathology. Using several large data sets, the task force attempted to provide evidence-informed criteria for all disorders, including disorder of dysregulated anger and aggression (replacing oppositional defiant disorder and the eating disorders).

This new field requires a strong understanding of developmental considerations, including the achievement of key physical milestones.

Practice Guidelines

- Although babies develop motor milestones in the same sequence, they vary in the length of time it takes to achieve each milestone. Practitioners should be concerned about a developmental delay when an infant has not achieved a milestone that 75% of infants have mastered by that age. The Ages & Stages Questionnaire is a screening tool that parents can accurately complete at home to help identify areas of concern and potential delays.
- Early detection and intervention for many delays can curtail the impact it has on the child's long-term development. For example, parents of blind infants can be taught to use auditory and other forms of sensory stimulation to enhance their infants' development.
- Some children will walk on the balls of their feet, also known as toe walking, when they are first beginning to walk. Most children outgrow it. However, it can result from cerebral palsy, muscular dystrophy, and autism spectrum disorder. Persistent toe-walking can increase the risk of falling or carry a social stigma. Children over the age of two should be seen by a doctor.

Biophysical Strengths, Hazards, and Risks

To new parents, babies often may seem like accidents just waiting to happen. Infants climb on chairs that topple over, fall down stairs, eat poisonous plants, choke on small objects, and fall headfirst into buckets of water. Infants require constant attention to protect them from injury. According to the CDC, unintentional injury deaths decreased 11% from 2010 to 2019, but injury is still the leading cause of death for children (highest for babies under one year). Parents need to baby-proof the house carefully and anticipate possible hazards to their child. Parents should remember that not all homes are baby-proofed, which means that when visiting other people's homes, they should be alert to possible hazards, such as swimming pools, medication bottles within the baby's reach, and exposed electrical outlets. Exhibit 4.3 lists some considerations for preventing accidents and injury.

Illness

Although babies are born with some natural immunity to rubella, measles, mumps, polio, and diphtheria, this immunity does not last past the age of three to six months. In addition, babies are susceptible to chicken pox, tetanus, whooping cough (pertussis), and streptococcal infections during this time (Betz, Hunsberger, & Wright, 1994). As stated at the beginning of this chapter, in the past, many children did not survive infancy because of these diseases.

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Exhibit 4.3 Preventing Accidents and Injury in Infancy

Hazard	Prevention
Falls	Don't leave infant unrestrained on any surface. Even very small infants can move and fall off a bed or couch. Don't place a baby in an infant seat on a table. The baby may wiggle the seat off and fall. Avoid use of infant walkers.
Poisoning	Lock up all hazardous materials, including cleaning supplies and medications. Use childproof caps on medications. Keep poisonous plants out of reach. Keep number of Poison Control Center near phone.
Choking	Keep small objects out of reach. Don't tie anything around the baby's neck, including the pacifier. Cut food into small pieces. Avoid hard foods such as nuts and hard candy. Parents and caregivers should learn the Heimlich maneuver.
Suffocation	Don't prop the bottle to feed. Keep plastic bags out of reach. Remove doors of old refrigerators. Don't shake baby powder onto baby (put it in your hand and apply). Avoid use of pillows, soft toys, and several blankets in crib. Use approved crib. Watch for drapery or blind cords near crib and within baby's reach throughout the house.
Drowning	Never leave the baby unattended in bathtub. Keep toilet seat down. Be careful of all containers of water. Babies can drown in only a few inches of water in a bucket. Use pool safety gates. Never leave the baby unattended near pool or any water. Parents and caregivers should take a CPR class.
Burns	Lower temperature of water heater to 120°–130°. Check temperature of bathwater with elbow. Push pot handles toward back of stove. Use nonflammable clothing. Install smoke detectors. Don't heat bottles in the microwave.
Auto accidents	Always buckle the child into approved car seat. Never place a baby in the front seat of a vehicle that has air bags.

Source: Based on Family-Centered Nursing Care of Children, by R. Foster, M. Hunsberger, and J. Anderson. Elsevier.

In fact, pertussis is still a major problem in the United States; it can be deadly for babies (particularly under three months of age), which is why the CDC recommends pregnant women receive a Tdap vaccine during the 27th to 36th week of each pregnancy. Doing so provides antibodies to the baby against whooping cough in the first months of life, until the infant is able to be vaccinated at two months of age. Now, the CDC recommends that infants six months and older receive a COVID-19 vaccine. Immunization is an important issue for both parents and children; Exhibit 4.4 lists the immunization schedule for infancy.

Babies are also very susceptible to upper respiratory infections (colds). Exposure to tobacco smoke can increase the risk of respiratory problems for infants, placing them at higher risk for bronchitis and pneumonia. Respiratory syncytial virus (RSV) is the most common respiratory pathogen in infants and children and the most common cause of bronchiolitis and pneumonia in children under one year of age in the United States (CDC, 2022). RSV infection causes respiratory distress in infants and results in increased risk of hospitalization for them, especially those who are premature, during the winter months. Almost all children will have an RSV infection by the time they are two years old and most of the time it causes a mild, cold-like illness. Infants at greater risk for a severe RSV infection that require hospitalization include young infants (under six months), premature infants, and infants with weakened immune systems or neuromuscular disorders. There are currently no vaccines to prevent RSV infection and it is highly contagious. Typically, RSV is a seasonal virus, hitting families during the cold winter months. Going into winter 2022, a record number of young children were being hospitalized with the virus. This has been attributed to children spending the last two years quarantining and social distancing at home due to the COVID-19 outbreak and not building immunity to common viruses, like RSV. RSV can also harm older people so it is important to practice the spread of RSV through frequent hand washing, avoiding close contact with sick people (including attending daycare while sick or kissing children while having cold-like symptoms), cleaning shared surfaces frequently, and encouraging children to avoid touching their face with unwashed hands.

Meningitis, a bacterial infection of the lining of the brain, is especially hazardous to infants. This illness can result in a 20 to 60% death rate or in neurological complications, including learning disabilities (Berardi et al., 2010). Preterm infants, males, and infants at day care have the highest risk of bacterial meningitis. Pregnancy factors

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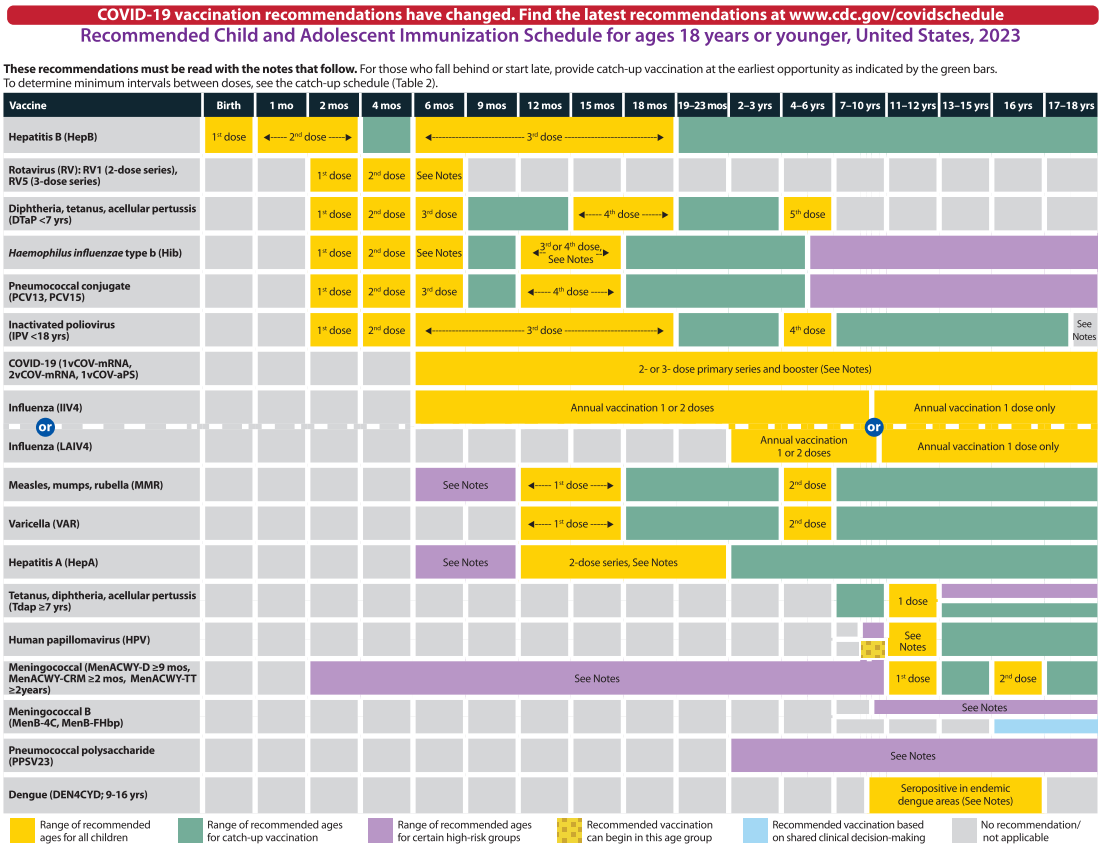
Exhibit 4.4 Immunization Schedule from Birth



Source: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html#birth-15

include genital herpes and mothers who test positive for Group B *Streptococcus*. Babies with meningitis are irritable, run a fever, have a high-pitched cry, and often have bulging fontanelles.

Breastfeeding

The World Health Organization (WHO) recommends that infants be breastfed exclusively for the first six months of life. Solids may be introduced at six months, but breastfeeding should not be decreased, and should continue for up to two years or more. Babies who are breastfed respond better to vaccinations and have more protection against many serious bacterial and viral infections, including respiratory tract infections, ear infections, bacterial meningitis, pneumonia, urinary tract infections, infant diarrhea, SIDS, and common colds and flus. This is because the mother passes her antibodies through her breastmilk to her baby, and because infants do not receive their first set of immunizations until two months of age, formula-fed infants are more susceptible to infections. There are also many long-term benefits of breastmilk to overall health as well, including reduced type 1 and type 2 diabetes, Hodgkin's disease, leukemia, obesity, high blood pressure, high cholesterol levels, Crohn's disease, ulcerative colitis, asthma, and eczema. Mothers who breastfeed are also at decreased risk for ovarian and breast cancer, heart disease, osteoporosis, and postpartum depression. These benefits increase the longer she breastfeeds (see Exhibit 4.5).

However, across the world, fewer than 40% of infants aged six months or younger are exclusively breastfed (Black, Victora, Walker, and the Maternal and Child Nutrition Study Group, 2013). Although breastfeeding is natural, it has to be learned and many women encounter difficulties at the beginning. It is important that mothers receive support for breastfeeding, particularly in the first few days and weeks that her baby is born. Many hospitals now have changed their routine practices in order to better support breastfeeding. For example, many hospitals no longer separate the mother and infant, use nurseries, or supplement with formula.

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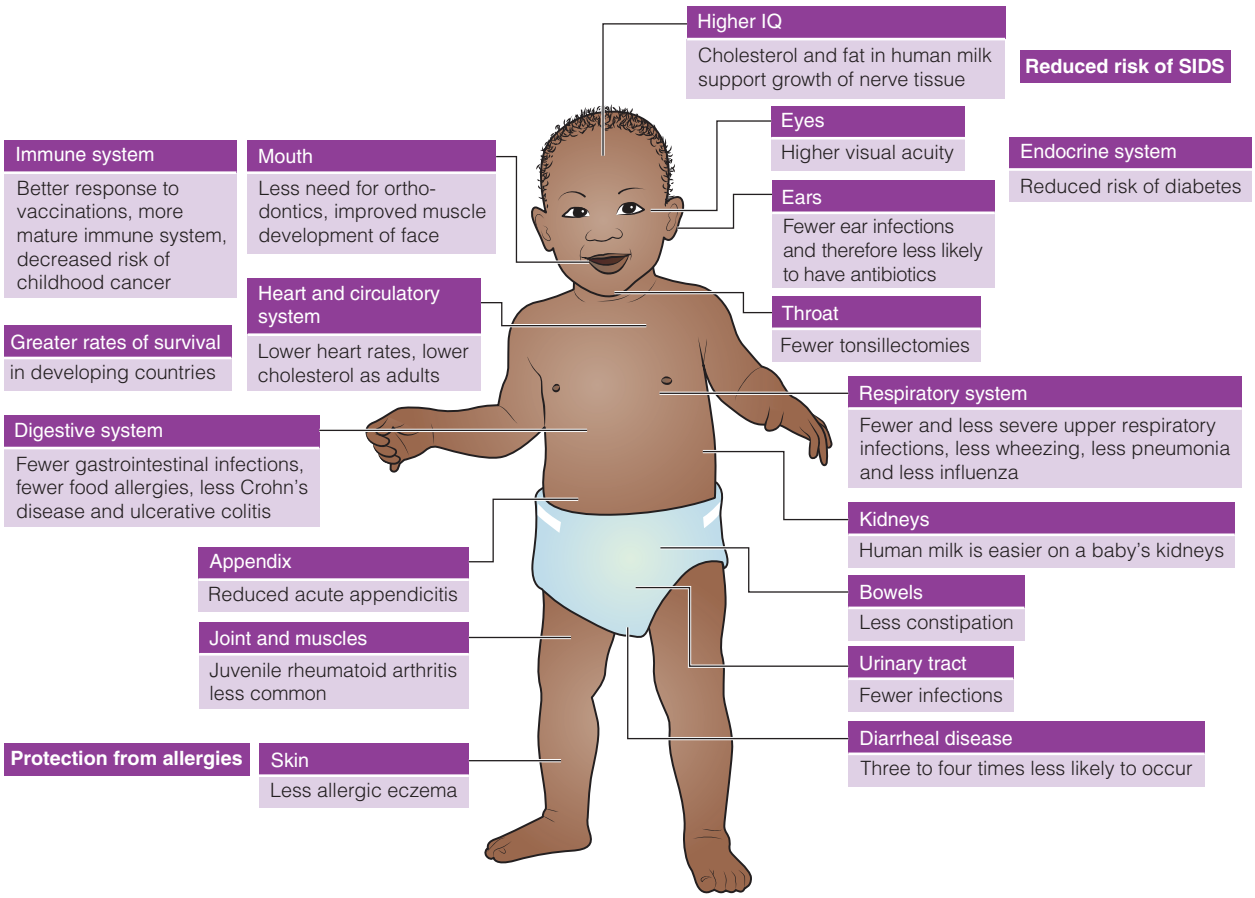
Exhibit 4.5 The Breastfed Baby



Sudden Unexpected Infant Death Syndrome

At 4:00 in the morning, Dana woke sweating. Something was wrong. She had put her two-month-old baby to bed at 7:00 the previous evening, and he was still asleep. He had never slept longer than six hours before. In fact, lately he had been sleeping poorly because he had a cold and had been waking often with a stuffy nose. Dana went to check on the baby and found him lying on his stomach, wedged up at the top corner of his crib. The sheet was crumpled, his blankets were kicked off, and there was a little blood on the mattress. Dana put her hand on the baby's back and discovered he was not breathing. Dana's screams woke her husband, John, and he called the paramedics. Unfortunately, efforts to resuscitate the baby failed, and he was pronounced dead at the hospital.

SUID refers to the sudden and unexpected death of an infant less than a year old, for which no physical cause can be found. These deaths usually occur during sleep or in the sleep area. SUIDs include SIDS accidental suffocation in a sleeping environment, and other deaths from unknown causes. Although SUIDs have declined since the 1990s due to safer sleep practices (e.g., the introduction of the "Black to Sleep" campaign in 2002), it is still the most common cause of death in the first year of life in the United States and significant racial and ethnic differences continue (Goldberg et al., 2018). In the United States, more than 3,400 infants die of SUID every year. Most SIDS deaths involve babies who are between one and four months old (Murphy et al., 2013). The American Academy of Pediatrics released a policy statement in 2022 (Moon et al., 2022) that stated SIDS occurs when an infant with a biological vulnerability (e.g., impaired arousal, cardiorespiratory, and/or autonomic responses) is triggered by an event in the environment (e.g., unsafe sleeping practice). Their recommendations of a sleeping environment included a supine position, a firm/non-inclined

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Focus on **The Lived Experience**

Breastfeeding

I knew I wanted to breastfeed my baby before he was born. My mom had breastfed me and my three younger siblings until we were toddlers and I had memories of my youngest sister snuggled up to her, drinking her milk. During my pregnancy, I had attended the breastfeeding class that was part of the birthing prep series. I thought I was set. My baby was born without complications. He was laid on my bare chest and he quickly latched on to my breast. I remember feeling confident that he was nursing well and even (naively) said to my partner, "We've got this parenting thing down." Three days later my milk came in after the first few days of initial colostrum. My breasts went from being soft and easy to latch to incredibly engorged and rock hard. It was so painful and also distressing because they were so full my baby couldn't latch to my nipple to nurse. We didn't know what to do. I took a hot shower and milk started spraying out of me, shooting across the shower in a steady stream. Even with that tiny relief, I was too engorged for the baby to latch. I spent the night crying as my hungry baby also cried.

The next morning, we went to see a lactation consultant. She helped me hand-express enough milk so that my baby could latch. However, his latch was incredibly painful and took my breath away. I didn't realize at the time that he was very sensitive to my forceful milk letdown and was clamping down to keep from choking. I struggled with continued engorgement and his painful latch for the next six weeks. I hated breastfeeding but continued with sheer grit. I had a very supportive partner, and I continued to visit the lactation consultant every week. I also went to breastfeeding support groups and read the La Leche League's website resources. I found an online breastfeeding support group on Facebook and relied on the virtual kindness and encouragement from strangers. After several weeks of painful nursing, I figured out some tricks that worked to make nursing better for both of us. I would latch him so that letdown could occur, then unlatch him and let the forceful initial spray into a burp cloth. Once the flow was manageable, I'd relatch my baby to my breast. I also would restrict nursing on my right side as it was super sensitive to engorgement and oversupply. I learned about this block feeding technique from the lactation consultant whom I was still seeing.

When my baby was just a week old, my friend asked me how long I planned to nurse him. In that early phase of painful nursing, my response was that it was my goal to nurse him until "noon tomorrow" because I couldn't imagine dealing with the pain and frustration any longer than 24 hours. That remained my goal for the next several weeks. Now, my sweet baby is a just-turned-two toddler, and he still enjoys his milk from me. Nursing a toddler has its own challenges (nursing gymnastics for one), but I'm grateful for the many benefits and that we preserved during those early weeks.

—Stephanie Springer, Tucson, AZ

sleep surface, room sharing without bed sharing, and avoiding soft bedding and overheating. Additional recommendations included breastmilk, a substance-free environment, routine vaccinations, and a pacifier. This policy report received a number of dissenting responses, including a response from the Spanish Breastfeeding Association, who disagreed that bed-sharing should be avoided in all cases. They argued that breastfeeding is supported through bed sharing, and without other risk factors, the evidence does not support increased risk for sleep-related infant deaths. In fact, rates of SIDS are lower in countries where infants routinely sleep with their mothers (Stipp, 1995); babies who sleep alone may go into deep sleep, whereas infants who sleep with their caregiver adjust their sleep patterns to synchronize with the caregiver's. The task force on SIDS responded to this criticism by arguing that the safest place for an infant to sleep is next to the parents on a separate surface. Clearly, this remains a hot topic in the United States and worldwide, in part, due to cultural factors that inform perceptions of best parenting practices. It is important for social workers to recognize this, and take the role of providing parents with current recommendations and risk factors associated with SUIDs.

In general, SUIDS occurs more often in male infants, low-birth-weight infants, premature infants, babies with low Apgar scores, babies with a sibling who previously died of SIDS, and babies who sleep on their stomachs (Martinez, 1996). Several maternal factors also increase the risk of SIDS, including young age, multiple births,

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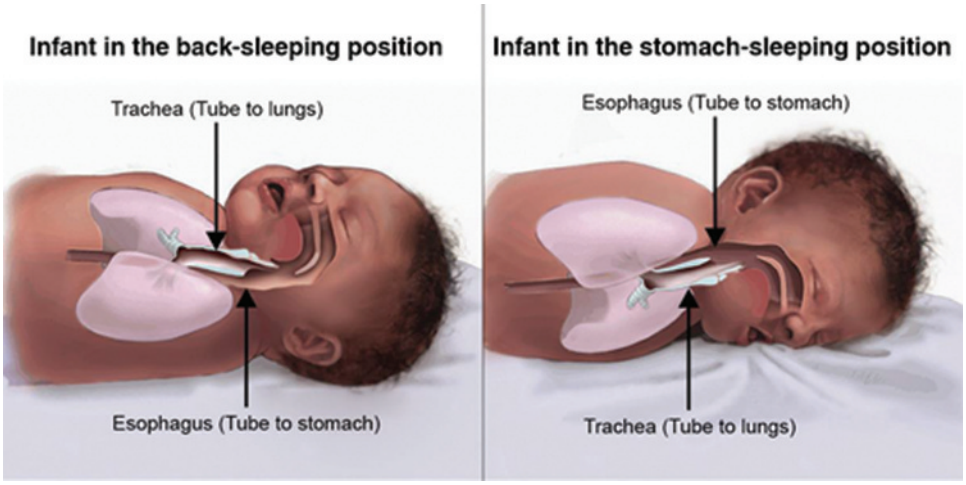

The placement of sleeping on the back allows infants to clear fluids; the trachea is on top of the esophagus, so anything that is regurgitated or refluxed cannot be aspirated into the trachea (i.e., choking) due to gravity. However, when laying on the stomach, aspiration or choking is more likely to occur because regurgitated or refluxed fluid can gather at the opening of the trachea.

Source: Image and caption courtesy of the Safe to Sleep campaign, for educational purposes only; Eunice Kennedy Shriver National Institute of Child Health and Human Development, http://www.nichd.nih.gov/sids. Safe to Sleep is a registered trademark of the United States Department of Health and Human Services.

smoking, prenatal drug abuse, low socioeconomic status, no prenatal care, and closely spaced pregnancies (Martinez, 1996).

"Tummy time" is recommended during periods when the infant is awake and supervised to assist in motor development and to help avoid the formation of flat spots on the back of their skull, which may result from sleeping in a supine position.

As of yet, no one knows what causes babies to die unexpectedly, but parents who lose an infant this way often blame themselves and try to determine what they did wrong, and their grief is almost unimaginable. Parents coping with the loss of an infant to SUIDS need much support. Organizations such as the MISS Foundation provide counseling, hold support groups, and sponsor community events, such as the Kindness Walk, to families who have experienced the death of a child.

Practice Guidelines

- It is recommended by the CDC and the AAP that healthy children be vaccinated against 14 diseases by the age of two. Immunizations are a public-health concern and are available for free for uninsured children. Despite these recommendations, many parents are wary of vaccines or are passionately opposed to them. Parents may believe that they are protected under "herd immunity." However, in order for a community to be protected, it requires 80 to 90% of its population to be vaccinated. Currently, we fall short of the government's goal of 80%, and infants who are not old enough to receive the vaccine are at the greatest risk of becoming sick. Practitioners are advised to create a welcome and nonjudgmental environment so that parents can have an open discussion on the benefits and risks to vaccinating their infant.
- Advocate for practices in birth centers and hospitals to put in practices that support breastfeeding. Mothers should have the opportunity to breastfeed the baby within the first hour after delivery and have available lactation consultants for additional support. Breastfeeding support groups can also be very useful for sustaining the breastfeeding relationship for a longer period of time.
- Encourage parents to put their child to sleep on their backs to help prevent SIDS. The crib should also have a firm mattress and be free from blankets, pillows, bumpers, or stuffed animals. Giving the baby opportunities to be off their backs during wakeful periods may help to prevent flat spots.
- Losing an infant can be a very difficult and lonely experience. Connect with organizations in the community that specialize in grief and loss of children and get parents connected with other parents who have faced a similar loss.

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Study Table Biophysical Dimension in Infancy

Biophysical Growth and Development

- Average newborn weighs a little more than 7 pounds. By age two, a child is half her adult size.
- A period of rapid growth and development.
- At birth, the bones are soft and pliable. The infant's skull is not fused together, which allows for movement of the infant through the mother's birth canal. Fontanelles are the soft spots on the skull where the bones are not joined.
- The brain is half its adult size by age one and is 75% of its adult weight by age two. Diet is very important. The majority of brain neurons are created before birth. Experience plays an important role in brain growth.
- Growth occurs in a downward and outward direction (cephalocaudal).
- Primary sensory functions are functional at birth. The prefrontal cortex is the last area to develop.
- Brain functions are determined by patterns of connectivity in our neuronal systems.
- The newborn's sleep-wake cycle provides useful information for assessing the integrity of the infant's nervous system. A delay in the development of sleep patterns and unstable sleep patterns are associated with premature infants and with some developmental disorders.

Biophysical Strengths, Hazards, and Risks

- Appropriate size for gestational age and temperament are key biophysical strengths.
- The household can hold physical hazards.
- Childhood illnesses such as rubella, measles, and mumps.
- Sleep patterns place infants at risk for SIDS.

Psychological Dimension

Cognitive Development and Information Processing

Suddenly a piece of space stands out. It's a pillar, thin and taut. It stands motionless and sings out a bright melody. Now, from close by, different notes drift in. There is nearby another pillar of space. It, too, sings—but in harmony with the first. The two v melodies mingle in a tight duet, one melody loud, the other quiet. . . .

Then from somewhere else, sounds a different note. A shooting star, it flashes past and quickly disappears.

—Daniel Stern

In this passage from *Diary of a Baby*, Daniel Stern describes a six-week-old infant turning his head and seeing first one crib bar and then another. Try to imagine what the shooting star could be (it is the baby's hand passing through his line of vision).

People have long been intrigued with trying to determine what babies think about, what they perceive, and how they process information. In the past, theories of infant development were based on the "clinical infant"—a construct developed by the therapist working with adult clients trying to remember early experience. Theories of infant development from developmental psychology are based on the observed infant. Today, researchers realize that infants hold important keys about understanding mind, brain, and evolution (Meltzoff, 2004), and they are setting up experiments to observe babies to determine their responses and capabilities (Stern, 2000). Although Jean Piaget was well regarded for his ability to observe human development, in the field of infant cognition, Piagetian theory no longer reigns (Meltzoff, 2004). We are seeing an explosion of new findings in this field that are revealing the presence of richer innate states that are possessed by infants than that were presumed by Piaget. Still, Piaget's classic writings on cognition provide useful insights into infant sensory and motor capabilities.

Piaget's Sensorimotor Stage

Piaget developed his theories of cognitive development by closely observing first his own children and then others. He classified the time from birth to age two as the **sensorimotor stage**. During this stage, the infant goes from having mostly random reflex actions to displaying goal-directed behavior. For example, instead of just watching a hand shoot past her eyes, she learns to use that hand to push a chair over to the kitchen counter, so she can

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climb up and get cookies. **Goal-directed behavior**, then, means putting together a series of actions to achieve a desired result. The infant in this stage also develops **object permanence**—the ability to hold an image of an object or person in the mind. According to Piaget, very young infants forget an object as soon as they can no longer see it. For instance, if you show a four-month-old infant a toy and then place that toy under a cloth, the baby will not lift the cloth to find the toy, even if the baby saw you put it there. But two-year-olds remember that those cookies are on the counter even though they can't see them, and they may thoughtfully solve the problem of how to get to them. Piaget's sensorimotor stage is divided into six substages (see chart on next page).

Information Processing

New research is finding that babies may be more competent than Piaget ever imagined (Davies, 2004). Innovative techniques make it possible to observe infants much more closely than Piaget did. These techniques look at how babies actually process the information they receive through sensory stimulation.

One way of observing babies is by studying their attention patterns. Infants display **obligatory attention**; that is, they will look intently at or fixate on something interesting and not be distracted from it (Stern, 1990). Researchers can determine how babies process information by measuring how long it takes a baby to stop paying attention to the same stimulus (**habituation**) and how long it takes the baby to become interested in a new stimulus (**dishabituation**). Babies will look longer at something they find interesting. After becoming familiar or bored with that stimulus, they stop looking at it, or habituate; then they will pay attention to a new stimulus, or dishabituate.

This infant is able to make purposeful actions. In this instance, she is intentionally biting a loaf of bread.

Researchers have discovered that babies not only pay attention to stimuli they have never seen before, but also pay more attention to events they have some control over, such as watching a mobile they can shake by kicking, and to events they did not expect to happen. Using this information, researchers have discovered some amazing capabilities of young infants.

Research has shown that infants as young as six or seven months display **categorization** (Bjorklund & Bjorklund, 1992). Categorization is the process of placing new experiences into older categories for classifying experiences; for example, understanding female faces (see Exhibit 4.6).

Some research suggests that very small babies can transfer information gained from one sense to another sense. This process is referred to as **cross-modal transfer**. An example would be exploring an unseen object with your hands and then trying to recognize a picture of that object. Piaget argued that babies learn this capability gradually through repeated associated actions, such as watching their hands grasp objects. However, current research suggests that this ability may be present in very young infants.

Other research has found that infants have better memories than had been believed. Rovee-Collier, Sullivan, Enright, Lucas, and Fagan (1980) placed two-and-a-half-month-old infants in a crib and attached a mobile to a leg or an arm with a ribbon. The babies learned to shake the mobile by moving that arm or leg. Two weeks later, when placed back in the crib with the same mobile, the babies tried to shake the mobile by moving the appropriate limb, even though the ribbon was not attached. Newborn infants are born conditioned to respond to affective touch; slow stroking activates C-tactile nerve fibers that are perceived as pleasurable (Croy, Fairhurst, & McGlone, 2022).

Indeed, studies seem to show that babies have an innate sense of how the world works and new research indicates that object permanence may occur much earlier than Piaget hypothesized; babies show surprise when objects disappear behind a screen or behave in unexpected ways. And babies may be able to imitate others earlier than Piaget believed possible.

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Exhibit 4.6 Sensorimotor Stages

1. Reflex Activity	Birth–1 month	■ Newborn reflexes ■ Actions are random
2. Primary Circular Reactions	1–4 months	■ Repeats actions that bring results ■ Simple motor habits center around own body ■ Sucks on hand because he discovers it is comforting
3. Secondary Circular Reactions	4–8 months	■ Focus shifts to objects in the world ■ Repeats actions that cause effects in surroundings ■ Kicks feet to make the mobile move
4. Coordination of Secondary Schemes	8–12 months	■ Intentional means-end behavior ■ Beginning of object permanence ■ Imitates actions performed by others ■ Babies can clap after seeing you clap, but they cannot initiate clapping
5. Tertiary Circular Reactions	12–18 months	■ Explore properties of objects through novel actions ■ Have object permanence but not invisible displacement ■ If a toy is placed in a box under a blanket, and then moved out of the box but still under the blanket, the baby will still look for the toy in the box even though the toy makes a bulge under the blanket
6. Representational Thought	18–24 months	■ Internal depictions of objects or events (full object permanence) ■ Deferred imitation ■ Clap for themselves when they are pleased

What does all this mean? As more sophisticated methods for observing infants are developed, more knowledge about their information-processing capacities will become available.

Judgments about Right and Wrong

Piaget and Kohlberg contend that children make judgments based on consequences up until they are around nine years of age. Information-processing research is showing that children can make more sophisticated judgments earlier than previously thought. Prior to an infant's first birthday, the infant can make distinctions between living and nonliving things. Around 14 months, children begin to show an ability to choreograph their eye movements with other humans' eye movements. If someone else looks at them, they look to cooperate through the process of providing joint attention. It is now believed that this is not just a joint focus of attention, but a joint sharing of thoughts and feelings that are relevant to the development of morality. Infants often look to their caretakers to see how they are responding to the object or person.

Crib toys are excellent devices for getting a baby to focus attention on objects in the external environment.

Pretend play involves a number of experiences that are key stepping stones for being able to make cognitive inferences about someone else's desires and thoughts (see Exhibit 4.7). Research supports that 15-month-old babies might be able to attribute rudimentary mental states to others, that is, consider others' thoughts or beliefs (Onishi & Baillargeon, 2005).

While newborns lack the capacity to move on their own, they have an inborn system of perception that helps them to generate expectations about the world. These expectations are available to them even before they have the capacity to act on the world by reaching for objects or

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Exhibit 4.7 Developmentally Appropriate Play

	Birth-1 month	2–3 months	4–6 months	6–9 months	9–12 months
Visual Play	Gaze at baby, at close range emin kuliyev/Shutterstock.com	Hold and move bright toys in front of baby	Place baby in front of infant-proof mirror	Play peek-a-boo with baby	Share picture books with baby
Auditory Play	Sing to baby	Shake rattle for baby Cheryl E. Davis/ Shutterstock.com	Call baby by name	Name body parts, foods, and people with playing with baby	Imitate animal sounds
Tactile Play	Cuddle baby	Baby massage	Give baby textured toys 8th.creator/Shutterstock.com	Allow baby to touch different textured fabrics	Let baby squish food in hands
Kinetic Play	Rock baby	Tummy time	Allow baby to rollover, crawl, and sit on floor	Dance with baby in arms	Help baby practice walking Vitalinka/Shutterstock.com

Sources: http://ofthehearth.com/what-to-do-with-baby-a-guide-to-developmentally-appropriate-play/; Zero to Three (http://www.zerotothree.org/child-development/play/tips-and-tools-play.html); and Wong et al. (2006). *Maternal Child Nursing Care.*

talking about their experiences with the objects (Hauser, 2006; Onishi & Baillargeon, 2005).

Moral development is closely associated with being able to differentiate between intentional actions and accidents. Children with attention deficit disorders and other disruptive behavior disorders often make false inferences about the causes of specific behaviors. For this reason, factors that impede an infant's capacity to coordinate their attention with the attention of caretakers is a risk factor for developing incompetence in assessing the intentions of others. Indeed, the newer research on information processing is suggesting that infants and children have a deeper understanding of intentions than has been thought.

Implications for Practice:

Should Babies Learn to Read?

If babies are so brilliant, should parents devote time and energy to teaching young children to read or perform math problems? Should parents place note cards that name items around the house to encourage language development?

Parents who attempt structured teaching of young babies may become invested in the success of their endeavors. Such attempts at early enrichment may turn into stressful parent–child interactions. Babies involved for long periods in a structured teaching session may miss out on opportunities for free play and exploration. Most young babies do not need to know how to read or add—they have better things

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to do. In addition, no evidence suggests that enrichment programs create "super babies" (Zigler & Stevenson, 1993). Parents should be encouraged to provide an interesting environment for the child to explore; to provide stimulating play materials; and to talk to, play with, and enjoy their baby.

Practice Guidelines

- Babies learn about the world through their innate abilities and opportunities to interact with their environment. Rather than having to "teach" infants about how the world works, encourage parents to provide their infants with interactive toys that contain sensory information; for example, a ball, blocks, or a rattle. Parents can support their infant by talking to their infant rather than moving the object for them. For example, letting the infant explore the rattle rather than holding the rattle in the infant's hand and shaking it for them.
- Appropriate play varies across infant development. See Exhibit 4.7, Developmentally Appropriate Play, for ideas on how to interact with babies and provide appropriate play activities by age.
- Encourage parents to observe how their infants' self-exploration behaviors are helping them learn about their environment. Place a well-rested and well-fed infant on the floor and watch what they do. Where does the infant look? What does the infant do with their hands? Does the infant kick their feet against the floor to move their body? Point out to parents how their baby is learning through self-exploration.
- Inform parents about the benefits of unstructured play as precursors to social skills, intentionality, and moral development.

Communication

Although newborn babies cannot speak words, they can communicate and are born ready to respond to the human voice. Babies will move in synchrony to human speech in a kind of dance that is slow and rhythmic. Neonates prefer human speech to noise; they prefer their own language to others; they prefer baby talk to adult speech; they prefer a female voice to a male voice; and they prefer their mother's voice to another woman's. By the end of infancy, the baby begins to learn to speak a language. Anyone who has tried to learn a new language as an adult knows how hard this can be. But a baby does it quite well and in a consistent and predictable fashion. Babies all over the world and throughout time have developed speech in the same sequence.

Crying and Cooing

The newborn communicates primarily by crying. At first, crying is unintentional, simply a response to discomfort or need. But as the caregiver responds to the infant's cries, the baby learns to cry for specific reasons. New parents often ask, "Why does the baby cry?" Babies cry when they are hungry, tired, cold, wet, hot, scared, lonely, in pain, bored—whatever. Most caregivers learn to distinguish between cries, such as the loud, piercing cry of pain or the fussy, whiny sound of tiredness or boredom.

By the end of the first month (three to five weeks), babies begin to coo or make vowel sounds such as "aaaaah" or "oooooh" (see Exhibit 4.8). At around three or four months, the baby throws in some consonants such as "b" or "k."

Babbling

Between three and six months, the baby puts vowel and consonant sounds together, repeats them over and over, and begins **babbling** with p, b, and m sounds. Common early babbling sounds include "mamama," "papapa," and "dadada." It is probably no coincidence that in many languages the common names by which infants to refer to their mother and father are mama, dada, and papa.

Babies all over the world begin making these repetitive sounds at this age. Babbling seems to be a maturational process, because even deaf babies who have never heard language will begin to babble by six months; however, with no auditory reinforcement, they stop babbling by eight months. (But if the hearing impairment is caught early and the parents communicate with the baby through sign language, the baby will repeat some signs over and over and "sign babble.")

Why do infants babble? Babbling may be a form of practice to develop the throat, lips, and tongue for producing sounds. Or it may be a way for infants to begin to relate socially with family members and to learn the basic social skills of communication. For the first six months, infants vocalize at the same time as someone talking to them. By seven or eight months of age, though, the baby begins to take turns in vocalizing. Now the baby will listen while someone else is speaking and then respond with babbling. By eight months, the infant takes on the accent of the native language, matches the speaker's tone of voice, and ends phrases with upward or downward inflection. The baby is learning the basics of communication.

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The infant then begins to make sounds that refer to specific objects, people, or actions. For instance, the baby may make an "rrrrr" sound when seeing a truck or say "mmmmm" when seeing food. Babies also accompany their speech with gestures such as pointing to get their message across. A popular form of this type of communication is the scream-and-point method. Babbling increases until the age of 9 to 12 months, when babies say their first word.

Exhibit 4.8 Expressive and Receptive Language in Infants

	Expressive Language	Receptive Language
By 3 months Lopolo/Shutterstock.com	■ Maintains eye contact when spoken to ■ Cries differently for different needs ■ Coo, goos, smiles	■ Shows awareness of speaker ■ Watches speaker's mouth or eyes ■ Quiets or smiles when spoken to
By 6 months Tatyana Vyc/Shutterstock.com	■ Begins babbling with p, b, and m sounds ■ Vocalizes to gain attention and express feelings ■ Uses and produces different kinds of sounds	■ Turns head to follow directions ■ Listens and responds when spoken to ■ Notices toys that make noise
By 9 months Photobac/Shutterstock.com	■ Produces 4+ sounds in babbling ■ Participates in vocal turn taking ■ Begins using hand movements to communicate wants and needs	■ Consistent responds to name ■ Looks at familiar objects and people when named ■ Follows some routine commands paired with gestures
By 12 months Flashon Studio/Shutterstock.com	■ Says one or two words, like "mama" or "dada" ■ Imitates speech sounds ■ Produces jargon: strings of speech-like babbling	■ Understands up to 50 words. ■ Responds to simple directions ■ Follows your gaze and points
By 15 months Oksana Kuzmina/Shutterstock.com	■ May use four to six different words ■ Imitates simple familiar words and sounds ■ Combines sounds and gestures	■ Consistently follows simple directions ■ Maintains attention to pictures ■ Identifies one to two body parts when named
By 18 months sashahaltam/Shutterstock.com	■ Uses 20 words, mostly nouns ■ Responds to questions ■ Continues to produce jargon	■ Points at familiar objects and people in pictures ■ Understands early direction words ■ Responds to yes/no questions with head shake/nod

Continued

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	Expressive Language	Receptive Language
By 21 months © Lela Rankin	■ Uses words more often than gestures ■ Consistently imitates new words ■ Vocabulary of 20 to 50 single words	■ Understand some emotion works ■ Understands some pronouns ■ Identifies three to five body parts when named
By 24 months siro46/Shutterstock.com	■ Uses at least 50 words ■ Beginning to use two-word phrases ■ Uses early pronouns (me, you, my)	■ Understands more than 300 words ■ Understand action words ■ Enjoys listening to stories

Holophrastic Speech

Babies begin to say their first words by 9 to 12 months. At this point, their receptive language is better than their expressive language; in other words, they understand more words than they can say. By the time babies speak their first word, they can understand almost 100 words. Babies begin to add new words slowly, one at a time, until they have a vocabulary of 10 words. Then the baby has a vocabulary spurt, or naming explosion, when new words are added rapidly. A major aspect of the CDC's revisions on infants' developmental milestones involved language development. The 2004 standards suggested a 24-month-old should have an average of 50 spoken words. However, the new 2022 guidelines have pushed that vocabulary milestone age to 30 months.

During the early speech phase, the baby uses one word to express the meaning of a whole sentence, which is referred to as **holophrastic speech**. For instance, a baby may point to a pitcher, whine, and say, "juice," meaning, "I would like some juice to drink." When you pour a cup and hand it to him, he may smile and happily say, "Juice," meaning, "Oh, good, some juice to drink at last." When the cup tips and spills juice on his shirt, he may grab the shirt, cry, and say, "Juice," meaning, "I've spilled juice all over me and now I'm wet and uncomfortable and I want a clean shirt." Babies at this age also use one word in a fashion referred to as **overextension**. This means that the word becomes generalized to include a larger category. For instance, babies often use the word dog to refer to any furry animal, but this overextension does not mean that the baby can't tell the difference between a dog and a cow. The baby often can accurately point out animals in a book before being able to name them. (Remember, babies know more words than they can say, but when your usable vocabulary consists of four words and you know the large mooing animal is not mommy, daddy, or a ball, then dog is your best guess.)

Telegraphic Speech

Between 18 and 24 months, babies begin to put words together to form simple phrases or sentences. Because these sentences are abbreviated, like the message in a telegram, they are referred to as **telegraphic speech**. When you have to pay for each word you use, as you do when sending a telegram, then you want to use only words that are absolutely necessary to convey your message. So, in telegraphic speech, babies use nouns, verbs, and adjectives. They omit auxiliary verbs, prepositions, articles, and pronouns. For example, 18-month-old Sarah had never said more than one word at a time. One day she was sitting quietly at her mother's feet looking at a lamp. After a few minutes, she climbed into her mother's lap and said, "Mommy, lamp, hot, burn, ouch." With a few words she had communicated the message that if you touched a hot lightbulb you would burn yourself, and it would hurt.

Implications for Practice:

Recognizing Speech Problems

Although infants develop speech in a predictable sequence, the amount of speech individual children evidence at age two can vary greatly. Some speak in simple two-word phrases, whereas others speak in longer sentences. Both are normal. But, as we mentioned earlier, it is important to recognize delays in speech, especially in the case of hearing-impaired children. If the hearing loss is caught early, children can learn sign language in the same progression as they would have learned spoken language. Hearing loss is often undetected because the infant begins to babble on schedule. Parents should instead note how the infant responds to loud noises. A baby who does not startle when hearing a loud noise,

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or does not look to find the source of a noise, may have hearing problems.

As we have seen, to develop speech, infants need to hear spoken language. But even some infants without hearing impairments can have problems with adequate verbal stimulation. Parents who lack developmental information may assume that a seven-month-old infant doesn't understand speech and thus may fail to interact verbally with the baby. This can be a particular problem with teenage parents. Adolescent parents need to be encouraged to speak to the baby, even if the essence of the speech is silly nonsense.

Adult Communication Patterns with Infants

Have you ever heard an adult say something like, "How's my little schnookums?" What happens to mature, sophisticated adults when they see a baby? All of a sudden, they begin speaking in a singsong, high-pitched voice, using short phrases, asking lots of questions, using many repetitions, and adding exaggerated emphasis to certain words.

"How's Daddy's little schnookums? What do you see? Is that a doggie? Yes? Where's the doggie? Hello, doggie. Nice doggie."

This kind of speech directed toward infants occurs in other cultures and is initiated by both sexes and people in various age groups, from elderly gentlemen to four-year-olds. Some parents attempt to avoid talking to their baby using this infant-directed speech, or baby talk, fearing that their baby will end up talking this way. But new research suggests that failure to use baby talk may be a mistake. Babies love to listen to this type of speech and actually seem to learn language better when addressed in this fashion.

Practice Guidelines

- Parents do not need to "teach" their infants how to speak, but they should be encouraged to talk to their babies throughout the day; for example, "Mommy's going to do some laundry." "Whoops, better wipe up that spill!" Babies prefer to hear their mother's voice and enjoy the attention but are also learning language.
- Children who experience language delays may be delayed because their expressive language (speaking) is behind their receptive language (understanding). That is, they may understand everything that is being said but are unable or choose not to speak. Other children may be experiencing delays in both receptive and expressive language. It is important to catch delays early so that any issues hindering speech, such as hearing loss, can be intervened with early and the infant can catch up to a normative development trajectory.
- Parents may feel silly using baby talk with their infants; however, babies not only prefer baby talk but it may actually help them to learn language. Whenever working with infants, try using baby talk and see how they respond. Point out your observations to parents to help them identify their infants' responses; for example, "See how you your baby smiles when you speak like that to her."

Attitudes, Emotions, and Regulation

In the past, research concentrated on cognitive development, with emotion being seen as the outcome of cognitive activity. The baby would engage in activities and learn that some were pleasant, some were sad, and some were scary. Recent research, however, indicates that emotions have a strong biological component. If this is true, then babies do not learn to be afraid of unfamiliar situations; they enter a developmental stage in which they begin to exhibit fear of strange people and places.

Babies all over the world develop emotions at the same ages in a predictable sequence: at birth, interest, distress, disgust, and happiness; and by two-and-a-half months to six months, anger, sadness, surprise, and fear.

Fear develops during the first year of life. At five to six months, babies begin to show **stranger anxiety**. Before this age, if given time to warm up, babies will smile at anyone. At eight months, though, babies will cry and turn away from an unfamiliar face. Between 8 and 10 months, babies begin to display **separation anxiety**, crying at being left by the primary caregiver. This fear begins to diminish at about 13 months, when the baby has acquired greater object permanence and can remember the mother when she is away and anticipate her return. At this time, the baby also may have a **transitional object**—a blanket, toy, or teddy bear to use for comfort in the caregiver's absence. During the second year of life, babies add complex or secondary emotions of embarrassment, shame, guilt, and pride. These emotions may require that the child have a sense of self and knowledge of appropriate conduct; in other words, the baby would realize that "Baby has done something wrong." By 18 to 24 months, babies are fairly accomplished in the emotional area and can display a wide range of emotions and even fake certain emotions, such as sadness, in order to manipulate others.

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Research suggests that emotional expression in infancy is predictive of later childhood emotional characteristics. Shy babies grow up to be shy children. Infant shyness, when infants start reacting shyly to adult strangers appears around 9 to 12 months of age and is distinct from self-conscious shyness, which appears at four to five years of age, and involves a conflict in temperament between the desire to approach strangers and the fear of strangers (Matsuda et al., 2013). Highly shy infants prefer strangers that avert their gaze and face to strangers that have a directed gaze and face.

Many researchers have wondered whether babies can read facial expressions. By two months of age, infants of depressed mothers look less frequently at their mothers and display more positive affect compared to infants of nondepressed mothers when their mothers stop engaging with them during a play activity (Graham et al., 2018). Babies at this age should look to the caregiver for emotional cues. For instance, if the baby sees a new toy, the baby will look to see how the mother feels about this object. If the mother smiles, the baby may approach the toy. By 12 months, babies will even look to strangers for cues on how to react. Looking to others for emotional information is known as **social referencing**.

Jerome Kagan studies human infant development, and Stephen Suomi conducts developmental studies of monkeys. These researchers have found that extremely inhibited children and uptight monkeys often behave in similar ways, and have similar physiological reactions, when faced with novel situations. Kagan believes that the limbic system—particularly the amygdala and hypothalamus—in these children and monkeys is activated more easily, and that this overactivation is inherited. Kagan found that timid children show a pattern of excessive physiological responses to mildly stressful situations that do not occur in more easygoing children. Under stress, these children have dilated pupils, a more rapid heartbeat, and elevated blood cortisol. Suomi's uptight monkeys, when stressed during infancy by brief separations from their mothers, showed the same rise in blood cortisol and increase in heart rate. The researchers found that these individual differences are stable. Neither the monkeys nor the children tend to outgrow these abnormal physiological responses to stress. Children who have high levels of shyness across infancy and childhood are at the greatest risk for developing an anxiety disorder later in development.

Suomi and Kagan agree that this extreme timidity seems to have a genetic foundation. The monkeys were reared together in nurseries and in peer groups, so parenting was not influencing their individual reactions to stress. Research by Robert Plomin and David Rowe has indicated that identical twins tend to exhibit the same reaction to strangers; however, being born shy does not doom a child or monkey to lifelong social difficulties.

Encouraging infants to play and interact with other children can help those with shy temperaments learn coping skills and social success. These infants—all aged 19 months—are developing their social skills.

Suomi found that monkeys can be helped to overcome their stress responses through changes in how they are reared. Environmental influences such as having a nurturing mother can offset the genetic tendency toward shyness. Surrounding a monkey with friendly, outgoing peers and a nurturing foster mother or grandmother helps the monkey learn coping strategies. When stressed, this monkey can seek out a nurturing friend or mother figure. This activity prevents the normal high-stress physical response. Growing up with a nurturing mother figure often helps these monkeys respond better than their peers and become leaders in their group.

Kagan's studies of human children provide evidence that, although timid toddlers tend to stay shy, these children can thrive in the right environment with help from their parents and peers (Willetts & Creswell, 2013). Social workers can help parents of very shy children recognize this temperament characteristic early, by exposing their child to novel situations and stimuli in the presence of a caring adult, and helping the child to learn effective coping skills. Parents should be careful not to become too overprotective of their shy children. By completely removing them from perceived stressful social situations or settings, they may actually exacerbate shyness and withdrawal (Burgess, Rubin, Cheah, & Nelson, 2005). Parents can help the child by setting up playdates with other children in one-on-one settings and by teaching the child how to cope with the physical response brought on by stressful situations.

The work of Suomi and Kagan has helped to clarify how heredity and environment interact to influence behavior and development. Some children may be born

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shy, but a supportive and nurturing environment can help them later develop social success.

Infant Temperament

Though all babies seem to possess primary emotions at birth, those emotions vary in how they are exhibited among individual newborns. Some babies are easily comforted and sleep and eat on a regular schedule. Some babies are more difficult to comfort and have very unpredictable daily patterns. The characteristic pattern in which an infant responds to and interacts with the environment is referred to as **temperament**. Some consider temperament to be the basis of later personality development. For the most part, temperament is thought to be biologically determined (Fox, Snidman, Haas, Degnan, & Kagan, 2015; Thomas & Chess, 1989).

In an extensive study of temperament, Alexander Thomas and Stella Chess conducted the New York Longitudinal Survey in the mid-1970s. They looked at 133 individuals from infancy through adulthood and identified nine dimensions of temperament, including activity level, rhythmicity, approach or withdrawal, adaptability, threshold of responsiveness, intensity of reaction, quality of mood, distractibility, and persistence and attention span (see Exhibit 4.9).

Based on the data obtained from their work, Thomas and Chess (1977) determined that the combination of these nine dimensions described three types of children: The flexible or **easy child**, the fearful or **slow-to-warm up child**, and the fiesty or **difficult child**. Approximately 40% of the children in their sample fit the description of the easy child. This baby is characterized by regular, positive responses to new stimuli, high adaptability to change, and mild or moderately intense mood, which is usually positive. In other words, this infant is apt to easily accept new toys, foods, individuals, and settings. This baby has predictable eating and sleeping schedules and is usually happy and pleasant.

Of the children studied, 15% were classified as slow to warm up. As babies, these children exhibit a more sedate and less exuberant orientation to the world. They

Exhibit 4.9 Dimensions of Temperament

Temperament Dimension	Examples	Possible Strengths
Activity level	■ Does the infant always wiggle and squirm? ■ Is it difficult to do diaper changes because they have difficulties sitting still?	■ May perform well in high-energy careers. ■ May be able to keep up with many different responsibilities.
Rhythmicity	■ Is the baby tired/hungry at unpredictable times?	■ May do well working unusual working hours or traveling.
Approach/ withdrawal	■ Does the infant seem hesitant and resistant when faced with new situations, people, or things?	■ May think before they act. ■ May be less impulsive during adolescence.
Adaptability	■ Does the infant have difficulty with changes in routines or transitions from one activity to another?	■ May be less influenced by peer pressure.
Sensory threshold	■ Does the infant startle easily to sounds? ■ Is the infant a picky eater?	■ May be more likely to be artistic and creative.
Intensity	■ Does the infant show pleasure and/or upset strongly and dramatically? ■ Does the infant react strongly or loudly to everything, even minor events?	■ May be more likely to have their needs met and have a greater depth of emotion. ■ May be gifted in dramatic arts.
Mood	■ Does the infant tend to react negatively to the world? ■ Is the infant generally serious?	■ May be more analytical and evaluate situations carefully.
Distractibility	■ Is the baby easily soothed when offered an alternate activity? ■ Is the baby distracted by sights and sounds while breastfeeding or drinking a bottle?	■ May be easier to divert from an undesirable behavior.
Persistence	■ Does the infant react strongly when interrupted in an activity? ■ Is the infant able to wait to have his/her needs met?	■ Sometimes children are labeled as patient (sticking with a tough puzzle) or stubborn (doesn't want to stop an activity). ■ May be more likely to succeed in reaching goals.

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have more negative responses and are slower to adapt to new situations. Like the easy child, the slow-to-warm-up child usually has predictable eating and sleeping schedules. Although these infants are wary of new experiences, such as visiting a new house, they are able to adjust over time if not hurried or pushed during the transition.

In contrast to the other types, the difficult child has unpredictable daily habits. As babies, they wake up at a different time every day and do not establish a regular napping schedule. Their appetite also varies from day to day. These infants exhibit negative responses to new stimuli, adapt slowly or not at all, and usually express an intense, negative mood. These babies protest loudly when introduced to new toys, foods, people, or situations; throw temper tantrums when agitated or frustrated; and squeal loudly when excited. Of the children in the sample, 10% fit this description. The other 35% of children fell in the middle range across these dimensions.

Since the work of Thomas and Chess, much research has been conducted to examine the validity of inborn temperament. Studies of twins have found temperament to be biologically determined to some extent. Our review of studies by Kagan found that shy babies grow up to be shy children, and difficult babies grow up to be difficult adults. In Thomas and Chess's study, 70% of the difficult infants entered psychiatric treatment later in life, but only 18% of the easy infants did so. Children as young as four months of age can be classified into different temperament categories based on their responses to unfamiliar events (Fox et al., 2015). In a laboratory setting, motor activity (limb and trunk movements) and crying/distress can be measured when infants are introduced to novel lights or sounds. Infants who display high levels of activity and distress are highly reactive and tend to avoid or withdraw from unfamiliar situations or objects during early childhood. This temperament characteristic is called behavioral inhibition. Boys with behavioral inhibition have poorer outcomes compared to girls, perhaps due to differential gender expectations and socialization practices. They are more likely to experience peer exclusion, depression, anxiety, and low self-esteem compared to shy girls.

Temper Tantrums

Temper tantrums typically start about at the age of 15 to 18 months. They are often associated with what is referred to as the "terrible twos." These emotional outbursts occur during the stage of development when increased independence and recognition of the power of choice collide with the child's emotional and verbal levels of immaturity (Reinberger, 2008). These outbursts are normal facets of development. However, extreme levels of rage have been observed in some infants. Kids during this phase of development can develop a persistent problem if they are willful about the expression of negative emotions as retaliation. Resistance to conflicts typically involves gaze withdrawal or other forms of avoidance initially, but retaliation involves the intentional use of force to harm others in the form of kicking, hitting, or biting (Hay, 2005). Retaliation in the form of using physical force typically starts at about 9 or 10 months of age and peaks between 18 and 30 months (Hay, 2005). Some children have frequent attacks of rage, coupled with self-destructive or violent forms of behavior that can suggest the presence of serious problems. The connection between emotional outbursts and aggression is a growing area of inquiry in the scientific study of the developmental origins of aggressive behavior (Tremblay, Hartup, & Archer, 2005).

Hay (2005) wrote that the developmental course of aggression is best understood by using a conflict framework. Hay defined a conflict as involving the infant's objection to the actions of others by protest, resistance, or retaliation. Most infants engage in protest and resistance responses to conflict prior to retaliation. When they turn about 18 months of age, they realize that their actions elicit responses from others. During this developmental phase, the frustration of toddlers' expectations in the form of "no's" results in disappointment and rage. "Unable to express their feelings with words, toddlers discharge them instead with irrational screaming and physical frenzy—temper tantrum" (Reinberger, 2008, p. 75). As children grow older and are better able to express themselves verbally, temper tantrums may begin to decrease.

Implications for Practice:

Goodness of Fit

Although research has found that one's personality seems to be partially genetically determined, the environment shapes personality development. ***Goodness of fit*** refers to how well the demands of the environment match the child's behavioral style. An active, intense baby with outgoing, high-energy parents who encourage loud play and exploration will have a better fit than will such a baby born to quiet, introspective parents who expect the baby to sit and look at books. Parents of difficult children should not take the children's behavior personally, should keep a sense

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of humor about the children's behavior, should be patiently available to the children, should have clear guidelines for behavior, and should develop a support system that allows the parents time away from the children. Parents of active children should structure the house and yard to allow for robust play. Parents of slow-to-warm-up children should take special measures in introducing their children to new situations, paying attention to when their mood changes from caution to enjoyment, and then step back. Easy children can be taken advantage of. They may not demand attention or complain, even when they should, and may therefore be ignored in the hectic pace of everyday life.

Practice Guidelines

- Infants start to experience fear before they have full object permanence. To help infants with coping in their parents' absence, recommend that they use a transitional object, such as a special blanket, toy, or teddy bear for comfort.
- Although shyness and stress responses are primarily biologically determined, social workers can help infants with this temperament by encouraging a nurturing parenting style. Caregivers who are warm and attentive may offset the risk associated with having a heightened stress response. Parents should be particularly mindful of gender expectations they may have.
- Encourage parents to set up playdates for their child. Infants who are shy may do better in smaller group, or one-on-one, social settings. Parents can help by teaching their child with coping strategies to help manage the physical response brought on by stressful situations.
- Children will have the most success when their environment matches their temperamental dispositions. A slow-to-warm-up baby may experience stress if the parents are highly sociable and always on the go. An easy child with a more difficult sibling may be ignored while the parents concentrate their energy on their other child.

Attachment

Erikson described the first task of infancy as developing trust. During the first year of life, babies respond to caregivers and strangers in a particular way because they have an innate desire to develop an **attachment**. In the first two to three months in development, babies indiscriminately respond positively to any caring adult. Their basic needs drive responsiveness. But by six to seven months, infants start to discriminate and show preference for one person over another. They may still be interested in strangers, but they direct the most emotion to close family members. After six to seven months, infants form clear emotional bonds, and most often with their mothers. During this stage, they prefer to stay close to the person with whom they have a close bond and may protest to being separated from that person. However, they are easily comforted by the return of that person. During this stage, the infant can form multiple close relationships and attachments with other people, such as close family, siblings, or babysitters (see Exhibit 4.10).

We know now that attachments do not form based on simply feeding the baby. Harlow's research on infant rhesus monkeys in the 1950s powerfully demonstrated that children have a biological need for affection. In Harlow's experiments, monkeys raised by an inanimate surrogate mother preferred the terry-cloth mother and would spend time cuddling with her, over the wire mother who fed them, when they desired comfort.

Different experiments have been designed in order to determine if infants have formed trust or an attachment with a caregiver. The Strange Situation was indeed a strange situation that Mary Ainsworth and colleagues (1978) developed to categorize different attachment styles of children between the age of 9 and 18 months. The mother and infant enter into a playroom with a variety of toys and are left alone to explore. An unfamiliar woman comes into the room and talks to the parent and then approaches the infant. After a few minutes the mother leaves the room, leaving her infant and the stranger alone in the room together. The stranger initiates playing with the baby. The mother returns to the room, comforts the infant, and then leaves again. The infant is alone. The stranger enters and interacts with the infant, and finally,

Exhibit 4.10 Bowlby's Phases of Attachment

Age	Behaviors
Phase 1:	Birth to 2–3 months; displays indiscriminate smiling, cooing, clinging toward anyone.
Phase 2:	2–3 months to 6–7 months; begins selective interactions; develops a true social smile directed at preferred caregivers; compares a stranger's face with caregiver's.
Phase 3:	6–7 months to 1 year; clearly attached to primary caregiver; cries when caregiver leaves; crawls after caregiver; wary of strangers and strange situations.
Phase 4:	Second year of life; has full object permanence; more secure in knowledge that caregiver exists when not in sight; more sociable with other people.

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the parent enters and greets the infant. The child's behaviors are scored by the amount of exploration, the child's reactions to the parent leaving, stranger anxiety when the infant is left alone with the stranger, and the infant's reunion behavior with the parent.

1. Secure attachment: These infants explore and play freely when their mothers are present, using her as a secure base throughout (e.g., looking back at their mothers). These infants engage with the stranger when their mothers are present, but when their mothers leave they will cry or protest. These infants are happy to see their mothers return and feel confident that their mothers are available and responsive to their needs.
2. Anxious attachment: These infants stay close to their mother and are reluctant to explore the playroom when their mother is present. These infants do not engage with the stranger when the mother is present and when their mothers leave, they become extremely upset and cry for long periods of time. These infants seek physical comfort from their mothers when they return, but they also hit or pull away from them. These infants are not easily soothed by their mothers, and they do not trust that their mothers will meet their needs.
3. Avoidant attachment: These infants appear to be indifferent to whether their mothers are present or not. They explore the playroom, but they do not use their mothers as a secure base and are not distressed when their mothers leave. They do not seek comfort or approach their mothers upon their return. These infants do not trust that their mothers will meet their needs, and they believe that their communication of their needs has no impact on their caregiver.
4. Disorganized attachment: These infants do not show a consistent or organized strategy to relieve their fears. They may show odd, unusual, contradictory, or conflicted behavior when the parent leaves and returns. For example, they may show distress when the parent leaves but indifference when the parent returns. Or they may seek proximity to the stranger instead of the parent after separation. They may show fear of the parent immediately upon their return or freezing (unable to choose between going toward or away from the parent).

Of middle-class infants, 65% display secure attachment behaviors. The other three categories are forms of insecure attachment. What factors influence the attachment process? How do 35% of infants end up not securely attached?

Risk Factors Associated with Attachment Failure

"Optimal development depends on a 'good enough' fit between the organizing and regulating systems of the mother and baby" (Van Horn, 2011, p. 12). The interplay between the mother's and the infant's systems affects both other affective and other psychobiological states (Van Horn, 2011). For this reason, factors involving the baby, the mother, and the home can interfere with attachment. First of all, characteristics of babies can affect the mother–infant relationship. For instance, premature babies may be at risk for attachment problems; these babies are not as "cute" as full-term infants and also are less responsive. Preterm infants can be less engaged with their mothers and receive less enjoyment in mother-involved play activities. In addition, preterm infants often spend an extended period of time in the neonatal intensive care unit, making contact with the mother difficult. Other infant-related factors that can affect attachment include drug exposure (Lester, 1992) and difficult temperament.

A parenting-related problem that affects the attachment relationship can occur with adolescent mothers. These mothers on average engage in less verbal exchange with their children and have trouble interpreting and responding to their cues. Depressed mothers also have more problems bonding with their babies. A depressed mother is less responsive to her infant. She may be preoccupied with her own pain that she misses the baby's social cues. The baby then tends to match the mother's mood even with other nondepressed adults. Depressed mothers who express themselves as stressed and anxious tend to have infants who develop insecure-ambivalent attachment. These babies appear anxious and restless when separated from the mother but show mixed behaviors when reunited with her. Infants often develop insecure-avoidant attachment when the mother expresses her depression by appearing disinterested and withdrawn. Babies with insecure-avoidant attachment seem independent when separated from the mother and avoid contact when reunited. Other parental factors that may affect attachment include alcoholism, childhood abuse and neglect, and an unplanned pregnancy. The most common cause of disorganized attachment is having an abusive parent. Nearly 80% of maltreated infants have disorganized attachment issues (Benoit, 2004).

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Factors in the home also can affect attachment. A mother with lots of small children may not have time to respond to a new infant. The marital relationship has an effect on the primary caregiver's interactions with an infant. When spouses or partners are supportive, mothers are more responsive and affectionate toward their babies (Crnic, 1984), and a mother's level of social support is critical, especially when she is parenting an irritable infant. On the other hand, a parent having a violence partner impacts the attachment formed in the child and often results in disorganization. A secure attachment is more likely when a mother has an adequate social support network. High levels of environmental stress also influence mother–baby interactions (Mantymaa, Puura, Luoma, Salmelin, & Tamminen, 2006). Mothers dealing with poverty, domestic violence, and their own personal trauma may not have enough emotional energy to engage an infant.

Implications for Practice:
Assessing Attachment Problems

How can we help promote secure attachments? In addition to the nutritional benefits of **breastfeeding**, nursing promotes attachment. Brain imaging research has found that rodents found nursing more rewarding than cocaine (Ferris et al., 2005). Hormones that are released during breastfeeding, such as oxytocin, help to promote attachment in both infants and mothers. Oxytocin has also been linked to affection and physical touch (Gordon, Zagoory-Sharon, Leckman, & Feldman, 2010). Interventions that encourage physical touch (such as skin-to-skin contact and babywearing) have been successful at promoting secure mother-infant attachments, particularly among mothers from lower socioeconomic status (Anisfeld et al., 1990) and adolescent mothers (Williams & Turner, 2020a). In addition to the biological response, close physical proximity to infants increases the mothers' awareness of her infants' needs (e.g., hunger), Ih subsequently allows her to be more responsive to those needs. Babywearing can be used as an effective tool to keep the infant in close proximity for longer periods of time. Additionally, many parents find crying and their infants' lack of responsiveness stressful because they view their inability to console their child as a reflection of their (inadequate) parenting skills. Early babywearing research found that babywearing for three hours a day significantly reduced crying by 43% overall and by 54% in the evening hours when crying is typically heightened (Hunziker & Garr, 1986). One mother, Crystal, describes her experience with attachment and babywearing: "I spent too many hours than I care to admit regretting my choice to become a mom. It was so much harder physically and emotionally than I ever imagined. But babywearing gave me an opportunity to build a bond simply by proximity until I started to experience one emotionally."

If attachment is so important to development, what are the signs to look for when assessing children that would point to attachment problems? Children with attachment problems are believed to exhibit the following behaviors in interactions: They do not show a preference for a particular adult; they may seek affection and attention from anyone and run up to and hug total strangers. They will wander away from their caregivers—the caregiver frequently loses the child in crowds and in public places. The child may be reckless and accident prone, and excessively clingy or aggressive toward the caregiver. The type of behaviors that Zeanah and Emde (1994) believe are suggestive of an attachment difficulty in young children and are listed in Exhibit 4.11.

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This mother-infant pair is participating in the "Still Face Paradigm" (Williams & Turner, 2020a), first developed by Edward Tronick in 1975. The procedure can be used similarly to the Strange Situation to assess infants' response to caregiver separation, and has been used to show differences in communication, gender, culture, attachment, and the effects of maternal depression on infants. In this example, this seven-month-old infant sits across from her mother at eye level. There are three 2-minute phases: Engagement (the mother interacts with her infant normally for two minutes), Still-Face (the mother is nonresponsive and assumes a neutral expression while continuing to look at her infant), and Reunion (the mother resumes interacting with her infant as she normally would). Securely attached infants are more easily soothed in the reunion episode (i.e., showed more happiness and attentiveness).

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Exhibit 4.11 Assessing Attachment Problems in Infants

Behaviors	Signs of Attachment Disorders
Showing affection	Lack of warm and affectionate interchanges across a range of interactions; promiscuous affection with relatively unfamiliar adults
Comfort seeking	Lack of comfort-seeking when hurt, frightened, or ill; comfort-seeking in odd or ambivalent manner
Reliance for help	Excessive dependence, or inability to seek and use supportive presence of attachment figure when needed
Cooperation	Lack of compliance with caregiver requests and demands by the child as a striking feature of caregiver–child interactions, or compulsive compliance
Exploratory behavior	Failure to check back with caregiver in unfamiliar settings, or exploration limited by child's unwillingness to leave caregiver
Controlling behavior	Oversolicitous and inappropriate caregiving behavior, or excessively bossy and punitive controlling of caregiver by the child
Reunion responses	Failure to reestablish interaction after separations, including ignoring/avoiding behaviors, intense anger, or lack of affection

Cultural Considerations in Examining African American Attachment Patterns

Practitioners should be aware that the cross-cultural validity of identified attachment behaviors has been called into question. As stated by attachment researcher Jacquelyne Faye Jackson (1993), "[b]oth execution of the 'strange situation' procedure and unequivocal classification of infant attachments have been technically difficult in cultures outside the USA (Sagi et al., 1985) and no transcultural distribution of types has been found (Van Ijzendoorn & Kroonenberg, 1988)" (p. 91). Jackson (1993) presented a compelling argument that the African American practice of sharing childcare responsibilities among relatives results in a negative misinterpretation of African American infant-attachment patterns. Jackson explained that, as a consequence of discrimination, African American mothers have, historically and currently, needed to work outside the home. As a result of this economic reality, African American culture has developed a distinct, adaptive cultural pattern to ensure that children receive the nurturance and care they require. African American children are less likely to be securely attached compared to White children, but this finding is likely due to poverty (hampering maternal sensitivity) as well as attachment to multiple caregivers.

Practice Guidelines

- Developing a secure attachment has a lasting impact. Parenting that is warm and responsive is likely to foster a positive attachment.
- Mothers who are having difficulty bonding with their baby may benefit from breastfeeding their baby. Babywearing can also promote bonding through prolonged physical contact and reduced crying.
- Find or establish groups in the community that have like-minded parenting practices. Many online groups are increasingly becoming available and are highly accessible. For example, if a mother is feeling overwhelmed and emotional at 3:00 a.m., she can share her frustrations through an online forum and find other mothers who are also awake with a hungry baby.

Self-Awareness

At what age does a baby know that he or she is a baby? Lewis conducted experiments to test babies' awareness of self (Lewis & Brooks-Gunn, 1979). He put a spot of rouge on the baby's nose and had the mother sit with her infant in her lap in front of a mirror. If the babies recognized themselves in the mirror, they touched their own nose. Babies under one year looked in the mirror but did not touch their nose. Some babies at 15 months would touch their nose; but by 18 months, 75% of the babies recognized themselves in the mirror and touched their

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This 10-month-old infant is developing his self-awareness—he recognizes that he is the same person who is reflected in the mirror.

nose. Further research has suggested that most babies have a sense of self by 18 months.

Margaret Mahler felt that developing a sense of self as separate from others was a major developmental process with a significant effect on personality development. In Mahler's view, the infant grows from being a newborn with no sense of self as separate from her caretaker to being an autonomous, independent individual. She termed this process ***separation-individuation***. During the first month of life, infants are in the normal autistic phase, unaware of self, other people, or the world. At one to five months, the babies are in the normal symbiotic phase, and aware that someone is caring for them but unaware of that person as separate from themselves. At five to nine months, in the differentiation phase, babies begin to get a sense of self and non-self. At this age, babies will sit in their mother's lap and explore the mother's face visually and tactually. As babies begin to crawl and then walk between 9 and 14 months, they enter the practicing phase. Now they can move away from the mother, but they need to check back often for emotional refueling (a look, a smile, or a hug). The rapprochement phase occurs between 14 and 24 months. Babies know they are separate from the mother but still need to check back regularly. The consolidation phase occurs between the age of two and three. Now babies can separate from the mother without becoming too upset.

In experiments involving information processing, Daniel Stern (2000) concluded that infants have a sense of self from birth that babies are always able to differentiate self from others. How? As we discussed in the Information Processing section of this chapter, babies are able to accurately discriminate sensory input at birth. Even newborns seem to have an innate core of knowledge about the world. They can tell when they are sucking their own or someone else's fingers. They can tell when they are moving their own arm or having it raised by someone to play "How big is baby?" And they can tell when they are causing actions or when someone else is.

In any case, by the end of infancy, children have a well-established sense of self as separate and independent. This notion of self is important for later development. For instance, as you may remember, a baby must have a sense of self before being able to express more complex emotions, such as guilt and shame. More important, a sense of self is a necessary foundation for social development (see Exhibit 4.12).

Regulation

Somewhere around the age of two, the baby learns to say "No!" This is a statement of independence and autonomy. The baby now has a sense of self and what that self wants and does not want. The ability to know right from wrong, good from bad, and want from not-want begins to develop after the age of 18 months. Regulation can begin when the infant has adequate language skills, a sense of self, more complex emotions of guilt and shame, and a sense of autonomy (Gross, 2010). Even babies who have been "easy" up to this point may not be as compliant now. They are more difficult to distract. They can formulate certain goals and realize whether or not they have obtained them.

Exhibit 4.12 Developmental Milestones for Social Behaviors

Age (in months)	Milestone
0–2	Smiles in response to a voice or touch
3–5	Smiles spontaneously; reaches for familiar people
9–11	Plays pat-a-cake and peek-a-boo; becomes upset when separated from caregiver
20–23	Plays near but not with other children
28–31	Is aware of differences between sexes
32–35	Can identify own sex Can separate easily from caregiver

Source: Johnson, J., "Developmental Assessment in Clinical Child Psychology," p. 5. Prentice Hall, 1992.

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And, in terms of moral development, they have internalized certain standards and become upset when those standards are not met. Where did they get these standards and ideas of right and wrong, good and bad?

These standards and ideas are based on the previous responses of others. Remember, babies engage in social referencing; that is, they look to an adult for guidance in how to respond in new situations. Babies learn through experience that when they throw things on the floor and break them, mother becomes upset. They learn that when they pour their juice on the floor, father becomes upset. So now when babies break or spill something, they become upset. At this age, babies often will reach out for an object and then look to their mother to see if she is going to stop them.

Babies at this age also are unsure of many standards, and they test parents to determine which actions are acceptable and which are not—usually more than once. "Will Mother get mad at me if I eat the food in this bowl on the floor? She lets the cat eat it. But Mother yelled at me last time I ate it. Why? Let's see what happens this time."

Through repeated experimentation, babies learn to be reasonably obedient in the presence of parents. But they do not possess the ability to obey when parents are not watching until about 36 months. To the two-year-old, it's okay to eat cat food unless mom catches you. In this context, the reason to be good is to avoid displeasure from mom.

Implications for Practice:

The Terrible Twos

During the second half of the second year of life, babies can become much more difficult. They begin to develop a sense of autonomy and independence. They want to do things for themselves, they want to do it now, and they want to do it their way. *No* becomes their favorite word. Even when asked whether they want ice cream, children may reply "No" and then cry when the parents don't provide the ice cream. Some parents become locked in power struggles with their children, sometimes erupting into food battles. Parents may try to force the child to eat, only to discover that some children would rather starve than eat when coerced. However, some parents allow the toddler to run the house. They hesitate to provide any structure for the baby, failing to set limits or establish regular routines. Even though toddlers struggle to obtain it, they are often afraid of their growing independence.

Practice Guidelines

- Up until this point, discipline has been relatively easy. Parents should receive support and encouragement to set boundaries, rules, and predictable routines for their child. Although they will test the limits, children are more less likely to misbehave when they know what to expect.
- Educate parents about children's understanding of right and wrong. At this point in development, their behavior is dictated based on their parents' pleasure or displeasure rather their own set of internalized rules of right and wrong.
- Help parents to set age-appropriate limits. The rules shouldn't be so rigid that the child is not allowed any independence. For example, the child may be allowed to pick which shoes they want to wear to school after the parent has preapproved which shoes they can choose from. Parents should avoid getting into power struggles with their child.

Psychological Strengths, Hazards, and Risks

What exactly are the effects on psychological development of losing a caregiver at a young age or even of failing to establish a bond with a primary caregiver at all? Loss of a primary caregiver has often been referred to as maternal deprivation, which can occur through separation from the caregiver, failure of the caregiver to interact with the infant, or neglect or abuse of the baby. If the loss occurs before six months of age, it can interfere with the baby's forming an attachment to a caregiver. If the loss occurs after six months, it can disrupt an existing attachment.

Failure to Form an Attachment

What happens to babies who fail to form an attachment? Research on this issue has to rely on separations that occur naturally, and it usually involves babies who have been institutionalized. A classic study was conducted by Spitz (1945) on children in orphanages in the United States and Germany. These babies received adequate medical attention, food, and physical care, but they received little social interaction. Most of their time was spent in cribs with a sheet over the rails. The death rate for children under two years of age in these institutions was high;

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many died from childhood diseases such as measles. The babies were emotionally apathetic and delayed in physical, mental, and social growth.

What about institutions that offer more stimulation? Tizard and Rees (1974) looked at British orphanages that had a high caregiver-to-baby ratio and lots of interaction. These institutions provided stimulating toys and materials but had a high staff turnover. Some babies experienced 50 to 80 caregivers before preschool age. These children were normal in intellectual development but had problems socially and emotionally. At the age of eight, many were restless, disobedient, and unpopular with their peers and constantly sought attention. Tizard found that the longer the babies were in the institution, the more difficulties they had with peer relations.

Infants who move from one foster home to another can have attachment problems. What happens when these children grow up? Bowlby (1980) looked at adolescents who had spent their infancy and childhood in institutions or foster care, often with repeated moves. These adolescents, who were not loved consistently as babies, were unable to love as teens. They displayed a lack of empathy and affection for others. Many children who fail to form attachments as infants grow up to exhibit disturbed behavior such as delinquency, disregard for life, and lack of empathy. So, early deprivation of a consistent caregiver can affect cognitive, emotional, and social development. But can these effects of early deprivation be reversed with good care at a later age? Quite by accident, Skeels (1936) had an opportunity to explore this question. Two infant girls aged 13 and 16 months from neglectful families were admitted to an overcrowded orphanage in Iowa. Because they appeared delayed and functioned at the age of six or seven months, they were placed in a home for women with disabilities. Six months later these girls were alert, lively, and functioning normally. Why? They had become the "darlings" of the women in the home and received a great deal of stimulation and interaction. Skeels followed these girls' development and found that they remained normal. He then conducted a study comparing children in the orphanage with children placed in the home for women with disabilities (Skodak & Skeels, 1945, 1949). Even as adults, the children who had been placed with the attentive women functioned better than did those who had been in the orphanage.

Suomi and Harlow (1972) raised infant rhesus monkeys in social isolation for six months. These isolated monkeys displayed a lack of social skills. For "therapy," these monkeys were placed with a three-month-old monkey for two hours a day, three days a week. Young monkeys were used as "therapists" because they would not know that the behavior of the isolated monkeys was abnormal and would not be as aggressive toward them, as older monkeys would have been. Because the young monkeys learned social skills from the regular monkey colony in which they spent most of their time, they taught the isolated monkeys how to interact. After six months of this type of therapy, the isolated monkeys learned social skills similar to those of normal monkeys.

So it appears that the effects of early deprivation can be reversed to some extent. But what happens to infants who form an attachment to a caregiver and then lose that caregiver?

Separation after Attachment

Babies who are separated from their primary caregiver show immediate effects. At first, they display acute distress by crying and complaining loudly. This is known as the protest phase. Then babies go into the despair phase, showing general misery and apathy. When the caregiver fails to return after a period of time, the baby becomes unconcerned and relatively peaceful once again. This is the detachment phase. The amount of distress a baby displays depends on the circumstances. For example, there is a difference between going to see grandma for a week and being admitted to the hospital for surgery. In the hospital, the baby may be separated from the whole family and experience scary and painful procedures. Children who are in another family situation—especially if with a sibling or other family member—adapt more easily.

How does the loss of a caregiver affect the child after these immediate responses? Recent studies have corroborated what Anna Freud suggested, "that separation is always traumatic in one way or another, but that it is particularly so for the young child" (Gerard & Dukette, 1954). The most profound responses occur if the separation takes place when the child is between 6 and 28 months (Beebe & Lachmann, 2013). These responses include a drop in developmental quotient (the child scores lower on standard developmental tests), low frustration tolerance, eating disturbances, depression, social withdrawal, inconsolability when left alone, and repeated efforts to make the lost object reappear (opening cabinet doors, waiting by doors). In particular, a sudden loss can

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Attachment has differential expression across cultures. Children love being physically connected with their primary caregiver.

be overwhelming for a small child and have long-lasting effects (Beebe & Lachmann, 2013).

So, which is worse, to have loved and lost (separation from a primary caregiver) or to have never loved at all (failure to form an attachment)? Rutter (1999) looked at children from homes separated by divorce and children from homes where the mother had died. For children, the effects of these two circumstances (death and divorce) can result in similar short- and long-term consequences (Kastenbaum, 1977). Rutter found that children from divorced homes displayed higher rates of delinquent behavior than did children from intact homes. But what was causing the behavior problems—the breakup, or difficulties in the home that led to the breakup? Rutter found that there was more delinquency in children from homes with family problems that caused the breakup than in children from stable homes where the mother had died. So, it may not have been the loss of the caregiver that caused the behavior problems, but difficulties in the homes. In general, there appear to be more problems for children who fail to form an attachment than for those who lose their primary caregiver.

Implications for Practice:
Fostering Secure Attachment

Labeling early loss or separation as maternal deprivation implies that the mother is solely responsible for her infant's well-being. However, there are actually few effects from the lack of attachment to a biological mother. What is important is the quality of stimulation the child receives and some sense of continuity. A baby needs care that is consistent and continuous. Consistent care means that one caregiver is predictable and reliable over time so that the baby can form a bond with that person. The mother is not the only person qualified for this role. Fathers, grandmothers, adoptive parents, aunts, and friends all can serve as primary caregivers. In fact, babies can form attachments to more than one person. A baby who receives nurturing care from a few people can form several attachments.

But this care needs to be consistent during infancy. Separations from the caregiver should be well planned, because babies tolerate separations better if they are prepared for the separation in advance. Trout (1995) has suggested that even a very young infant be given information

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about a pending separation over and over. The child should be told that they may feel afraid, lonely, and sad. Children in foster care should receive regular visits with parents unless the parents are dangerous or there is no possibility of a reunion. Babies separated from caregivers do better if they are placed in a family-like environment. In fact, spending some time away from the caregiver—at grandma's or a friend's home—may help children deal with later, more difficult separations.

Children in foster care receive either the "extended-respite model" or the "child-centered model." In the former, the role of foster parents is to ensure safety and to provide food, clothing, and shelter. In the later, the role of the foster parent is to become an attachment figure, in addition to the physical provisions. However, psychological safety and security are just as critical as physical safety. The child-centered model should be used for children of all ages, but particularly for infants and young children. Infants need to form attachments to the caregivers with whom they live with; a few hours of visiting their biological parent are not sufficient to sustain attachment for young children (older children can, even with infrequent contact). This requires a substantial emotional investment by the foster parent, providing love and attention as if they were their own child (Zeanah, Shauffer, & Dozier, 2011).

In general, recovery from early separation and loss depends on the child, the circumstances of the loss, and what occurs after the loss. With good, loving care, children may be able to overcome the effects of early deprivation. Although it was once believed that trauma and deprivation in infancy would scar a person for life, research shows that infants are extremely resilient. With an adequate environment, appropriate intervention, and care provided in an enduring fashion, children may recover from early loss and deprivation (Emde, 1987).

Failure to Thrive

By definition, **failure to thrive** occurs when a child's weight falls below the 5th percentile for his or her age. Many failure-to-thrive babies begin life at normal weight but then decrease their rate of weight gain significantly. Some babies may be constitutionally small and naturally fall into this weight range. But in order to be classified as failure-to-thrive babies, their height and weight, in relation to other infants, must drop simultaneously. For failure-to-thrive babies, weight drops before their relative height or head circumference begins to decline.

Cases of failure to thrive are usually divided into two classifications: organic and nonorganic. In organic failure to thrive, there is an underlying medical condition such as congenital heart disease, cystic fibrosis, or renal disease that causes the growth decline. In nonorganic failure to thrive, no medical cause can be found. Cases of nonorganic failure to thrive usually have been attributed to emotional deprivation. Selma Fraiberg (1980) stated that nonorganic failure to thrive "is almost universally associated with the impairment of the mother's capacity to nourish, both in the material and in the psychological sense of the word" (p. 104). In this instance, then, failure to thrive can be considered to have a psychological cause: maternal deprivation. And, in fact, many mothers of failure-to-thrive infants are found to have been deprived in some way in their own childhoods. Many of these mothers report an unhappy childhood and a difficult relationship with their own mothers. These factors may interfere with a woman's ability to emotionally respond to her infant and adequately meet his needs. Some believe that this emotional deprivation causes a decrease in the amount of growth hormone produced in the infant's pituitary gland, resulting in slow growth. Emotional tension also may increase the likelihood of the infant having vomiting and diarrhea or loss of appetite.

Failure to thrive can happen in families in which parents obviously care about their children. Some babies are very difficult to feed—for instance, babies with cerebral palsy. An example would be the feeding scene from the movie *My Left Foot*, where a harried mom, in a very stressful family situation with an undemanding child with cerebral palsy, spoons a couple of bites of mush into her child's mouth and then goes off to do a mountain of chores. Low-birth-weight, premature babies can be difficult to feed, irritable, and hard to care for.

Family situations can also contribute to failure to thrive. Families with high levels of stress may have a chaotic lifestyle and may fail to establish regular mealtimes. Family members may be too preoccupied with problems of living to notice that the child is not eating. They may feed the child in front of the TV, which can be very distracting. Some parents may be too controlling and get into "food battles" with their toddler. In this situation, the child gains power by not eating. Some weight-conscious parents may think that fat is bad and switch the baby to low-fat milk. Some mothers may be struggling with their own eating disorder, such as anorexia nervosa or bulimia, and may fail to understand

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the caloric needs of small children. Some families are dealing with depression, substance abuse, or domestic violence. Parents with developmental delay may have trouble understanding nutritional requirements for babies. And, of course, another contributing factor may be poverty. The Supplemental Food Program for Women, Infants and Children (WIC) provides only enough formula to meet 75% of an infant's daily needs. Some families may run out of money for food before the next Temporary Aid to Needy Families check, packet of food stamps, or paycheck comes. These parents may dilute formula to make it last longer. Poverty also contributes to overcrowding, disorganization, and increased distractions in the home, all of which can interfere with feeding an infant.

Implications for Practice:

Treating Failure to Thrive

Infancy is a time of rapid growth, and good nutrition during this time is vital for optimal development. Nutritional deficits during infancy can have long-lasting effects, including growth deficits, decreased resistance to infection, later personality problems, learning disorders, poor academic performance, and developmental disabilities. But blaming the mother for her infant's slow growth only makes her defensive and resistant to help. Failure to thrive is not the result of maternal emotional deprivation but is a problem of family dysfunction with multiple causes. Failure-to-thrive families are not "bad" families but people with problems who need help.

These families may need counseling to deal with depression, substance abuse, grief and loss issues, and environmental stress. Parents may need help in establishing techniques to deal with a difficult, hard-to-feed infant.

Many parents need help in improving parent–child interactions, especially in creating positive, rewarding feeding experiences free from coercion, food battles, and the distraction of television. Information on infant developmental norms and nutritional needs can benefit many new parents. Because of the risk of developmental delay, failure-to-thrive infants often are eligible for early intervention services. Infants with severe failure to thrive may require hospitalization, but many families require intensive, months-long outpatient and in-home treatment from a team of professionals including a pediatrician, a nutritionist, and a social worker.

Practice Guidelines

- Infants can overcome the effects of early deprivation when integrated into a loving, home environment.
- Supportive family, friends, and neighbors can help buffer the effects of maternal loss. Infants can form attachments with more than one caregiver and do better when they are prepared for separations in advance.
- Encourage parents to carefully monitor that their child is meeting their nutritional needs. Help families get access to community resources and services that can support infant feeding. Education around food nutrition and/or family counseling may be beneficial as well.

Infant Mental Health

On hearing the term *infant mental health*, many people laugh and ask how you do therapy with a baby. Does he lie in a crib and free-associate? Selma Fraiberg first coined the term *infant mental health* in the 1970s. Actually, in the last 20 years, there has been a significant increase in the knowledge of the emotional, social, and cognitive functioning of infants. Along with this knowledge has come an interest in working with the problems of infancy. Infants are vulnerable creatures subject to abuse and neglect. They may withdraw from interactions and even seem to suffer from depression. They can also develop problems with feeding, sleeping, and behavioral regulation. But as we have seen, they are very resilient and can respond to appropriate intervention.

Problems in the infant–parent relationship can occur as the result of many different factors, including previous pregnancy loss, postpartum depression, medical/developmental problems of the infant, drug use by parents, abuse of the infant, prolonged separations, family stress, mental illness of a parent, or a parent with a long-standing attachment disorder of his or her own.

Out of concern about the psychological problems of infancy has come the multidisciplinary specialty of infant mental health. This specialty is concerned with the factors that affect the psychological health of infants and with development of methods to assess and treat these small clients (Lieberman, 1985; Lawless, 2010). The traditional knowledge base and intervention skills of social workers

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are especially suited for work in this field (Bonkowski & Yanos, 1992). The Education of the Handicapped Act Amendments of 1986 require that states provide family-based services for at-risk children from birth to age three. This requirement opens opportunities for social workers to become actively involved in providing services to infants and their families.

Assessment Tools:

Assessment and Interventions of Infant Mental Health

The University of Southern Maine has developed a tool to assess and enhance children's emotional well-being from birth to five years of age. This brief assessment instrument is called AIMS, which is an acronym for the following areas:

Attachment—The emotional tie between a primary caregiver and an infant
Interaction—A communicative exchange of information between caregiver and child
Mastery—The child's development of increasingly complex physical, cognitive, linguistic, emotional, and social abilities
Social support—A network of people, resources, and influences available to families, which enhances healthy attachment, interaction, and mastery of developmental skills

The AIMS tool looks at children at 2 weeks; 2, 4, 6, 9, 12, and 18 months; and 2, 3, 4, and 5 years of age. At each age level, the tool offers guidelines for psychosocial practice, including interview questions and points of observation to use in assessing each of the AIMS areas of emotional development. The tool also suggests brief interventions to help strengthen each area of emotional development. The following interventions are suggested to help strengthen attachment of children aged 0 to 5 years:

1. Show admiration for the baby/child (appearance, personality, health, behavior) in the presence of the parent.
2. Point out parent's ability to "hear" child's cries/requests and to respond appropriately.
3. Discuss the role of the other parent in caregiving.
4. Discuss upcoming stages of infant/child development.
5. Comment on how proud the parent must be to see the baby/child doing so well.

For more information, contact Project AIMS, Human Services Development Institute, University of Southern Maine, 96 Falmouth St., Portland, ME 04103; phone (207) 780-4430.

Other specific interventions include the following:

- Speaking for the baby—expressing what you interpret the baby is trying to say to the parent, such as "I would like to eat now"
- Watch, wait, and wonder—having the parent observe the infant and wonder what the infant is thinking or feeling or is trying to communicate
- Developmental play—guiding the parent in age-appropriate play activities with child
- Nurturing the dyad—encouraging the parent to engage in nurturing activities with infant (rocking, cuddling, massage)

Social Dimension

Groups and Families

A baby is no longer seen as a passive creature controlled by her basic instincts but is viewed as an active participant in the family environment. Treatment of an infant cannot be separated from treatment of the family. Interventions with infants require a systems approach, because problems with a baby do not reside in the baby but in the interactions between the baby and a caregiver or the baby and the family. In working with infants, then, you do not concentrate on the baby or parent alone but on the parent–child relationship and on the relationships among other family members.

Family Influences

Factors in the family that can affect development include parental personality and temperament, parental mental illness, major family transitions such as death and divorce, and periods of parental unresponsiveness, such as those that occur with depression. Intergenerational patterns also often affect the family environment. Parenting styles are passed on from parents to children, who then use the same style with their own children. Parents who abuse their children often were abused as children themselves.

Interactions in the family seem to occur in a circular pattern. Parents who are satisfied with the marriage may

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Study Table Psychological Dimension in Infancy

Cognitive Development and Information Processing

- Sensorimotor stage of development. This stage is divided into six substages: reflex activity, primary circular reactions, secondary circular reactions, coordination of secondary schemes, tertiary circular reactions, and representational thought.
- Object permanence.
- Attention is influenced by infants' interest; obligatory attention; attention processes are studied by observing the habituation and dishabituation to stimuli.
- Preliminary capacity at 6 to 7 months for categorization.
- Cross-modal transfer: transferring information gained from one sense to another sense.

Communication

- Newborns prefer human speech to noise, and they prefer the higher-pitched voices of females.
- By the end of infancy, the baby begins learning to speak. Prior to this phase, they communicate by crying. By the end of five months, babies begin to coo. Between three and six months, they babble by putting vowel and consonant sounds together. Babbling is a form of practice for using the throat, lips, and tongue to produce sounds. A baby's first words are said between 9 and 12 months.
- Early speech uses one word to express a whole sentence, which is known as "holophrastic speech."
- Overextension is another characteristic of the speech of babies—overextending the meanings of words to fit a specific situation.
- Telegraphic speech, in which they forget auxiliary verbs, begins between 18 and 24 months.

Attitudes and Emotions

- Emotions have a strong biological component.
- Between ages 2.5 and 6 months, the infant displays anger, sadness, surprise, and fear. Fear develops during the first year of life.
- Stranger anxiety begins between five and six months and diminishes at about 13 months. Baby may develop a transitional object.
- Emotional expression in infancy is predictive of later childhood emotional characteristics.
- Infants are influenced by the emotions of others when they are around 8 to 10 months.
- Social referencing (12 months): when infants look to others for emotional information.
- The characteristic pattern in which an infant responds to, and interacts with, the environment is referred to as *temperament*. Temperament is biologically based. Key dimensions of temperament: activity level, rhythmicity, approach or withdrawal, adaptability, and threshold of responsiveness.
- The degree of fit between the infant's temperament and the primary caregiver is important.
- The parents and the infant's behavior influence attachment. Attachment failure can be caused by the mother's mood (depressed). How the mother expresses the depression also influences the nature of the attachment.

Social Cognition and Regulation

- Most babies develop a sense of self at around 18 months.
- Separation-individuation is the process in which infants shift from no sense of self as separate from the caretaker to being autonomous or independent: some sense of self and nonself begins between five and nine months (the differentiation phase), exploration of their environment between 9 and 14 months (the practicing phase), realization that they are separate from the primary caregiver but check back for emotional refueling between 14 and 24 months (the rapprochement phase), and the final phase occurs between the age of two and three (the consolidation phase).
- Around age two, babies learn how to say no. This phase of development cannot occur without some sense of self.

Psychological Strengths, Hazards, and Risks

- A strong parent–infant bond can have important and lasting effects on a child's development.
- Separation after attachment can place infants at risk for emotional and other disturbances. Loss of a parent can have serious consequences for infants.
- A key complication during infancy is failure to thrive (child's weight falls below the 5th percentile for his or her age); two classifications: organic and nonorganic.
- Infant mental health studies the psychological problems of infancy. From birth to age three, infants need to be able to (1) experience, regulate, and express emotions; (2) form close and secure interpersonal relationships; (3) explore the environment and learn in the context of the family, the community, and the cultural expectations of young children.

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interact positively with the baby and have a responsive infant. Stress in the relationship can preoccupy the parents and affect the quality of their interaction with the infant, negatively affecting the baby's development. Ironically, one major source of stress in relationships can be the babies themselves. A demanding infant can increase the family stress level, which can then interfere with the parents' interactions, which in turn can affect the baby's responses.

Belsky (1981) described these interactions as **circular influences**. He stated that "what transpires between husband and wife might affect a parent's caregiving attitudes and/or behavior, which in turn could influence the infant's functioning, which, coming full circle, might affect the marital relationship."

Fathers and Babies

On the birth of his first son, one of the authors of this book asked, "When do I get to throw him in the air?" Studies have found that this is a common male response to interacting with an infant. Though fathers' engagement with their children has increased in the last 30 to 40 years, in general, fathers spend less time with the baby than mothers do. Pew research conducted during the COVID-19 pandemic indicated though there was relatively little change in the amount of time parents spent directly caring for their children, the time they spend on secondary care (that is supervising children while trying to work or do chores) went up significantly and the brunt of this fell on mothers.

When fathers do spend time with the baby, that time usually involves playing more than duties of caregiving. Mothers actually play more with babies, but that is because they spend more time overall with the infant. The type of play that fathers engage in with the infant differs from that of mothers. Mothers involve the infant in verbal interactions, whereas fathers are more physical and rougher with their babies. A pivotal study conducted in the 1980s (Belsky, Gilstrap, & Rovine, 1984) found that fathers also spent more time reading and watching TV with infants, whereas mothers spent more time nurturing and caring for them—these findings have held nearly 40 years later. This does not mean, however, that fathers cannot be nurturing and sensitive caretakers. Fathers who do spend more time with babies and engage in caretaking activities can be sensitive to an infant's cues. What happens when the father is the primary caregiver? The father is just as competent in giving care as the mother is, but the father still plays in a more physical way with the infant.

Fathers, then, can be competent primary caregivers. Babies can form an attachment with fathers much the same as they do with their mothers. The more the fathers interact with infants, the greater the effect they can have on development. But currently some have argued that fatherhood is in crisis in America. According to the U.S. Census Bureau (Anderson, Hemez, & Kreider, 2021), one of four children do not live with their biological father. In fact, the United States has the world's highest rate of children living in single-parent households. In comparison, in Canada, rates drop to 15%, and in India, Nigeria, and China rates drop to 5%, 4%, and 3%, respectively. Children in homes without a father are four times more likely to be living in poverty. Though single-parent homes are typically headed by mothers, more dads are staying home to take care of their children (17% of all stay-at-home parents were fathers in 2016, compared to 10% in 1989).

We have learned from research on paternal hormones over the past 20 years is that fathers also go through biological changes after birth (Storey, Alloway, & Walsh, 2020). New fathers experience a drop in testosterone, and more involved fathers typically have lower testosterone levels compared to fathers less involved in infant activities. When fathers are given intranasal oxytocin (the hormone involved in attachment discussed previously), they have higher-quality interactions with their infants (both in typically developing infants and autistic infants). Interestingly, these infants increased their oxytocin levels in response. Research with functional magnetic resonance imaging *(f*MRI*)* has allowed us to take a closer look at brain activity—fathers and mothers show activation in specific brain regions after the birth of their child (for example, socio-cognitive cortical regions in fathers). There are some sex differences; however, after digging deeper, these differences appear to be more related to the role fathers play in infant care. Fathers who are primary caregivers (either single fathers or fathers in same-sex partnerships) look similar to primary-caregiving mothers in heterosexual relationships (for example, more activation in regions associated with processing facial emotions).

But what about a father who is not living with the mother of his baby? What sort of role will he have in raising his baby? Research has shown that roughly 90% of these fathers spend some time with their babies during the first 15 months of life, but contact tends to decrease over time (Vosler & Robertson, 1998). Single mothers, especially adolescent ones, often return to live with their parents. Sometimes, if there is not a strong relationship between the baby's father and the mother's family, the maternal grandmother can act as a barrier to the father's

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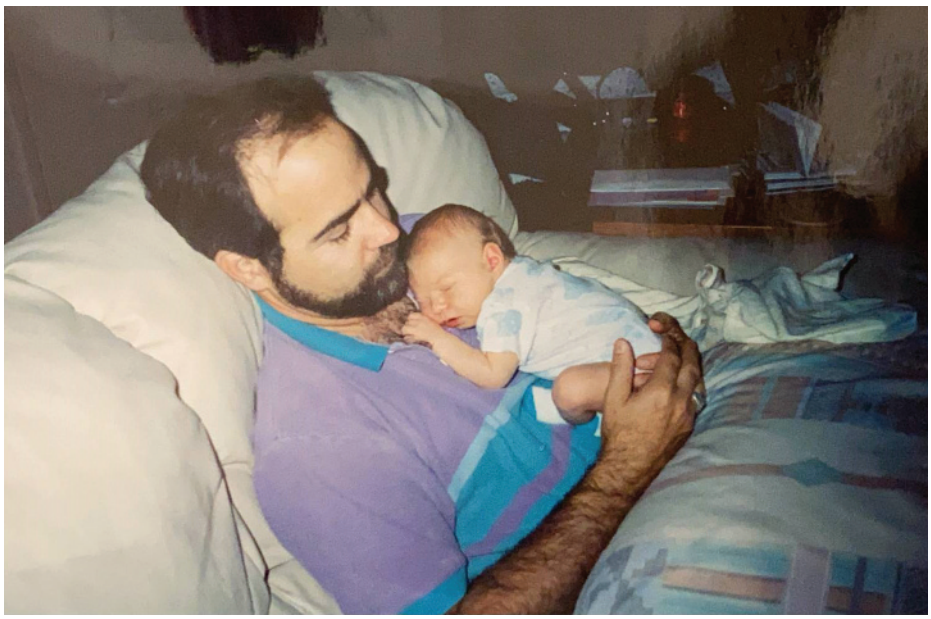

Fathers are an important source of sensory, affective, and social stimulation for infants

interaction with the baby (Vosler & Robertson, 1998). Additional factors, such as poverty, maternal depression, and minimal parental education, can also contribute to father noninvolvement in nonmarital co-parenting situations (Vosler & Robertson, 1998).

Father involvement matters to child development. One recent study examined father–infant interactions in their homes in a prospective longitudinal study and found that fathers with disengaged interactions with their three-month-old infants predicted early behavioral problems at one year of age (Ramchandani et al., 2013). In a study of teen parents over 10 years, children who had more contact with their fathers had fewer behavioral problems and were better readers (Howard, Burke Lefever, Borkowski, & Whitman, 2006).

Here's an interesting question: Can fathers experience postpartum depression? While it is not termed as such, some research supports the notion, specifically for inexperienced fathers. Ferketich and Mercer (1995) found that inexperienced fathers evidenced significantly more depression than experienced fathers do, largely because of the changes in identity and lifestyle that first-time parents experience.

Grandparents and Babies

Next to the baby's father, the maternal grandmother is the main source of support for most mothers. For single mothers, the maternal grandmother is often the first source of support. In the case of teenage mothers, the grandmother can even step in as the infant's primary caregiver.

Studies have found that infants who have frequent contact with their grandparents interact with grandparents in the same manner they do with their parents (Gross, 2010), and babies whose grandparents interact with them show higher developmental scores, much as they do when they have highly responsive parents. When the mother is struggling with difficulties that interfere with her ability to care for a baby, the grandmother can mediate the effect of these maternal problems on the infant. When the mother is young, single, and struggling with mental health issues or substance use, the grandmother can provide consistent and nurturing care for the baby.

In addition, with so many mothers returning to work after the birth of their babies, grandmothers often are assuming childcare responsibilities (Gross, 2010). Particularly during the COVID-19 pandemic, grandparents faced increased pressure to take on more of the routine childcare. Only 12% of grandparents lived in a multigenerational home in 1980, which is a stark contrast to the norm in the 19th century (approximately 75% in 1850), but 20% did in 2020, in part due to the financial crises of the early 2000s as well as the pandemic. However, even grandparents that are living apart from their grandchildren, are increasingly involved in childcare. This is especially true for lower-SES families. In some cases, because

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This infant's grandmother provides daily care for her grandson while his mother goes to work. Grandmothers are the main source of support for most mothers, especially when mothers return to work.

of parents' substance abuse, poverty, hopelessness, and disability from AIDS, grandparents serve as primary caregivers and raise the children. Grandfathers can fill the role of absent fathers for children of single mothers. In fact, the American Association for Retired Persons now publishes a newsletter for grandparents raising grandchildren; it also provides a grandparent information center.

Playing with Baby

Every baby is unique, and each may enjoy a different amount of stimulation through play. For new parents, as well as parents of special-needs babies, it can be difficult to know when and how much a baby wants to play. Following are a few guidelines that parents can keep in mind (adapted from Griffith, 1992):

1. Never "force" a baby to play when they are distressed or disinterested. Look for signs such as distress due to overstimulation, averting of eyes, yawning, sneezing, changes in skin color, rapid breathing, and crying. Stopping play at the first signs of distress can help a baby regain control, which aids in the development of self-regulation skills.
2. Calm the baby immediately if they reach a frantic state of crying. Swaddle them to help them relax and control body movements. Providing a pacifier for sucking can help a baby soothe themselves.
3. Play with the baby at times when they are calm and alert. Avoid overstimulation by presenting only one toy at a time and keeping toys relatively simple (e.g., rattles and balls).
4. Increase intensity of play (duration, frequency, new objects) as the baby becomes more comfortable.
5. Unswaddle the baby during play and at times when they are awake and calm. This allows freedom to explore and provides them with opportunities to develop motor control.

Practice Guidelines

- The more support the caregiver receives, the better the care the infant receives. As we have seen, social support is especially important for caregivers of handicapped or premature infants, and for caregivers with problems such as depression. Caregivers deal with stress better—whether it is from the infant or other factors of life—if there is adequate support. Jackson's (1998) research on the role of social support found this to be especially true of low-income, single Black mothers.
- Implementing evidence-based programs within your community or agency can increase father involvement. The National Fatherhood Initiative (www.fatherhood.org) includes a list of training resources. For example, InsideOut Dad is an evidence-based program for incarcerated fathers. Programming specifically targeted for fathers when taken early, such as during pregnancy, can have a long-term impact on both infants and fathers.
- Grandparents can often serve the role as a parent. Ensure that they receive support while in these roles as they may feel isolated from their friends who have moved into a different stage of life.
- Play is good for the infants' development; however, it is helpful for parents to be able to recognize cues when their baby has had enough. Teach them how to recognize these cues and the optimal times to engage in play behaviors.

Adoption

Most adoptions in the United States are actually adoptions by a stepparent. However, many couples are interested in adopting a newborn, and each year, fewer and fewer infants are available to adopt. In the United States, there are about 2 million couples wanting to adopt—yet of the nearly 4 million children born each year, only 18,000 are voluntarily placed for adoption. As of 2021, the percentage of never-married women who choose to place their infant up for adoption has declined from nearly 9% to less than 1%.

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On average, adoptive families will wait more than two years to adopt a baby, though this varies a lot, as in almost every case it is the birth parent who selects the family they want to parent their child. Adoptions can be arranged through an agency or a private source. Most states have agencies in the state welfare department or department of children's services that handle adoptions. Children also can be adopted through private agencies that are regulated by the state.

Because there are fewer White infants eligible for adoption in the United States, some parents choose to adopt older children, special-needs children, or foreign infants. One-half of children adopted are over two years old. Special-needs children include those who have disabilities, and the state may provide a subsidy to adopting parents to help cover medical expenses. International adoptions hit an all-time high in 2004 but have since dropped sharply due to longer wait times. China still leads all other countries in the number of children adopted internationally, but more than 50% of its adoptions have shifted to "waiting children" (children with special needs).

Open Adoption

In years past, parents who adopted a child as an infant often debated whether or not to tell him or her about the adoption. Many children grew up not knowing they were adopted, and the birth mother's identity was kept secret from those who did know. Parents are now encouraged to be honest and open with the child from the beginning. In 1975, laws changed to allow adults who had been adopted to obtain information about their birth parents if those parents did not object. This change in attitude toward adoption information has led to open adoptions.

In **open adoption**, the birth mother and sometimes the birth father participate in choosing a family for their baby. That family may choose to attend childbirth preparation with the birth mother and be present at the baby's birth. The birth mother may stay in contact with the family as the child grows, exchanging letters and photographs. Sometimes visits are arranged between the birth mother and the child. In some cases, these visits are arranged through the adoption agency and are limited to once or twice a year, whereas in other cases the birth mother may serve as the child's babysitter.

Open adoptions have their challenges though. What about families with adopted children from different birth parents? What if one birth mother stays in contact and the other does not? What if the birth mother ceases contact with the child at a later time? In addition, adoptive parents may agree to any conditions of the birth mother in order to have a baby. How does this affect their parenting abilities? Also, the birth mother may change her mind after the baby is born, leaving a couple—who may have waited through the pregnancy, furnished a nursery, and attended the birth—without a child. But when both sets of parents agree on the conditions of the open adoption, this arrangement can be satisfactory to all involved.

Transracial Adoption

Adoption of children of a race different from that of the adopting family—**transracial adoption**—is highly controversial. The majority of couples looking to adopt a child are White, but many of the children available for adoption are not. Without transracial adoption, many White couples remain childless while minority children wait in foster care for permanent homes twice as long as White children. But the National Association of Black Social Workers (NABSW) has historically been opposed to transracial adoptions, believing that African American children raised in a White home will lose connection with their race and culture—that the children will grow up not fitting into either culture.

The Multiethnic Placement Act of 1994 prohibits adoption decisions based solely on race, color, or national origin. This law was developed in order to reduce the amount of time minority children wait to be adopted. (This law does not affect the Indian Child Welfare Act, discussed in the next section.) The National Association of Social Workers still states that efforts should be made to place a child in the home of parents who are of similar racial and ethnic background. The NABSW now recommends that transracial adoptions be considered only as a last resort.

Prospective foster and adoptive parents need to become familiar with and understand racial and cross-cultural issues before adopting a child of different race. Efforts need to be made to increase the number of prospective foster and adoptive parents from all races and cultures.

Native American/Alaska Native Adoption

Another controversy surrounds the adoption of American Indian/Alaska Native (AIAN) children. In the 1950s and 1960s, 25 to 35% of all AIAN children were removed from their families. Many of these children were taken from parents who were poor and lived in homes with no indoor plumbing. After adoption, these children were often raised in circumstances that deprived them of their

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Focus on **The Lived Experience**

International Adoption

We always knew adoption would be part of our family's story, so in June 2009 after hearing about Generations pilot program in Uganda, we decided to make the leap. The excitement and anticipation for our future son was all consuming. We couldn't wait to meet him and hold him in our arms. In March 2010, after a move from Texas to California, we received the call we had waited for since first contracting with Generations. We had our referral! It's a day we will never forget. Sitting in a friend's living room, I stared at a few photos of the most beautiful baby boy I had ever seen.

Our son-to-be turned one on June 2 of that year. Loving Hearts Babies Home sent us monthly updates on this boy who might one day be our son, and each time we saw his face, we fell more in love with him and became more invested in being a part of his future. In August 2010, I traveled to Uganda alone to meet Rowan.* Seeing this precious child in person is another day I will never forget. It was pure magic, like the whole world stood still. After crying tears of joy, I started the fun part of getting to know our future son. After almost three months, Jared arrived in Uganda to meet Rowan for the first time.

In court in Uganda, we were all balls of nerves, having heard our judge was a stickler for details, only later realizing what a great protection that is for Ugandan children. Luckily, our lawyer and the babies' home had done their homework and followed protocol thoroughly. Within a week of the court date, the judge invited us into his chambers with two other families to read the ruling aloud. I still remember sitting in a stiff wooden chair and rubbing my extremely sweaty palms together as I nervously held Rowan in my lap. At last, the judge granted guardianship in a quick one liner—the case was cut and dry he said. Hallelujah!

Rowan, 3.5 years, with his two parents and brother.

The farewell gathering at the babies' home was another unforgettable day. Even now, we still maintain contact with several "aunties" and "uncles" from Loving Hearts Babies Home. They forever have a place in our hearts and our sincerest gratitude.

Since returning to the United States in November 2010, we completed Rowan's adoption in December of that year, making him our forever son! We then moved our family to Japan for three-and-a-half years. During that time, Rowan continued to attach well! He thrived in preschool and in Japanese culture. He is a caring and compassionate child, sensitive to the experience of others. He loves to run around with a superhero cape and mask, swim for hours in the pool, and spend time playing transformers with his dad. We have since had two more children, biologically. He adores his little brother and sister and receives consistent accolades from his teachers (both in Japan and in Arkansas where we now reside). He is an absolute blessing!

—Aly Paslay

culture and heritage. Critics of the practice argued that it threatened the future of AIAN tribes (Doyle, 1995).

In 1978, Congress passed the Indian Child Welfare Act, giving tribes control over adoption of AIAN children. Adoptions involving AIAN children require not only a release from the birth parents but also a release from the tribe. Even when the parents agree to the adoption by a non–Native American family, the tribe can veto the process and place the child with an AIAN family. Critics claim that children have been removed from adoptive parents and returned to a tribe even when the birth parents did not live on a reservation and had no tribal affiliation. Tribes argue, however, that to preserve heritage, AIAN children need to be raised by AIAN families.

Birth Fathers

The rights of birth fathers are another area of concern. The well-publicized case of Baby Jessica illustrates this problem. Jan and Roberta DeBoer adopted a one-week-old baby girl after the baby's birth mother agreed to the adoption and signed the release. However, the birth mother lied about the identity of the baby's father, claiming the father was her present boyfriend. She changed her mind

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about the adoption after several weeks and told the real father of the baby—her ex-boyfriend, Dan Schmidt—of the child. He then petitioned for custody of the baby on the grounds that he had not signed a release for the adoption as the father of the infant. The DeBoers challenged the petition in court for two years. Finally, the Supreme Court refused to hear the case, upholding a lower court decision giving custody of the baby to the birth parents, who had in the meantime married and given birth to another child. As the nation watched on television, Jessica, then two years old, was removed, crying, from the arms of her adopted mother and turned over to her birth parents.

In 1972, the Supreme Court ruled that unwed fathers could not be denied custody of their children unless they were proven unfit as parents. But how long a time period should an unwed father have to assert his parental rights? Some states allow six months, which is a long time for a baby to wait for a home. Some agencies will not consider an adoption unless the birth mother names the father of the baby so his release may be obtained. But some birth mothers will not do so, whether out of fear or simply because they do not want him to be involved (Betz et al., 1994). Many men do not learn of the birth of a child until the child has been placed in an adoptive home. At that point, should the baby be removed from a home they may have lived in for several months and be turned over to the birth father? Or, if the man is not an unfit parent, should the birth mother be allowed to decide the fate of his child without his consent?

In 1983, the Supreme Court ruled that men could not claim rights to a child unless they had established a relationship with the child. How can a man establish a relationship, though, if the birth mother keeps the pregnancy and birth a secret from him? In response to this problem, at least 24 states have established a putative-father registry for unwed fathers. An unmarried man must register so that he can be notified of any adoption proceedings involving a potential offspring.

Birth Mothers

For Monica, from Her Birthmother
When I had to say good-bye to you
I didn't know how much that I'd go through
Wanting to be with you all the while.
I pray you have someone to care
And friends that always, always will be there
A family to support you all the time
Who give the love I long to give a child of mine.

—Imelda Buckley (Roles, 1989, p. 7)

The decision to voluntarily relinquish your child is likely the hardest one will ever make, yet birth mothers are often ignored and feel invisible. In recent years, social workers have recognized that birth mothers require counseling and support and be given the space to talk about their feelings with compassion and dignity. Birth mothers often face negative judgments from others regarding their choice to place the baby up for adoption. However, the primary reason birth mothers choose adoption is "out of a belief that it will offer a better life for their child than they are able to provide" (Resnick, Blum, Bose, Smith, & Toogood, 1990, p. 341).

Implications for Practice:
Making Difficult Decisions in Adoption Practices

Adoption brings up the question of what takes precedence: the best interests of the child, or the rights of the birth parents, ethnic group, or tribal affiliation? Children have been removed from homes they have lived in for months because of issues of paternal rights, same-race placement, and tribal affiliation. Some claim that children's rights should be considered first and that the children should remain in homes where they have come to consider the adoptive parents their family. But the issue is very complicated. For instance, many were appalled that baby Jessica was removed from the only home she had ever known and given to total strangers who just happened to be her parents. But her birth father had petitioned for parental rights when she was only three weeks old. The DeBoers fought a long battle that lasted two years, but some believe that the best decision for the child would have been to surrender the baby in the beginning instead of keeping her until she was attached to her adoptive family.

Social workers need to consider these issues carefully. What are the rights of birth fathers? Should children be raised in same-race homes? How long should children wait in foster care for same-race families? Should tribes have the right to protect cultural heritage?

Another issue concerns children placed in foster care because of abuse or neglect. These children may wait for years for parental rights to be terminated, so they can be released for adoption. Many believe that these children should be permanently removed from their parents and placed for adoption without delay. Others favor family preservation efforts with the ultimate goal of reuniting children with their birth families. They believe that people with low incomes are penalized by having their children taken away. Many birth mothers have low income and are single,

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whereas couples wishing to adopt are financially secure and married. And sometimes children love their parents even though those parents are inadequate. The consequences for children kept in such homes can be dire. As discussed later in the chapter, in cases of ongoing child abuse and neglect, children suffer long-term consequences and, in some cases, even death.

How Adoptive Families Fare

About 25% of adopted children, compared with 15% of non-adopted children, require clinical intervention for severe behavioral problems. Researchers, however, have found that adopted children and their adoptive families do quite well.

David Brodzinsky at Rutgers University has been studying adoption for more than 20 years, and he reports that approximately 75–80% of adopted children are well within the normal psychological range. Adopted children are most often referred for clinical treatment for problems such as acting out or aggression starting at ages five to seven years, when they are just beginning to understand that they've lost their birth family and gained an adoptive family. Brodzinsky found that coping styles affected their experiences: children in adoptive families who had a problem-focused, assistance-seeking style of coping fared much better than did those with an avoidant style of coping. He also found that adopted children have neither more nor fewer serious problems than do non-adopted children when their parents divorce—it affects both groups "in a serious way."

Anu Sharma and her colleagues at the Search Institute in Minneapolis conducted a study of 181 adopted adolescents and found that most of the teens were functioning within the normal mental health range and that the teens described themselves as attached to their parents. It also has been found that openly adopted children who maintain contact with their birth mothers are not confused about their parents' identity, as some people had feared. Harold Grotevant at the University of Minnesota and Ruth McRoy at the University of Texas at Austin found that the children view their adoptive mother as their mother and view the birth mother as an aunt or friend.

Adoptive parents grow closer to each other by sharing the adoption experience. Cornell University researcher Jeffrey Haugaard has found this to be especially true in cases in which the child has problematic behavior, because the parents must cooperate to deal with this behavior. Haugaard also found that older adoptees form stronger attachments to their adopted fathers than to their adopted mothers; he speculated that this may be because they feel abandoned by their birth mother. Ellen Pinderhughes at Vanderbilt University has developed a family-systems model to research situations such as those in which birth mothers' maternal rights have been terminated owing to abuse or neglect (Brodzinsky & Pinderhughes, 2002).

Practice Guidelines

- We now know that open adoption has the best outcomes for children. Talk with adoptive and birth parents about how they would like that relationship to look like. Families can decide together how much contact they want birth parents to have with the child as part of their adoption plan.
- Birth fathers need to be informed of their baby being placed for adoption. Whenever possible, all family members should be given the opportunity to talk about their feelings regarding the adoption decision. Even though there may be mixed feelings regarding the decision, it is important to support the birth parents in a way that is nonjudgmental.
- Social workers can support birth parents in the following ways: (1) find a support group of other birth mothers who have chosen adoption, (2) find an adoption agency with sensitive birth parent programing, (3) demonstrate competence in issues of relinquishing mothers and show nonjudgmental support for the birth mothers' decisions, and (4) create a safe space where birth mothers can prepare for the relinquishment and create a plan for contact with her child following the adoption (e.g., sending letters and photographs).

Communities and Support Systems

Day Care

In the chapter on middle adulthood, we discuss the fact that, in general, maternal employment may have a positive effect on children's development. But what about infants less than a year old whose mothers work full time outside the home? Does maternal employment in the first year interfere with attachment? Do babies who grow up in day care suffer any ill effects? Many researchers have tried to answer these questions.

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Regarding how day care affects attachment, Belsky and Rovine (1988) concluded that it is too hard to say what the effects are because it depends "on the child, the family, and the particular day care arrangements." In fact, some professionals are beginning to think that day care gives children a secure caregiver with whom to form an attachment when the home lacks a secure, reliable caregiver (Brown, Bakeman, Coles, Platzman, & Lynch, 2004). However, research by Brooks-Gunn and colleagues (2002) showed negative outcomes between maternal employment during the first year of life and children's cognitive development at age three. These results were based on data obtained on 900 European American children from the NICHD Study of Early Child Care. Similarly, the effects of Quebec, Canada's full-day year-round childcare for all children under age five launched in 1997, indicate clear negative effects for social-emotional outcomes (anxiety, aggression, and hyperactivity). However, there were also positive effects when children were exposed to the highest quality day care. Having higher adult-child ratios and more sensitive and positive caregiving was associated with better cognitive performance and fewer behavioral problems in adolescence. But how do we ensure that all children can access high-quality day care? Clearly, more attention is needed to this issue, as most American families rely on day care and the effects of day care persists across development.

Implications for Practice:

The Realities of Day Care

Although it is interesting to discuss the effects of day care on child development, many mothers do not have much choice about whether or not they return to work after the birth of a baby. Financially, many women need to work to pay the bills and buy necessities. Some return to work within weeks of giving birth. Some studies have suggested that good day care can increase the cognitive and social functioning of disadvantaged children. One study examining the cognitive effects of the federal Head Start program found that children who attended Head Start showed more cognitive improvement than children either who did not attend preschool or who attended a preschool program other than Head Start (Devaney, Ellwood, & Love, 1997). However, many jobs available to low-income women do not pay enough for them to afford good day care, and there are not enough federally subsidized day-care centers for low-income women. Without federally subsidized care, these women must rely on other arrangements that may not be as beneficial to the baby's development. Indeed, many mothers employed in low-wage jobs are not very comfortable about their main childcare arrangements.

Economists recognized that the cost of childcare affects the labor-market decisions of mothers with young children. In 1997, 58% of married couples with children under six years of age and 69% of single-mother families with children under the age of six were employed (Gabe, Lyke, & Spar, 2001). Some of the latest available data shows that poor families devoted 18% of their family income to paid childcare, whereas financially stable families devoted about 7% of their income. According to the Department of Health and Human Services (HHS), childcare is affordable if it costs households no more than 7% of their income. For multiracial, Black, or Native American/Alaska Native families, childcare was nearly 9% of their average income in 2021. Just in the last decade, the Census Bureau data indicate that childcare costs have sharply increased 28% (2020 compared to 2010). The lack of affordable childcare is often a key impediment to having poor families leave welfare (Gabe et al., 2001). The cost of quality childcare also reduces the incentives and returns for working families who are not poor and make more money. The Dependent Care Tax Credit is another piece of federal legislation that is designed for families with tax liabilities, offering parents a tax credit to offset part of their childcare expenses. The American Rescue Plan Act of 2021 temporarily increased the size of the existing child tax credit but the payments expired at the end of 2021.

Research in the past 20 years has demonstrated that quality early childcare and early childhood education are among society's best hopes for optimizing the long-term outcomes for low-income children and children living in poverty (National Center for Early Development and Learning [NCEDL], 1997). Outcomes that have correlated with program quality include cooperative play, sociability, creativity, ability to solve social conflicts, self-control, language, and cognitive development (Frede, 1995; Love, Schochet, & Meckstrom, 1996; NCEDL, 1997). Quality of childcare means different things to different people. Some authorities define quality strictly in structural terms: group size, child–staff ratios, physical space, teacher qualifications, staff training, wages, and safety (Perry, Ashford, & Gonzalez-Santin, 2003). Indeed, proper stimulation and nutrition in the earliest months and years of life play a pivotal role in influencing future development (National Governors' Association and National Association of State Budget Officers, 1998; Perry et al., 2003).

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Quality of Childcare

More than half of the children living in the United States are in the care of someone other than their mother for significant periods of time. What type of childcare best supports a child's healthy psychological development? Until now, the answer wasn't clear, but a study of childcare conducted by the NICHD provides some revealing data.

Researchers found that children are most likely to receive higher-quality care when there are fewer children being cared for and the child-to-adult ratios are low. Less authoritarian beliefs about child-rearing on the part of caregivers, as well as the provision of stimulating physical facilities, are more likely to result in higher-quality caregiving. According to the research, the highest quality of caregiving was provided by fathers and grandparents as well as by in-home caregivers, whereas the lowest quality of caregiving was provided by childcare centers. However, regardless of care type, an adult–child ratio of one to one was the best predictor of high-quality caregiving. Anna Fels's *Necessary Dreams: Ambition in Women's Changing Lives* (2005) and Judith Warner's *Perfect Madness: Motherhood in the Age of Anxiety* (2005) are popular books that examine many of the frustrations and obstacles encountered by women in trying to balance work and family with the availability of poor childcare services in this country.

Practice Guidelines

- Advocate for policies that help delay the entry into childcare settings. Parents are optimally positioned to best meet their needs of their infants. If parents have the benefit of paid parental leave, then they can spend crucial one-on-one time early in their child's development.
- Childcare is not always negative. It can promote positive development in infants when it has small child-to-caregiver ratios, high teacher qualifications, proper stimulation, and a good physical environment.

Multicultural, Gender, and Spiritual Considerations

When feeding their infants, mothers in Yorkshire, England, tell them something about the spoonful of food "going to Auntie Mary's in Bradford." Mothers in Newfoundland tell small children that if they don't eat the crusts of their bread, the Crust Man will steal the children away. Many American mothers fly spoonfuls of food like airplanes into their children's mouths. In other cultures, such as among the Malay, as soon as children learn to walk, they are expected to feed themselves when they get hungry with no encouraging comments from the mother (Dettwyler, 1989). These various feeding practices illustrate the fact that parents in different cultures bring different beliefs, attitudes, and practices to the raising of their children. Even in the United States, the child-rearing practices and beliefs of ethnic groups can be quite different from those of the majority culture.

Infants of color are more likely to live in homes with younger mothers, single mothers, and large extended families (Coll & Meyer, 1993). Families of color face problems including socioeconomic disadvantage, inadequate access to health care, residential segregation, substandard housing, and unemployment. Coll and Meyer (1993) have emphasized the importance of ethnic and minority status in working with families:

> If we recognize that these minority and ethnic families experience different cultural expectations, family constellations and access to economic and social resources, in addition to being subjected to prejudice, racism, classism, sexism, and segregation, we would expect that their world view and their infants' developmental outcome would be profoundly affected by these life experiences. (p. 60)

Developmental Assessment of Infants of Color

Of particular concern is the developmental assessment of infants of color, because the norms established for developmental assessment instruments are based on the majority of children in this country, who are Anglo. Compared with these norms, some children of color may appear abnormal. In particular, African American infants appear developmentally advanced, whereas American Indian/Alaska Native (AIAN) and Asian infants may be a bit reserved on standard measures. You may remember from the last chapter that there is some evidence these characteristics may be genetic, but infant care practices among cultures also vary and contribute to this difference. African infants are handled vigorously by their mothers from birth. Their mothers place them in an upright position for most of the day and encourage early sitting, standing, and walking (Cintas, 1988). AIAN and Asian infants, in contrast, are more protected by their parents.

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© Carolina Marquez

Religious institutions support family traditions and practices that celebrate the birth of a child. This family is celebrating the baptism of their first child.

Cintas (1988) has cautioned that practitioners should be sensitive to developmental differences associated with culture:

> [Practitioners] working among a heterogeneous population such as that in the United States need to be cognizant that cultural variations in developmental patterns do exist. Further, since infant care practices appear to have some influence on neuromotor performance, North American therapists and families can perhaps benefit from knowledge of parent care methods in other cultures. (p. 17)

Gender Issues

Some mothers joke that the first time you hand a baby boy a truck, he will push it on the floor and say, "Rrrrrrr," or some other appropriate truck noise, whereas a baby girl will try to feed it her bottle. Just how different are baby boys and girls, and how much of that difference is learned from their parents?

Although children do not start to label themselves as boys or girls until they are tw-and-a-half to three years old, they display gender differences in behavior from birth (Coll & Meyer, 1993; Maccoby, 1998). As summarized in Bjorklund and Bjorklund (1992), boys are more aggressive and more active, take more chances, are more demanding of parental attention, and get into more mischief as toddlers. Girls are more nurturing and more compliant at this age.

In the second year of life, infants begin to show toy preferences. By 18 to 22 months, boys play more with trucks and cars, and girls play with dolls and soft toys (Smith & Daglish, 1977; Jadva, Golombok, & Hines, 2010). But to what extent is this a social conditioning of gender rather than innate differences associated with sex? How do parents, and others, encourage children to play with these sex-associated toys?

Babies actually are treated differently from birth based on their sex. Parents are more rough and active with baby boys and more verbally interactive with baby girls. Fathers give fewer positive responses to boys who play with cross-sex toys, and mothers give more verbal instructions to girls. Parents encourage girls to participate in dancing, playing dress-up, and playing with dolls, whereas they encourage boys to play with blocks, trucks, and push-and-pull toys.

Coll and Meyer (1993) have offered this conclusion about the literature on gender and infants:

> Gender differences in behavior from birth have been documented in a variety of cultures.… But more important than actual sex differences in behavior may be the caregivers' interpretations of an infant's behavior, development, and needs as a function of the infant's gender. (p. 59)

Interest in the genetic roots of gender differences has persisted for hundreds of years (research as early as the 1600s included digging up male and female skulls, filling them with sand, and measuring weight differences). But what we've learned from neuroscience calls into question differences that we have long attributed to genetics. This is based partly in the fact that the brain we are born with is continuously molded and changed daily by our environment. Thus, nature and nurture are intertwined. Further, many ways in which we behave are unconscious and a product of our social gender. For example, mothers talk more to female infants than to male ones. Gina Rippon states in her book *Gender and Our Brains* (2020):

> A persistent focus of the brain research agenda, effectively since the early nineteenth century, has been driven by the perceived need to explain differences between two groups divided by their biological sex. [W]e are only just

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starting to wake up to the idea that there is currently no good evidence of there actually being any relevant differences either in the brains of these two groups or in the behaviors those brains support. For sure, there are average differences between the groups, but the effect sizes are characteristically very small, and averaging will wash out any interesting individual differences (p. 351).

Practice Guidelines

- Childcare practices are impacted by cultural values and beliefs. Social workers can learn from parent care methods in other cultures that have positive outcomes on development.
- The experience of social gender starts at birth. Parents should encourage their children to play with a variety of toys that encourage different aspects of development (e.g., building blocks, toy cars, dolls, picture books).

Social Strengths, Hazards, and Risks

As we discussed in the last chapter, poverty can have a detrimental effect on development. Infants in families with low incomes are more likely to have inadequate nutrition and also are more likely to have increased blood lead levels. Infants living in poverty have more health problems and more injuries, and when abused or neglected they are more likely to be removed from their homes. Duncan and Brooks-Gunn (2000) have pointed out that income appears to matter most for children's development in early childhood.

Low income affects children in a number of ways, including parental mental health, and neighborhood of residence. For example, studies have found that parents' economic stress and hardship are environmental factors that are associated with increased depressive symptoms, less nurturant parenting and, thereby, less optimal child outcomes. (Jackson, 2003)

Infants living in poverty are more likely to have an impoverished environment with irregular daily routines, overcrowding, little attention for the baby, and lack of parental responsiveness. Poverty adds to the caregiver's stress and can contribute to depression, making it difficult to care for an infant. The effects of prenatal poverty may have resulted in a premature birth or a baby with complications. The infant may need extra care and parental responsiveness, but the energy of the mother must go to dealing with the problems of living and not to the infant. Halpern (1993) states that "a fussy, disorganized, low-birth weight infant is likely to overtax the limited physical and emotional resources of an already overstressed mother" (p. 75). The mother may then avoid interacting with the infant.

Unhoused infants are at the highest risk. Having no home makes it very difficult to meet the needs of an infant. How does an unhoused caregiver prepare bottles, store infant food, wash clothes, provide a safe environment to explore, and find toys? Because of poverty, then, a difficult-to-care-for infant may be born to an overstressed mother with few resources. The infant adds to the mother's stress, and the baby is at increased risk of abuse and neglect.

Environmental Context and Child Development

So far, in considering factors that can affect development, we have looked at the characteristics of the child and then of the family. A third important variable in optimal development is the type of environment the child experiences—in other words, the child's home. The quality of the home environment, including the cognitive, socioemotional, and physical environment, affects the health and development of an individual, and a poor environment may result in poor development.

Cognitively, infants develop well if they receive rich and varied verbal interaction from their caregivers. The caregivers should place an emphasis on learning and provide a variety of stimulation for the baby. In the socioemotional realm, infants need parents who are responsive, warm, and nurturing. Harsh punishment can have negative effects for the baby. The physical environment should be safe and well organized. The baby should have adequate areas to explore. Appropriate and stimulating toys and play materials should be available for the infant to investigate and manipulate. Early intervention was mentioned previously in the chapter as a means of assisting infants who have a developmental delay or disabilities. But early intervention programs also can help infants who are at risk because of socioeconomic factors. Research shows

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Focus on **The Lived Experience**

Understanding Different Cultural Beliefs

Understanding different cultural beliefs is important when working with diverse families. Coll and Meyer (1993) discussed the clinical implications of working with families from minority cultures. First, the family with different attitudes and beliefs may not feel that a "problem"—whether biological, psychological, or social—exists. For instance, in some cultures, having a baby as a teen is a way to gain status and respect in the community. Dealing with the "problems" of teenage motherhood in such a community, then, could be difficult. In fact, Burton (1990) found that in one African American community with a high level of male unemployment, teenage childbearing was encouraged because the maternal grandmother would care for the infant, as she (as the mother of the teenager) would be young enough to take care of and enjoy the baby. Families have different ideas as to the origin of a problem, as well. Some families may see a developmental problem as an act of God, as punishment for past sins, or as a test of faith. Some may turn to faith healers or religious leaders for a cure. Families also differ in their expectations of treatment. Play therapy to facilitate parent–infant interactions may be inappropriate for cultures that do not see the mother's role as including playing with her children. In those cultures, grandparents, siblings, and other children are expected to interact with infants. Asian American mothers often take on the role of teacher of their infants.

Coll and Meyer (1993) suggest a series of cultural assessment questions that can help provide an idea of how a family views a problem—what the problem is, how it originated, and what the family expects in terms of treatment:

1. What do you think caused your child's problem?
2. Why do you think it started when it did?
3. What do you think the problem does to your child? How does it work?
4. How severe is your child's problem? Do you expect it will have a short- or long-term course?
5. What kind of treatment do you think your child should receive?
6. What are the most important results that you hope your child will receive from treatment?
7. What are the main challenges the problem has caused for you and your child?
8. What do you fear most about your child's problem?

that at-risk infants involved in early intervention between birth and three years of age exhibit improved cognitive development and social competence (Zero to Three, 2016). And these benefits seem to be long-lasting. Positive effects of preschool age and continued intervention can be maintained through age 12.

Taking these factors into consideration, what is an impoverished environment? This would be a home that is overcrowded, noisy, and disorganized. The baby would have no set routine or predictability. Multiple caregivers would come and go. Siblings as young as nine years old would be responsible for watching the baby. Someone might calm the baby by handing the child a bottle filled with soda. The baby might be confined to a small area with few toys or interesting objects to manipulate. The baby could receive little or no verbal interaction or warmth from caregivers. Caregivers might fail to respond to or meet the baby's needs.

Unfortunately, the negative effects of the infant's environment can have long-term consequences. Infants and children living in poverty are exposed to an array of problems that put them at risk for biological, psychological, and social difficulties. Poor nutrition, lack of health insurance, and poor or inconsistent caregiving are some risk factors that children in poverty consistently face. Federally funded programs have been instituted that specifically target risk factors such as these.

The WIC was mentioned in the previous chapter as a source of supplemental nutrition for low-income pregnant women and their children up to five years of age. This program has proven to be highly successful in its goal of providing nutrition for low-income infants, with statistics showing close to 100% coverage of eligible babies. Unfortunately, only 57% of eligible children between one and four years old are enrolled.

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Focus on **The Lived Experience**

Rural Unemployment and Its Effects on Families

The Globe-Miami area of southern Gila County, Arizona, has a population of 7,162 residents (U.S. Bureau of the Census, 2021). Observing this small community, of which 46.8% members are Hispanic or Latino, offers a unique opportunity to witness aspects of cultural variability that are not always so readily apparent in larger populations. The reduction in workforce at the area's largest employer, an open-pit copper mine, provides a recent illustration of particular components of cultural variability within a rural mining community. In January 2002, 64% of the 250 mine employees who lost their jobs at this mine were Hispanic males between the ages of 45 and 57. The effects of premature loss of income on these men and their families have not been formally researched.

Fox and Bartholomae (2000) reported that familial stress is related to the deleterious effects of insufficient economics on all aspects of family relationships. Parenting practices are negatively impacted because parental support is reduced. Many adults in midlife serve the function of supporting younger couples with infants, but this is not possible when their middle-aged parents are struggling with unanticipated unemployment in a small town.

Economic stress can be a culprit in contributing to increased levels of depression and antisocial behaviors in children. Family economics are also the single, strongest indicator of a child's sense of health. Marital satisfaction also may be compromised, contributing to hostility on the part of the husband and a reduction in warmth and supportiveness toward his spouse (Fox & Bartholomae, 2000). However, these and other correlates of economic strain have been generalized in the literature and were not specific to Hispanic families. Observations appear to support the relevance of these findings and is directly relevant to the Hispanic experience. Divorce petitions and notices of bankruptcies filed by people with Hispanic last names, printed in the local paper, have increased substantially during the last two years.

Many Hispanic families in the Globe-Miami area who were affected by the copper mine's reduction of its work force exhibit depression and high levels of anxiety. Copper mining is the last viable industry in this area. There are no employment opportunities within the community that offer comparable wages and benefit packages. Many Hispanic families help support their parents financially in addition to raising and supporting their own children. Relocation is not feasible, as the intergenerational connections and responsibilities are strong. Social workers representing rural minorities, whose cultural identity and economic well-being are often enmeshed with industries in decline, must therefore identify ways to provide incentives to achieve higher levels of education and to recognize alternative opportunities within their communities of origin.

—Melinda Fairfield

Implications for Practice:

Assessing the Home Environment

Quality of the home environment should be considered when making an assessment. Researchers have Id various methods for measuring the quality of a child's home. The most widely used measurement is the Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell & Bradley, 1984). A revised and updated HOME Inventory Administration Manual, as well as online training (three to four hours), is available from the Family and Human Dynamics Research Institute at Arizona State University (access from https://theconnectcenter.asu.edu/comprehensive-manual-2022). This instrument is designed to measure the quality and quantity of stimulation and support available to the child in the home. It consists of 45 items separated into six subscales: parental responsiveness, acceptance of child, organization of environment, play materials, parental involvement with child, and variety of stimulation (see Exhibit 4.13). Assessment of the environment consists of observation of the home and a semi-structured interview conducted in the child's home with a primary caregiver (Bradley & Brisby, 1990).

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Exhibit 4.13 Sample Items from the Home Inventory (Infant-Toddler Version)

Emotional and Verbal Responsiveness of Parents
Parent responds to the child's vocalizations with verbal response.
Parent caresses or kisses child at least once during visit.
Acceptance of Child
Parent does not shout at child during visit.
Parent does not interfere with child's actions or restrict child's movements more than three times during visit.
Organization of the Physical and Temporal Environment
When parent is away, care is provided by one of three regular substitutes.
Someone takes child to grocery store at least once a week.
Provision of Appropriate Play Materials
Child has some muscle-activity toys or equipment.
Parent provides toys or some interesting activities for child during visit.
Parental Involvement with Child
Parent consciously encourages developmental advance.
Parent structures child's play periods.
Opportunities for Caretaking Every Day
Family visits or receives visits from relatives once a month.

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Practice Guidelines

- Optimal home environments are ones that are safe, well organized, and have adequate areas to explore. Appropriate and stimulating toys and play materials should be available for the infant to investigate and manipulate.
- Programs such as WIC, Medicaid, and Head Start cannot eliminate the existence of poverty, but they can help counteract many of its negative effects.

Infant Abuse

One-third of the child victims of abuse are less than one year old, and are the largest single group of children entering foster care (Zero to Three, 2016). Factors that put children at risk for abuse and neglect during the first year of life include poverty, minimal maternal education, maternal depression, presence of other young children in the home, and the mother's separation from her own mother before age 14. A common injury to babies at this age is head trauma. Infants who are difficult to soothe and who cry uncontrollably are at particular risk of this type of injury. Head trauma may occur from someone hitting the baby's head against a hard object, but a head injury also can occur if someone shakes the infant. This form of abuse is known as **shaken baby syndrome**. Some parents who would never dream of hitting a baby's head against a wall will pick a crying infant up and, out of sheer frustration, shake the baby. Difficult and demanding infants may be at a higher risk for this type of abuse. The frustrated parent shakes the infant to stop them from crying. Unfortunately, the baby suffers a head injury, and possibly a concussion, and becomes quiet. The next time the infant cries, the parent is more likely to shake the infant again. But shaking an infant can cause severe injury or death. Babies have weak neck muscles and cannot control their heads well. When shaken, the head moves back and forth rapidly and the brain hits the skull. There is usually no external evidence of injury, such as bruising, but there is usually bleeding of the brain and retinal hemorrhage. Many shaken infants suffer permanent neurological damage, seizure disorders, blindness, and deafness. Visible symptoms of a shaken baby include lethargy, crying, vomiting, loss of appetite, and seizures. Among infants with these injuries, 25% die. However, shaken baby syndrome is preventable. The most common trigger for shaking a baby is inconsolable or excessive crying, a normal phase in infant development.

Parents at risk of physically harming their infants need help. They need information on ways to deal with a crying infant. Parents need to understand that the baby's responses are not intentional; the baby is not out to get them. They need help in learning to control and modify their infant's responses, and they may need to adjust the level of stimulation the baby receives. Parents need to understand differences in temperament—that a difficult, demanding baby cannot help being that way. They may need help dealing with stress in their lives and finding adequate resources and social support. These parents need to know that, when they are at the end of their rope and on the verge of lashing out at the infant, they should put the baby in the crib, close the door, and take a break. They can call someone else to come over and care for the baby for a while. They especially need to know to never shake a baby and that they should consider obtaining treatment for depression.

Another form of infant abuse is **Munchausen's syndrome by proxy**. In this form of abuse, the caregiver (usually the mother) induces symptoms of illness in her child.

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The mother may administer syrup of ipecac to the baby to induce vomiting or may place drops of blood in the infant's urine. Of particular concern are babies who seem to be suffering from apnea (episodes where breathing stops). This apnea may be a result of efforts by the mother to fabricate by smothering the infant and then seeking help to resuscitate her or him. This form of abuse places infants at high risk of death. Infants who are intentionally suffocated by the caregiver are sometimes dismissed as a SIDS death. Normally, a complete autopsy and death investigation must be conducted to determine a diagnosis of SIDS. Unfortunately, SIDS death and death from suffocation cannot be distinguished by autopsy (American Academy of Pediatrics, 1993). In fact, one study estimated that nearly 5% of SIDS deaths were caused by abuse (American Academy of Pediatrics, 1994). Situational and familial factors play an important role in helping distinguish abuse from SIDS, such as history of apnea in the presence of one caregiver, death at an age greater than six months, and unexplained deaths of one or more siblings (American Academy of Pediatrics, 1994). An example of child abuse mistaken as SIDS is the case of Marie Noe, who in 1999 confessed to suffocating eight of her babies between the years 1949 and 1968 (McCoy, 1999). At the time, each infant's death was attributed to "crib death," a term used before the concept of SIDS was established.

Other evidence of abuse of infants includes bruising, skull fractures, broken bones, and burns (see Exhibit 4.14).

Exhibit 4.14 Accidental Versus Inflicted Injuries (Child Abuse): What to Look for

Accidental Injury
The story of how the injury occurred is clear and consistent.
The resulting symptoms occur immediately after the accident.
The caregivers seek treatment for the infant immediately after the injury occurs.
The accident is witnessed by lr person.
Someone knows the answer to "What happened?" and "How did it happen?"
A major injury that is accidental is the result of a major event. For example: ■ Major injuries occur outside the house. ■ Falls are not a major cause of death or injury. ■ Falls that cause injury are from a significant height (more than 10 feet). ■ The child must be old enough to be active and climbing.
Inflicted Injury
No one knows how the injury occurred and/or the story changes.
The symptoms occur up to days after the alleged injury.
The caregivers may delay seeking treatment for the symptoms.
No one saw the accident, or it occurred while only one person was present.
The story is "the same old story"; that is, the baby fell off the couch or bed. (Police refer to "the killer couch.")
A major inflicted injury is described as being caused by a minor event, such as the following: ■ The child fell from a height of 2–3 feet. ■ A sibling dropped the child. ■ Several minor injuries occurred to explain the major injury. ■ The child is nonmobile—that is, the child is not yet active and climbing.

Foster Care

Infants who are abused or neglected may be removed from their parents and placed in foster care. In many cases, the aim is to return the child to the parents when the abusive or neglectful situation changes. Some children, though, remain in foster care for a long time, waiting to return home or to be placed for adoption. However, some children move from one foster home to another. This lack of permanence and continuity of care can have detrimental effects on an infant. There is evidence that abuse, neglect, and late age of adoption placement increase emotional and/or behavioral problems in children (Dumaret, Duyme, & Tomkiewicz, 1997), which can influence the success of foster-care placement. Foster and adoptive families should be made aware of a child's history, so they can be more sensitive to the child's needs.

Fahlberg (1991) offered the following guidelines for children placed in foster care. The child's previous caregivers should participate in the placement decision. The caregivers should be included in a separation interview to help determine what type of placement would be best for the child. Caregivers should continue visiting the child in foster care; visitation allows the attachment relationship to continue and allows the caregivers to practice positive interactions with the child. Davis, Landsverk, Newton, and Ganger (1996) found that parents who visited their children as recommended by the courts had high rates of reunification, although compliance with visitation was not a predictor of which children remained in their parents' home after 12 months. Whenever possible, siblings should be placed in the same foster home.

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Parents with Mental Illness

Children whose parents have a mental illness are more at risk of developing mental illness themselves (Seifer & Dickstein, 1993). Some of this risk is genetic, but some risk comes from the parents' behavior. The risk is particularly high if the parent has bipolar disorder or schizophrenia, has a substance use disorder, or depression. These types of mental illness can interfere with parent–infant interactions.

For example, a depressed mother may fail to make eye contact when feeding the infant, may be less inclined to play with the infant, and may be less responsive to the infant. To a depressed mother, the infant may seem demanding and troublesome. Because the mother is more likely to be negative in her interactions with the baby, the baby then reflects the mother's mood and is more negative in interactions with both the mother and with other adults. In fact, new research suggests infants may become depressed. As a toddler, the child of a depressed mother seems more negative and impulsive, engages in more conflict with the mother, and may exhibit an insecure attachment (Seifer & Dickstein, 1993) (see Exhibit 4.15).

Maternal depression is of particular concern because a large percentage of women experience low feelings after having a baby; these feelings are usually attributed to changing hormones or fatigue. Typically, this clears up in a few days or weeks. But some women may display clinical signs of postpartum depression that lasts for months. Women who have a history of depression are more likely to experience postpartum depression. Women who have postpartum depression have been shown to be less attuned to their infants and are less affirming of the infant's experience (Murray, Cowley, Hooper, & Cooper, 1996). The affective interaction of a depressed mother also can influence the infant's attachment. There is some question as to whether this type of postpartum depression is different from other forms of depression (Seifer & Dickstein, 1993). In fact, the DSM-V classifies postpartum depression as "Major Depressive Episode with Peripartum Onset" if the depression occurs during pregnancy or within the first four weeks of delivery. Women who experience postpartum depression should not pass the depression off as "baby blues" but should be encouraged to seek treatment.

Exhibit 4.15 Questions for Parents to Assess Signs of Depression in Infancy

Does my baby appear withdrawn, perhaps frequently staring into space?
Does my baby's facial expression appear sad (infrequent smiling)?
Is my baby expressing a vibrant range of emotions?
Is it difficult to get my baby to engage with me socially?
Is my baby quiet and subdued?

Parents with a History of Developmental Delay

Jill took her one-month-old daughter to the ER. The baby was having seizures and was admitted to the Pediatric Intensive Care Unit. Jill was a 20-year-old developmentally delayed (DD) mother. She lived with her daughter and the baby's father, who was also DD. Jill had proven to her DD case worker that she could manage her own finances, so her case was closed. However, after the birth of the baby, she had trouble making ends meet each month. She had been evicted three times in the past year for failing to pay the rent. By the end of each month, she had run out of WIC vouchers and money for food and milk. Jill's mother usually helped out with food for the baby. Jill explained to the social worker that at the end of this month, her mother was out of town and she had had no money to buy food or milk for the past week. As a result, the baby had not eaten or had milk to drink for the last two days.

Several problems can arise for infants of parents with a history of developmental delay. Many mothers with developmental disabilities may not be emotionally available to the infant, and they may lack skills in reading and responding to the baby's cues. They may lack judgment about what is safe handling of an infant and may be rough with the baby. They may lack the ability to be flexible and adapt their responses to the changing needs of a growing child. They may be unable to budget and plan finances adequately or access resources in a crisis.

In-home help and parenting programs can benefit many parents who are developmentally delayed. Having another adult in the home can make a critical difference (Tarleton & Ward, 2007). Some parents with developmental delays live with their own parents who provide support and help with childcare.

Several issues need to be considered in this situation. Federal and state laws have assured equality to people with disabilities, including the right to have children (Bromwich, 1985). But what is in the best interests of the baby? Should a baby who is not growing be removed from the home? What if the baby is attached to the parents? What happens as the unimpaired child grows up with parents with developmental disabilities? Perhaps more programs need to be developed to address the needs of children living with

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such parents and help those parents provide adequate care for their children. Bromwich suggested that, as we protect the rights of parents with a history of developmental delay to have children, we must also protect the rights of those children "to be exposed to social and educational experiences that will foster their healthy growth and allow them to develop their own capabilities to the fullest" (p. 12).

Implications for Practice:
The Importance of Social Support

Infants need a safe and stimulating environment and nurturing, responsive caregivers. Several difficulties may interfere with a caregiver's ability to provide an adequate environment or to interact with an infant. As we have seen, these problems include living in poverty, substance use disorders, mental illness, marital difficulties, adolescent parenthood, and developmental delay. In all of these situations, we have stressed the importance of social support. Mothers interact more positively with their infants if fathers are supportive and help with childcare. Single teen mothers do better with the help of involved grandparents. Parents of difficult or delayed infants fare better when they have friends who call to ask how the parents are coping or who offer to sit for the child to give the parents a break.

New parents need the help of other people—family, friends, neighbors, churches, agencies, and community programs. You may hear this African proverb often in your career, but it describes social support so well: "It takes a whole village to raise a child."

Practice Guidelines

- Parents who are at risk of physically harming their infants need to understand that the baby is not intentional or personal. They also require education on how they can help soothe a baby or when they need to take a break from the situation.
- Children placed in foster care benefit from as much stability as possible. Try to consult with others who have cared for the child to help decide the best fit. Ideally, children can continue attending the same school.
- Parents are at risk for experiencing depression or anxiety following the birth of a child, particularly if they have a history of mental illness. Mothers should be assessed in the first few days to weeks for signs of PPD or PPA.
- Parents with developmental disabilities should have the opportunity to discuss their reproductive desires in an open and nonjudgmental environment. Counselors should meet with their families to discuss how this would look and if the parents are capable of being a good parent for a child with the right support system and resources in place.

Developmental Guidelines for Assessment in Infancy

Exhibit 4.16 presents the developmental guidelines for infancy. These guidelines help social workers understand development when making assessments.

Study Table Social Dimension in Infancy

Families, Groups, Communities, and Support Systems

- All interventions with infants require assessments of the interaction of the infant with the family.
- Mother–father relations influence infant development; circular influences.
- Most of the social support for mothers will probably come from the father or partner. Fathers and partners have been neglected in the study of infants. Fathers spend less time with the baby than do mothers, and the quality of the relationships also differs. Fathers may experience postpartum depression; three out of five children see their grandparents at least once a week.
- Adoption leads to the formation of families. Open adoption is when the birth mother and sometimes the birth father participate in choosing a family for the baby. Transracial adoption and the adoption of AIAN children are controversial.
- The quality of early childcare and early childhood education represents one of society's best hopes for optimizing the long-term outcomes for low-income children and children in poverty. The lack of quality childcare is an impediment to having poor mothers leave welfare.

Continued

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Multicultural, Gender, and Spiritual Considerations

- Minority infants are more likely to live in homes with younger mothers, single mothers, and large extended families.
- Consider cultural assessment questions that can be used in assessment.
- Families that you are working with may not assume that the child has a problem; across cultural differences.
- Male and female infants behave differently at birth, and they are treated differently. By the second year of life, infants begin to show toy preferences.

Social Strengths, Hazards, and Risks

- A good neighborhood is a key factor to promoting positive developmental outcomes; access to quality childcare and other family life choices.
- Home environment: Infants need verbal interaction; a variety of stimulation; warm, responsive caregivers; a safe, well-organized home and freedom to explore it; and appropriate and stimulating toys.
- Poverty can have a detrimental effect on development. Infants born in poverty to overstressed caregivers are at increased risk of abuse and neglect.
- Forms of infant abuse: shaken infant syndrome; Munchausen's syndrome by proxy.
- Lead poisoning from eating paint chips or absorbing environmental lead can cause learning problems and delayed growth and development.
- Children born to parents with mental illness and parents with a history of developmental delay may be at increased risk for developmental problems.
- Early intervention and social support can mediate problems in these families.

Exhibit 4.16 Developmental Considerations in Assessment in Infancy

Routine Observations	Developmental Issues (Not Problems)
Perceptual abilities	Some difficulties warming up
Reflexes	Sleep irregularities
Weight gain and growth (height)	Infant is perceived as fussy
Sleep patterns	Limited interest in eating
Patterns of crying, cooing, and body language	Object permanence
Feeding patterns	Limited vocalizations
Rhythms and capacity for self-regulation	How infant sleeps (on stomach)
Temperament	Teen parents
Fit between infant temperament and parenting style	Poor parental preparation for the infant
Attachment and strategies for maintaining relationships	Preparation of siblings for arrival of infant
Parents' nurturing capabilities	
Parental supports	
Childcare resources	
Strengths and Landmarks of Development	**Developmental Observations Requiring Attention**
Good health	Lack of physical growth (failure to thrive)
Well-developed senses	Insecure attachment
Shows preferences	Colic
Recognizes primary caregivers	Overarousal or underarousal in the infant
Demonstrates responsiveness to caregivers	Parent depressed or has other mental illness
Play develops within attachment relationships	Lack of supports and good childcare
Ability to entertain self for brief periods of time by 6 months	Serious health problems in the child
Flexible attention	Serious parental healthcare concerns
Reaches physical milestones for fine motor, crawling, and grasping	Insecure attachment
	Separation after attachment
Regular sleep, wakefulness, feeding, and elimination	Infant neglect or abuse
	Poor fit between infant temperament and parenting styles

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Applying the Framework

Failure to Thrive

Roberto was referred to the Growth and Nutrition Clinic by his pediatrician. The social worker in the clinic completed the initial psychosocial assessment. The baby is a 15-month-old Hispanic male who weighs 19 pounds 2 ounces. His rate of growth has been dropping since he was two months old and is now well below the 5th percentile for his age. Roberto's parents both have a history of developmental delay. His pediatrician is concerned about Roberto's lack of growth and his parents' ability to care for him adequately. For this reason, he has referred the case to Child Protective Services (CPS) for failure to thrive.

Developmental History

This was the first pregnancy for Roberto's mother, Angelica. She carried the baby to term and had a normal vaginal delivery. Roberto weighed 5 pounds 12 ounces at birth, with Apgar scores of 8 and 9. Angelica denies any drug or alcohol abuse during the pregnancy. She reports that she experienced persistent vomiting throughout the first half of the pregnancy. Until her sixth month of gestation, she was almost unable to hold down any food or drink, and she was hospitalized three times for dehydration. She states that she and her husband, Raul, very much wanted a baby. Although she was very happy to be pregnant, she was so sick that she was glad when it was over.

At 15 months, Roberto is only now beginning to pull to stand. His mother is not sure whether he says any words other than "mama" and "dada."

Biophysical Considerations

Since he was two months old, Roberto has suffered from almost constant ear infections. Roberto was bottle-fed, and his mother reports that he was a very slow eater, sometimes taking more than an hour to finish a bottle. Often he would take only a couple of ounces at a feeding. Roberto is especially hard to feed when he is ill, as he tends to have a very poor appetite. The doctor believes that Roberto's failure to gain weight makes him more susceptible to illness.

Psychological Considerations

Cognitive Development

Roberto's development seems delayed; he does not walk alone yet. His mother reports that he did not sit alone until he was nine months old. Roberto appears to be thin and sick and quite wobbly on his feet even when holding on to something.

Communication

Roberto says no words other than an occasional "mama" or "dada." He does startle to loud noises. He sometimes appears to comprehend basic requests but often ignores them. He communicates mostly by pointing and grunting.

Attitudes and Emotions

Roberto's mother reports that as a baby he was loud and intense. He was very unpredictable in daily habits. He never has liked cuddling very much and has always been difficult to calm. On observation, when Roberto looks to his mother, she looks past him. When asked to hold the baby in her lap, she faces him away from her. He squirms to get down and screams until she lets him go. He plays well with his father. They make eye contact and smile at each other. His father talks to him, shows him interesting objects, wrestles on the floor with him, and changes his diaper when needed.

Social Cognition and Regulation

Roberto makes few social overtures to his mother or to the social worker during the interview. He ignores all requests from anyone. He seems interested only in exploring the room, and he can be distracted only by physical play with his father. According to his parents, Roberto is very hard to feed. He often refuses to eat. Roberto will sit in his high chair only for a few minutes before wanting to get down. His parents have been so worried about his lack of weight gain lately that they now spend longer than an hour trying to force the baby to eat. Mealtimes have become a nightmare for everyone. When Roberto does eat, he refuses to eat from his own plate but takes food from his mother's. In other areas, the baby seems to have no set routine. He has no regular bedtime or bedtime routine. His parents allow him to stay up until he falls asleep on the living room floor.

Social Considerations

Family

Roberto's parents are married and live in a one-room apartment in a poor section of town. They are both Mexican American. Roberto's father is from Mexico and does not speak English. On standardized tests, both parents

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Failure to Thrive (continued)

exhibit developmental delay. Roberto's father works as a food server in a Mexican restaurant, and his mother stays at home to care for the baby. Though she has poor reading skills, Angelica graduated from high school. Raul completed the sixth grade in Mexico. Angelica's mother and sister live in town, but all of Raul's family lives in Mexico. Angelica thinks her baby is doing well. She says he is just not that interested in eating, but she feeds him when she can. Angelica says that as a child, she didn't have much of an appetite either, but that was good because her family did not have much to eat. She doesn't understand why everyone is so worried about her son's weight.

On observation, Angelica is a small, thin woman who looks sad most of the time. She does not brighten even when her baby comes up to her. Even when he smiles at her, Angelica avoids eye contact with her son.

Although they are developmentally delayed, Angelica and Raul have been doing well on their own. They maintain an apartment, hold a job, and pay the bills. Though they live in a poor neighborhood, the apartment is clean. The baby has few toys to play with. Also, they have no transportation and rely on public transportation, which is somewhat lacking in their town. This lack of reliable transportation makes getting to appointments a long ordeal. Lunchtime is often spent in waiting rooms or on the bus.

Social Support

Angelica has a close relationship with her mother and sister. They babysit for her sometimes and come over to help out. Angelica and Raul attend parenting classes through the Department of Developmental Disabilities. They have an in-home parent aide who visits them once a week. They really don't have any friends, and although they are religious, they do not attend church on a regular basis. The local CPS has a day-care program. CPS will pay for the child to attend a day-care center full time, where he can experience a set routine, receive up to three meals a day, and observe other children eating and enjoying mealtimes.

Multicultural Considerations

When Roberto has been sick with ear infections, his parents have often used folk remedies. They say he doesn't like to take his antibiotics; in fact, he tries to spit out the medication. Raul's grandmother suggested they feed the baby sweetened manzanita tea. He likes it and will drink it, and his parents think it helps with his fevers.

When asked what she thinks is wrong with the baby, Angelica replies emphatically that she had "nervios" during pregnancy. When asked to elaborate, Angelica explains that Raul lost his job when she was five months pregnant, and they had no money until Raul found his present job three months later. Angelica was under a lot of stress during this time and worried constantly about how they would support a baby. She is sure this is why Roberto is so irritable and hard to feed.

Because they are unable to get him to eat enough, the parents often light candles and recite prayers asking that they be able to keep their baby and not lose him to CPS. They pray that he will soon eat well, grow, and walk on his own, so that everyone will think they are good parents and they can keep their son.

Raul is the higher-functioning parent, but he does not speak English. Because no one at the clinic speaks Spanish, communication with Raul is through a volunteer interpreter. The interpreter often seems to be changing what was originally intended in the messages to Raul. The staff suspects that the interpreter is giving his own advice to the parents. On one occasion, a staff member with some understanding of the language thought she heard the interpreter tell Raul not to worry, that he just needed to make sure the baby drank *la leche* (milk). It is often difficult to tell whether the parents understand instructions about their baby.

Summary and Impressions

Roberto seems to have the following problems:

1. Failure to thrive
2. Possible developmental delay, possibly due to inadequate food intake
3. Chronic ear infections, which may contribute to lack of appetite
4. Difficult temperament
5. Behavioral problems with feeding

Additional problems:

1. Parents with a history of developmental delay
2. Poverty
3. Possible poor environment
4. Lack of routine and order in care
5. Possible poor mother–infant interactions
6. Possible maternal depression

The parents have many strengths and resources. They are able to maintain an apartment on their own. Angelica and Raul obviously love and care for the infant. Though Angelica in particular may have some problems in interactions with the baby, she is very concerned about his health and development. The parents have kept all their appointments at the clinic. They cooperate well with the

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parent-training program and with the parent aide. The baby seems to be especially attached to his father.

Both parents are highly motivated to do whatever is necessary to keep their baby. They can follow simple written instructions regarding care and feeding of their child. They are keeping clear and accurate food logs about what Roberto eats each day. They are willing to work at establishing a schedule for the baby—to feed him six times a day and establish a regular bedtime routine. They are also considering the daycare program for Roberto. The baby has been referred for developmental assessment. Several members of the clinic staff have signed up for an accelerated Spanish course.

Four Ps' Formulation for Integration of the Data

Practice Exercise:

Fill in each of the four Ps for the case that is applying the biopsychosocial framework for this chapter.

Use the results of the four Ps' formulation to:

1. Identify relevant problems, diagnoses, or other relevant judgments about the case described in the Applying the Framework section of the chapter.
2. Describe an appropriate biopsychosocial intervention based on the findings in your four Ps' formulation of the case.
3. Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial integrative data that you identified in your formulation of the four Ps.
4. Describe how you would evaluate your invention based on the data captured in your four Ps' assessment.

	Biological	**Psychological**	**Social**
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

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Reviewing Your Competencies

You should be able to:

1. Describe the key developmental themes present in infancy.
2. Understand the key aspects of biophysical growth and development (breastfeeding, SUIDS).
3. Describe the key themes in the psychological dimension for infancy (infant mental health, information processing, attention, learning, failure to thrive, social referencing, attachment).
4. Describe the key themes in the social dimension for infancy (adoptive families, HOME inventory, infant injuries).

Key Terms

active sleep
attachment
babbling
breastfeeding
categorization
cephalocaudal
circular influences
cross-modal transfer
difficult child
dishabituation
easy child
failure to thrive
goal-directed behavior
goodness of fit
habituation
holophrastic speech
Munchausen's syndrome by proxy
myelinization
object permanence
obligatory attention
open adoption
overextension
proximodistal
quiet sleep
sensorimotor stage
separation anxiety
separation-individuation
shaken baby syndrome
slow-to-warm-up child
social referencing
stranger anxiety
telegraphic speech
temperament
transitional object
transracial adoption

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Chapter 5

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Early Childhood

Learning Objectives

1. Describe the key developmental themes present in early childhood.
2. Understand the key aspects of biophysical growth and development (nutrition and gross- and fine-motor skills).
3. Describe the key themes in the psychological dimension for early childhood (autonomy, Piaget's preoperational stage, memory, social and emotional functions of preschool, responses to environmental/historical events, aggression/violence, emotional intelligence, language development, empathy).
4. Describe the key themes in the social dimension for early childhood (parenting styles, peer relationships, early intervention programs such as Project Head Start, diverse families, media use).

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Developmental Themes	Key Concepts
	■ Stage: autonomy versus doubt. Development of greater autonomy, physical ability, and language skills; mastery of basic self-help skills; increased social skills. Play is critical for healthy development.
Biophysical Dimension	
Biophysical Growth and Development	■ Physical development. Gross-motor skills. Fine-motor skills.
Biophysical Strengths, Hazards, and Risks	■ Nutrition. Physical activity. Prevention and treatment of asthma.
Psychological Dimension	
Cognitive Development and Information Processing	■ Imaginative thought. Piaget's preoperational stage. Information processing. Infantile amnesia; memory. Developmental waves.
Communication	■ Language as innate. Language development by age. Mastering morphological rules; syntax; semantic skills; conversation. Communication disorders.
Attitudes, Emotions, and Regulation	■ Emotional regulation. Emotion coaching. Fears. Posttraumatic stress disorder (PTSD). Grief and loss. Aggression. Altruism and empathy. ■ Self-concept. Self-esteem. Sociability of preschoolers. Social skills training for preschoolers. Regulation.
Psychological Strengths, Hazards, and Risks	■ Growth in psychological functioning, flexibility. Disorders of childhood. Diagnosis and assessment issues. Elimination problems: enuresis, encopresis. attention-deficit/hyperactivity disorder (ADHD)
Social Dimension	
Groups and Families	■ Family influences. Parenting styles. Nature versus nurture. Nontraditional families. Mother's role. Father's role. Children of prisoners. Sibling relationships. Peer relationships.
Communities and Support Systems	■ Play. Preschool environment. Kindergarten. Head Start. ■ Full-service schools; effects of TV.
Multicultural, Gender, and Spiritual Considerations	■ Development of racial identity. Cross-cultural adoption. Development of gender role and sexual identity. Sex stereotyping.
Social Strengths, Hazards, and Risks	■ Social capital, family group decision making poverty, and child abuse.

Developmental Themes

When Skyler's dad asks him a question, his response is "no, no, no!" His dad asks, "Skyler you like ice cream?" "No, no, no," he answers. He continues to shake his head. Skyler grabs his father by the finger, pulls him into the family room, and demands to play with his favorite toy. His father reluctantly complies. Afterword, Skyler is ready for refueling—obtaining some emotional closeness before moving on to his next activity.

Early childhood often represents a struggle for independence and self-mastery. Children expend a lot of energy striving for inner control. They push for independence, yet at the same time feelings of dependence overwhelm them. A critical task at this age is achieving a balance between these two forces. The "terrible twos" or the "threenagers" are a result of this desire to establish autonomy. Toddlers, like the child mentioned in the paragraph above, delight in learning to do tasks independently and making their own decisions.

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Caregivers find they must often adjust their pace to make room for the child's wish for more autonomy—failing to make parental adjustments can result in frustration and unnecessary power struggles. Erikson referred to this toddler (two to three years old) stage as "autonomy versus doubt." Children who successfully master this stage develop a sense of self-control and adequacy. Children at this age are fast becoming more independent, trying out all kinds of activities, and learning many self-care skills that facilitate their autonomy. Children who do not realize a sense of independence and self-control at this age are likely to have feelings of self-doubt and shame about themselves.

During the toddler/preschool years, from ages two to five, children are transformed from infants and toddlers into little boys and girls. Exhibit 5.1 presents a striking comparison between one-year-old and four-year-old children. Physical and cognitive changes continue to unfold, but perhaps the most profound changes during this period occur in children's social and emotional growth and language acquisition. Preschoolers are honing the skills they will need in preparation for formal education in the middle childhood years.

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Ivy, at three-and-a-half years, is mastering autonomy and self-confidence.

Exhibit 5.1 Comparison of One-Year-Old and Four-Year-Old Children

1-Year-Old Children	4-Year-Old Children
Goal is to master mobility	Mobility is used for exploration and independence
Imitates sounds	Masters spoken language, communicates thoughts
Manipulates physical world to learn	Uses mental symbols
Sense of self begins but connected to parents	Pursues relationships separate from parents

Children in this stage increasingly demonstrate greater autonomy, physical ability, and language skills in their activities and relationships. They revel in their sense of accomplishment and mastery in the areas of basic self-help skills such as toiletry, dressing, and hygiene and in recreational skills such as running, jumping, and bike riding. This mastery also extends to verbal skills used in expressing thoughts, singing, playing pretend games, and playing social games.

Older preschool children, ages three to five, face the psychosocial crisis Erikson referred to as "initiative versus guilt." Children at this period ideally initiate motor, cognitive, fantasy, imaginative, and language activities, and they achieve some proficiency and mastery in these areas. Perfection is not a goal; however, feeling that their efforts will be encouraged and praised is crucial to children developing a healthy sense of initiative. Children who feel that they can take on and participate in a task with the expectation that they will achieve some degree of mastery will be more ready to meet the challenges involved in learning at school.

The primary tasks of early childhood, between the ages of two and five years, include developing better-coordinated gross-motor skills, acquiring social skills to enhance relationships, and achieving immense growth in cognitive abilities and expressive language skills, all of which are fostered during play. Play is crucial to physical, cognitive, and emotional growth for preschool children. Learning and relationship skills are acquired through daily, active play. By the end of the preschool period, most children will have developed the necessary attention, coordination, and social skills to transition successfully to middle childhood, when school and peers will become the primary focus of children's days.

Practitioners working with families with children in this developmental stage must be familiar with developmental milestones associated with this period of immense growth. At the same time, it is critical to be mindful of the changes occurring in the parent–child relationship, the frustrations and the joys and fears families have as their infant becomes more active, opinionated, and engaged in the social environment.

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Photo credit Lela Rankin

Ivy, now six years old, has better coordinated gross-motor skills, and is ready to tackle early childhood.

Study Table Developmental Themes in Early Childhood

Developmental Themes	■ Development of independence, self-mastery, and inner control. ■ Toddler stage (two to three years); autonomy versus doubt. ■ Preschool stage (three to five years); initiative versus guilt.

Practice Guidelines

- Ask families to outline the routines regarding sleep, mealtimes, and play time.
- Discuss each caregiver's experience and expectations around limit setting and managing temper tantrums.
- Discuss each caregiver's experience and expectations regarding toilet training.
- Allow caregivers a nonjudgmental environment to reflect on their parental satisfaction and self-care skills as they adjust to a period characterized by greater child autonomy.
- Daycares and preschools should have a predictable daily rhythm with opportunities for children to express autonomy.

Biophysical Dimension

Biophysical Growth and Development

Physical development refers to two processes. Physical development encompasses the growth of the entire human body as well as the ability to perform motor skills. On average, the human grows 2.5 inches and gains 5 to 7 pounds in early childhood. By the time children turn three years old, they have doubled in height and are four times heavier than they were at birth. Because of this rapid physical growth (though not as rapid as in infancy), proper nutrition is essential. Practitioners who work with families experiencing this developmental phase will often encounter caregivers who have concerns about their child's eating habits; both "picky eaters" and "over eaters" can be stressful for parents. Picky eating is typical as this is one area in their lives where they have some control; by refusing to eat, your toddler is practicing autonomy. Refusing a food based on its color, wanting to eat only one food and nothing else, losing interest in a food they used to love, or only wanting to feed themselves with a specific utensil are all common reactions toddlers can have to eating (American Academy of Family Physicians, 2022). Problems associated with picky eating occur in 25 to 35% of children in early childhood (Leung, Marchand & Sauve, 2012). Emerging research on child nutrition and satiety has developed helpful practical guidelines for supporting the development of healthy eating habits during this period (Agras et al., 2012). Exhibit 5.2 provides some suggestions for how parents can address eating difficulties.

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Exhibit 5.2 Division of Responsibility

Parent's Responsibility	Child's Responsibility
What: The parent makes a wide range of nutritious and tasty food available. Parent should avoid making children separate meals as a response to complaints as they are less likely to be as nutritious and will cause stress for the parent over the long run. As the child is transitioning from being a picky eater, the parent ensures there is at least one food the child will eat at each meal.	How Much: To help children maintain their natural satiety cues, parents should allow the child to dictate how much they will eat. If the food choices offered by the parent are healthy, there should not be too much concern about overeating. Pushing a child to eat when they are not hungry will cause mealtime stress.
Where: Parent sets the tone for mealtimes by choosing where children eat. Not every family has to eat together at the table every night, but using the time when possible to talk and connect can be beneficial to family cohesion. Also, parents should be aware that studies show eating in front of a television increases the likelihood for over eating.	Whether: If a child refuses to eat, a parent simply wraps the meal up and saves it until the child is ready to eat. This can be done without expressive argumentation and fighting, which reduces mealtime stress.
When: The parent ensures children will be hungry for meals, and therefore more likely to try new foods, by monitoring snack intake between meals.	

Practice Guidelines

- The American Academy of Family Physicians (2022) recommends 1 tablespoon of food for each year of age (e.g., two Tbsp of a given food for a two-year-old). This is often much smaller than a parent thinks it should be.
- Explore with caregivers what mealtimes and food means in their culture. Traditional upbringings tend to favor "eating everything on your plate," which can disrupt children's natural satiety cues and lead to habits of overeating; however, be careful to validate parents' beliefs and practices because food can carry a lot of emotional significance in terms of love and providing.
- Encourage parents to minimize power struggles over mealtimes while still exposing children to a variety of foods. Strategies such as placing a small amount of a new food on the child's plate, without insisting he or she try it, and keep offering it without too much attention to if it gets eaten or not, have been successful at reducing picky eating habits.
- Mixing foods (i.e., pairing a new food with a familiar food) is more effective at getting your child to have less fear of a new food than hiding a new food.
- Encourage parents to provide opportunities for autonomy that are not overwhelming: "Should we use the blue plate or the green plate?" "Would you like to use a fork or a spoon?"
- Remind parents that regular mealtime routines, parental modeling, and resisting the temptation to prepare separate meals in response to complaints will pay off in the long run in terms of peaceful family meals and healthy child development.

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This three-year-old is attempting to eat dinner at a formal wedding.

Gross-Motor Skills

Early childhood is an exciting time of physical growth and motor development. At this age, children run, jump, climb, and tumble repeatedly for the sheer joy derived from challenging their bodies. They are stimulated and delighted by their accomplishments. The typical three-year-old child can ride a tricycle, walk up and down stairs, throw a ball overhand, and catch a ball that is bounced. By age four, children refine their coordination of large muscle groups and can jump higher and farther, run faster, throw a ball with more speed and precision, and hit a ball off a tee. Five-year-olds can hit a ball pitched to them, jump rope, and roller-skate (Lee & Graves, 2000). Preschool children are at a special point in development where they thrive on activity—at the age of three, the activity level is higher than at any other age in the human life span. Helping

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children obtain the energy (through nutrition) they need and get the exercise they crave will maximize their developmental strengths during this period. Just as infants love "peekaboo," preschoolers never tire of "chase" and "hide and seek," games that allow them to shriek and run at high speeds with someone in hot pursuit.

Developmental Screening

For assessing a child's developmental progress, one of the most common screening tools used in early childhood practice is the Ages & Stages Questionnaires, ASQ-3 (see agesandstages.com; Squires & Bricker, 2009). Early childcare centers might use the ASQ to assess child readiness for kindergarten. Early intervention practitioners often use this tool with at-risk families to determine if there is a developmental delay and a need for early intervention services. For children between the age of one month and five years, six months, practitioners select the questionnaire that matches the child's age. For example, the screen examines factors such as gross-motor skills by asking questions such as:

> Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.
>
> When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it?
>
> Does your child jump with both feet leaving the floor at the same time?

Fine-Motor Skills

Fine-motor coordination during early childhood progresses rapidly as well. However, children in this age group can be frustrated by the limitations in their precision and dexterity. Some projects are difficult for preschoolers because they can cognitively conceive the goal but cannot achieve the intended result because of fine-motor limitations. For example, a child might want to make a beautiful necklace but struggle to loop tiny beads on a string. That same child might want to build a tower as tall as his or her brother's, only to watch it wobble and topple.

The average three-year-old likes to build tall towers and enjoys solving large-piece puzzles and manipulating figures in cars and playhouses. Three-year-olds also strive to conquer zippers, snaps, and scissors. Four-year-olds enjoy building complicated towers and buildings and begin to understand basic structural and design requirements to accomplish the task. Four-year-olds can manage buttons and draw stick figures. Five-year-olds can print capital letters, simple letters, and numbers. Preschoolers learn to master scissors, paints, pencils, and crayons quite readily. They enjoy the tactile and creative expression afforded by these media.

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Preschool children need opportunities to development different types of gross-motor skills.

Biophysical Strengths, Hazards, and Risks

Perhaps the greatest biophysical strength in early childhood is being healthy and using the developing fine- and gross-motor skills. Good nutrition is important because what children eat impacts their skeletal growth, body shape, and ability to fight diseases. Unfortunately, toddler obesity is a significant problem in the United States. In the years 2017–2020, the prevalence of obesity (defined as a BMI at or above the 95th percentile of the Centers for Disease Control and Prevention (CDC) sex-specific age-growth charts) in the

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United States was 12.7% of children ages two to five years old (Centers for Disease Control and Prevention, 2022). Obesity rates are higher among children from families with low incomes compared to those with higher incomes. There are long-term developmental, emotional, and physiological consequences to obesity early in life. Research is showing an important connection between an adult's disposition for gaining weight and his or her early childhood diet. The food children eat influences the genes that control how our bodies store and metabolize nutrients. Thus, the early diet of children has an important connection with the health of adults (Langley-Evans, 2015). Early childhood obesity has improved some since its peak in 2004, primarily attributed to public efforts to address childhood obesity, such as public-awareness campaigns directed to parents to serve healthier food to their children; increases in healthful menus at fast-food chains; campaigns to increase access to fruits and vegetables in low-income neighborhoods; health-conscious policy changes in the Woman, Infant and Children Program; and longer breastfeeding (Itali, 2014). However, globally we took a step back during the COVID-19 pandemic—the rate of BMI nearly doubled during the pandemic among children aged 2 to 19 years (rates during March 1, 2020–December 30, 2020 compared to January 1, 2018–February 29, 2020; Lange, Kompaniyets, Freedman, et al., 2021). These increases were attributable to disruptions to food security, income, time away from structured school settings, and other social determinants of health.

The most significant biophysical hazards of early childhood include the fatal disorders of birth defects, cancer, and heart disease. Prevention strategies to reduce the fatality rates for children under age five include reducing prenatal exposure to substances such as tobacco, alcohol, and drugs; adequate birth spacing; prenatal care; breastfeeding; immunizations; and special feedings before, during, and after serious illnesses.

In early childhood, children come into increasing contact with other children, which places them at a higher risk for communicable diseases. Immunizations have been one of the most significant advancements in reducing preventable early childhood fatalities. For example, before the vaccine was introduced in 1987, Hib meningitis killed 600 children each year. It also caused seizures, permanent deafness, and intellectual disability in many survivors. The rate of Hib meningitis has since declined by 98% (Association of State and Territorial Health Officials, 2010). In 1998, a scholar named Andrew Wakefield published a 12-patient case study proposing a link between MMR vaccine and autism, which sparked a decade's-long popular controversy about the use of immunizations in early childhood. The original paper was retracted in 2010, and its author was found guilty of professional misconduct in the study—however, many parents remained concerned that immunization may harm their child. The American Academy of Pediatrics (AAP) released in 2013 a comprehensive review of the literature demonstrating that vaccines are safe and there is no evidence of a link to autism (American Academy of Pediatrics, 2013).

Practice Guidelines

- The Association of State and Territorial Health Officials (2010) have conducted studies on how to best speak to concerned parents about immunizing their child and have produced helpful literature for practitioners. They found focusing on the benefits of immunizations, rather than negating their fears is more effective. They suggest sticking to the facts while validating the parents' desire to keep their child safe.
- New parents often face overwhelming judgment from multiple sources as they make child-rearing choices. Advice—and frequently conflicting advice—from family, friends, neighbors, websites, professionals, and even strangers can cause parents incredible stress. Under this type of scrutiny, it is easy to see why parents may be defensive about their parenting choices. As a helping professional, it is critical to create a safe environment for parents to explore what parenting strategies fit with their values, their culture, and their capacity given their circumstances. Parents will be more likely to be open to incorporating new ideas if they feel listened to, respected, and do not feel judged.

Asthma

The leading cause of chronic disease in children is **asthma**. An estimated 6.8 million children under the age of 18 in the United States have asthma. The rates have increased steadily overtime (Bloom, Jones, & Freeman, 2013). The impact of the disease is far reaching from school absenteeism, emergency room visits, and even fatalities. While asthma is hereditary, the expression of the illness is impacted by environmental factors, many of which are related to social

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economic status. Children in low-income, densely populated urban environments have higher rates of asthma and experience greater morbidity due to asthma (Gern, 2010).

Risk factors associated with development of asthma in young children include maternal smoking during pregnancy; exposure of the child to secondhand smoke; and low birth weight, exposure to pollutants, stress, and poor diet (Gern, 2010). Social workers often have played a key role in the case management of asthmatics by teaching families how to treat the illness, conducting home visits, and teaching children how to properly use inhalants when needed (Egan, 2010). Attention to the home environment can help protect against asthma attacks. Social workers can assist families in combating potential triggers by replacing bed and pillow covers with allergen-proof zip-up covers, installing air filters, vacuuming regularly with HEPA (high-efficiency particulate air) filters, and exterminating cockroaches (Farber & Boyette, 2001). Motivation interviewing strategies have been effective in helping parents reduce secondhand smoke. The CDC's National Asthma Control Program (NACP) developed a set of six strategies (EXHALE) as a community-wide effort to reduce asthma-related hospitalizations and healthcare costs (see Exhibit 5.3).

Exhibit 5.3 EXHALE Strategies

Education	on asthma self-management
X-tinguishing	smoking and exposure to secondhand smoke
Home	visits for trigger reduction and asthma self-management education
Achievement	of guidelines-based medical management
Linkages	and coordination of care across settings
Environmental	policies or best practices to reduce asthma triggers from indoor, outdoor, or occupational sources

Source: See the CDC NACP website for guidelines on using EXHALE (https://www.cdc.gov/asthma/exhale/index.htm).

Psychological Dimension

Cognitive Development and Information Processing

Early childhood is a time of fanciful, creative, and imaginative thought. Children can think about themselves and others in new and important ways. Imaginative thought leads the way for the development of humor, **empathy**, and

Study Table Biophysical Dimension in Early Childhood

Biophysical Growth and Development

- Average child grows 2.5 inches, gains 5 to 7 pounds. Girls smaller than boys, more body fat; boys more muscle tissue.
- Great physical growth and development that is stimulated by children's accomplishments. Children can ride tricycles, throw a ball, catch a bounced ball.
- The highest activity level of any age group exhibited by three-year-olds.
- Daily physical exercise that uses large muscles is important. Development of fine-motor skills, yet dexterity is limited, which can be frustrating. Mastering snaps, zippers, and scissors is important.
- At age five, children can print letters but typically do not formally read.

Biophysical Strengths, Hazards, and Risks

Maintaining health and developing fine- and gross-motor skills are strengths at this age.

- The fatal diseases of early childhood include birth defects, cancer, and heart disease. Reductions of fatalities have occurred with birth spacing, prenatal care, breastfeeding, immunizations, and proper nutrition after illness. In developing countries, malnutrition and dehydration have led to millions of child deaths that could have been prevented with oral-rehydration therapy.
- Asthma is the leading chronic illness among children. Asthma is a respiratory illness that makes breathing difficult because of narrowing of bronchial tubes. Asthma occurs because of viral illnesses, allergens (dust mites, pollen), and heredity. Treatment is typically medical with a bronchodilator, but increasingly this approach is combined with home visiting where social workers often visit the home to reduce allergens in the environment and teach families proper medical care.

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altruism. Consider these examples of both the strengths and limitations of preschoolers' minds (Marti, 2003, p. 257):

> Nicholas, a three-year-old boy, asks his mother why his blood does not come out from his mouth when he opens it.
>
> Nora, a five-year-old girl, tells her sister that the box of candies is empty because she does not want her to find them.
>
> Carlos, a three-year-old boy, says that thunders have big mouths because they make a lot of noise.

The fascinating mind of the preschooler has been studied by many researchers, notably Piaget and, more recently, scholars in the information-processing field.

Three-year-old children can use abstraction and symbols in increasingly complicated ways. They can classify objects according to one feature, such as color or shape, and recognize that cats and dogs fit into different categories (see Exhibit 5.4). At about age four, children can begin to categorize objects along two dimensions and understand that both cats and dogs fall into the larger category of animals. Numbers symbolize more than just words for the preschool child, who learns to understand the meaning and function of numbers and to use them in everyday tasks. For example, a child may count three books to read at naptime or ask for five more pitches before dinner.

Preschoolers can understand objects as ideas that exist mentally when the object is not physically present. Until children reach the age of about five, they have little concept of time, past or future. They have difficulty imagining something they have never experienced before. Without a concept of time, they cannot think logically about cause and effect. However, around age five, a sense of time and logical thinking begin to take shape. Five-year-olds begin to imagine likely outcomes of their behavior. In addition, they have more experience on which to base these logical consequences.

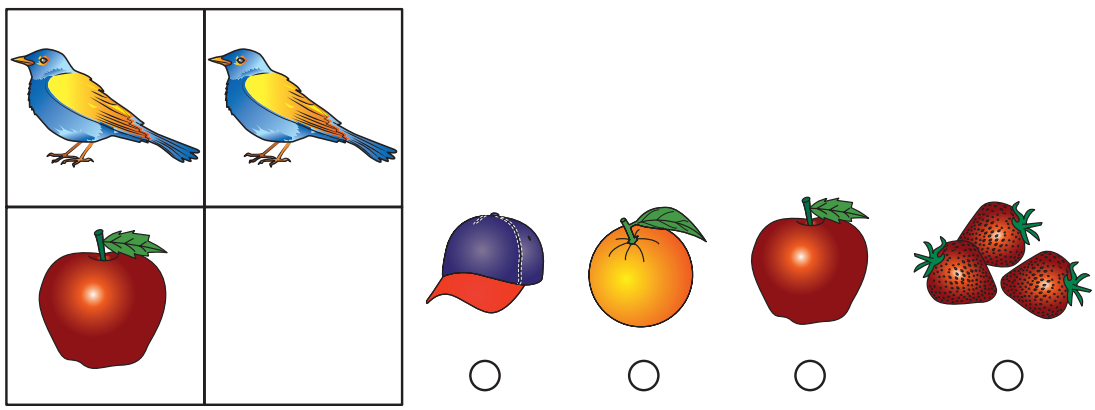
Piaget's Preoperational Stage

Piaget's work laid important foundations for our understanding of what children know (Piaget, 1967). Piaget labeled the early childhood years, roughly from the age of two to about seven, the "preoperational stage" of cognitive development. Children in the preoperational stage cannot perform certain mental tasks that older children can handle. For example, they cannot understand the meaning of properties such as weight, volume, size, or height without a physical representation of the concept.

During the preschool years, mental reasoning, stable concepts, egocentrism, and magical beliefs emerge in children's thoughts as they make the transition from a simple use of symbols to more sophisticated use. Piaget described two substages of **preoperational thought**: symbolic function and intuitive thought. The ability to think symbolically is called symbolic function. Children between the ages of two and four typically possess abilities characteristic of the symbolic function substage. This means that they can now represent objects mentally that are not present in their immediate environment. At this stage, children can draw scribbles that represent an object or person, play pretend games alone and with other children, and talk about people and things not present (Marti, 2012). They can begin to imagine whole scenarios about other people and themselves and incorporate these ideas into their play and language. For instance, children in the symbolic function stage can play "house" or "school," taking the roles of mother, father, student, or teacher. Because they can now conceive of, and share, increasingly complex

Exhibit 5.4 Children Begin to Classify Objects According to Shared Features

85.



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thoughts and ideas, their social interactions move to a deeper level of involvement and satisfaction.

Egocentrism is another characteristic feature of the symbolic function substage, according to Piaget's theory. Egocentric children cannot distinguish between their own perspective and another person's. For example, preschool children playing hide and seek will think that if they cannot see you, you cannot see them. They cannot understand that you have a vantage point different from theirs.

Piaget's second substage of the preoperational stage, intuitive thought, develops between the ages of four and seven. Children in this substage employ primitive reasoning but not formal logic. During this substage, children typically ask a lot of questions, want to know the "how" and "why" of everything, and are sure of what they know but not certain of how they came to know it. Some developmentalists question whether thinking emerges in the exact manner described by Piaget. Small variations in the procedure of an experiment have led to different conclusions, such as instructing a child to attend to relevant aspects of the experiment and finding greater cognitive ability as a result of the instructions. Additional critiques of Piaget's work have focused on the applicability of his work to racial and ethnic groups and low-income children. A lot of contemporary researchers are now using an **information-processing** model to study how cognitive abilities mature and explore the broader applicability of these ideas. The information-processing method identifies the various components of the task the child is performing.

Information Processing

The research in the field of information processing focuses on how children come to know something, rather than on what they know when. Examples of information processes include developmental changes in attention and memory. During early childhood, children make great strides in both abilities. A child's ability for sustained focused attention plays a role in cognitive development, compliance, ability to delay gratification, emotion-regulation skills, and social adjustment (Gaertner, Spinrad, & Eisenberg, 2008).

As you will remember, infants' attention spans tend to be relatively short and wandering. Preschoolers, in contrast, develop the capacity to attend for longer and longer periods of time if they are motivated by the activity. For example, children at this age are interested in books that tell a story, especially about a favorite topic, can watch about a half-hour television show, and can play simple board games. By the time they begin school at age six, children can attend for increasingly long periods of time. This increased attention span is necessary for the child to benefit from formal education.

Most children have little or no memory for specific events before the age of three. This phenomenon is known as infantile amnesia. This lack of conscious memory means very young children cannot recall their suffering for long periods of time. They will not remember getting their immunizations, taking a tumble off of a bed, or having a diaper rash. According to many experts, this is why in cultures across the world, painful procedures are performed in infancy. This is not to say that events we cannot remember are not important or don't have an effect on development. Rather, the hippocampus, the area in the brain responsible for converting short-term memories to long-term memories, doesn't mature until age three or four. So, while a two- or three-year-old can remember a special family vacation for a few months, the hippocampus is required for long-term storage of those memories. It's a hippocampus overload issue; as brain growth slows, the brain is better at keeping track of how memories get stored, which is why long-term memories get better throughout childhood.

At age three, children can begin to embellish their stories, and these additional details help put their memory in context. Still, as children grow older, they are socialized to remember things, and memories take on a different kind of importance (Dehn, 2010). Recounting stories is a way of communicating with others. In fact, before the advent of recorded public information, people used memory as a public record. When one person sold a piece of land to another, they would gather a group of small boys from the area to observe the exchange of money for land. Then they would beat the boys, so they would not forget the transaction as they grew older. Negative memories are easier to recall than ones that are not paired with emotion. Social workers need to be mindful that when painful memories are recalled, it can retrigger the same painful feelings all over again, and can even contribute to retaining those memories and exacerbating clinical symptoms (Young, Bellgowan, Bodurka, & Drevets, 2013). Memories can also be modified when they are recalled. To understand children's eyewitness testimony, we need to be mindful and consider children's basic memory abilities and their reasons for recalling events. Kadushin and Kadushin (2013) describe in their book, *The Social Work Interview*, the importance of understanding children's encoding and retrieval skills when conducting assessments with children. On the positive side, children may have the capacity to reduce the pain associated with negative memories.

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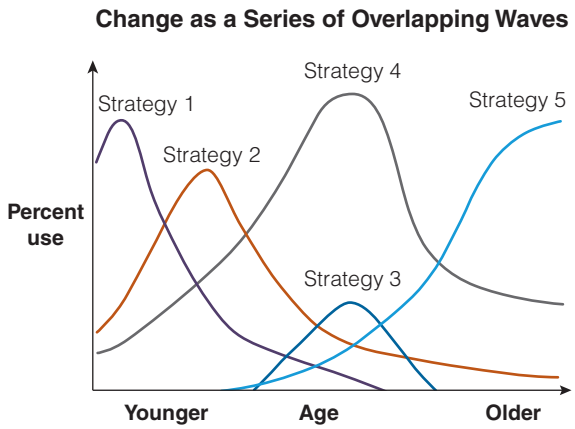
New neuroscience evidence indicates that we can adapt and update negative autobiographical memories with positive content by finding positive meaning in them (Speer, Ibrahim, Schiller, et al., 2021). Positive content includes having the child elaborate on something that was learned or something positive that occurred because of the event. This strategy leads to feeling less negative about the event when the memory is recalled in the future. It's important to note that this approach is not asking to forget about aspects of the memory or inserting artificial information into the memory. **Adaptive memory upgrading** finds positive meaning in events and changes how we feel and what we remember long term, resulting in changes in how the memory is represented in the brain across time. The researchers made an important caveat that memories with very high emotional arousal and vividness, such as memories for traumatic events, may be more challenging to update.

Traditionally, child development was seen as a stair step; skills are mastered and then sequentially built upon. However, because of the great variability in children's development, traditional theories are being challenged by a new model that suggests that "overlapping waves," as opposed to steps, to better account for how children learn and use strategies (Chen & Siegler, 2000). Children learn a new strategy slowly, and they frequently revert to using the old strategy as they are learning the new; they tend to use older, more time-consuming strategies for difficult tasks; and they choose a correct strategy more often when approved by their partner while working in pairs. Although this work has introduced new ways of thinking about how development advances, it does not discount the previous work put forth by stage or level theorists. These theoretical viewpoints may complement each other to broaden our understanding of children's cognitive development (see Exhibit 5.5).

Exhibit 5.5 Developmental Waves



Communication

Children learn an average of seven to eight words a day, starting from about one years old (Oates & Grayson, 2004). Even so, the pace of language acquisition speeds up tremendously in the years leading up to school. Mostly three-year-old children have a vocabulary of about 900 words. By age six, their vocabulary will have increased between 8,000 and 14,000 words. In addition to vocabulary, young children begin to use language in different ways. Children can use language to express increasingly abstract thoughts as well as begin to experiment with using language to engage in more socially complex interactions. For example, at about age three, children develop the skill to converse about people, objects, and places not present. Exhibit 5.6 demonstrates what expressive and receptive language skills children have at various stages of development, according to the American Speech-Language-Hearing-Association.

Most of what we know about how language develops comes from observing children learning to speak. As children develop, they learn the "rules" of speech—not "The cookie I want" but rather "I want the cookie." For a long time, the presumption was that the child's mind was a blank slate on which the rules of language were written (Pinker, 2003). Experts now believe that structural facets of language, the ground rules, must be innate. A well-known perspective offered by the linguist Noam Chomsky is that individual languages are variations on a single pattern, which is referred to as universal grammar. Why do we believe this? Observations show that all children have an appreciation of language. Infants show a clear preference for speech-like sounds over all others. In this sense, children are programmed to learn language. Consider that all children the world over learn language in basically the same manner, starting with labels, such as "me," and advancing to subject–verb structures, such as "me want." Next come subject–verb emphatics: "Me want now." Cross-cultural studies show that children all begin to babble in a systematic way. Some aspects of language still baffle us: children always learn to say no before yes.

Preschool children's comprehension precedes their speech. They can understand much of what is said around them and to them before they can verbally express their ideas on the subject. The process of acquiring language skills proceeds in a relatively uniform way for most children, although the time frame may vary. Language acquisition during the preschool years is quite remarkable: children advance from putting one and two words together

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Exhibit 5.6 Receptive and Expressive Language Skills

Age	Receptive	Expressive
One to two years	Can identify several body parts when asked. Follows simple commands and understands simple questions. Listens to simple stories, songs, and rhymes. Points to pictures in a book when named.	Says more words every month. Uses some one- or two- word questions ("Where kitty?" "Go bye-bye?" "What's that?"). Puts two words together ("more cookie," "no juice," "mommy book"). Uses many different consonant sounds at the beginning of words.
Two to three years	Understands differences in meaning ("go-stop," "in-on," "big-little," "up-down"). Follows two requests ("get the book and put it on the table"). Listens to and enjoys hearing stories for longer periods of time.	Has a word for almost everything. Uses two or three words to talk about and ask for things. Uses k, g, f, t, d, and n sounds. Speech is understood by familiar listeners most of the time. Often asks for or directs attention to objects by naming them. Asks "why?" May stutter on words or sounds.
Three to four years	Hears you when you call from another room. Hears television or radio at the same loudness level as other family members. Understands words for some colors, such as red, blue, and green. Understands words for some shapes, such as circle and square. Understands words for family, such as brother, grandmother, and aunt.	Talks about activities at school or at friends' homes. Talks about what happened during the day. Uses about four sentences at a time. People outside of the family usually understand child's speech. Answers simple who, what, and where questions. Asks when and how questions. Says rhyming words, such as hat-cat. Uses pronouns, such as I, you, me, we, and they. Uses some plural words, such as toys, birds, and buses. Uses a lot of sentences that have four or more words. Usually talks easily without repeating syllables or words.
Four to five years	Understands words for order, such as first, next, and last. Understands words for time, such as yesterday, today, and tomorrow. Follows longer directions, such as "Put your pajamas on, brush your teeth, and then pick out a book." Follows classroom directions, such as "Draw a circle on your paper around something you eat." Hears and understands most of what is said at home and in school.	Says all speech sounds in words. May make mistakes on sounds that are harder to say, such as l, s, r, v, z, ch, sh, th. Responds to "What did you say?" Talks without repeating sounds or words most of the time. Names letters and numbers. Uses sentences that have more than one action word, such as jump, play, and get. May make some mistakes. Tells a short story. Keeps a conversation going. Talks in different ways depending on the listener and place. May use short sentences with younger children or talk louder outside than inside.

Source: Adapted from: American Speech-Language-Hearing-Association.

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Preschool children begin to integrate language and thought more effectively.

to, in just a few months' time, forming complex sentences and questions incorporating the correct morphology, syntax, semantics, and pragmatics of conversation.

As children get older, they begin to integrate language and thought more effectively. Consider one of the author's sons, who wanted to stay up late and watch a special TV show on the brain. Unlike a four-year old, who would say, "I need to watch that show," he said, "I have to do a science report, and maybe I'll do it on the brain." Unlike a four-year-old, this seven-year-old can consider what other people value. Most important, for preschool children, language begins to serve a wide range of functions: reasoning, solving problems, making friends, and playing games of imagination (Mayes & Cohen, 2003). In preschool children, communication is an instrument of thought. Toddlers, in contrast, use language as a road map to what they see and do. Language for the preschooler not only represents a means of expressing needs but also becomes a social reinforcement. Language allows children to share and interact with others in ways not previously available to them. Language opens up a whole new world of secrets, jokes, cooperative play, and positive reinforcement. Furthermore, language skills facilitate independence, allowing children to respond to and initiate verbal requests.

Language Acquisition Disparities

Across the board, children learn to speak at very different paces. In some cases, a slow start is not indicative of future problems; the child will catch up in several months. However, for other children, a limited vocabulary and delayed language processing skills will impact them academically for years to come (Fernald & Marchman, 2012). In a seminal study by Hart and Risley (2000), it was demonstrated that there were large gaps in vocabulary development between children raised in different socioeconomic environments. However, since then, significant concerns have been raised over the published "30 million fewer words by age three gap" between high-income and low-income families. One criticism is it may be that educated parents are more likely to show off by talking and lower income families, particularly those of another race, may be intimidated into silence, when an observer is present. Using a less-intrusive way of observing, such as a small digital recording device worn on the body, Gilkerson and colleagues (2017) found a much smaller word gap: 4 million by age four. More recently, Sperry, Sperry, and Miller (2019) were unable to replicate a word gap at all and instead highlighted that families within each socioeconomic group varied substantially in vocabulary exposure. Further, by excluding exposure to multiple caregivers and bystanders talk, we are underestimating the number of words that lower income children are exposed to. They further critiqued using the word gap concept as racially and culturally loaded. We are missing the boat by focusing on language exposure rather than on cultural mismatches that happen for children of color when they enter school. Are children with low-income families not ready for school or are schools and teachers not ready for these children? Children who grew up speaking a different language or dialect must learn to "code switch"—speaking a different way at school than they do at home. Parents who ask their children lots of questions prepare them to answer questions in school; however, that is a practice common among mostly middle-class White parents. Though the concept of a "word gap" needs reframing, it is important to not lose focus on the importance of a positive early start for later student outcomes. The results of these early studies generated significant interest in investing in early childhood school readiness interventions, which have helped to diminish the educational and racial divide. However, we must also be mindful of honoring the values of diverse families rather than having families change their values to align with schools.

Program models that combine center-based early education and parent outreach (such as home visitation or parenting groups) have demonstrated substantial long-term gains in cognitive and language development (Gomby, 2003). The concerted effort to improve children's readiness for school across socioeconomic strata has demonstrated some significant improvement in the past few decades.

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This five-year-old is picking out books he would like to read before bedtime.

- While some parenting practices span cultures, practitioners must continuously be aware that certain parenting practices related to communication and parent–child interactions (e.g., play and verbal praise) are highly culturally contextualized. Practitioners must take time to understand and respect the values that undergird parenting practices before ever attempting to introduce new strategies.
- Schools should adapt teaching methods and modalities to meet the needs of students with diverse family values. Children with less vocabulary may find learner-centered, project-based, hands-on learning difficult because they believe that they are supposed to sit quietly and listen in order to learn.

Practice Guidelines

- Children often experience frustration as they find they are unable to communicate as clearly as they would like. Parents can help reduce frustration and improve language skills by demonstrating their interest in what the child is attempting to express. Parents can repeat and expand on ideas. For example, the child may say, "Big dog." The parent might respond, "You are right, that dog is bigger than our dog at home! The dog is running. What color is that dog?" Parents can also show interests by taking time to express empathy and repeat what is not clearly understood. "Evie, I know you are frustrated that I don't understand. I can tell you want a toy, but tell me again which toy you want."
- Encourage parents to develop pre-reading skills with children ages two to four—letter identification, handling books, and regular reading time can benefit reading readiness. Educational computer games and tablet applications are available that can engage pre-readers.
- Pretend play can help encourage cognitive skills that build the foundation for storytelling, writing, and reading.
- Parents who speak languages other than English can often times feel confused and anxious about how to best help their child develop language. Encourage these parents that more communication—regardless of which language—will benefit their child's cognitive skills.

Communication Disorders

Language develops rapidly during the preschool years. For the most part, children learn language in a predictable and sequential fashion. Developmental delays can occur, and these are typically outgrown. Communication disorders, however, can continue throughout adulthood, with first signs showing up in early childhood. These include expressive language disorder and stuttering.

Children with **expressive language disorder** understand what others are saying, but they have a hard time expressing their own ideas when they speak. Expressive language disorder is a communication disorder and not a speech disorder; it does not affect how people pronounce words and it is not associated with intelligence. Genetics, problems in pregnancy and birth, a brain injury, or illness can be a cause of expressive language disorder. Sometimes it is related to autism.

Stuttering is a speech disorder. Children who stutter know what they want to say, but they have difficulty saying it. They may have a prolonged pause during speech because they reached a word or sound they have trouble with. Stuttering is common when first learning to speak because children's speech sometimes can't keep pace with what they want to say. Most will outgrow it. However, sometimes stuttering persists throughout life and can impact children's self-esteem and relationships with others. Risk factors include other developmental delays, genetics, and stress.

Therapy for both disorders can be beneficial, particularly when identified early.

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Practice Guidelines

- When screening children for communication disorders, the procedure should include multiple sources of information. The family's perspective should be central in the data gathering and interpretation stages.
- Misinformation about bilingualism has caused confusion for professionals and parents alike. Bilingualism does not cause speech or language problems and may in fact have cognitive advantages in the long term. Some children who have been in a monolingual environment and then are placed in an environment where a different language is spoken (e.g., the transitioning from an exclusively French-speaking home into an exclusively English-speaking school) may experience a "silent period" of several months as they adjust to the new language.

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Emotional regulation is an important skill for young children to develop.

Attitudes, Emotions, and Regulation

An early childhood play scene might include the following interaction: Recess starts with a swift run to the basketball hoop. James shows Sam how to dribble and do a layup. Sam takes the ball and heads for the basket but misses. Gary, sitting on the sidelines, asks tenuously, "Can I play?" After a nod from James, he runs out into the court and trips. Tom, the class bully, comes over quickly to laugh and make fun of Gary.

What do attitudes and emotions have to do with development? For one, they can have a great impact on the nature of our social interactions. One child may become angry when his goal-directed behavior is thwarted. In our example, Sam was intent on learning the layup and would become angry at efforts that slowed his progress. Gary's interactions were entirely different, because his attitude was cautious and he displayed a lack of confidence in his abilities. Tom displayed an irritable attitude, easily provoked when others are perceived to be "in his way." Attitudes and emotions are central to children in early childhood, as they are still learning about how their emotions impact others and the importance of emotional regulation.

Preschoolers often need a lot of support for developing emotional regulation (Denham, Salisch, Olthof, Kochanoff, & Caverly, 2010). This support can help children learn the most effective ways to manage their increasingly complex emotions. Adults can assist children in using cognitive coping strategies: "If you feel yourself getting angry take a deep breath and try not to respond immediately," a parent might advise. Or for younger children, instruct them to hold up their hand and pretend their fingers are birthday candles, "Now blow each of the candles out, putting each finger down until you get to 5." Often, helping professionals will teach children emotional language to help them understand and regulate their emotions. Also, many parents will spend time with their children problem solving around emotional situations and either teaching a form of behavioral coping strategies or suggesting an environmental strategy, such as agreeing not to have two friends over at the same time because there is usually a conflict.

One of the major developments in understanding children's attitudes and emotions has emerged from research, referred to as "emotion coaching":

> "I want Zebra! I want Zebra!" she moaned again. Then she started to cry .... By now I was getting "do something" looks from the passengers, the airline attendants, from my wife seated across the aisle .... I felt bad. Then it dawned on me: I couldn't get Zebra right now, but I could offer her the next best thing—a father's comfort ....
>
> "You wish you had Zebra now," I said to her. "Yeah," she said sadly. "You're tired now, and smelling Zebra and cuddling with him would feel real good. I wish we had Zebra here so you could hold him." ... "Yeah," she said with a sigh. "I'm so sorry," I said, watching the tension leave her face. She rested her head against the back of her safety seat. She continued to complain softly a few more times, but she was growing calmer. Within a few minutes, she was asleep .... Finding out that I understood how she felt seemed to make her feel better ....
>
> [I]t was a memorable testament to the power of empathy. (Gottman, 1998, pp. 69–70)

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This exchange between a father and his daughter represents "emotion coaching." Emotion coaching is a process by which a parent or caregiver assists a child in recognizing his emotions and then uses the experience as a way for the child to learn about himself and to problem solve. Gottman (1998) has described emotion coaching as consisting of five steps:

1. Become aware of the child's emotion.
2. Recognize the emotion as an opportunity for intimacy and teaching.
3. Listen empathically, validating the child's feelings.
4. Help the child find words to label the emotion he is having.
5. Set limits while exploring strategies to solve the problem at hand.

Gottman has found that children whose parents used emotion-coaching techniques were better able to regulate their own emotions, soothe themselves when they were upset, focus attention, and respond well in difficult situations (e.g., in conflicts with other children). Gottman believes that negative emotions are important for children to experience and that they can provide rich opportunities for teaching and relationship-building between a child and a parent. Social workers can draw from Gottman's model when working with families as a way of assisting parents in understanding their child's emotions and helping him or her develop adaptive coping skills (see Exhibit 5.7).

Fears, Grief, and Trauma

Preschool children enjoy wonderfully exciting imaginations and fantasy lives. For example, children often invent an imaginary friend at this age to serve many purposes. An imaginary friend can try out negative, risky, and even miraculous behaviors and feelings; provide companionship; and foster creativity.

A preschool child's emerging cognitive abilities and imagination also promote empathy and humor. However, the downside of these new cognitive abilities is the onset of new fears. Fears become issues for preschool children, as do nightmares and **night terrors**. Fears of the dark, monsters, loud noises, and strange places crop up in imagination in ways that were not possible before the child was capable of symbolism and abstraction. Several steps can be taken to help children learn to handle negative feelings and fearful thoughts adaptively. Children benefit from discussions to prepare and reassure them about their fears and strong emotional responses. We also can teach children to talk about their feelings. Preschool children may not be able to act on these suggestions but will benefit from the discussion and may themselves generate some healthy coping strategies through the process (Denham et al., 2002).

Exhibit 5.7 The Five Steps to Emotion Coaching

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Trauma-informed services can help children cope with disasters and loss.

As a result of the COVID-19 pandemic, 1 out of 500 children has experienced orphanhood or death of a grandparent caregiver (Hillis et al., 2021). Children of color accounted for 65% of those who list a primary caregiver due to the pandemic. Conceptualizing death can be complex for children and dependent on their emotional and cognitive development (Talwar, Harris, & Schleifer, 2011). Loss of a parent is among the adverse childhood experiences (ACEs) associated with mental health problems, including, lower self-esteem, school drop-out, sexual risk taking, and increased risk of substance abuse, suicide, violence, and exploitation. While it is true that children who are directly affected by a disaster, can be the hardest hit, it is also important for social workers to be aware of how traumatic events in communities and societies impact children (see Exhibit 5.8). For example, evidence suggests that exposure through the news or other media sources can induce traumatic stress reposes in children and adults who have not been directly affected (Holman, Garfin, & Silver, 2014).

Children under emotional distress might begin to show symptoms of **posttraumatic stress disorder** (PTSD), a psychological disorder in which the child feels as though she is re-experiencing or reliving the trauma, sometimes months or years after it occurred (American Psychological Association [APA], 2002). According to a meta-analysis of studies, risk factors that might increase the likelihood of PTSD in children exposed to trauma include environmental

Focus on **The Lived Experience**

Talking to Children about Financial Stress

According to APA's March 2022 Stress in America survey, 87% of adults in the United States say that inflation is a top source of stress. Stress about money is the highest ever recorded since 2015, including half of all U.S. adults see housing costs as a significant stressor. Parents are more worried than adults without children about their ability to afford food and housing and day-to-day expenses. There are racial disparities as well: Latino (75%) and Black adults (67%) note money as a significant stressor more frequently than White (63%) and Asian (57%) adults. Culturally, we are in a global crisis. Most (87%) feel like there has been a constant stream of crises, without a break, over the last two years—and three out of four are overwhelmed. How can social workers help?

1. Talk about financial concerns at age-appropriate levels. Older children and adolescents are more likely to want to be included in conversations of the economy and its impact on families, whereas young children are more likely to interpret the situation as more serious than it actually is. Address younger children's fears by reassuring them.
2. Phrasing of financial concerns is important. Young children who overhear "that vacation broke the bank" may take it literally. You can ease fears by answering questions directly.
3. Frame your children's expectations about material things. Children in early childhood can start saving their own money and pay for small things they want when shopping. This framing focuses on the positive while also teaches how to handle money responsibly.
4. Look for signs of distress. Changes in sleep, appetite, or avoidance of certain places or people are signs that a child is experiencing stress. Modeling healthy coping strategies, such as going for a family walk or playing a board game together, are inexpensive activities that also foster bonding.

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Exhibit 5.8 Child Development and Grief

Approx. Age/Stage	Grief Symptoms/Reaction	Helpful Approaches
Zero to two years. Piaget's sensorimotor stage (goal-directed behavior, object permanence). Erikson's trust vs. mistrust stage	Don't understand what death is; sense feelings of adults; depend on nonverbal communication; won't remember the deceased person; general distress, sleeplessness, shock, despair, protest; nervousness, uncontrollable rages, frequent sickness, accident prone, antisocial behavior, rebellious behavior, hyperactivity, nightmares, depression, compulsive behavior, memories fading in and out, excessive anger, excessive dependency on remaining parent, recurring dreams, wish-filling, denial, and disguised anger.	Need physical care, affection, and reassurance; need a consistent nurturing figure to take the place of a mother; include in funeral rituals.
Two to five years. Piaget's preoperational thought (egocentrism, animism)	Confusion, agitation at night, frightening dreams, regression; child often understands that a profound event has occurred; may seem unaffected; repeated questioning; child's understanding of "death" is limited; may know the word "dead" but have little understanding of its meaning; view death as being temporary or reversible.	Simple, honest words and phrases; reassurance; secure, loving environment; drawing, reading books, playing together; include in funeral rituals; need reassurance, love, care, honesty, daily routine, and structure.
Erikson's autonomy vs. doubt and initiative vs. guilt	Question cause of death; may feel the loss of someone loved as a punishment; have difficulty handling abstract concepts, such as heaven; feel sadness, which is short-lived; regress; increased aggression; idealize the lost person; give up attachment to the loved one, attach to substitute people (teachers, neighbors, etc.); escape into play at times to relieve themselves of the reality of the loss; seem not to be reacting to the loss or indifferent; may not remember the deceased person; fear is that no one will take care of them; may fear losing the other parent and thus cling desperately to him or her.	

Source: Adapted from The Hospice Foundation of Florida Suncoast (2009), *Children's developmental stages and reactions to grief*, and L. Costa & D. Holliday (1994), "Helping children cope with the death of a parent," *Elementary School Guidance and Counseling, 23*(3), 206–212.

factors—such as low social support, and low socioeconomic status—and individual factors—such as comorbid psychological problem (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Assessment tools that are age-appropriate for pediatric PTSD are now available; for example, The Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001). Examples of assessment items from the PTSD Scale include the following items rated on a four-point scale from not at all or only at one time, to five or more times a week/almost always:

1. Having upsetting thoughts or images about the event that came into your head when you didn't want them to.
2. Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again).
3. Having feelings in your body when you think about or hear about the event (e.g., feeling scared, angry, and sad guilty).

Parents might notice behavioral changes in these children, including difficulty sleeping or nightmares, enuresis (bedwetting), increased aggression, increased "clinging," crying or sadness, appetite changes, social withdrawal, obsessive play, hyperactivity, and increased physical complaints, such as stomachaches and headaches.

Increasingly, social workers must consider how disasters impact children's development. Public events such as the Boston Marathon bombing, Sandy Hook Elementary shootings, and other violent event provide ample evidence of the need for social workers to be prepared to provide trauma-informed service to children and their families. It can be difficult for adults to comprehend and process disasters such as these. For children, it can be even more frightening and confusing. After a traumatic event or disaster, social workers help children cope with complex emotions such as fearfulness, loss of control, anger, loss of stability, isolation, and confusion (American Academy of Pediatrics, 2015; Masten & Narayan, 2012; Pfefferbaum, Newman, Wind, & Nelson, 2014).

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In addition to being alert to behavior changes in the child, a significant role of social workers assisting children experiencing trauma is to support caregivers. Trauma Focused Cognitive Behavioral Therapy (Cohen, Mannarino, Deblinger, 2012) is an example of an evidence-based intervention for trauma-related symptoms that integrates both the child and the parents into the process. Caregivers whose children have faced trauma are prone to feelings of guilt, shame, and helplessness as they struggle with the reality of being unable to protect their children from difficult life experiences. Children are incredibly resilient and can be remarkably adaptive when the adults in their lives are able to provide emotionally supportive environments.

Practice Guidelines

After a trauma or crisis, encourage the family to explain to their child what has happened in clear, direct terms but also in a way that is age appropriate.

- Continually monitor the caregiver's emotional response. While focusing on the child might feel more pressing, the adults surrounding a child will have the greatest influence on how safe and secure the child feels.
- Watch for changes in the child's behaviors such as sleep disturbances, changes in appetite, social withdrawal, and hyperactivity that were not present before.
- Encourage adults to limit ongoing exposure to the trauma (overhearing adult conversations, media coverage, etc.).
- In conversations with the child, find out what they have already heard. The child may have misinformation or misconceptions. Listen for what is most scary for them about the crisis; it may not be the same as what adults find most disturbing.
- Encourage the family to hold open dialogue in developmentally appropriate ways. Younger children may not need to know every detail, but encourage parents to answer questions and initiate conversations; avoiding the topic may only increase the child's feeling of being unsafe.
- Help families to find ways to reassure the child of their safety; for example, explaining what steps have been taken to keep them safe.
- Try to keep children in their families as much as possible. Children needing kinship or foster care must rapidly receive services in the face of caregiver death.
- Strategies for children need to be age-specific and sensitive to racial disparities and structural inequalities. Programs need to reach the children who need them most.
- Advocate for policies and programs that strengthen economic supports for families, enhance quality childcare and educational support, and promote evidence-based programs to improve parenting skills and family relationships.

Aggression

If you were to observe a preschool classroom, you might be surprised at the high rates of anger and physical **aggression** you would see. For most of us, aggression usually has negative associations and calls up various images of violence. But how do we define aggression in developmental terms? What forms might aggression take as children mature? To grow, develop, and survive, we are equipped with a biological drive for aggression. In developmental terms, it is important to understand what forms aggression might take, what the meaning of aggressive acts are, and how these forms and meanings might change over time. Exhibit 5.9 shows the trajectory of normal preschool aggressive behavior.

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Many young children have not developed the social skills necessary to control their aggressive behavior.

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Exhibit 5.9 Normal Preschool Aggressive Behavior

- The total amount of aggression tends to peak at about age four and then decreases.
- Temper tantrums with no recognizable antecedent tend to decrease during the preschool period and are almost nonexistent after age four.
- At about age three, preschoolers increase their retaliatory aggression in response to frustration or attack.
- Young preschoolers, ages two to three, tend to behave aggressively after parents have set limits. Older children tend to act aggressively in response to peer conflict.
- Young preschoolers tend to kick and hit to get something they want, such as a toy. Their aggression is primarily proactive in nature. Older preschoolers tend to use verbal aggression in the form of teasing, name calling, and tattling. They still argue over objects, but their aggressive acts become more hostile, designed to hurt another.

Based on Coie and Dodge (1998), Côté, Vaillancourt, LeBlanc, Nagin, and Tremblay (2006), Hartup and Abecassis (2002), and Underwood (2002).

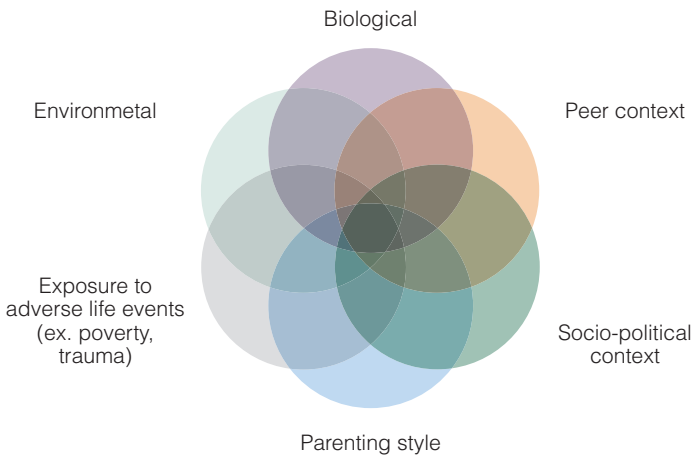
In many professional settings, such as in schools and hospitals, social workers will be asked to assess children for aggression. It is vital social workers have a strong understanding of the interlocking biological, cultural, and social factors that contribute to children's development of aggression and adult perceptions of it (see Exhibit 5.10).

It is well accepted that boys engage in higher rates of physical fighting than girls do. However, recently it has been recognized that this finding ignores more subtle forms of hurtful behaviors that are often used among girls (Underwood, 2003). For example, girls may engage in a more indirect form of aggression where a person is not attacked physically but through some form of social manipulation. For example, they can intentionally harm others by spreading rumors that humiliate or demean the victim or by excluding the victim from participating in group activities (Tremblay, Gervais, & Petitclerc, 2008).

The developmental course of aggression is impacted by overlapping influences such as biological, environmental, peer context, social-political context, parenting style, and exposure to adverse life events (Holman et al., 2014). In some cases, there are prenatal factors at play. Exposure to tobacco products, chemical drugs, and hazardous substances (e.g., lead and toxic fumes) can impact the neurological development of a fetal brain, specifically in the areas that control temperament and self-control, which in turn correlates to conduct problems throughout the lifetime. Shortly after birth, difficulties in self-soothing and emotional regulation, in combination with the parental response to having a challenging infant, have demonstrated correlation to later aggressive behaviors (Frankel, Umemura, Jacobvitz, & Hazen, 2015). This seems to suggest that interventions that include working with mothers directly before and after birth to improve their prenatal health and infant parent–child relationships and attachment will assist in the prevention of future aggressive behavior in some children. Nurse–Family Partnership and Health Families America are two evidence-based programs that work with pregnant mothers to reduce prenatal risk factors.

By the end of the first year, children possess a level of coordination to be able to hit, kick, and bite others. The first evidence of this ability appears between 6 and

Exhibit 5.10 Interlocking Factors Influencing the Trajectory of Aggression



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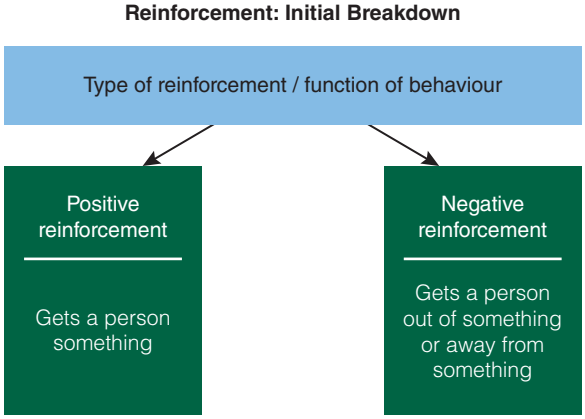
12 months of age. These behaviors increase between 12 and 24 months, with hitting being the most common form of physical aggression. By three years of age, children are capable of a wide range of aggressive acts. In fact, children in the preschool phases of development display more aggression than those in any other stage of development. Under normal, low-risk conditions, most preschool aggression diminishes naturally after age four as children learn better language, negotiation, and other relevant social and emotional skills. They learn to resolve differences verbally in tandem with the increased expectations of parents and teachers about the use of aggression in solving problems.

The burgeoning defiance, constant activity, and the emergence of aggression naturally occurring in early childhood are immensely stressful on caregivers, even under the best of circumstances. Understandably, for caregivers struggling with additional stress factors such as poverty, community or domestic violence, health problems, or their own difficulties managing emotions, child misbehaviors can lead to tense home environments and never-ending power struggles. The interaction of child behavior and parental response in the context of those behaviors has been the focus of much study. Parenting hyperactive children is an immensely difficult and exhausting task, requiring parents to consistently walk a very fine line of warmth and authority. Families can develop unhealthy patterns of reacting to misbehavior that can be difficult habits to change once they have formed. Parents may inadvertently reinforce negative behavior when they "give in" to the demands made by their child, creating coercive interactions. While it removes a noxious behavior in the moment, it "ups the ante" for future power struggles, because it has taught the child that escalating behaviors result in their desired outcome. Exhibit 5.11 shows the difference between positive and negative reinforcement. Both types reinforce the behavior.

Exhibit 5.11 Positive and Negative Reinforcement



Positive social reinforcement, affection, and approval are more effective at achieving desired behavior. Programs that encourage healthy interaction patterns in early childhood can have a lasting impact on parental effectiveness and family cohesion for the rest of the child life, impacting multiple life domains such as future delinquency, academic success, social-emotional development, and even health (Dawson-McClure et al., 2014). Evidence-based early childhood family programs such as Parent–Child Interaction Therapy, Incredible Years, Abriendo Puertas (developed specifically for Latino families), and Triple-P Parenting not only reduce aggression in the short term but also have long-lasting impacts on child and family success. In addition to family based preventative interventions, a number of school and classroom-based interventions have also demonstrated success in reducing early childhood aggression. The Second Step and the FAST Track focus on helping students learn empathy and social skills, impulse control, problem solving, and anger management.

Curbing Misbehaviors

In recent years, added emphasis has been placed on watching for signs of aggression in children, starting as early as preschool. The hope is that aggressive acts in later years can be avoided if aggression is curbed early in a child's life.

Exhibit 5.12 lists numerous warning signs for aggression and violent behavior in toddlers, preschool-age children, and school-age children. The social work values of cultural competence and social justice dictate, however, that social workers be aware that adult perceptions of childhood aggression are deeply embedded in social and cultural context (Bell, 2015). For example, in a study of 196 three-year-olds, researchers found that teachers were more likely to report African American children's hyperactivity, attention problems, and aggression higher than their parents. Likewise, Latino families were more likely to report that their child exhibited hyperactivity and inattention than the child's teachers (Harvey, Fischer, Weieneth, Hurwitz, & Sayer, 2013).

The fact that teachers are more likely to rate behavior as aggressive when it is committed by an African American child and may contribute to the 2014 finding by the U.S. Department of Education Office for Civil Rights that African American children represent 18% of preschool children enrollment, but 48% of preschool children receiving more than one out-of-school suspension. Boys of all

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Exhibit 5.12 Warning Signs for Violence and Aggression in Children

Toddler and Preschool-Aged Child
Has multiple temper tantrums in a day, each lasting more than 15 minutes; child is not easily calmed by parent or caregiver
Has frequent aggressive outbursts, often with no reason or cause
Behaves impulsively and fearlessly
Frequently refuses to follow directions and listen to adults
Appears not to be attached to parents
Spends a significant amount of time watching violent television shows
Engages in play that has violent themes
Acts cruelly toward other children or animals
School-Aged Child
Often disrupts classroom activities in school
Gets into frequent fights at school
Reacts to disappointment, criticism, or teasing with intense anger, blame, or revenge
Watches violent television shows and/or plays violent video games
Has few friends at school, is often rejected by other children because of his or her behavior, and makes friends with other children known to be aggressive or unruly
Does not listen to adults
Does not exhibit sensitivity to the feelings of others
Acts cruelly toward pets or other animals

races are more likely than girls to receive harsh punishments for misbehavior, such as out-of-school suspension and expulsion (United States Department of Education Office for Civil Rights Data Collection, 2014).

Exhibit 5.13 outlines primary evidence-based strategies to reduce aggression in the children. The Center for Social Emotional Interventions for Young Children at the University of South Florida promotes evidence-based screening tools to help early childhood service providers and educators identify and address social-emotional concerns in children (Henderson & Strain, 2009). Some instruments, such as the Indicators of Individual Growth and Development for Infants and Toddlers, are available free of charge (Carta et al., 2013).

Exhibit 5.13 The ABCs for Managing Children's Behavior (Adapted From the Child Mind Institute, 2022)

Antecedents	What are the "triggers" of the behavior?	Be clear about what the expectations are, avoid giving multiple instructions, and give a warning when a transition is about to occur. For example, "We will be leaving in 15 minutes. I need you to put your shoes." Removing distractions in the environment, providing countdowns, and giving choices can be helpful. For example, "Do you want to pick up your toys before dinner or after dinner?"
Behaviors	What are the specific behaviors you want to encourage or discourage?	Target specific behaviors that are observable and measurable. For example, "brushing teeth before bed" is something everyone can agree on that happened. "Stop being wild" is poorly defined and not specific.
Consequences	What are the natural consequences (positive or negative) that logically follow the behavior?	Giving negative attention (yelling, spanking), overreacting (a large consequence), or positive consequences (putting on their shoes for them out of frustration), can actually increase negative behavior. Rather, give positive attention when you see good behavior, ignore minor misbehaviors (withholding attention and giving positive behavior as soon as it is seen), setting consistent rules, and using time-outs correctly; for example, pulling the car over and staying silent until the behavior stops. Start driving once positive behaviors are seen.

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Self-Esteem and Competency

A discussion about children's self-concept would be lacking without addressing the debate that has raged over the utility of promoting self-esteem versus competency. In fact, some developmental psychologists would argue that self-esteem is not the important ingredient in children's success and that false praise actually can do some harm.

First, the data legitimately show positive self-esteem to be highly correlated with academic achievement; positive social skills; and resistance to drug involvement, early sex, gangs, and delinquency. However, proponents of self-esteem as a "vaccine" to protect against social ills misinterpret the data to infer causality. The reverse conclusion is just as likely but cannot be inferred from existing data, either. That conclusion states that self-esteem increases as a function of increased competency and mastery, better skills for dealing with problems, and an improved ability to evaluate oneself accurately.

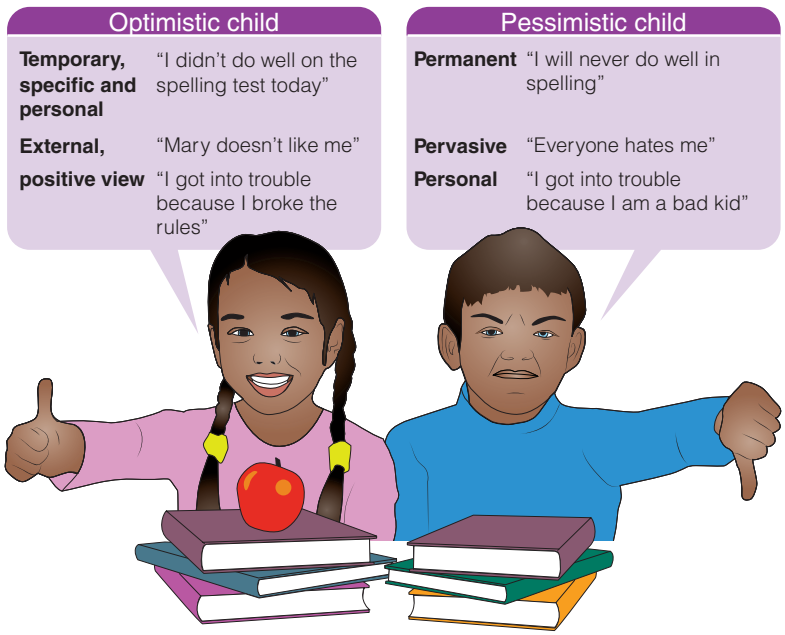
The second argument pertains to the practice of dispensing praise liberally and with no real basis. This practice can actually produce the opposite effect, causing children to distrust both adults' opinions and their own judgment. Furthermore, as a result of unwarranted praise, children do not learn to assess their strengths and weaknesses accurately.

In his book *The Optimistic Child*, Seligman (2007) pointed out that "failure, in itself, is not catastrophic." Rather, it is the child's interpretation of the failure that can lead to problems such as depression (p. 14). The child's explanatory style, or the way she thinks about causes, can strongly influence how she thinks about the good and bad events that happen to them. Seligman argued that a child who has an optimistic explanatory style is better equipped to deal with the ups and downs of life. Seligman conceptualized explanatory style using three dimensions: permanence, pervasiveness, and personalization, detailed in Exhibit 5.14.

Permanence—sometimes versus always: When bad events happen, a pessimistic child believes they are permanent. An example of a pessimistic statement regarding a negative event might be "I never do well on spelling tests." An optimistic child would explain a negative event as something temporary with the potential to change, saying, "I didn't do well on the spelling test today." Also, an optimistic child would explain a good event as having a permanent cause, such as, "I received good grades because I worked hard," as opposed to a temporary cause, "My grades were good because Mom made me study."

Pervasiveness—specific versus global: When causes are seen as pervasive, they are projected onto many aspects of life, not just a single episode. A global, or pessimistic, statement might be "Everyone hates me," whereas a specific, optimistic statement might be: "Mary doesn't like me." Regarding good events, optimistic statements are global ("I'm a smart person"), and pessimistic statements are specific to a situation ("I do well at reading").

Exhibit 5.14 Childhood Explanatory Styles



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Personal—internal versus external: Personalization involves deciding who caused something to happen or simply who is to blame. Children can blame themselves (internal) or other people or situations (external). Children who continually blame themselves when bad things happen tend to have lower self-esteem. However, this does not imply that the way to feel good is to blame others; children must hold themselves accountable for their wrongdoings and faults. The key is for children to use behavioral, rather than general, self-blame. Behavioral self-blame is optimistic in nature (temporary and specific)—for example, "I was punished because I disobeyed the rules." General self-blame is pessimistic (permanent and pervasive): "I was punished because I'm a bad kid."

Seligman (2007) concluded that, instead of helping children "feel good," parents, teachers, and social workers should assist children in "doing well," which involves developing the "ability to think and to cope with the basic challenges of life" (p. 32). Like Gottman (1997), Seligman felt that negative emotions and experiences are important to a child's emotional growth. Seligman would likely argue strongly against the recent trend in some schools to eliminate failing grades. In being prevented from failing, children are also missing the opportunity to experience normal and natural emotions, such as sadness, anxiety, and anger. From this perspective, by protecting children from failure, we make it more difficult for them to develop the skills of mastery, which results, ironically, in lowered self-esteem.

Sociability of Preschoolers

As children age, they naturally come into contact with a larger social audience that includes other adults, teachers, peers, siblings, and older children. Children aged two and three still stay physically close to adults and seek physical affection. Older preschoolers tend to seek the attention and approval of their peers through antics and playful gestures.

Researchers have examined the question of sociability among preschoolers from several angles. Baumrind (1971) has focused attention on features of parent–child relationships that promote sociability and has found that warm, supportive parents who set reasonable standards and expectations for their children's social interactions tend to raise well-adjusted, socially competent children. Permissive parents who do not set or enforce social rules, on the other hand, tend to raise children who are more rebellious, aggressive, and uncooperative. These four main parenting styles are still used by child psychology today (see Exhibit 5.15 for a review of parenting styles).

Observational studies have examined the social behavior of three- and four-year-old children attending preschool. Over the course of the observational period, children began to interact more with one another than with the teacher and became more playful and outgoing as opposed to forceful and aggressive. Results concluded that children's social skills were enhanced by their participation in preschool. Some children who lack social skills tend to miss more school for unknown reasons (Giler, 2011). Social skills training becomes essential for these children, so they, too, can reap the benefits of the preschool social environment.

Longitudinal studies have produced data suggesting that sociability is a highly stable trait. By the age of two, children's social behaviors are fairly predictable. The social behaviors assessed include reactions to play

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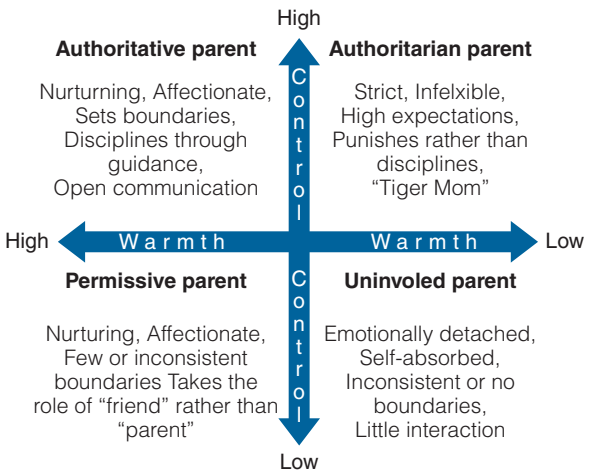
The sociability of children is often reflected in skills such as initiating play activities, communicating effectively, cooperating, giving help, affection and approval shown to peers, and resolving conflicts.

Exhibit 5.15 Parenting Styles



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sessions, initiation of social interactions, and time spent interacting with other children, which predict sociability at three-and-a-half years in preschool. These findings are particularly salient when one considers the long-term effects on unsociable children. Later on, in middle childhood and adolescence, peer rejection becomes a forceful determinant correlate of behavioral and emotional difficulties (Giler, 2011).

To develop sociability skills in children, we must first consider exactly what skills we would like to improve. Initiating play activities; communicating effectively; cooperating; giving help, affection, and approval to their peers; and resolving conflicts, support the development of effective social skills. This is exceedingly important because poor peer relationships are often the result of poor social skills. Poor peer relations, especially rejection by peers, have been linked steadily with increases in delinquency, psychopathology, and low self-esteem.

Implications for Practice:
Teaching Children Social Skills

Measurement instruments, such as the Devereux Early Childhood Assessment Clinical Form (Lien & Carlson, 2009) and the Social Skill Rating System (Fantuzzo, Manz & McDermott, 1998) can be used in practice to help measure and address childhood social skill development. Several therapeutic approaches have been designed to remedy social skill problems in children. These approaches include reinforcement, modeling, and cognitive strategies. Reinforcement and modeling strategies may be necessary at first to make immediate gains and motivate children to pursue more complicated strategies, such as problem solving and role-play, that are associated with long-term gains.

To implement positive reinforcement strategies, two essential elements must be present. First, positive reinforcement in the form of verbal praise, attention, and even tangible rewards can be used to shape socially appropriate responses. For example, every time a child shares, praise can be bestowed. This works best if the praise is awarded consistently to every child who demonstrates desirable social behavior according to a group reinforcement plan. In this way, unsociable children can see others rewarded for positive behavior, as well. While positive social behavior is being rewarded, less desirable behaviors such as solitary play and aggressive behaviors are ignored as much as possible, so as not to reinforce them inadvertently.

Second, the environment often requires slight manipulation to instigate social contact that can then be reinforced. We can structure a play setting relatively easily by introducing social games, such as tag and duck-duck-goose that draw in the less sociable children. In addition, children deficient in social skills can be given a valuable commodity such as treats to give out to playmates. This strategy creates a social interaction in which everyone will want to interact with the unsociable child.

Modeling techniques have also been shown to help socially shy or withdrawn children enter play groups with less fear. The best models are people who are like the unsociable children in appearing initially hesitant to engage others socially. When the models' positive social behaviors (and the natural benefits of those behaviors) are pointed out to the group, undersocialized children imitate the positive behaviors more often.

Role-playing and problem-solving techniques represent another behavior change strategy (LeCroy, 2015). In this case, children discuss hypothetical problems and generate potential solutions for them. Shure and Digeronimo (1996) developed a 10-week program aimed at preschoolers. The children used puppets to act out problem scenarios and helpful solutions. Then the preschoolers were guided in discussing the feelings of all the characters involved in the problem situation. Gains were made not only in the puppet exchanges, which became less aggressive, but also in the kinds of solutions worked out by the students themselves in the classroom.

Psychological Strengths, Hazards, and Risks

Many disorders of childhood affect behaviors in very specific domains, such as eating, sleeping, eliminating, speaking, paying attention, and learning. Mood disorders, including anxiety and depression, and even the beginnings of antisocial conduct can be seen in children as they attempt to cope with normal developmental issues as well as situational and traumatic stressors. These disorders are considered developmental in that they represent an aberration in the normal course of development.

The disorders of childhood generally fall into one of three categories: developmental delays, developmental disorders, and developmental psychopathology.

Developmental delays represent a slower rate of skill acquisition, or normal behaviors such as bedwetting that occur at an inappropriate age. Delays can occur in almost any area of functioning; however, most children catch up

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Kirk, age five, and Ivy, age two-and-a-half, are role-playing at being a dinosaur. Kirk, near the end of early childhood, is more skilled at pretending to be a dinosaur. Children in Piaget's preoperational stage really enjoy pretend play.

before any real damage is done. Delays in critical areas, such as speech, tend to be more readily recognized and produce more profound negative effects for the child.

Developmental disorders occur in the areas of eating, sleeping, speech, eliminating, and attending. These disorders are characterized by a disruption in the performance of these skills. As such, they tend to cause problems for those caring for the children as well as for the children themselves. Children with developmental disorders are more likely to be referred for treatment than are children who show delays in the acquisition of normal behaviors, unless the delays are extreme. Examples of developmental disorders include enuresis, encopresis, stuttering, attention-deficit disorder, and night terrors.

Developmental psychopathology results when a child's healthy adaptation is impeded by an inability to rally resources and cope with stressors (see Exhibit 5.16). Although the child's response may in fact be a reasonable response to an identifiable stressor, the child's functioning becomes impaired by an inability to cope with and recover from trauma. Instead of one behavioral domain being affected, multiple areas of the child's life are compromised, including peer and family relationships, school performance, activities, and developmental goals. In this sense, developmental psychopathology is pervasive. Examples of developmental psychopathology include mood disorders such as anxiety and depression. Depression and anxiety are the most common mental health disorders in children and often go hand in hand. Although these disorders have counterparts in adult psychopathology, the etiology, course of the disorder, and prognosis are different for children (Campbell, Cummings, & Davies, 2002).

Diagnostic and Assessment Issues

Age is a critical factor in determining whether a particular behavior falls within an expected and normal developmental range. Children develop and change rapidly compared with adults, making a diagnosis of problem behavior difficult for parents and professionals. This difficulty is compounded by the fact that many normally developing children experience occasional transitory problems to which they quickly adjust.

Exhibit 5.16 Developmental Delays, Disorder, and Psychopathology

Developmental Delays	Developmental Disorders	Developmental Psychopathology
Slower than usual developmental of skills. Example: ■ Toilet training delays ■ Speech delays	Disruption of performance (little or no progress far beyond the normal age of skill development) ■ Temper tantrums after age four ■ Biting behavior after age four	Functional impairment, behaviors meet DSM criteria for a mental disorder ■ ADHD ■ Depression

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Children are dependent on adults not only to recognize the existence of a problem but also to seek help for them. Parents who have grown accustomed to a child's usual behavioral patterns, and those who do not have the opportunity to observe their child in the company of age mates, may not possess the requisite understanding of normal developmental behavior patterns to ascertain whether their child needs help. Furthermore, treatment of childhood disorders frequently involves the cooperation and participation of parents and family members, only some of whom are capable and willing.

In the following sections, we will examine childhood disorders involving elimination, speech, attention, anxiety, and depression.

Elimination/Toilet Training

Problems in toilet training can arise from unreasonable parental expectations, because children must be physically, emotionally, and cognitively mature enough to master the task. In our culture, children are generally daytime toilet-trained by the time they enter the preschool years and nighttime trained about one year later. Girls' ability and motivation generally precede that of boys, and a wide normal range exists among children.

Enuresis is defined as a lack of bladder control after age five (American Psychiatric Association, 2000).

Nocturnal enuresis, or bedwetting at night, was once thought to be a psychological condition, but it is the most common type of elimination disorder effecting 7% of boys and 3% of girls age five. It now appears that psychological problems are the result of enuresis, not the cause. Bedwetting is not likely to be an act of rebellion, as many people believe, but rather it is more likely to be a heritable disorder. Most children will outgrow enuresis by the time they reach adolescence (only 1% of males, and less than 1% of females have this disorder at 18). The most effective treatment for enuresis is the bedwetting alarm (Thiedke, 2003).

Encopresis is defined as a lack of bowel control after a normal age and is distinguished as either primary or secondary. Encopresis is not diagnosed before age four and is typically due to constipation. The disorder is more common in boys than in girls and occurs in about 1 to 3% of the population. About one out of four encopretic children are also enuretic. Factors associated with encopresis include inconsistent toilet training, painful bowel movements, and psychosocial stressors, such as entering school or the birth of a new sibling. Encopresis rarely becomes chronic, and well-developed behavior-management strategies have been used in its treatment (Christophersen & Friman, 2010).

Common Psychiatric Disorders of Early Childhood

ADHD, behavior problems, and depression are the most commonly diagnosed mental disorders in early childhood. Although these diagnoses increase in middle childhood and adolescence, one in six U.S. children aged two to eight years have a diagnosed psychiatric disorder (Cree et al., 2016). These rates increase for children living below 100% of the federal poverty level to one in five. Children with more adverse childhood events (ACEs), and perceived racial discrimination, also experience more mental health problems (Hutchins et al., 2022). A systematic review on the psychosocial consequences of the COVID-19 pandemic in children and families found that overall, parents experienced more increases in anxiety during the COVID-19 pandemic than their children (Stavridou et al., 2020). Many families were able to buffer their children's stress through establishing new routines, creating family activities like reading and exercising, and using online sources for tips and activities. Parents of children with special needs experienced disproportionate mood swings and concern about the COVID-19 impact. Children with ADHD had more episodes of uncontrollable anger, increased difficulty focusing, or performing everyday routines. Children with autism spectrum disorder (ASD) had increased difficulty following through on instructions, lost their independence and communication skills, and preformed pranks for attention. New guidelines have been established to help address the mental health issues of children, including monitoring medication, maintaining a strict sleep schedule, and daily physical activities to avoid the consequences of inactivity due to increased screen time.

Anxiety

Separation anxiety disorder is characterized by severe anxiety about leaving home or separating from the child's primary attachment figures. Children typically fear harm will come to them or their family if separated, and they go to great lengths to prevent separations. Children develop somatic complaints, refuse to attend school, and behave in clingy, demanding ways with parents to ensure their closeness. These children also experience sadness, loss of interest in activities, withdrawal, and difficulty concentrating on school or play. In the course of normal development, separation anxiety peaks at about one year and gradually lessens with age. Separation anxiety is most frequently seen in very tight-knit families and following some sort of trauma for the child.

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Avoidant disorder, commonly called a fear of strangers and strange or new situations, can be socially debilitating to a child. This response is normal between the ages of eight months and two to three years, but in some cases it may continue into childhood. A child may severely limit involvement in social and academic settings to avoid this fear. As a result, the child may feel lonely and depressed and lose self-confidence, causing further avoidant behavior.

Overanxious disorder, or generalized anxiety disorder, is distinguished from separation anxiety in that the child's fears have no specific focus. In the case of overanxious disorder, children anticipate something going wrong in almost any situation and worry about the possibility. Children with these unfocused worries doubt themselves and their abilities. Worries often center on school and sports performance, and children frequently redo tasks in an attempt to make sure they are good enough. Children living in homes where love and acceptance are granted for good behavior tend to be approval seeking and perfectionistic (American Psychiatric Association, 2013). A vicious cycle unfolds when children's performance is handicapped by worries and anxiety, which in turn cause them to fail, which produces even more anxiety.

Attention-Deficit/Hyperactivity Disorder

Attention-deficit/hyperactivity disorder (ADHD) is characterized by persistent inattention and/or hyperactivity (American Psychiatric Association, 2013). It is the most common childhood behavioral disorder (Centers for Disease Control and Prevention, 2022), with approximately 9.8% of children 3 to 17 years of age (6 million) diagnosed with the disorder as of 2019. Although many children meet the diagnostic criteria for this disorder, it is often difficult to diagnose in children younger than five years because of the behavior variation normally seen at this age. The AAP recommends parent training in behavior management for children with ADHD younger than six years of age. Behavior therapy should be tried before medication because young children experience more side effects than older children, and the long-term effects of ADHD medication on young children is not clear. For children older than six years of age, a combination of medication and behavior management is the most effective treatment. Schools and behavioral classroom interventions are recommended as well. For example, schools that reward positive behaviors and offer organizational training have been effective.

Childhood Depression

Only 40 years ago, most professionals doubted the existence of depressive disorders in children because they believed children lacked the cognitive structure to experience such problems. Depression in children does occur but is frequently unrecognized. Symptoms can range from simple sadness to major depression or a bipolar disorder. The symptom pattern can differ from that exhibited by adults. Children tend to display more than one symptom and can act clingy, disobedient, irritable, sad, and hopeless; refuse to attend school; and show a decreased interest in usual activities. Children are rarely suicidal, although this possibility increases in adolescence. Children who experience depression tend to have mood disorders as adults. Prevalence rates for prepubertal males and females are about equal, but by the time girls reach adolescence and adulthood, they are more than twice as likely as males to report depression. Depressive episodes often result from a severe psychosocial stressor in a child's life, such as the loss of a loved one, separation, or other trauma.

Autism Spectrum Disorder

Kevin's parents thought he was a little odd as a baby. He was rather fussy. When they fed him and tried to stroke his back, he would stop eating and fuss until they stopped the stroking. When they picked him up for play, he would often avert his gaze or look past them. As a toddler, he liked to play by himself. He would sit for long periods of time just watching a patch of sun on the floor or dropping blocks over and over. His language development seemed especially slow, but he was their first baby and they had no expectations regarding language acquisition. The pediatrician told them Kevin would learn to speak soon. When he went to preschool at the age of three, however, the teacher called the parents in for a conference because Kevin would not play or interact with any of the children in the class. He spent most of his mornings sitting and rocking, and he rarely spoke to anyone. In fact, the only thing the teachers had heard him say was "water" when he needed a drink.

Autism spectrum disorder is characterized by pervasive difficulties in social communication and interaction across multiple settings in such a way that impair social and/or occupation functioning. These individuals will frequently exhibit restricted or repetitive patterns of behaviors and interests. The disorder is present at birth, and is a highly heritable disorder; however, it is often not diagnosed until the child is about two years old, when language deficits can be distinguished from speech delays. Early

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detection and intervention are critical; however, previously measurement instruments were limited. Parents and early childhood education providers can use the CDC's Learn the Signs Act Early program (discussed in the previous chapter) has free materials and an app (CDC's Milestone Tracker app) to monitor when there is a concern and identify when more screening is needed. All children should be screened for ASD during regular well-child visits at 18 and 24 months. The Autism Diagnostic Observational Schedule and the Modified Checklist for Autism in Toddlers (M-CHAT) are two methods that show promise in diagnosing autism, or the need for additional follow-up, as early as 18 months (Azar, 1998; MacReady, 2002). The M-CHAT is a two-stage screening tool that is available for download from www.mchatscreen.com. The instrument is described in Exhibit 5.17.

Exhibit 5.17 Modified Checklist for Autism in Toddlers

1. If you point at something across the room, does your child look at it? (e.g., if you point at a toy or an animal, does your child look at the toy or animal?)
   ○ Yes ○ No
2. Have you ever wondered if your child might be deaf?
   ○ Yes ○ No
3. Does your child play pretend or make-believe? (e.g., pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)
   ○ Yes ○ No
4. Does your child like climbing on things? (e.g., furniture, playground equipment, or stairs)
   ○ Yes ○ No
5. Does your child make unusual finger movements near his or her eyes? (e.g., does your child wiggle his or her fingers close to his or her eyes?)
   ○ Yes ○ No
6. Does your child point with one finger to ask for something or to get help? (e.g., pointing to a snack or toy that is out of reach)
   ○ Yes ○ No
7. Does your child point with one finger to show you something interesting? (e.g., pointing to an airplane in the sky or a big truck in the road. This is different from your child pointing to "ask" for something [Question #6.])
   ○ Yes ○ No
8. Is your child interested in other children? (e.g., does your child watch other children, smile at them, or go to them?)
   ○ Yes ○ No
9. Does your child show you things by bringing them to you or holding them up for you to see—not to get help, but just to share? (e.g., showing you a flower, a stuffed animal, or a toy truck)
   ○ Yes ○ No
10. Does your child respond when you call his or her name? (e.g., does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)
    ○ Yes ○ No
11. When you smile at your child, does he or she smile back at you?
    ○ Yes ○ No
12. Does your child get upset by everyday noises? (e.g., does your child scream or cry to noise such as a vacuum cleaner or loud music?)
    ○ Yes ○ No
13. Does your child walk?
    ○ Yes ○ No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?
    ○ Yes ○ No
15. Does your child try to copy what you do? (e.g., wave bye-bye, clap, or make a funny noise when you do)
    ○ Yes ○ No
16. If you turn your head to look at something, does your child look around to see what you are looking at?
    ○ Yes ○ No
17. Does your child try to get you to watch him or her? (e.g., does your child look at you for praise, or say "look" or "watch me"?)
    ○ Yes ○ No
18. Does your child understand when you tell him or her to do something? (e.g., if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)
    ○ Yes ○ No
19. If something new happens, does your child look at your face to see how you feel about it? (e.g., if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)
    ○ Yes ○ No
20. Does your child like movement activities? (e.g., being swung or bounced on your knee)
    ○ Yes ○ No

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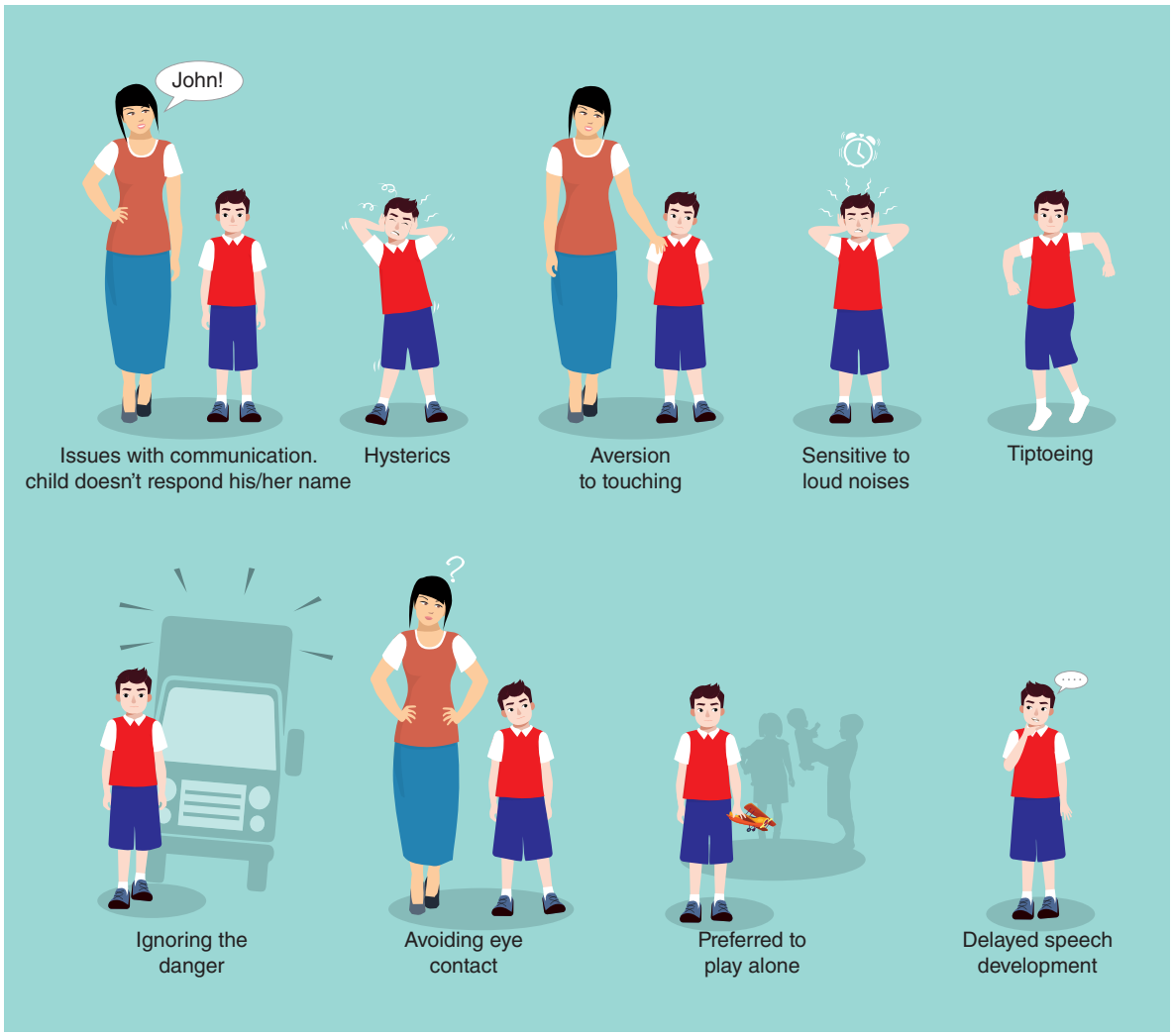
Speech deficits are prominent in autistic children. We often see autistic children play in rigid, unimaginative ways. These children demand sameness and predictability in their environments and daily routines.

Parenting a child on the autism spectrum can be extremely difficult, frustrating, and sad. When a child does not respond or relate, the quality of parental and sibling interactions and stimulation can taper off. Treatment efforts result in slow, minimal gains. Behavioral therapy techniques have documented empirical support. These techniques include token-economy strategies, modeling, social skills training, and language and speech training. Technology is increasingly being leveraged effectively to help improve communication and social skills in children with autism spectrum disorders (Grynszpan, Weiss, Perez-Diaz, & Gal, 2014). Treatment is often an individually based program in which each child's developmental profile is considered and treatment components are designed accordingly (see Exhibit 5.18).

Exhibit 5.18 Signs of Autism



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Study Table Psychological Dimension in Early Childhood

Cognitive Development and Information Processing

- Imaginative thought begins in early childhood.
- Children can categorize objects in two dimensions (at four years old).
- The meaning and function of numbers is understood. At age five, time and logical thinking begin. Until children reach the age of about five, they have little concept of time, past or future.
- Children (ages two to seven) are in Piaget's operational stage of development, which has two substages: symbolic function and intuitive thought. They are egocentric, unable to distinguish between their perspective and another person's.
- Children at this stage begin primitive reasoning but not formal logic. In their information processing, children begin to acquire cognitive control of their attention.
- Children younger than three years have little or no memory for specific events. After three years, children can begin to recount memories and develop processes for the storage and retrieval of information.
- Early developmentalists assumed children developed in stages; today, changes are believed to occur more as "**developmental waves**." A more complex understanding of information processing has emerged from research.

Communication

- Language development was previously believed to be imprinted on a blank slate.
- It is now recognized that language is more innate.
- Children use a universal grammar demonstrated by the subject–verb structures that emerge ("me want").
- A three-year-old has a vocabulary of 900 words; by age six, the vocabulary is 8,000–14,000 words.
- Morphological rules and syntax develop as children use plurals and possessives, ask questions, and so forth.
- At ages four to five, semantic skills develop—comparisons such as big/little can be made, and children understand "I" as the speaker and "you" as the object.
- Talking with children can promote their language development.
- Children who develop bilingual skills perform better on measures of language than monolingual children.
- Language begins to take on more social functions as children get older.
- Communication disorders such as expressive language disorder and stuttering can begin to emerge.

Attitudes, Emotions, and Regulation

- As children begin more social interactions, the impact of attitudes and emotions becomes more central. Emotional coaching is recommended for children as they learn about themselves and how to problem-solve in the face of difficult emotions.
- Children whose parents used emotion-coaching techniques were better able to regulate their own emotions.
- Emotion coaching consists of a five-step process: awareness, using emotions to teach, validating the child's feelings, helping the child label the emotion, and setting limits and problem solving. Fears and phobias, especially fear of the dark, begin to develop in early childhood.
- Social events such as September 11 can provoke fears in children. Posttraumatic stress disorder can emerge when children experience trauma.
- When experiencing a traumatic event, children may feel fear, loss of control, anger, loss of stability, isolation, and confusion.
- Grief and loss are difficult for young children to comprehend. In preschool, there is a lot of social aggression (peaks at age four), which is defined as behavior intending to harm another person and by which the victim perceives him or herself as being hurt.
- Although aggression is considered a normal drive, higher levels are related to family and social factors as well as poor maternal health habits.
- Aggression demonstrates stable qualities for both boys and girls as children develop.
- Aggressive children often come from homes characterized as coercive. Warning signs for aggression have been identified, and strategies for reducing aggression include ignoring, time-out, modeling and coaching, and creating nonaggressive environments.
- Altruism and empathy begin to take hold in early childhood. At age four, children show empathic sharing primarily in the context of peer interactions; however, children cannot cognitively understand another person's feelings.

Continued

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- Modeling can enhance empathic responding in children. Prosocial behaviors have been found to differ according to cultural background.
- Children's altruistic behavior is influenced by opportunities to provide compassion. In particular, the Western values of competition and individual achievement can lower altruistic behavior.
- Preschoolers' self-concepts are based on their physical characteristics and physical abilities. Their self-evaluations are positive because they cannot distinguish between the real and desired self. In the past, much effort has been focused on increasing children's self-esteem.
- Critics believe that indiscriminately praising kids can be harmful, recommending instead an optimistic explanatory style that uses three dimensions: permanence (sometimes versus always), pervasiveness (specific versus global), and personalization (internal versus external).
- The overall strategy is not to help children "feel better" but to help them "do better," which includes thinking about and coping with life's challenges.
- In preschool, children need to develop their social skills, and preschool provides an environment that facilitates children's sociability.
- Sociability is a highly stable trait.
- When difficulties in children's social behavior exist, social skills training can be helpful.
- Skills such as communicating effectively, cooperating, and giving help are taught through reinforcement, environmental modification, modeling, role-playing, and problem solving.
- As children develop, they gain more regulation over their emotions and actions. Tantrums stop and verbal control begins to take hold. Instead of physical aggression, they learn to use words.

Psychological Strengths, Hazards, and Risks

- Growth in psychological functioning. Brains become nine-tenths of their adult size.
- The development of a clear sense of "I" begins. Many children's individual strengths emerge.
- The disorders or hazards that emerge are usually developmental delays (bedwetting), developmental disorders (ADHD), or developmental psychopathology (pervasive mood disorders). Age and development must be considered in any psychosocial assessment. More common childhood disorders include elimination problems, anxiety disorders, ADHD, childhood depression, and autism.

Social Dimension

Groups and Families

By the time a child reaches the period of early childhood, the family has undergone numerous changes. These changes are noted in the marital relationship, parent–child relationships, work, and family systems dynamics. The couple has become a family, and that family may continue growing with the birth of another child. The developing child plays an active role in promoting healthy change in the family structure and dynamics while adjusting to the changes.

Parents of preschoolers begin to change their focus from physical care to encouraging self-care, greater independence, and compliance with rules of social systems such as the family, peer group, preschool, and society. Effective parents allow their children to try out new activities and develop some self-sufficiency, and they set reasonable limits with their children. Parents who are too rigid or demanding impose unrealistic expectations on their children, causing them to feel as if they cannot measure up and to feel guilty for failing to accomplish something on their own.

According to Erikson's theory, the psychosocial crisis facing children during the preschool years is one of initiative versus guilt. Parents of preschoolers, much like the parents of adolescents, must help their children discover personal and social abilities and limits while enjoying their accomplishments and sense of self-reliance. In this way, measured against the backdrop of peers and society, children continue to learn about themselves.

Parenting Styles

As mentioned earlier in the chapter, parenting style is a central focus of early childhood interventions. Some of the most influential research on parenting has come from Diana Baumrind, who believes that the best parenting results when parents are neither too punitive nor too aloof but focus on developing clear rules within the context of warm and affectionate parenting. She has investigated parenting styles over several decades (1971, 1991) that still are used today. Her research described three styles of parenting and their consequent effects on children: authoritarian, authoritative, and laissez-faire (permissive). Maccoby and

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Martin (1983) have further differentiated the permissive parenting style to include two distinct types, neglectful and indulgent. Parental warmth refers to the acceptance and approval shown to children across a number of different occasions. These parents offer their children encouragement and praise and are generous with affection. Hostile parents, on the other hand, tend to criticize, reject, or ignore their children and their bids for attention. Parents tend to be characterized as either warm and approving or hostile and rejecting, and these styles tend to be mutually exclusive.

The construct of parental control taps into the number of demands, restrictions, and limits that parents place on their children. Permissive parents encourage their children to explore and make independent decisions. Restrictive parents impose more demands and enforce more rules on their children, controlling their actions and decisions. Parents tend to become more permissive as children age and develop the experience and ability to make healthy decisions for themselves. All children need guidance and monitoring, which can be flexible and change according to their developmental needs.

What effects do we see on children reared within the context of these distinct parenting models? Parents need to adapt their style of relating and interacting, as well as discipline, to their child's developmental level. As children enter the preschool years, parents can begin to rely on verbal exchanges, reasoning, moral sanctions, and giving and withholding of special privileges. Discipline strategies that invoke logical and immediate consequences tend to be the most effective for preschool children, who are beginning to understand cause and effect. Such strategies also help children develop the ability to think logically about actions and to make choices based on likely outcomes. Furthermore, the use of logical consequences helps avoid power struggles between parents in imposing discipline. Logical consequences just happen, because of their very nature, and the child begins to learn about problem-solving in the real world.

Research studies of lower-income families and families living in poverty suggest that these parents tend to be more authoritarian in their child-rearing practices; they expect more obedience from their children, engage in less verbal exchange, and exhibit less warmth. But does this make lower-income parents less desirable or effective parents? There are several reasons why lower-SES parents may be more authoritarian with their children, adapting to the circumstances of their environment.

Conditions of stress make it harder to be warm and caring. The children themselves may be more difficult to parent. Many lower-income mothers are young and may not have received adequate prenatal care. As a result, these mothers may have delivered premature, low-birth-weight, or substance-exposed babies. As we have discussed, such babies are more difficult to care for. Also, lower-income neighborhoods may be more dangerous and authoritarian parenting is more protective against the development of antisocial behavior. Practitioners can help families of all parenting styles and parenting contexts to focus on the core elements of successful development.

Practice Guidelines

- Different parenting styles may be present within one family. Differences in parenting style can be a substantial stress factor among coparents, whether the coparents are biological parent dyads or, for example, grandparent–parent dyads. Assess the parenting styles of all the adults who take on significant caregiving responsibilities.
- It is critical for practitioners to evaluate their own beliefs and values in regard to parenting styles to be aware of any unexamined cultural bias present in interactions with families who have different parenting context and practices.
- Common practitioner errors such as generalizing ("grouping" the family rather than acknowledging the individuality of families), demanding overly prescriptive adherence to suggestions, displaying judgments or comparisons, or relating in a condescending way will sever engagement with families.

Nontraditional Families

In today's society, families can look many different ways. For example, many children are raised in families with same-sex parents. Fifteen percent of same-sex couples in the United States had at least one child under 18 in their home, compared to 38% of opposite-sex couples, in 2019 (Taylor, 2020).

Studies reveal that children raised by gay or lesbian parents show no psychological or adjustment differences from children raised in opposite-sex families. Some critical differences do emerge; however, they receive less support from extended family members and experience greater stress. Lack of support and intolerance from the general public are often significant sources of stress. The bottom line, according to the research, is that it is not the parent's sexual orientation that influences the child's adjustment but

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rather the quality of the parent–child relationship and the relationship between the two parents (Farr, 2017).

Mother's Role

Although preschool children need their mothers for physical care less than they did as infants, the need for emotional support and encouragement is just as great as ever. While in recent years, the childcare responsibilities in homes have become somewhat more equitable, much of a mother's time with her preschooler revolves around childcare duties.

What kinds of things do preschoolers learn from their mothers? Studies reveal that mothers tend to introduce soothing activities, such as reading, drawing, and music. In this way, children learn how to soothe and comfort themselves. Children also learn a great deal about feelings and relationships. During play, mothers tend to be more verbal and visual with their preschoolers than fathers. This interaction during play may contribute to the child's understanding of relationships and coping strategies.

In addition, preschoolers are attuned to learning about the meaning of their gender. Children start to become conscious of physical differences between boys and girls at two years. During this time, children also learn gender role behavior; that is, what they see girls do and what they see boys do. However, cross-gender preferences and play are a normal part of gender development and exploration regardless of their future gender identity (Rafferty, 2022).

Father's Role

The relationship between preschoolers and their fathers broadens the children's perspective on the world. For the most part, even today, preschool boys and girls are raised in almost exclusively female environments. They spend most of their time with mothers and with babysitters and teachers, who are usually female. The child's father may be the only male figure with whom they have regular contact.

As discussed in the last chapter, fathers play differently with their children than mothers do. Remember, father play has been described as more provocative and vigorous, and less conventional and verbal, than mother play. These differences were found to be especially true of play with preschoolers, and with sons more so than with daughters. Fathers who play physically and roughly with their children tend to raise children with increased social competencies. This physical play is important to children because learning to cope with the exhilaration, challenge, and unpredictability of their fathers' physical play prepares them for later life experiences.

Josep Suria/Shutterstock.com

Fathers play with their children in a different manner than mothers.

By watching and interacting with their fathers, children also learn that there are numerous ways to complete a task. The father may not do things exactly the way the child's mother does, and the child is shown another way to solve a problem. Of course, family structures and parenting styles vary. Mothers and fathers may assume complementary but nonstandard roles that work just as well for their children and family.

Around age four or five, both boys and girls find their relationship with their fathers especially appealing and important, and they seek him out as a playmate more often than they seek their mother. Adult males help young boys define their own developing masculinity by encouraging and supporting their accomplishments. Boys model themselves after their fathers at this age. Girls seek out fatherly attention and time, as the father's role helps them define their feminine side. Preschool girls may also be resentful and jealous of their mother's special relationship with their father. Involved fathers help preschool children understand more about themselves and the larger world.

Children of Prisoners

Although both mothers and fathers play important roles in the child's development, some children must cope with a missing parent because of incarceration. As of 2022, there are almost 2 million people incarcerated in the United States (Sawyer & Wagner, 2022). In the first year of the pandemic, the number of people in prisons dropped 15 to 25%. However, that was largely due to the pandemic-related slowdowns in the criminal legal system rather than permanent policy changes. Prison and jail populations have already begun to rebound to pre-pandemic levels. Eighty percent of these individuals

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are parents, leaving 1.5 million children in this country with at least one parent in prison. Children of prisoners often live in homes with poverty and substance abuse or violence before parental arrests occur. After a parent is arrested, many children then find themselves placed in a new living situation. Some children can be placed with a grandparent, but more than one-quarter will be placed in foster care or in informal arrangements with extended family or friends (Bilchik, Seymour, & Kreisher, 2001).

Children with parents in prison are more likely to develop emotional and behavioral difficulties, such as withdrawal, aggression, anxiety, and depression, and are at high risk for second-generation incarceration. Recognizing the critical number of children living with one or more parents incarcerated, the federal government has formed the Children of Incarcerated Parents Working Group, in order to centralize the best available information on helping these children and ensure that the development of international standards for incarcerated parents is informed by children's realities. One resource hosted on the Children's Bureau website is a web-based training toolkit to help provide practitioners with the skills required to respond to the unique needs of children of parents who are in prison or have an incarceration history.

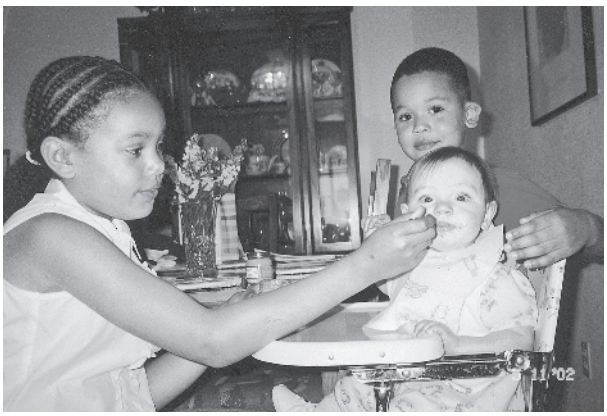
Siblings

Most children grow up in a family enriched and complicated by the presence of siblings. In the United States and Britain, this figure is estimated to be about 82%. The birth of a sibling often occurs when the first or previous child enters the preschool years. The exact influence of one sibling over another depends on many factors, including birth order, birth spacing, number of siblings, and gender.

Sibling rivalry tends to begin early. Frequently, an older child has to make adjustments and concessions, willingly or not, as soon as the next baby arrives. Even before the birth of a sibling, during pregnancy mothers can be incapacitated and unable to perform all of their usual childcare responsibilities. For most children, the period of adjustment to a new sibling is relatively short. As the youngest becomes capable of responding to an older child, positive interactions soon begin to dispel the initial reaction of anger and resentment. The children also develop a relationship of their own, not contingent on the parents' involvement.

Although sibling rivalry may come and go between brothers and sisters, there are those siblings who seem as though they will never get along. Researchers hypothesize that in these cases there may be a "clash" in temperament between the two children that prevents them from developing a quality relationship. The concept is similar to "goodness of fit," where the temperament of the baby is very different from the personality and lifestyle of the parents. With siblings who have very dissimilar temperaments, conflict can arise simply because each child's emotions, behaviors, and coping mechanisms are different. However, just because two siblings have very different temperaments does not mean that they will never have a quality relationship. Other factors, such as the parent–child relationship, parental management of sibling conflict, and a positive and prosocial family environment, can ameliorate the conflict between siblings.

Even with this range of difference, when children live together as siblings, they tend to contribute to each other's development in unique ways. They serve as teachers and models of both prosocial and negative behavior, communication partners, playmates, and rivals. Even children as young as preschoolers provide valuable and attentive emotional support to younger siblings, especially when they have been shown basic care skills and can identify the baby's source of distress. Siblings also can be an important source of support to children faced with stressful experiences. For example, the problems associated with growing up in conflicted homes can be dampened when there is a good sibling relationship.



Older children are often very effective in challenging the development of younger children.

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Peer Relationships

During the early childhood period of development, children continue to rely heavily on their parents for social and emotional support, care, and companionship. However, the security fostered by healthy family relationships provides children with the stability necessary to initiate play and friendships confidently with peers (Hymel, Vaillancourt, McDougall, & Renshaw, 2002). By about four years old, the majority of children (75%) will be involved in mutual friendships. Friendship networks will remain fairly small, averaging 1.7 for boys and 0.9 for girls and increasing to 3–5 during middle childhood. Throughout this period of development, peers play an increasingly important role in the child's life.

Just how important are peer relationships in early childhood? We see peers providing a different learning environment from that of the family. Compared with the non-egalitarian family atmosphere, peer relationships tend to be of equal status. Preschoolers need other peers close in age to compare skills and their own abilities, learn social skills and information, and try out ways of interacting in a safe environment. Through this comparison, children find out more about themselves and others. Peer relationships have been associated with normal social development, whereas peer isolation and rejection have been linked to a host of behavioral problems in children, including delinquency and poor mental adjustment. Peer rejection has been shown to predict more deleterious effects than peer isolation.

How would we characterize preschool children's peer groups? Preschoolers typically play with children of the same sex, a pattern that develops as early as ages one to two years old and continues through middle childhood. This observation should not come as a surprise to us, given that children are socialized by parents who may think boys should play with boys and girls with girls. Furthermore, because gender role development and stereotypical behaviors and interests peak during these years, we would expect children to play with others who share their interests.

What kinds of influences do preschool friends exert on each other? Even preschoolers distinguish preferred playmates from acquaintances. They share more readily, are less hostile, and make more personal sacrifices for the benefit of a friend. They also reinforce sex-appropriate behavior and extinguish behavior that does not conform. Preschoolers have also been observed to mimic a friend to instigate a positive social encounter and influence the other child.

In addition, several factors were found to contribute to the popularity of preschoolers with their peers. Research has found that popular children are more sociable, helpful, and cooperative than less-popular children. They also display better leadership and perspective-taking and problem-solving skills. Finally, they are perceived to have some assets, such as being athletic, attractive, and stylish. Children born without some of these innate characteristics may benefit from developing compensatory social skills to achieve positive status within their peer group.

Communities and Support Systems

Preschoolers' Play

As we have stated in previous sections, play is the primary medium for learning among preschool children. For all ages, play is a pleasurable activity, rewarding in its own right for the positive feelings it engenders. In addition, frustrations, tensions, conflict, and anxiety can be explored through play experiences. Play increases children's peer affiliations, social contacts, conversational abilities, and social skills. Piaget (1967) observed that children's cognitive skills are exercised and promoted during play. Vygotsky (1962) emphasized the importance of imaginative play for preschoolers. Berlyne (1960) described how play fulfills a child's need for exploration, curiosity, surprise, and novelty. Pellegrini (2002) has discussed the value of rough-and-tumble play, especially for young boys with their fathers. These opportunities provide children with information about themselves and their world.

Current research now looks at play as a function of both social interaction and cognitive ability. Preschoolers primarily engage in pretense (symbolic play), constructive play, and rough-and-tumble play. These current representations of children's play are described in Exhibit 5.19. The most common type of play for young children is symbolic play, and it serves four primary functions: enhancing the child's cognitive development, developing self-control, providing an opportunity to explore reality, and providing an opportunity for peer interaction (Corsaro, 2005).

Preschool Environment

Today, many preschoolers will attend preschool or daycare for three to five years. The emphases of preschool

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Exhibit 5.19 Preschool Children's Play Styles

Play Type	Child's Behavior
Unoccupied play	Unengaged with other children or activities, not goal directed, least frequent type of play.
Solitary play	Child plays alone, engaged in task but not with other children, typical of two- to three-year-olds.
Onlooker play	Child watches other children play and talks, asks questions, and participates verbally but does not engage in the play directly. Interested, but not involved.
Parallel play	Child plays with toys like those others are using, but does not play with other child. More common among younger children than older ones.
Associative play	Children play actively together. The interaction is more important than the task or organization of the play. Social skills such as turn-taking and follow-the-leader are objects of the play.
Cooperative play	Children play an organized activity with a lot of social interaction. Social games, formal activities arranged by a teacher, and competitive games fall into this category. Not as frequent among preschoolers.

programs vary greatly; some focus primarily on cognitive, academic development, and others focus almost exclusively on social and emotional development. However, for a child to appreciate a preschool setting fully, the curriculum should closely match the child's developmental goals.

Overall, preschool children tend to perform well in school when they have learned some self-control and self-discipline. These skills allow them to work with others, delay gratification, and handle the frustration inherent in the problem-solving that accompanies school tasks. The family environment, and parents in particular, can create situations in which the child experiences frustration and mastery, as well as learning to accept no for an answer. Children will learn internal self-control by first learning to accept external control of their behavior imposed by parents. As a side effect that is beneficial to the child–teacher relationship, children learn to respect and cooperate with adults and those in authority but not to fear them. These skills smooth children's transition to formal educational settings.

Kindergarten

The concept of kindergarten was first developed by Freidrich Froebel in the 1840s. He conceived of kindergarten as a "garden for children," where they would be carefully nurtured, like plants. However, over the course of shifting trends in social and educational practices, some kindergartens have become focused and concerned with success and achievement as opposed to nurturing the developing child. This approach also worries some developmental experts, who fear that too much pressure is placed on children to succeed and achieve at the expense of real learning.

One issue that has received a lot of attention is what to do when children aren't ready for kindergarten. Schools have traditionally sought one of two solutions, delayed entry into school, or retaining the child for an extra year. Conflicting research suggests that neither practice offers an ideal way to assist children who are not ready to succeed in kindergarten (Holloway, 2003). Coley (2002) has argued that to reduce inequalities in students' success in school, the differences that exist among children must be addressed before they start school. His approach is based on identifying children who are at risk for school failure and providing preschool experiences that ensure they have the opportunity to develop readiness skills. He has cautioned policymakers not to target students on the basis of a single criterion, such as income. The National Association for the Education of Young Children (2002) has suggested it is not productive to adjust children to meet specific expectations of a kindergarten program but that schools should respond to the diverse range of abilities within any group of children. One alternative suggested is the opportunity for children to engage in full-day kindergarten as a way to improve their skills and reduce chances of being retained in kindergarten (Miller, 2002).

Whatever the model taken for children to enter kindergarten, research has confirmed the importance of a good transition to school for all children (Bohan-Baker & Little, 2002). In a review of research studies, family involvement has been determined to be a critical aspect of the successful transition to kindergarten. The ecological context of the school can provide important ingredients to facilitate parent involvement in the transition, such as attitudes of the teachers toward parent involvement, attitudes of supervisors, and development of a school

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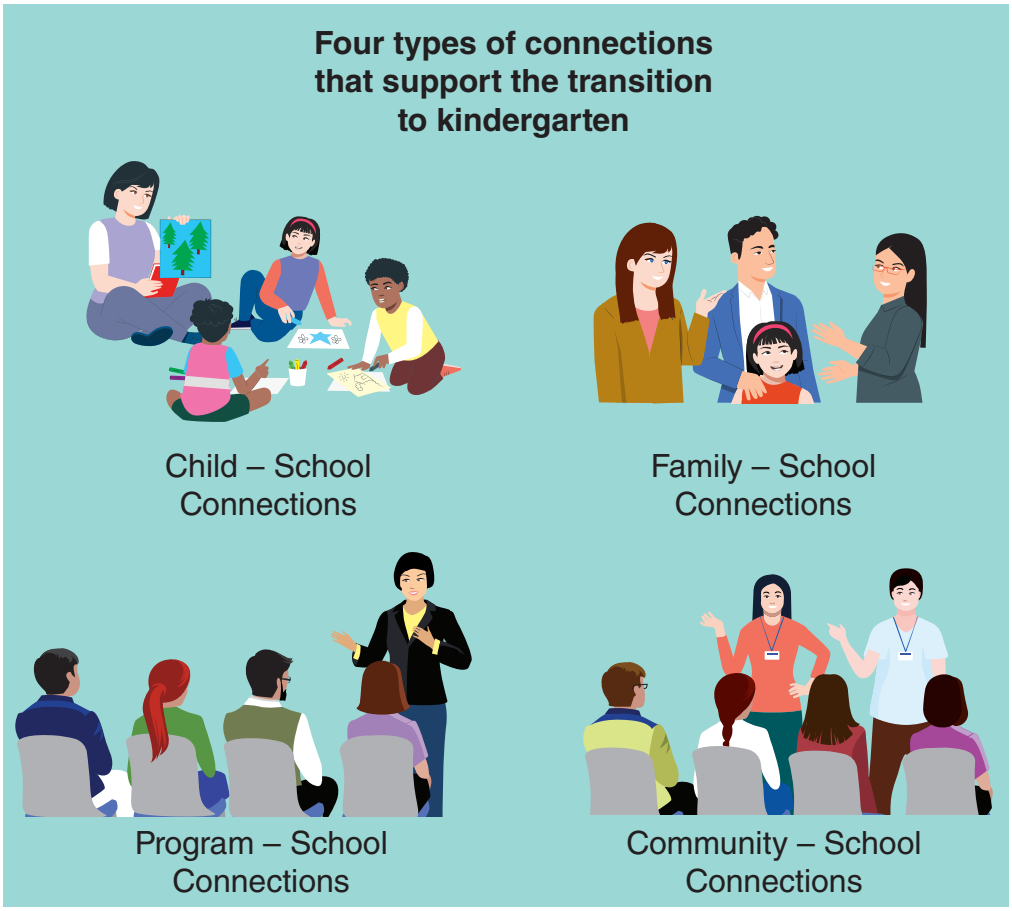
Exhibit 5.20 Office of Head Start: The Kindergarten Transitions are Most Successful When Families are Engaged. Good Communication and Collaboration Between Families and School Staff and Administration is Key



and program transition team. Exhibit 5.20 provides a summary of the promising practices to involve families in the transition to kindergarten. Although preschool and kindergarten are among the resources available to assist in preparing children for formal education, parents play the largest and most critical role in preparing their children for school.

Project Head Start

Project Head Start was spearheaded in 1965 as part of Lyndon Johnson's Great Society initiative. Today, it is a $8.2 billion federally funded program that serves more than 900,000 children. The overall goal was to break the cycle of poverty by providing a preschool experience for children from economically disadvantaged families at risk for school failure. Several research studies (Chow, Jaffee, & Snowden, 2003; Kim, Hong, & Rowe, 2000) have documented that various outcomes for children (e.g., school performance, mastery, educational aspiration) are impacted by the experience of economic hardship. According to this research, parents in these families feel helpless to control events in their lives and as a result are detached from their environment and unresponsive to their children's needs. They fail to teach their children ways of mastering their environment, and the children in essence inherit the attitude of helplessness. When the children cannot fulfill their own expectations to perform well in school, they become detached, as well, and feel helpless to succeed. Their natural curiosity and motivation are thwarted from the beginning.

To counteract this phenomenon, the program was first offered to four- and five-year-olds during the summer preceding their kindergarten year. Now the program is available for an entire year prior to enrollment in kindergarten. In some areas of the country, the Early Head Start program

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An African American teacher is showing a group of children something on a board.

directs its interventions toward infants and toddlers in an effort to enhance development through the creation of partnerships with parents. Head Start shares many features of other early intervention programs (Zigler, Marslano, & Lord, 2011), but it makes unique contributions in the areas of parent participation, health, and nutrition. The curricula for specific Head Start programs are determined by each of the approximately 2,000 programs that exist in slightly different forms. All Head Start programs, however, are committed to improving the quality of life for the children and family participants. Efforts are under way to reduce Head Start's funding, which is likely to have serious implications for the readiness of low-income preschoolers to enter kindergarten.

What have we learned over the past 50 years of administering Head Start and other early intervention programs? First, we have refined our evaluation skills. We have learned that specific goals for any project must be outlined to ensure a proper evaluation of the program's intended effects. Initially, the effects of Head Start were evaluated only in terms of increases in children's IQ scores. But these scores represent only one small factor in determining school success. Effects on the health and motivation of the children and on the parent component were not examined, although they clearly influence school achievement, as well (Zigler et al., 2011). As a result, the evaluation failed to measure change in the most prominent areas of the program and caused undue disenchantment with the program. Fortunately, more comprehensive, better designed follow-up evaluations of Head Start have shown that children who participated in this program were more likely to succeed at school and experience more positive child outcomes. The success of Head Start programs has also been impacted by the range in the quality of program delivery across centers. We have learned from exemplar programs, that is programs that have shown improvements on third-grade reading performance, absenteeism rates, and grade-level retention numbers, that there are specific factors that increase the success of Head Start programs, including:

- full-day programs
- lead teachers holding bachelor's degrees
- professional development opportunities for teachers (for example, how to support dual-language learners)
- extensive family engagement practices (for example, a team that runs group meetings and education programs for parents and conducts home visits)
- program staff to analyze data and inform program-level and classroom changes
- tailoring the curricula to meet the needs of kids.

The program is still underfunded and cannot provide enrollment for all eligible children, despite substantial evidence that Head Start is a successful antipoverty program with evidence of intergenerational transmission of effects in the form of increased educational attainment, reduced teen pregnancy, and reduced criminal engagement in the second generation (Barr & Gibbs, 2022). Federal and local monies fund the program, which is provided free to all eligible children.

Media Use and Screen Time among Preschool Children

Many parents of all backgrounds will readily admit that being able to occasionally plop their child in front of screens can be a welcomed and necessary break for caregivers; however, the concern about passive media, such as television, is that it can replace vital human interaction and serve as a childcare substitute. Bronfenbrenner (1986) suggests that the presence of TV decreases the amount of time families spend actively participating in mutual activities requiring discourse, argument, and reciprocity, which promote children's learning (such as playing games, going on outings, and talking). However, the landscape is changing. Media has become an important socializing agent, particularly in a post-COVID-19 era, and we are just beginning to understand its influence on behavior and development in early childhood. It really has not been that long since the first-generation iPhone was first introduced in 2007; in the same year, Netflix introduced streaming services. The iPad followed in 2010. Never have television and video games been so portable and easily accessed.

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The World Health Organization (WHO) and the American Academy of Pediatrics (AAP) responded to these developments with the recommendation that children younger than 18 to 24 months avoid screen time entirely except for video chatting (such as Zoom or FaceTime, which is not included in the definition of screen time because it is responsive and interactive). Their recommendations are that children in early childhood (aged two to five years) should limit screen time to one hour or less per day.

A recent longitudinal study of 2,441 mothers and children found that increased screen time at 24 to 36 months predicted poorer performance on behavioral, cognitive, and social development at 36 months (Madigan et al., 2019). But is it that more poor-performing children are using screens more? That hypothesis did not hold, so it seems that it's not a matter of parents using screens to handle a more challenging child. Experts in childhood development acknowledge that there are distinctions between interactive media (content designed to facilitate active, creative, and socially engaging use) and passive media. Passive media, such as the *Baby Einstein* videos, does not teach children as much as live interaction, particularly for toddlers because of their cognitive stage in development—they are not able to translate what they see on a screen to real life. However, as we have seen from research on *Sesame Street*, by the time children are three to five years old, they can learn from more slow-paced, thoughtfully designed educational media. For example, children who were randomly assigned to watch 20 episodes of *Super Why!* outperformed children who watched a comparable educational science series. Further, children from lower socioeconomic backgrounds achieved greater gains, presumably because they had less exposure to a rich literacy enrichment than the more privileged children (Nichols, 2015). There are opportunities for social and emotional growth as well; in one study, children who watched *Daniel Tiger's Neighborhood* showed greater emotion recognition, empathy, and self-efficacy, if they were able to talk to their parents about the show or their parents watched it with them (Rasmussen et al., 2016).

Though three out of four children aged two or younger are watching TV, there is a trend toward using more interactive media; overall, children are increasing their time playing interactive activities on mobile devices (Pew Research Center, 2020): 64% of children aged two to five years, and 35% of children aged two or younger, play games on a tablet computer and 62% of three- to four-year-olds interact with a smartphone. Prior to the COVID-19 pandemic, very few children in early childhood were using social media, but as of 2021, 5% of children younger than five were using TikTok. From March 2020 to 2021, increases in children under age five using a tablet (51 to 69%) or a game device (16 to 29%) rose substantially, particularly in homes with less parent education.

The content of the media, whatever may be the device, is also important for parents to monitor. How children are affected by media is determined, to a large extent, by what they are watching. For many years, it was observed that watching a violent TV program was shown to increase aggressive behavior, such as hitting and kicking (Bandura, 1965; Steuer, Applefield, & Smith, 1971). This effect is amplified by interactive media and is particularly pronounced for children who already displayed hyperactive and aggressive behaviors before engaging in media violence (Swing & Anderson, 2014). In addition to violence, media may present diverse developmentally relevant topics that parents can use to discuss the themes, staging, cultural biases, and peddling of consumerism depicted on television with their children. Open, nonjudgmental discussions can teach children to be informed viewers and not just consumers of TV hype.

Video chatting has increased in popularity and does not count as screen time. Once children have learned how to use Facetime (see Exhibit 5.21 for tips to increase child engagement), it can be used as a tool to give parents a break, and provide opportunities for grandparents and loved ones separated geographically to connect, creating greater bonding, learning opportunities, and increased feelings of closeness. Research has shown that children can comprehend books using this modality just as well as being read to in person (Gaudreau et al., 2020).

Interactive media is being used in a variety of clinical settings with young children, even before the onset of the COVID-19 pandemic, including assisting in language development and fine-motor skills (Radich, 2013). Teletherapy has advantages over face-to-face options; it can overcome geographical barriers, and there are a variety of computer-based technologies that support parent training. A recent study found better parent fidelity and language improvements among children with autism spectrum disorder who participated in teletherapy compared to face-to-face therapy (Hao, Franco, Sundarrajan, & Chen, 2021). Interestingly, child improvements were attributed to the parent's improvement in treatment fidelity, rather than on the modality of therapy itself. That is, it seems that therapy will have the greatest impact when parents are better able to attend and engage in the intervention, so they should participate in the format of therapy that appeals most to them.

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Exhibit 5.21 Three Tips for Getting the Most out of Video Chatting With a Child in Early Childhood

1. Be present. Ask questions and initiate interactions. Model asking questions and initiating interactions with the other person by sitting next to your child. They are learning by watching you respond to the person on the screen.
2. Observe and point out things you see on the screen and how it is relevant. Children learn by helping you focus their attention to information on the screen.
3. Engage in games or activities. You can read a book, sing, play peek-a-boo, dance, or share favorite toys while Facetiming. Making the interaction more fun will increase the likelihood that they will want to participate in it again.

Multicultural, Gender, and Spiritual Considerations

The preschool years are important for developing a positive and unique sense of self (Seefeldt & Wasik, 2010). Preschool children begin to recognize ethnic physical characteristics in themselves and in others. One of the early classic studies on racial awareness was conducted by Clark and Clark in 1939. The researchers asked three five-year-old African American children to identify themselves from a series of drawings that included various animals, a clown, a White boy, and an African American boy. They discovered that by age four, children would begin to identify the African American boy, and by age five, their identification with the African American boy was well developed.

Young preschoolers may not understand ethnicity as a fixed personal attribute until they have developed the concept of conservation, which occurs close to age five. Preschoolers do not understand that these features may have a social significance beyond what is visible to the eye. Just as children cannot cognitively understand the meaning of sexuality, they cannot understand the social meaning of membership in one culture or another. As soon as they identify with one ethnic group, children learn who they are in comparison with others. They learn to evaluate themselves along the dimensions of appearance, ability, group membership, and hopes for the future (Gelman, 2003).

What preschool children come to know about their own heritage is determined largely by their parents and extended families. They have not often branched out into the larger community unprotected by caregivers. Children who feel valued in their own right learn to respect themselves and others. In addition, parents who teach their children the truth about racial inequality and discrimination may be preparing them to deal squarely with problem situations when they are encountered.

Cross Culturally Adopted Children

As we mentioned, children learn about their heritage and ethnicity largely through their parents and extended families. But what about a child who has been adopted into a culture that is different from their birth culture? What factors are involved in the development of this child's ethnic identity?

Although very young children cannot cognitively understand the process of adoption, they are able to recognize that there are physical differences between themselves and their parents. Especially for internationally adopted children, there may be no opportunity to see or interact with people who share their culture of origin, which can make ethnic identity formation more difficult. Unable to identify with either their birth culture or their adoptive culture, these children can find themselves confused about where they belong. This is especially true for adopted children of color, who often realize that they are different because of comments and questions from teachers and friends. Although no distinct guidelines exist for raising a child in a culture different from their culture of origin, studies find that transracially (adopted by parents of a different ethnicity) and internationally adopted children do not differ in their self-esteem or adjustment compared to children adopted into same-race families, especially when the child is adopted at a young age. It does appear, however, that the child's environment, family, and community play an important role in successful adjustment and ethnic-identity formation.

Practice Guidelines

- Research indicates ways that parents can help cross-cultural children develop a healthy ethnic identity.
- Parents should openly acknowledge the physical differences between themselves and their child, modeling to the child that differences are positive.
- Placing emphasis on global commonalities, such as emotional, psychological, and social similarities, can help develop an integrated view of self and others.
- Parents should expose the child to affirmative role models from their culture/country of origin.

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Gender Role and Sexual Identity Development

Gender role development and sexual identity development are separate yet intrinsically linked processes. What factors contribute to gender and sexual identity development? As we discussed in the last chapter, babies show gender differences from birth, and certainly social and cultural expectations permeate child-rearing from a very early age. Parents, families, teachers, peers, and physical and cognitive development all contribute to a child's sexual identity formation. In our society, gender roles are often unintentionally codified from an early age. Studies have demonstrated that in heterosexual couples, mothers and fathers often approach discipline differently. For example, when toddlers explore, you are more likely to hear a mom say, "Come down from there!" as she focuses on protection. The father, though, may like to encourage these behaviors and say, "Climb up higher!" There may also be gender differences in parental approaches to sleep problems in children, as mothers want to comfort the child and fathers are more likely to let the child fuss. Mothers verbalize more, whereas fathers give more commands (Leaper, Anderson, & Sanders, 1998; Sears, Sears, Sears, & Sears, 2011). Differences also emerge when researchers examine parental interactions with sons and daughters. Both parents provide sons with more task-oriented, directive, and approval-based instructions than daughters. Girls, on the other hand, are taught to be more cautious and cooperative, and they receive more feedback about their performance than boys. The implicit messages from both parents convey stereotypical gender role expectations. More aggressive behavior is tolerated, if not encouraged, in boys, whereas girls are taught cooperation and empathy (Sears et al., 2011; Yelland, 1998).

By the preschool years, boys will play with boys and girls with girls (Hartup & Abecassis, 2002). This represents the beginning of gender role identity, in that boys and girls tend to play differently during the preschool years. Preschool boys and girls already have strong notions of sex-typed play (Golombok & Hines, 2002). Sex play becomes more common in this age group and is usually nothing more than a healthy curiosity about their bodies. Children at this age are fascinated with everyone's body and bodily functions. Modesty and privacy are not concepts that have any meaning to them; curiosity wins out. Masturbatory play is also common during this period. The preschool years are an excellent time to introduce the notion of "private" and "public" selves. In addition, these concepts become useful in talking about safety and in preventing sexual abuse of children.

At this time, children also strengthen their identification with the same-sex parent. They will dress like them and engage in sex-stereotypic behaviors. They are busy exploring what it means to be a boy or girl in their world. They identify whether boys or girls cook, play with cars, fight, climb trees, and kiss. Gender-specific toy preferences are also evident at this young age, and parents encourage sex-typed play in young children, as well. This is especially true of fathers, who may tolerate tomboyish activities for girls but tend to express more concern about cross-sex activities for boys. Not surprisingly then, boys adopt sex-typed behavior and toys earlier than girls do. By age three, children have a fundamental sense of gender identity. They can answer the question "Are you a boy or girl?" By age four, children develop gender stability and realize that gender does not change over time. However, they still believe that children can change gender by changing their behavior—if a boy wears a dress, he can become a girl.

Children express their gender identity through their clothing or hairstyle, their preferred name or nickname, social behaviors, physical gestures, and social relationships including the gender of friends (Rafferty, 2022). It Is important to note that while gender-specific behavior is influenced by the social environment, such as exposure to stereotypes or identification to people in their lives, the internal sense of being a girl, boy, in between, or something else is gender identity and cannot be changed. All children go through the process of gender development and need support, love, and care from family and society to grow into well-adjusted adults.

The Effects of Sex Stereotyping

What are children learning about their sex roles in our society? By early childhood, children have been found to attribute greater competency to boys than to girls. In one seminal study, three- to five-year-old children, when asked who was smart, pointed to the baby that was labeled the "boy" (Haugh, Hoffman, & Cowan, 1980). However, parents tolerate a girl acting like a boy more readily than they do a boy acting like a girl. In fact, a common societal notion is that girls spend their developmental years trying not to be babies, but boys spend these years trying not to be girls. Even children's literature makes being a boy more interesting than being a girl. In traditional literature, boys have adventures, whereas girls get rescued and clean up after others. This same representation of gender roles is

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also seen in television cartoon characters. Male cartoon characters outnumber female characters almost four to one, and, as in children's literature, the male characters are usually portrayed as powerful, strong, and smart, while the female characters are often portrayed as "damsels in distress" (APA, 1997). Are things getting better? They might be. In an analysis of princess characters in movies released from 2009 to 2016, Hine and colleagues (2018) found more diverse gender roles and more representation for androgynous characters. Princesses showed an almost equal number of masculine and feminine behaviors, and princes adopted more feminine behavioral profiles, particularly in later films. Further, male and female characters were equally likely to display rescue behaviors and more princesses were remaining single.

Many people believe that societal attitudes have contributed to inequality of women globally, and they support teaching children to be androgynous. **Androgyny** refers to a combination of feminine and masculine attributes in the same individual. Advocates for androgyny argue that many girls and women have suffered from a loss of opportunity because of traditional sex stereotypes. Classic research by Bem (1974) suggested that well-adjusted people possess qualities that are both masculine (assertiveness, competitiveness) and feminine (cooperation, nurturance). Perhaps the real problem is not in gender role differences but in the cultural value assigned to those roles and sex-type characteristics.

Children should have opportunities to explore different gender roles and styles of play. It is recommended that children are exposed to books that show men and women in non-stereotypical and diverse gender roles (stay-at-home dads, male nurses), that they have a wide range of toys to choose from (for example, dolls, action figures, blocks), and that they are allowed to make choices regarding friend groups, sports, and other activities they are interested in.

Social Strengths, Hazards, and Risks

Many people—educators, policymakers, families, and the public at large—agree that families of young children need support and that we as a society value providing that support. This is why Hilary Clinton's reflection on the now famous African proverb "It takes a village to raise a child" became so well known. It was an important reminder that children can thrive when families are thriving and when society supports them. Social strengths are reflected in social programs and policies that embrace the ideas of creating a caring community. In order to build such communities, we need to enhance our collective connectedness.

Such connectedness is often referred to as **social capital**, which is the network of norms, obligations, expectations, and trust that can occur among people who share common values. Early childhood policies and programs cannot be properly supported without such connectedness—in other words, not having this social capital is a major impediment. Sociologist theorists such as Amatai Etzioni and Robert Bellah have been outspoken in their criticism of society's focus on individualism. They have pointed out the need instead for communities with common values that can counteract individualism.

Family-Group Decision Making: A Strengths Model

In many ways, the rise of family-group decision making or family-group conferencing is an apt example of social capital and a strengths-based approach to the serious social problem of child abuse and neglect. In recent years, there has been an ongoing focus on involving the family in the processes of child protection. One model that originated in New Zealand, based on Maori culture (Connolly & McKenzie, 1999), emerged from legislation that formalized the principles of family decision making in child protection work. This model of child welfare practice was spurred by several developments in the field, such as increasing numbers of children living in out-of-home care, and living in such care for longer periods; children experiencing multiple out-of-home placements; the large representation of minority families; and concerns about providing ethnically sensitive services.

In essence, family group decision making is a new approach to working with families involved with the child welfare system. The American Humane Association (2014) supports family group decision making as a major program initiative and offers training throughout the county on this program model. The process involves bringing family members (experienceing extended family) and professionals together for a "conference" to make a decision about the care of a child who has become part of the child welfare system. The social worker identifies families appropriate for family-group decision making and brings professionals and families together in a one-day conference that begins with information sharing. This is followed by the family meetinexperiencen which families typically meet in private

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and experiencehe focus is on a plan to ensure the child is cared for and protected from further harm. The family then reconvenes with the child welfare workers, and they agree on the terms of the final plan. The family group decision-making model is family centered and strengths oriented, culturally based, and community based. It places emphasis on texperienceily, because the family has the most information to make well-informed decisions for itself. The model explicitly encourages families to connect with each other and their communities in solving their problems. While new models of community support are receiving a lot of attention, a critical hazard for children in industrialized experience is the experience of poverty.

Poverty and Development

As discussed in the previous chapter, poverty impacts children's lives even before they are born. Nearly one in six children under the age of six are living in poverty, half are living in extreme poverty, and 71% are children of color (Children's Defense Fund, 2020). Historical, systemic racism, and institutional barriers mean that children of color are particularly vulnerable to poverty. Child poverty improved in 2021, according to the U.S. Census Bureau data released in 2022, which was attributed to the expansion of anti-poverty programs during the COVID-19 pandemic.

How does poverty affect the preschool child's development? Years of research have examined this question and documented the negative child outcomes associated with living in poverty [see Lindsey (2008) and Clay (2015) for a review]. These negative effects are most pronounced during the first five years of life. In general, studies find negative effects in three primary areas—poor physical health, lower intellectual attainment, and poor school performance—and report the increased presence of social, emotional, and behavioral problems (Mullainathan & Shafir, 2014).

It Is noteworthy that the children living in the most extreme poverty have the worst outcomes (Guo, 1998; Lindsey, 2008). In spite of these negative effects, many impoverished children show **resiliency** to the conditions they haveIced and become positively adjusted. What makes these children and families so resilient is a critical question addressed by a good deal of research.

Child Abuse

Child abuse, or the maltreatment of children, implies a range of conditions that violate social norms regarding the care, security, and safety of minors. Although state laws regulating the treatment of children vary, each state defines child maltreatment to include one or more of the following: physical abuse, sexual abuse, physical neglect, educational neglect, and psychological abuse (Maluccio, Tracy, & Pine, 2002).

Physical abuse involves injuries such as broken bones, serious and minor burns, head injuries, and bruises. In addition, there may be physical contact, such as slapping, punching, and striking a child with a belt or a paddle, which does not always result in a visible injury.

Sexual abuse typically refers to various forms of touching, penetration, and exploitation. *Molestation* is the term used to describe inappropriate touching—which may or may not involve genital contact—of minors. Exploitation refers to involving a child in sexual activities such as prostitution or pornography. Penetration includes oral, anal, or genital contact and can involve the use of body parts (fingers, penis) or objects.

Child neglect can include less explicit forms of abuse because it refers to both active and passive behaviors from adults. Physical neglect includes abandonment, delay or refusal of health care, inadequate supervision, and inadequate provision of basic care such as food, housing, clothing, and personal hygiene. If these areas of neglect are to be avoided, parents need continual support, resources, and initiative in caring for their children. Child neglect is often the result of a severe lack of resources.

Educational neglect includes not enrolling a child in an educational program, allowing frequent absences from school, and refusing to respond to special educational needs. At times, parental values regarding the role of formal schooling and the challenges of developmental conditions may come into conflict with the mandates of education laws and the values of special education providers. These potential conflicts cloud the issues of educational neglect, thereby creating difficulty in substantiating negligence in some cases.

Psychological abuse refers to physical restraint, repeated threats, exploitation, rejection, and degradation. Although its definition is less concrete, descriptions of psychological abuse suggest that verbal messages should be regulated with regard to their effect on children's well-being. For example, negative labels and name-calling are forms of degradation.

People often think of child maltreatment as abusive behavior from a parent. In fact, children can be mistreated by any adult who is responsible for their general well-being and supervision. Thus, the adults potentially involved in child maltreatment may include parents, members of extended family, teachers, childcare providers, clergy, and so on.

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Factors That Contribute to Child Abuse

Many risk factors that contribute to child maltreatment have been identified, including family stress, child and family characteristics, interaction style, parental problems, and values regarding violence (see Exhibit 5.22).

The exhibit presents a framework for organizing the factors that have been found to contribute to child abuse and neglect. The most consistent factor is that parents who abuse or neglect their children often were abused or neglected in their own childhoods. Another major factor in child maltreatment is substance abuse. The use of crack, cocaine, or methamphetamines can seriously affect one's ability to care for children. Alcohol abuse also contributes to the risk of child abuse, especially when combined with other drug abuse.

Children who are perceived as different, such as children with developmental disabilities and children with difficult temperaments, are at increased risk for abuse.

Exhibit 5.22 Risk Factors Associated With Child Abuse and Neglect

Parent or Caregiver Factors
Personality and psychological well-being
History of child abuse
Substance abuse
Attitudes and knowledge
Age
Family Factors
Family structure
Marital conflict and domestic violence
Stress
Parent–child interaction
Child Factors
Age
Disabilities
Environmental Factors
Poverty
Unemployment
Social isolation
Lack of social support
Violent communities

Source: Adapted by the authors from National Clearinghouse on Child Abuse and Neglect Information (2004).

Marital conflict, domestic violence, employment and financial stress, and social isolation all exacerbate negative interactions within a family that can increase the risk of child maltreatment (National Clearinghouse on Child Abuse and Neglect Information, 2004). A history of animal abuse has been related to child abuse. Many studies have established a strong relationship among poverty, social isolation, and child abuse or neglect (see Pecora, Whittaker, Maluccio, & Barth, 2000). In addition, unemployment, lack of housing, daily stress, and community violence contribute to increased risk. Specifically, researchers have found that families who live in communities with little social support or lack of community identity have higher incidences of child abuse and neglect, as well as juvenile delinquency, drug trafficking, and violent crime.

But, as we have pointed out in previous chapters, the presence of these factors does not automatically mean that family caregivers will abuse their children. Factors that contribute to child abuse in one family may not result in child abuse and neglect in another family. Although it is noted that child abuse is related to living in poverty, it must be remembered that most people living in poverty do not harm their children.

Incidence of Child Abuse

According to the most recent statistics from the National Child Abuse and Neglect Data System, more than 3.9 million total referrals were made to child protection agencies in the year 2020, alleging maltreatment of 7.1 million children. Over half of those cases were "screened in" for investigation for potential child abuse or neglect. This is a 3% decrease from total referrals in 2016, though the true number of children abused or neglected is not known. More specifically, for every 1,000 children in the population in that year, approximately 8.4 were victims of maltreatment (1,713 child deaths were recorded, 46.4% were younger than one year old) marking an 8.7% decrease from the 2016 data. While the 2020 decrease may be due to the COVID-19 pandemic, the number of victims has fluctuated. States have different policies about what is considered child maltreatment and the level of evidence required to substantiate an allegation, all of which contribute to variations in victimization rates. From 1990 to the present, the rate has varied from a high of 15.3 per 1,000 to a low of 8.4.

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Focus on **The Lived Experience**

A Child Called "It"

The *New York Times* bestseller *A Child Called "It"* is the story of a young boy severely abused by his alcoholic mother. He is not allowed to interact with the rest of the family, he sleeps in the basement, and his mother refuses to feed him for days at a time. When she catches him stealing food to survive, she makes him throw it up and then eat it again. She pushes his face into a soiled diaper. She cuts him with a knife. Here is his account of the psychological effect of years of abuse:

> At the core of my soul, I hated myself more than anybody or anything. I came to believe that everything that happened to me or around me was my own fault because I had let it go on for so long. I wanted what others had but saw no way to get it, so I hated them for having it. I wanted to be strong, but inside I knew I was a wimp. I never had the courage to stand up to The Bitch, so I knew I deserved whatever happened to me. For years Mother had brainwashed me by having me shout aloud, "I hate myself! I hate myself!" Her efforts paid off. A few weeks before I started fifth grade, I hated myself so much that I wished I were dead.
>
> School no longer held the exciting appeal that it had years ago. I struggled to concentrate on my work while in class, but my bottled-up anger often flashed at the wrong times. One Friday afternoon in the winter of 1973, for no apparent reason, I stormed out of the classroom, screaming at everyone as I fled. I slammed the door so hard I thought the glass above the door would shatter. I ran to the bathroom, and with my tiny red fist I pounded the tiles until my strength drained away. Afterwards, I collapsed on the floor, praying for a miracle. It never came.

—From Pelzer (1995), P. 21

Child maltreatment is not evenly distributed across genders and ages. We also know that slightly more girls (52%) than boys (48%) are victims of child maltreatment and that more girls than boys are sexually abused. Also, it is well established that the youngest and most vulnerable children, those under age three, have the highest rate of abuse. Sex trafficking is more likely to occur in adolescence; however, in 2020, 2.5% of victims were less than six years of age. In terms of the perpetrators of child maltreatment, 91% of children were abused by one or both parents. Over a quarter of victims have a caregiver with a history of intimate partner violence (28.7%) or drug abuse (26.4%). Reports of child maltreatment include people from all educational, economic, and ethnic backgrounds. However, children living in poverty and children of color are more likely to be reported.

Reporting Child Abuse

Social workers, especially the ones working in clinics and hospitals, are the ones that can spot a child bearing the traces of any form of abuse. For instance, a mother walks into a clinic with a child that appears too small and thin for his age, but no medical analyses can determine the real reason of why the child is not developing right. A social worker will try to find out some details regarding the background of the child, family, and other conditions. During the discussion with the mother, he might find out that the mother has other children, all with behavioral or development issues, but without a medical reason. Eventually, the mother confesses to having a husband who drinks a lot, who's been charged with intimate partner violence and hit the mother several times, including in the pregnancy period. This obviously puts a great amount of stress on the mother and children, creating an unhospitable and careworn environment within the family.

Should the social worker report this case as child abuse? Will the decision be the right one, not creating any more problems for the child? These are issues everyone found in such positions will ask themselves, although social workers should be the first to report any suspicion regarding child abuse or neglect. This is not only a moral duty but also the need to respect the regulations regarding their jobs as social workers as mandatory reporters. After a report has been made, Child Welfare Services will unroll an investigation to determine the severity of the case and if any intervention is necessary. Only one-third of the total reports are severe cases. From the severe cases, very few will end up in court, and most parents will be guided to ask for specialized help (Maluccio, 2002).

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Investigation of Child Maltreatment

Child abuse is often difficult to substantiate. Confirming the history of child maltreatment requires comprehensive, time-consuming assessments, but child protection workers often must make immediate decisions with limited data. The child's safety must be ensured, but the rights of the parents and children involved must also be protected (Maluccio et al., 2002).

Child welfare organizations use an assessment system that addresses the nature and severity of child maltreatment and the further risk to child safety. The collected information is used to determine what services are needed and what services are available, as well as the intervention's chances of producing a successful outcome (Pecora et al., 2009).

Practice Guidelines

In conducting the initial assessment/investigation, the primary issues to consider include the following:

- Is the child safe? If not, what measures are necessary to ensure the child's safety?
- Did the child suffer maltreatment, or are they threatened by harm as defined by the state reporting law?
- Is maltreatment likely to occur in the future? If so, what is the level of risk of maltreatment?
- Are there emergency needs in the family that must be met?
- Are continuing agency services necessary to protect the child and reduce the risk of maltreatment occurring in the future?

Collecting this information is a time-consuming task. Thorough interviews of adults and children involved in child maltreatment require extensive time and skill. Often, the adults involved are unwilling to divulge information concerning individual and familial history, the nature and extent of stress present in the family, negative feelings toward the child, and the possibility of irresponsible behavior on their part. Parents may be reluctant to discuss their situation fully for fear that the only outcome is losing their child.

Interviewing children to confirm abuse is very difficult because of several developmental concerns, including language, cognition, emotional growth, and attachment to significant adults. Before age five, children's expressive language is still developing so that a child may not have the expressive vocabulary and sentence structure to describe experiences with accuracy and detail. Also, very young children have difficulty distinguishing real events from imagined ones. Children who are awakened from a deep sleep during an abusive incident may have difficulty orienting to the time, place, and authenticity of abusive behavior.

Feelings of guilt about the abuse are common among victims. Children who have been convinced that they are somehow responsible for an adult's reactions may internalize the blame or assume responsibility for abusive conditions. Some children may believe that if they could just be "good," the abuse would stop. The loyalty and bond between children and the significant adults in their lives may also contribute to a child's feelings of guilt about disclosing abuse. Children may realize that disclosure of the abuse could break up the family and may worry about its well-being. For instance, if the father is the sexual abuse perpetrator and goes to jail as a result of the disclosure, the family may lose its main source of income.

The Effects of Child Abuse and Neglect

Although it is difficult to pinpoint direct consequences of child abuse and neglect, there are effects that can be documented for some children. Infants who suffer head trauma or shaking can have long-lasting neurological deficits including blindness, deafness, mental disabilities, and cerebral palsy. Children can also suffer psychological effects, including bedwetting, tantrums, hyperactivity, low self-esteem, school problems, social withdrawal, oppositional behavior, compulsivity, and aggression (National Clearinghouse on Child Abuse and Neglect Information, 2004). Children who are physically abused exhibit more self-destructive behavior, such as suicide attempts and self-mutilation. Children who have been maltreated are also at risk of attachment problems that can affect interpersonal relationships throughout life.

Developmental Guidelines for Assessment in Early Childhood

These guidelines are meant to be helpful to social workers who need to understand development when making assessments.

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Study Table Social Dimension in Early Childhood

Families, Groups, Communities, and Support Systems

- Families move from addressing the physical care of children to setting limits and encouraging self-care, play skills, language development, and other methods of enhancing the child's self-control.
- The Erikson stage for preschool children is initiative versus guilt.
- Three styles of parenting: authoritarian, authoritative, and laissez-faire (permissive). Permissive parenting also includes two subtypes: neglectful and indulgent. Parents can be classified as warm or hostile. Parents need to adapt their parenting style to the child's developmental level.
- Parents begin to rely on discipline strategies based on logical and immediate consequences. Discipline styles of mothers (verbalizations) and fathers (commands) differ.
- Low-income parents tend to use more authoritarian parenting for a variety of reasons. In addition to parenting, the cultural context can shape children's behavior.
- Studies show that children raised by gay parents show no adjustment differences compared to children raised in "traditional" families.
- Mothers are involved in primary childcare duties, and fathers spend more time playing with children. Mothers provide soothing activities and are more visual and verbal than fathers, who are more provocative and physical in their interactions.
- Preschoolers identify with the same-sex parent, but at ages four to five, children find fathers important and seek them out as playmates.
- Of incarcerated adults, 80% are parents, making children of prisoners a significant issue, especially because they represent children with identifiable risk factors (particularly for criminal activity).
- By age 4, 75% of children have developed friendships—typically with children of the same sex. Peer relationships are essential to development, and peer rejection is a strong predictor of a host of behavioral problems.
- Play is an important aspect of a child's healthy development. It is related to positive feelings, reduced tension and conflict, the exercise of cognitive skills, and the development of social skills. Play behavior has been categorized into five types: sensorimotor, practice, symbolic, social, and constructive.
- Preschool programs can vary; some emphasize academics, others emotional development. Kindergarten was designed to nurture the developing child, but children must be ready for the experience. When they aren't, schools may use delayed entry or retain children for an extra year.
- Children who are at risk for school failure should be identified and provided preschool experiences that support their development of readiness skills.
- Family involvement has been shown to be vital in the successful transition to kindergarten, and promising practices exist to promote such involvement.
- Head Start is a government program designed to address poverty by providing a preschool experience for children to help successful transition into kindergarten. Evaluations that examined Head Start found disappointing results when measuring IQ alone as an outcome. However, other evaluations, using a broader range of outcomes, have documented the program's positive effects. Like Head Start, which helps enhance parent participation, health, and nutrition as well as school readiness, "full-service schools" are being developed in many communities to provide health care, parent education, and case management.
- At an average of 20 hours per week, children spend more time watching TV than they do with parents or in school. Research finds that TV viewing is associated with attention problems and aggressive behavior in children and that TV may have an addictive influence over people. Because of the relaxed state TV can put people into, people may become conditioned to associate TV viewing with reduced tension. Also, TV has an "orienting response," which may explain why it is hard for people to stop watching. Advantages also exist for TV, such as exposure to information, knowledge, and learning.

Multicultural, Gender, and Spiritual Considerations

- Preschool children recognize ethnic characteristics in themselves and others. A notion of ethnicity as a fixed attribute emerges at age five, but preschoolers do not yet understand that physical features have a social significance.
- When children do identify with an ethnic group, they will begin to make comparisons with others. Children adopted cross culturally face special issues in the development of their identity.
- In preschool, gender role identity begins. Sex-typed play is common. Children strengthen identification with the same-sex parent. By age three, children have a sense of gender identity, and at age four there is gender stability. Two behaviors that appear to be genetically influenced are aggression in boys and nurturance in girls.

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- The effects of sex stereotyping emerge in early childhood, and children of this age are rigid in their sex-type behaviors. As a result, many people advocate teaching children to be androgynous.

Social Strengths, Hazards, and Risks

- Early childhood is a time when most people agree that families need support in their efforts to nurture children.
- Social programs and policies are more likely to be embraced by the community for this developmental period. One example of a strengths-based model of family programs is family-group decision making, an alternative to traditional child welfare in which family members "conference" to make a decision about how they can care for a child who has become part of the child welfare system.
- Poverty takes its toll on young children, and one in six children under age six live in poverty.
- Research documents the many negative consequences for children who grow up in poverty (poor health, poor school performance, and more social and behavioral problems).
- Teachers often have lower achievement expectations for lower-income children.
- Child abuse is a serious social hazard for young children. Child neglect can include abandonment, inadequate supervision, or severe lack of resources. Several factors contribute to child abuse and neglect, including family stress, child and family characteristics, parent problems, and violence in the home. Past abuse of parents and substance abuse are consistent factors for predicting child abuse. Environmental factors such as poverty, unemployment, and community violence are also crucial.
- Children under the age of three have the highest rate of abuse.
- Social workers are mandatory reporters and have legal and ethical obligations in reporting child abuse and should be aware of state laws that govern their actions.
- The consequences of child abuse and neglect include neurological deficits and psychological effects such as bedwetting, social withdrawal, and self-destructive behavior.

Exhibit 5.23 Developmental Considerations for Assessment in Early Childhood

Routine Observations	Development Issues (Not Problems)
Gross- and fine-motor skills	"Stuttering"
Toileting	Occasional soiling or wetting
Speech	Messy play
Use of mental symbols	Won't put things away
Peer relationships and siblings	Stubbornness
Play preferences	Aggressive and possessive play
Nursery school	Refuses new foods
Limits, discipline, and daily routine	Immature behavior when ill or sick
Dreams and night terrors, fears	Asserts independence and fusses
Interest and skill development	Occasional temper tantrums
	Unreasonable fears (short-lived)
Strengths and Landmarks of Development	**Developmental Observations Requiring Attention**
Bedtime ritual (transitional objects early on)	Persistent soiling and wetting
Two- and three-word speed (two years old), creative use of speech (three to four years old)	Persistent eating problems
Successful toilet training (two to three years old)	Disturbed sleep patterns
Accepts limits (two to three years old)	Nonspeaking (beyond 18 months)
Development of special skills/talents (e.g., music, dance, and manipulative skills)	Inappropriate play behavior
Self-talk to guide behavior	Excessive body rocking, finger sucking, and tics
Some leadership capacity in groups (three to four years old)	

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Applying the Framework

Developmental Delay in a Four-Year-Old

Developmental History

Missy, a four-year-old White girl, was referred to the Speech and Language Center by her pediatrician. Missy's mother, Mrs. Jones, stated that she was not concerned about Missy until her relatives started commenting on her speech. She reported they would say things like, "Well, she'll probably be talking in whole paragraphs once she gets going." Other than this small problem, Mrs. Jones stated that Missy had been "pretty much average, just like my first daughter" in development. She reports no pregnancy or birth complications that she can remember. She added that she has not found her daughter to be a problem and that they get along well and "understand each other just fine."

Biophysical Considerations

Missy is rather small for her age, appearing thin and tired. She has some trouble with gross-motor coordination and cannot skip or throw a ball yet. Her fine-motor coordination appears to be normal, although she is hesitant to initiate tasks and slow to complete them. At the preschool teachers' request, Mrs. Jones had Missy's hearing tested a year ago. The examination concluded that Missy's hearing was within normal limits.

Psychological Considerations

Information Processing

Missy exhibits difficulties with information-processing tasks. Specifically, she is inattentive at times, staring out into space rather than paying attention to the task at hand. She appears easily distracted during conversation, but she plays the same games for hours on end at home, according to her mother. Her memory is poor in testing; however, her mother says she can replay events over and over days after they happened. Mrs. Jones related that Missy attended preschool last year for a brief time, but she removed her because the school "wasn't right for her." When asked to elaborate on this, Mrs. Jones added that there was not enough structure in the school program, and Missy would just play imaginary games by herself all day. The teachers asked Mrs. Jones about hearing and speech difficulties. Mrs. Jones followed up with her pediatrician and had Missy's hearing tested.

The Wechsler Preschool and Primary Scale of Intelligence was administered to Missy, and she achieved a full-scale IQ score of 92, placing her in the average range. Her performance IQ score was 97 and her verbal score was 80. Assessment of Missy's intellectual functioning revealed that her scores for expressive language development were below her overall intellectual functioning scores. Also, her scores on tests of her ability to understand language were in the normal range, significantly above her expressive language scores. Furthermore, her performance on the visual-motor tasks showed slight impairment.

Communication

Missy speaks when spoken to, hardly ever initiating communication. During the interview, her speech was slow and quiet. Her mother reports that she responds to questions at home but does not carry on lengthy conversations. Her mother added that Missy's older sister often completes sentences for her. Testing revealed that Missy's vocabulary was limited for her age. In addition, she used the wrong tense in her responses to questions. Missy tended to hesitate when speaking, as if waiting for someone to help her. She nodded her head or gestured whenever possible.

Attitudes, Emotions, and Regulation

Missy's mother reports that Missy is a compliant child who usually does what she is told and does not argue or "sass back." Missy's demeanor is quiet, but she can become quite animated and insistent when playing with her dolls. Missy rarely cries or calls attention to herself in the family, Mrs. Jones recalls. To her, Missy looks content most of the time and is never demanding of attention. Her mother completed the Child Behavior Checklist (Achenbach & Edelbrock, 1983), and Missy's scores were in the normal range, with no elevations. However, her scores for internalizing behaviors were significantly higher than her externalizing behavior score.

When asked, Missy reports that she feels "fine." She states that she rarely has upsets but admits to feeling sad much of the time, except when playing with her dolls. When asked if she cries very often, Missy says that she does not. She plays with her dolls or goes to the neighbor's house when she feels sad. When asked about her favorite activities, she listed playing with dolls and playing with the family dog alone outside in the backyard.

Missy agreed to draw a picture of herself for formal assessment. She did so hesitantly and slowly. Her picture was developmentally appropriate, although very small and in one corner.

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Mrs. Jones reports that Missy has one friend in the neighborhood. Together, they play dolls. Usually, Missy visits the friend's house and brings her dolls along. She is quite willing to share as long as her game is being played. Missy does not often play with her sister or her brother, but instead plays alongside them. Mrs. Jones noted that her oldest daughter spends a lot of time at her aunt's house next door. Mrs. Jones commented that Missy usually talks "baby talk" when playing dolls, and her older sister complains about this when they do play together. Missy's older sister is often rude to Missy, too, according to her mother. She calls her names and teases her.

Missy relates that she likes her older sister but also likes it when she is away from home at her aunt's house, stating she doesn't have to "worry so much." Missy never argues with her sister. Neither Missy nor Missy's mother report any incidences of verbal or physical aggression instigated by Missy. Her friend does not seek out her company but will usually play when asked. Missy often tries to convince the friend to play dolls when the friend wants to play another game instead.

In terms of Missy's self-care skills, she generally has no difficulties. She feeds herself, brushes her teeth, and dresses herself but does not fasten her own buttons. She sometimes has difficulty choosing clothing to wear and will wait until her mother comes into her room to ask for help. Mrs. Jones states that Missy goes to bed easily but often lies in bed for over an hour before falling asleep. Missy denies nightmares or fears associated with sleep. She admits to worrying about her family and says she "sometimes just waits and listens." She says she likes to have her dog sleep in her room with her at night. Mrs. Jones reports that Missy is not a big eater but will usually nibble at whatever she is served. Missy states her appetite is adequate but that she doesn't feel like eating very often.

Social Considerations

Family Situation

Missy lives with her mother, father, older sister, and younger brother in a small house owned by her father's sister. Mrs. Jones reluctantly admitted that her marriage is not perfect. She stated that she and her husband argue frequently about money, his help in the family, and the children. She added that he blamed her for the children's problems because she "partied too much and did too many drugs in high school." Neither she nor her husband finished high school, and both are currently unemployed. Mrs. Jones reported that her husband does not spend much time with the children, even though he is home most of the day. He yells at them when they are too loud, but he has never struck the children. She described the home as usually quiet, without anybody talking to the others unless something is wrong. Mrs. Jones stated that she has thought about leaving her husband but has nowhere else to go. Mrs. Jones added that she often feels trapped in the house; her husband will not let her go out without him very often, except to take the children to their appointments. Mrs. Jones conceded she spends little time playing with her children because most of her time is spent performing household duties, childcare, and taking her children to their appointments.

Missy stated that she was closer to her mother but was afraid her father would be angry if he knew. In vague terms, Missy admitted to worrying about what will happen to her family. She says she likes to play at the neighbor's house and was happy going to school. Missy states that she plays dolls most of the time and stays in her room when home. She is not allowed outside to play very often, even though she lives near a school.

Groups, Communities, and Support Systems

Missy's family interacts primarily with social welfare institutions. Her family receives assistance in the form of temporary aid for needy families and food stamps. Her mother goes with the children to the appointments because her father will not attend, or will not babysit the children when she is out.

Multicultural, Gender, and Spiritual Considerations

Missy lives in a fairly homogeneous neighborhood and rarely has contact with people of a different ethnic background. Her family does not participate in community events, and the preschool she attended briefly was also primarily White.

As for her gender development, Missy plays with stereotypical girl toys when she has the opportunity. She identifies herself as a girl and drew long hair and a bow on herself in her figure drawing.

Summary and Impressions

Missy has several problems that became evident during the assessment.

1. Expressive language disorder—mild (American Psychiatric Association, 1994)
2. Poor peer relations and lack of social skills
3. Excessive worries interfering with sleep and appetite
4. Possible childhood depression
5. Inadequate self-system
6. Possible problems with coordination

Continued

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Developmental Delay in a Four-Year-Old (continued)

Additional difficulties include the following:

1. Poor family communication
2. Inadequate social and peer opportunities
3. Marital conflict and possible abusive behavior directed toward her mother by her father
4. Inadequate gross-motor play opportunities

Missy was cooperative with the social worker. However, her limited verbal skills, including poor vocabulary, inaccurate sentence structure and grammar, and reluctance to engage in conversation, made information-gathering a difficult task. There is also some concern about Mrs. Jones's ability to attend to Missy's physical and emotional needs. Furthermore, the Jones family does not appear capable of providing a sufficiently interactive and stimulating environment to promote healthy growth and remedy Missy's language delays.

On a positive note, Missy possesses adaptive skills, in the sense that she can adjust her behavior to minimize the damage her environment imposes on her. She is quiet and does not make demands on a family already stressed by unemployment and marital conflict. In addition, she and her mother appear to have a close relationship compared with other family members. She also has a friend with whom she enjoys spending time and with whom her feelings are reciprocated to some degree. Last, she would most likely develop more friendships and improve her motor skills if given the opportunity.

Four Ps' Formulation for Integration of the Data

Practice Exercise:

Fill in each of the four Ps for the case that is applying the biopsychosocial framework for this chapter.

Use the results of the four Ps' formulation to:

1. Identify relevant problems, diagnoses, or other relevant judgments about the case described in the Applying the Framework section of the chapter.
2. Describe an appropriate biopsychosocial intervention based on the findings in your four Ps' formulation of the case.
3. Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial integrative data that you identified in your formulation of the four Ps.
4. Describe how you would evaluate your invention based on the data captured in your four Ps' assessment.

	Biological	**Psychological**	**Social**
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

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Reviewing Your Competencies

You should be able to:

1. Describe the key developmental themes present in early childhood.
2. Understand the key aspects of biophysical growth and development (nutrition and gross- and fine-motor skills).
3. Describe the key themes in the psychological dimension for early childhood (autonomy, Piaget's preoperational stage, memory, social and emotional functions of preschool, responses to environmental/historical events, aggression/violence, emotional intelligence, language development, empathy).
4. Describe the key themes in the social dimension for early childhood (parenting styles, peer relationships, early intervention programs such as Project Head Start, diverse families, media use).

Key Terms

adaptive memory upgrading
aggression
altruism
androgyny
asthma
attention-deficit/hyperactivity disorder (ADHD)
autism
avoidant disorder
child abuse
developmental waves
egocentrism
empathy
encopresis
enuresis
expressive language disorder
information processing
night terrors
overanxious disorder
physical development
posttraumatic stress disorder
preoperational thought
resiliency
separation anxiety disorder
social capital

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Chapter 6

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Middle Childhood

Learning Objectives

1. Describe the key developmental themes present in middle childhood.
2. Understand the key aspects of biophysical growth and development (motor skills, physical activity).
3. Describe the key themes in the psychological dimension for early childhood (industry, Piaget's concrete stage, emotional intelligence, language, social-role taking and interpersonal awareness, Child Behavior Checklist, internalizing and externalizing problems).
4. Describe the key themes in the social dimension for early childhood (peer relationships, parent training methods, effective schools including Public Law 94-142, sex role identification, divorce).

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Developmental Themes	Key Concepts
	■ Child culture: games. Stage: industry versus inferiority. Development of physical and cognitive skills. Greater interaction with peers; increased capacity to learn from others.
Biophysical Dimension	
Biophysical Growth and Development	■ Slow, consistent growth until prepubertal years. Motor development: sports, sit-down games, concentration. Sex differences: boys develop more gross-motor skills, girls develop more fine-motor skills. Importance of exercise; decrease in physical activity.
Biophysical Strengths, Hazards, and Risks	■ Development in cognitive and physical capacities. Movement skills assist with peer interactions and positive emotional health. Poverty and nutrition.
Psychological Dimension	
Cognitive Development and Information Processing	■ Concrete reasoning: conservation; mental reversal of operations. Information processing. Emotional intelligence. Childhood competency to testify.
Communication	■ More correct and complex language, development of abstract connotations, reading and writing abilities refined. Speech disorders. Bilingual children.
Attitudes, Emotions, and Regulation	■ Emotional competence: experiencing emotions, expressing emotions, understanding emotions. Social role-taking. Moral development. Interpersonal awareness, friendship-making skills.
Psychological Strengths, Hazards, and Risks	■ Self-worth. Self-concepts become more individuated. Erikson's theory and industriousness. Externalizing and internalizing problems. Achenbach Child Behavior Checklist. ADHD; medication.
Social Dimension	
Groups and Families	■ Peer groups: group formation, power of peers in psychological development.
	■ Teaching skills for friendship making. Drug-abuse prevention. Family strength. Parental discipline: power assertion, love withdrawal, induction. Parent-training models.
Communities and Support Systems	■ School influences. Good schools. Impact of self-expectations. Enhancing school-community relationships. Public Law 94-142.
Multicultural, Gender, and Spiritual Considerations	■ Individual racial and gender identification develop and broaden; continued development of ethnic and gender roles. Rites of passage for African American youth.
Social Strengths, Hazards, and Risks	■ Neighborhoods and communities. Violence. Bullying. Marital conflict and divorce.

Developmental Themes

"It feels like it's actually happening"

"Cos you can pretend that you are flying or something"

"Sometimes you're playing a game and it's so good and then you have to stop. It's like you're having a dream and like, someone comes into your room and they wake you up and a perfect dream's ended. Sometimes you forget you're playing and you forget your life and you just say this is my life."

—Howard, Miles, Rees-Davies, & Bertenshaw (2017).

This excerpt from middle school children in the United Kingdom exemplifies the prominent role of games and

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play in middle childhood. These children described the emotional intensity of play (for example, made them feel like "screaming" or "singing") as well as a magical ability to move between lands of reality and make-believe.

As children move from early childhood to middle childhood, their capacity to play games unfolds. Their focus is on developing rules, ensuring fairness, and creating sanctions for rule breakers. Children at this age can be in charge of the rules—in fact, they can create their own new rules. Piaget learned a great deal from children's games, referring to them as "the most admirable social institutions." The philosopher Rousseau said that the work of children is play, and they learn and grow from it. Children place a great deal of emotional attachment to play—excitement and elation during play, and a host of negative emotions when they are unable to play (Howard et al., 2017). Play is particularly critical in the middle childhood years. The type of play varies, with outdoor and traditional games being rated as highly to children as playing with electronic devices (Howard et al., 2017).

Middle childhood is the stage in life that begins at age six and ends at age 12 (or at the onset of puberty, when adolescence begins). Children at this stage are ending their preschool years and beginning to learn new skills and competencies. This stage was often referred to by Erikson as one of industry (which means "to build") versus inferiority. Children in this stage develop competence in intellectual, social, and physical skills. Children who fail to gain this sense of competence may develop feelings of inferiority.

Many of the skills most important to children at this age are indicated by their daily pursuit of games, sports, reading, writing, and other school-related activities. This is a critical time for the development of coordination, physical strength, and flexibility. During this stage, children continue to make impressive cognitive gains in their intellectual functioning. As they move closer to adolescence, they develop some sophisticated logic and problem-solving abilities. The development of role-taking abilities becomes important as children's interactions with peers become more important. Successful adaptation to friendships and peer groups is a major developmental task for this age group. Much of this adaptation is played out in the school system because this is where the child now spends half of their waking hours. Successful adaptation can be complicated by psychological problems associated with learning or communication, or by social problems such as peer difficulties, family disruption, or school closures.

Study Table Developmental Themes in Middle Childhood

Developmental Themes	■ Middle childhood, ages 6 to 12, is characterized by a child culture characterized by rules, reciprocity, and fairness. ■ Erikson described middle childhood as industry vs. inferiority. ■ As children make the transition from early to middle childhood, their capacity to play games unfolds. Their focus is on developing rules, ensuring fairness, and creating sanctions for rule breaking. Successful adaptation to friendships and peer groups is a major developmental task for this age group.

Biophysical Dimension

Biophysical Growth and Development

Throughout middle childhood, children experience a slow but consistent growth pattern. This slow growth is sandwiched between the rapid growth of early childhood and the growth spurt of the prepubertal years (10–13 years old for girls, 12 to 16 years old for boys). For instance, during the early and middle childhood years, children grow an average of two to three inches per year. By age 14, boys exceed girls in weight and height, and they continue to do so throughout adulthood.

In middle childhood, fat tissue develops more quickly than muscle tissue, although through middle childhood there is actually a decrease in the growth of fatty tissue and an increase in muscle development. Girls retain the fat tissue longer and become rounder and softer, and boys develop muscle tissue more quickly. Girls weigh less than boys until about age 11, when they have a growth spurt and end up weighing three pounds more than boys within the span of only one year.

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Motor and Physical Development

In middle childhood, development in both the large and small muscles facilitate changes in the child's coordination, agility, and smoothness. Although only one child in a thousand can hit a tennis ball over the net by age four, by age 11 most children can learn to play tennis well (Santrock, 2012). Elementary school children become fascinated with many sports activities, such as climbing, throwing and catching a ball, swimming, skateboarding, and skating. At this age, gross-motor activity is emphasized. Often, school-age children have difficulty controlling their impulses—they jump, run, bicycle, and climb everywhere. Such activity can sometimes lead to unrecognized fatigue that is exhibited in quarrelsome or crying behavior. By seven and eight years of age, children, although still very active, develop more interest in sit-down games because they have an increased attention span and better cognitive abilities. By 8 and 10 years of age, children are involved in activities that require longer and more concentrated attention and effort, such as baseball, gymnastics, or soccer. As children get to the end of middle childhood, they become more interested in peer-related physical activities.

Photo credit Little Windows Photography

Children typically learn to tie their shoes at age six. This boy is nearing the end of middle childhood and has mastered this task, even with cold fingers. Tying shoes requires strong fine-motor skills of finger isolation, dexterity, visual perceptual skills, bilateral coordination, and hand strength. Children have been learning to tie shoes at later ages because there are many alternatives to laces, such as Velcro, curly laces, lock laces, and dial sneakers. Different-colored pipe cleaners can help with learning the sequence and motor movement, without the added difficulty of keeping them in place.

During middle childhood, boys' gross-motor development exceeds that of girls. However, girls are better than boys at fine-motor skills. Boys' greater gross-motor development may partially explain why they are more interested in physical activity than girls (Kohl & Cook, 2013).

Child developmentalists often repeat the well-worn statement that children are not miniature adults, although they become increasingly adult-like. Many of the child's physical elements are not completely developed. The child's optic nerve is not fully developed, and the child therefore cannot see as well as an adult. The child's bone growth and muscular development are far from complete. It is important to understand the child developmentally, because otherwise we may expect certain behaviors at an age at which the child is not physically or intellectually prepared to perform them. The result is likely to be discouragement on the part of the child. **Readiness** is an important concept in human development. For example, if we give a child special reading lessons at the age of four, they learn over the course of one or two years, whereas the average six-year-old will learn to read in a matter of weeks.

Physical Development

Children's physical development has received increased attention in recent years, particularly because many children are not getting the exercise they need.

Although video games may help hand-eye coordination, in the United States, children are gaining weight and becoming increasingly sedentary. Moderate-to-vigorous physical activity is dropping off significantly during childhood and adolescence (Farooq et al., 2019). A systematic review and meta-analysis of longitudinal studies indicate the most notable decline is at age nine for both boys and girls, but the decline is greater for girls (–7.8 vs. –10.2%). Why is there such a marked decline in physical activity? Psychologists speculate that many children are leaving sports teams as athletics become more competitive, academic demands take over, and parents stop signing them up for sports classes and camps. Others cite children's fixation on video games and television. Many blame children's lack of knowledge about

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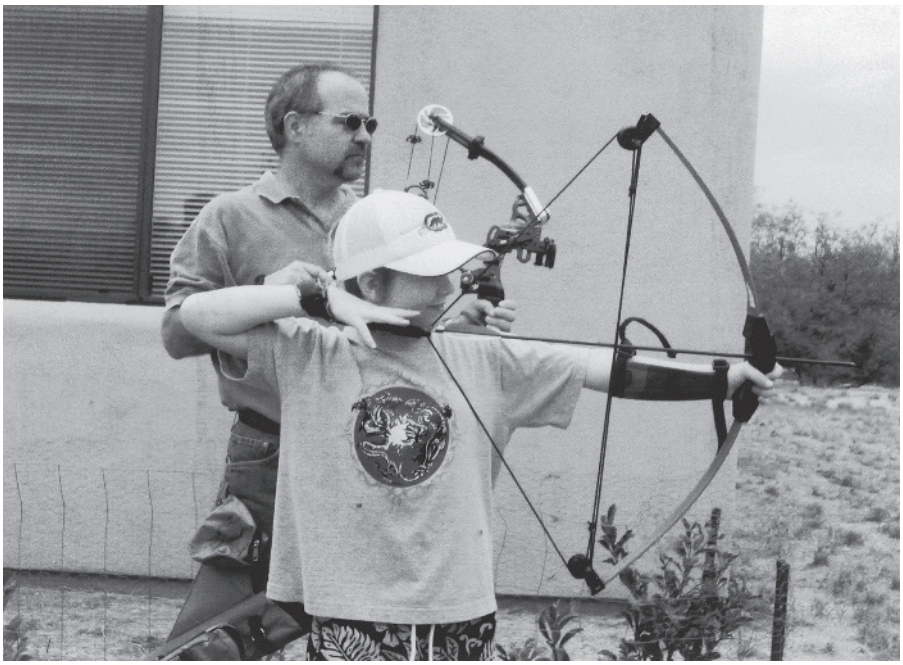

In middle childhood, children become more coordinated and have increased attention spans and abilities that promote the development of specialized skills.

exercise's benefits and the failure of parents and physical education (PE) teachers to instill in children a lifelong exercise ethic.

For example, if you observe a PE class, you may see most of the class standing around waiting their turn while one or two children practice a skill. In one study, researchers found that elementary students spent only 11.9 minutes of moderate to vigorous physical activity (Nader, 2003). The standard set by the U.S. Department of Health and Human Services (HHS, 2018) is that school-age children should be doing bouts of moderate- and vigorous-intensity physical activity that add up to 60 minutes or more each day. However, only one-third of children in the United States are meeting these guidelines. Before the COVID-19 pandemic, children spent an average of seven and a half hours in front of screens daily; school closures and movement to online learning has only exacerbated screen usage. Exhibit 6.1 presents a description of guidelines for types of physical activity; however, the critical factor is the total amount of physical activity for achieving health benefits, rather than any one component or a specific mix of activities (aerobic, muscle strengthening, bone strengthening).

The old-fashioned notion of PE where students work to "get in good physical shape" has been superseded by games and activities that may not accomplish the same goals. At the same time, there is evidence that children exposed to school-based physical activity programs are three times more likely to engage in moderate to vigorous physical activity during the school week than those who do not have access to school-based activities (Dobbins et al., 2013). While PE might not be a perfect solution, it seems that for many children, this time is may be their only opportunity for moderate to vigorous activity. Research also indicates that elements of a child's neighborhood are associated with higher or lower levels of physical activity (Carroll-Scott et al., 2013). For example, strong social ties in the community are positively associated with more frequent activity across socioeconomic lines. In the same study, it was found that access to safe parks and playgrounds were also associated with higher activity levels; however, these amenities are generally less available for lower-income children.

Because kids do not recognize the health benefits as adults do, adults must be creative. For example, exercising with a friend, making up stories while running, or seeing who can spot the bluest cars while bicycling may entice children into getting outdoors. Additionally, PE programs should view physical fitness as a primary goal, as well as

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Exhibit 6.1 Guidelines for Physical Activity in Middle Childhood Include at Least 60 Minutes of Moderate-to-Vigorous Intensity Physical Activity Each Day

Aerobic activity	Activities that increase your heart beat, such as walking or running	Bike riding, riding a scooter without a motor, swimming, playing catch, martial arts, soccer, jumping rope, or vigorous dancing MidoSemsem/Shutterstock.com
Muscle strengthening	Activities such as climbing or doing push-ups	Tug of war, rope or tree climbing, climbing on playground equipment, yoga SergiyN/Shutterstock.com
Bone strengthening	Activities such as jumping or running	Hopping, skipping, sports that involve rapidly changing direction or jumping glenda/Shutterstock.com

teaching them games of physical activity, self-discipline, and goal setting. The bottom line is this: If you do not train them while they are young, they will not exercise when they are adults.

Practice Guidelines:

Encouraging Physical Development

- Both families and schools play a pivotal role in helping to encourage healthy behaviors in children. Social workers can help support efforts in both of these settings in a variety of ways:
- In family practice, motivational interviewing has emerged as a promising strategy to support healthy habits and prevent childhood obesity (Borrelli, Tooley, & Scott-Sheldon, 2015). Families have many competing stressors for their energy, resources, and time. Social workers can assist in helping to align a family's motivation for change with their values and capacities using motivational interviewing techniques.
- In school settings, social workers can help encourage school administration to hold to best practices suggested by the Department of Health and Human Services (2012) such as enhancing PE classes to include more physical activity, health education, classroom physical activities, enhanced recess, social marketing campaigns, before- and after-school programs, active transportation to school, parent and family involvement, and physical environment enhancements.
- Advocate for schools to prioritize physical activity. Participating in physical activity has an immediate positive impact on brain development and school performance.

Biophysical Strengths, Hazards, and Risks

Middle childhood is a period of major cognitive and physical development. A child who develops cognitively will begin to show advanced reasoning, increased vocabulary, and interest in reading. All of these developments lay a pathway to positive growth. On the other hand, major advances in motor skill development and physical activity can be hampered under extreme conditions of poor living.

Movement Skills

An important biophysical strength in middle childhood is the opportunity for children to develop their movement skills. Like other skills, movement skills need to be learned and practiced for the child to obtain maximum

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Study Table Biophysical Dimension in Middle Childhood

Biophysical Growth and Development

- In middle childhood, boys and girls exhibit a slow but consistent growth pattern.
- Girls retain their fat tissue longer than boys do; boys develop muscle tissue more quickly.
- Continued development in the large and small muscles enhances the child's coordination, agility, and smoothness.
- Sports become popular as boys and girls enjoy climbing, throwing, swimming, and skating. Boys have greater gross-motor development, and girls are better than boys at fine-motor skills.

Biophysical Strengths, Hazards, and Risks

- Middle childhood is a time when children experience major development in both cognitive and physical capacities. Development shows interest in more complex games with rules.
- Movement skills contribute to a child's peer interactions and emotional development. Environmental conditions can affect the child's health and development.
- Poverty and lack of food can be very damaging.
- Physical activity drops off significantly during childhood, peaking at age nine, a risk factor for obesity.

benefit, and developmental theory proposes "critical periods" when movement learning can have its greatest impact on various aspects of a child's development. For example, the refinement of fine-motor skills can play an important role in biopsychosocial development because a 7- to 10-year-old child is often asked to join in some type of physical play. With good motor skills, the child can maximize these opportunities. More broadly speaking, movement skills can influence the extent to which a child participates in culture. Having "movement competence" contributes to the positive emotional development of children.

Most children demonstrate a strong innate capability to grow in an orderly, healthy sequence. However, both the rate and pattern of growth can be altered by adversity. When the environment does not meet the child's fundamental needs, growth can be affected. Nutrition, amount of rest and sleep, opportunities to learn, amount of affection, and extent of security—these and other factors can determine how fast and to what degree a child develops.

In America, food insecurity is a critical social problem. Government supports such as the child tax credit and the Supplemental Nutrition Assistance Program benefits were helpful in reducing food insecurity from 38 million (in 2020) to 34 million (in 2021), although a 11.4% increase in food costs means that food insecurity will continue to be a global issue. If we take a worldwide perspective, it is easy to discover that children suffering from poverty and lack of food are unable to achieve healthy development. Also, conditions that exist during times of war or global pandemics, such as lack of food, constant fear, and loss of or separation from parents, can lead to permanent physical damage. Although human development is marked by great resilience, some environmental conditions will produce marked changes in growth.

Psychological Dimension

Cognitive Development and Information Processing

Middle childhood is an exciting period of study in terms of cognitive development. Piaget classified children in this age group as operating from concrete operational thought. He described the concrete operational stage as a series of operations or mental actions that are reversible. Such an operation is characterized by rules of logic. This stage is referred to as concrete because the child's thinking is limited to real objects. A child at this stage cannot use the logic of formal operations to compare the ideal with the actual or to think hypothetically.

The best way to understand these concepts is through the mind of Piaget himself. Piaget was a frequent observer of children and he devised many ingenious experiments or tasks to test his ideas. His task of conservation is one of the most famous and is a hallmark of the concrete-operations stage.

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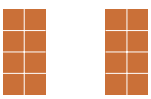
Conservation has to do with the quantitative aspects of objects or things that do not change unless something has been added to or subtracted from the object (although other changes may lead to perceptual differences). Exhibit 6.2 shows tasks that can be used to measure conservation of number, mass, length, and area. Let's look at an example of conservation of mass. Suppose we give a child two equal balls of clay, and then take one ball and roll it out into a long, narrow shape. The child is asked whether the snakelike object contains the same amount of clay as the original ball of clay. A child who is five or six years old will say that the long, narrow piece contains more clay. However, a child who is seven or eight years old is likely to reason that, although one ball of clay was rolled into a snakelike shape, it could be reformed into a ball, and it would still contain the same amount of clay. This task also shows that the child can use the operation of **reversibility**. Rather than focusing exclusively on the physical characteristics of the objects, the child is able to coordinate information about both shapes of the clay, demonstrating concrete operational thinking (thought processes governed by rules of logic).

Although Piaget's influence on, and contribution to, understanding cognitive development is unmistakable, there are some important new developments in the field. In particular, Piaget argued that children's cognitive

Exhibit 6.2 Tests of Conservation

	Typical tasks used to measure conservation	Typical age of mastery
	Conservation of number Two equivalent rows of objects are shown to the child, who agrees that they have the same number of objects.	6–7
	One row is lengthened, and the child is asked whether one row has more objects.	
	Conservation of mass The child acknowledges that two clay balls have equal amounts of clay.	7–8
	The experimenter changes the shape of one of the balls and asks the child whether they still contain equal amounts of clay.	
	Conservation of length The child agrees that two sticks aligned with each other are the same length.	7–8
	After moving one stick to the left or right, the experimenter asks the child whether the sticks are of equal length.	
	**Conservation of area** Two identical sheets of cardboard have wooden blocks placed on them in identical positions; the child confirms that the same amount of space is left on each piece of cardboard.	7–8
	The experimenter scatters the blocks on one piece of cardboard and again asks the child whether the two pieces have the same amount of unoccupied space.	

Source: Weiten (2003). Psychology: Themes and variations (6th ed.). Belmont, CA: Wadsworth/Thomson International.

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development proceeded according to a predetermined sequence of stages. However, recent research has discovered that there is tremendous individual variation in the performance of children of the same age and supposedly the same stage. In addition, changing the instructions for the task—even slightly—can throw off the results considerably. Consequently, many of the researchers who continue in the Piagetian tradition now refer to "levels," which are considered less-specific developmental milestones than "stages."

Intelligence

What's more important, cognitive intelligence (IQ) or **emotional intelligence** (EQ)? Cognitive intelligence includes your ability to reason, use short- and long-term memory, process visual and spatial information, and your overall knowledge of the world. However, standard measures of intelligence (i.e., IQ scores) are narrow, culturally biased, and lack a full range of human intelligence. On the other hand, EQ refers to your ability to identify emotions, control your emotions, perceive and evaluate how others feel, relate to others, and use emotions to communicate socially. Historically, IQ was viewed as the determinate for success in life, and it is still recognized as an important element; people with high IQs typically do well in school, earn more money, and have better health outcomes (Richardson & Norgate, 2015). But now, many organizations are mandating emotional intelligence training and are using EQ tests as part of the hiring process. EQ has been shown to be an important quality for leaders and managers (Srivastava, 2013). In fact, higher EQ in middle childhood is associated with greater school achievement (Marti, Caballero, & Sellabona, 2022). But how do we measure EQ? It seems that the ability to delay gratification is a master skill, a triumph of the reasoning brain over the impulsive one. In short, it is a sign of EQ (Goldman, 2006; Gottman, 1998).

Do you believe that a scientist can see the future by watching four-year-olds interact with a marshmallow? The researcher invites the children one by one into a plain room and begins a gentle torment. "You can have this marshmallow now," he says, "But, if you wait while I run an errand, you can have two marshmallows when I get back," and then he leaves.

Some children grab for the treat as soon as the researcher walks out of the door. Some last a few minutes before they give in. But others are determined to wait. They cover their eyes; they put their heads down; they sing to themselves; they try to play games or even fall asleep. When the researcher returns, he gives these children their hard-earned marshmallows. And then science waits for them to grow up.

MmeEmil/Getty Images

This boy is waiting to eat this single marshmallow until an adult returns with two more. The ability to delay gratification shows a high level of emotional intelligence.

By the time the children reach high school, something remarkable has happened. A survey of the children's parents and teachers has found that those who as four-year-olds had the strength to hold out for the second marshmallow generally grew up to be better adjusted, more popular, adventurous, confident, and dependable teenagers (Mischel, 2014). The children who gave in to temptation early on were more likely to be lonely, easily frustrated, and stubborn. They buckled under stress and shied away from challenges. And when some of the students in the two groups took the SAT college entrance exam, the kids who had held out longer scored an average of 210 points higher. What does this mean for social work? Nowhere is the discussion of EQ more pressing than in schools, where both the stakes and the opportunities seem greatest. Instead of constant crisis intervention, or declarations of war on drug abuse or teenage pregnancy or violence, perhaps preventive interventions based on EQ should be the focus. Bar-On and Parker (2000) developed one of the first measures of EQ and believed that it can be improved through training and education. Schools, often with the support of school social workers, can implement social-emotional learning (SEL) strategies, which are related to school-level increases in achievement scores, attendance, and fewer disciplinary problems (Mahoney, Durlak, & Weissberg, 2018), indicating that SEL programs

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bolster rather than detract from academic success. These strategies encompass a wide variety of school climate issues such as instruction techniques, discipline policies, and parental engagement efforts. Exhibit 6.3 shows five aspects of social, emotional, and academic learning that can be promoted across three levels: family and community, school policies and practices, and curriculum and instruction.

Middle Childhood Competency to Testify

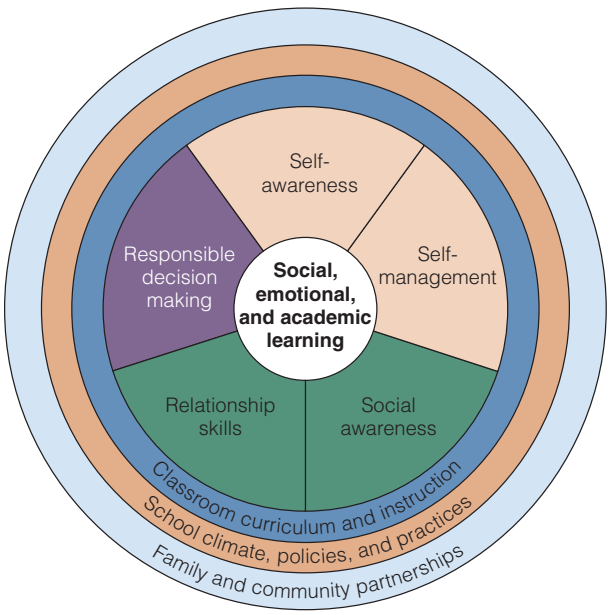
Is a child in the period of middle childhood cognitively competent to testify as a witness? Children are sometimes needed as witnesses to acts of crime and negligence. They are also victims of abuse, crime, or neglect. To testify in these matters, they must be able to truthfully and accurately communicate their personal knowledge of relevant facts. The American Academy of Pediatrics (AAP) released a policy statement in 2017 regarding having a child as a witness that includes testimonial accuracy as well as the psychological impact of testimony, with recommendations to minimize adverse consequences for child witnesses (Pantell and the Committee on Psychological Aspects of Child and Family Health, 2017). Children that are testifying on violence they have experienced or witnessed are at risk of experiencing secondary trauma with long-term consequences without the use of child advocates and other supports.

The validity and reliability of a child's testimony have been challenged on a number of grounds: memory, cognitive development, moral development, and suggestibility (Westcott, Davies, & Bull, 2002). Qualifications for a child to provide testimony include an assessment of competence in the following areas (Pantell et al., 2017):

1. Understanding of the obligation to tell the truth
2. Ability to understand, observe, recall, and communicate events
3. Ability to comprehend the seriousness of an oath

These guidelines cannot be implemented without understanding the key cognitive developmental milestones in childhood.

Exhibit 6.3 Social Emotional Learning (SEL) Strategies Improve Academic Achievement and Increases Prosocial Behaviors Such as Kindness, Sharing, and Empathy



Communication

Middle childhood is the period of linguistic refinement. In early childhood, the focus in language development is on things such as correcting the past tense of irregular verbs. Children's use of language becomes increasingly grammatically correct and more complex than simple yes-or-no questions or general "why" questions. Language develops in deaf children much as it does in hearing children. As children develop, they become increasingly aware that words can have multiple meanings, and they understand the notion of abstract connotations. This ability to "go beyond the information" is referred to as **metalinguistic awareness** (Sigelman & Rider, 2015). As this ability develops, children begin to appreciate the humor in jokes, riddles, and puns. At about age 10, children can begin to understand and use metaphors such as "People who live in glass houses shouldn't throw stones."

Language development is central to healthy development in children. Language is the door to obtaining information from others. It allows you to make requests of other people and makes a wealth of information accessible. Piaget's research led him to conclude that many logical concepts are learned before the development of the language that corresponds to those concepts. For

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In middle childhood, children learn more complex ways of communicating from parents and other adults.

example, a child first learns the concept of "bigger" and then begins to use the language that describes the concept.

We can teach children with communication difficulties better communication skills by having them learn to focus on the differences among the stimuli in their conversations (Varughese, 2011). Also, we can teach children to be better listeners by having them evaluate what they hear and ask questions to clarify statements they don't understand.

Speech and Language Disorders in Children

Speech refers specifically to sounds produced by the oral mechanism (e.g., the lips, tongue, vocal cords) and is the most common way to transmit language. Language is the code or symbol system for transforming ideas, thoughts, or memories into events that can be perceived by other people. Speech disorders and language disorders can occur separately or together. For example, a child may have poor articulation yet intact language skills (a speech disorder) or poor comprehension yet be able to produce speech sounds normally, such as reading words they don't understand (a language disorder). Speech and language disorders affect between 3 and 16% of U.S. children, with 2% falling into a severe category (Committee on the Evaluation of the Supplemental Security Income Disability Program for Children with Speech Disorders and Language Disorders, 2016).

Speech and language can vary substantially depending on the values and expectations of the culture, community, and family. Speech disorders refer to deficits that prevent speech from being produced at or speech that is poorly understood. Language disorders are more often linked to a disability or injury (e.g., autism spectrum disorder, problems in pregnancy, Down syndrome, cerebral palsy, or a brain tumor). The development of a speech disorder can have a negative effect on a child's healthy development. It is not uncommon for children with speech disorders to have difficulties with intellectual and academic achievements, as well as social and emotional difficulties (Forrest et al., 2018). Such children may be teased and as a result have low self-confidence. Family problems can also develop, especially if family members pressure the child (Bernstein & Tiegerman-Farber, 2001).

There is a wide variation in the nature of speech disorders. Some are extremely mild and almost unnoticeable; others can be so serious that they affect day-to-day living. We don't know what causes the majority of speech disorders, but there can be a combination of physiological, psychological, or environmental circumstances. Speech disorders manifest themselves in a variety of forms, including articulatory problems, voice abnormalities, stuttering, and aphasia, the inability to speak. Symptoms of stuttering typically start in early childhood; however, it can happen any time before adolescence. Signs of stuttering in childhood include:

- frequently repeating the sounds at the beginning of the word three or more times (ba-ba-ba-backpack)
- when stuck on a word, replacing the vowel sound with "uh" (buh-buh-buh-buh-backpack)
- dragging out certain sounds (baaaaaaaaackpack)
- speaking quickly
- using long pauses in odd places (back-pause-back)
- showing distress while speaking or having trouble talking when nervous

Speech disorders are more common among children who have hearing impairments, physical impairments (such as cerebral palsy), intellectual disability, and emotional disturbances. Severe speech and language disorders have a large impact on children because of the adverse effects on other areas of development, and that these negative consequences cascade and build on one another over time. They are also an important point of entry to early intervention, as severe speech and language disorders may be one of the earliest detectable symptoms of other serious neurodevelopmental conditions.

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Bilingual Education in the Schools

Language and communication are difficult skills for children to develop, and this development can be even more complicated when two languages are being learned at the same time. **Bilingual** children (those who can speak more than one language) are often spoken to in one language at home and taught another language in school.

Does being bilingual impede a child's language proficiency or negatively influence his or her intellectual development? Although the majority of people in the world speak two languages, bilingualism is not the norm in the United States, and has been assumed to increase the risk of speech and language disorders. However, there is no evidence to support that belief (Committee on the Evaluation of the Supplemental Security Income Disability Program for Children with Speech Disorders and Language Disorders, 2016). Before age three, children can develop good proficiency in two languages (although typically there is some mixing up of both languages for a period). Well-designed research has consistently found that there are advantages to bilingual education. Students learning to be bilingual show no harmful effects and outperform their monolingual peers in language, literacy, communication skills, and cognitive skills (Bialystok, 2018).

The age at which a child acquires a second language impacts their ability to be competent and proficient in both languages: early bilinguals (exposure to two languages before age three) achieve greater mastery than late bilinguals (remaining monolingual until age five or six). When looking at school performance, early bilinguals have similar reading performance as monolinguals in both languages (Kovelman et al., 2008). Late bilinguals have less optimal reading performance but only in their new language. Further, there is evidence that monolingual children benefit from being at a bilingual school. Kovelman found that the English-only speaking children attending bilingual Spanish-English schools showed an advantage in phonological awareness compared to English-only speaking children who attended English-only schools. This is important as phonological awareness is the strongest precursor skills for reading.

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Bilingual education offers advantages to children.

Culture and Language American Dialects

A child's language development can be influenced by both environmental and cultural factors. As discussed in early childhood, living in poverty is associated with restricted vocabularies, however, there are additional considerations that need to be considered when assessing a child's language ability. An important distinction needs to be made between language performance and language competence. Grammatical "correctness" may be a relative or arbitrary issue. Within the United States, there are various recognized English dialects, including African American Vernacular English (AAVE), Cajun Vernacular, Latino Vernacular, Pennsylvania Dutch English, and Yeshiva English (Adger, Wolfram, & Christian, 2014).

AAVE, known as Black English or Ebonics, for example, is spoken in many African American communities. Unique characteristics of AAVE that distinguish it from Standard English include pronunciation, distinctive slang, and the use of different tenses (Turner, Mille, & Montgomery, 2002). The sentence structure of AAVE can be traced to languages spoken in Niger, Condo, as well as some elements of 18th-century British English. This dialect emerged as a result of the transatlantic slave trade and has organized, internally consistent grammatical rules. The Conference on College Composition and Communication released a position statement on Ebonics (revised in 2021) that included the importance of Ebonics as a reflection of the Black experience, traditions, social truths, and as crucial to Black identity.

When a child says, "Me and him ain't goin' to no movie," the child is speaking an imperfect sentence according to the American school system of the larger middle-class society. However, this construction is typical in African American dialects in which the verb "to be" incorporates a tense, referred to as habitual (Turner et al., 2002). The habitual tense expresses an action that occurs frequently or continually. Therefore, "He be playin'" in

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standard English is "He's still playing," "He's always playing," or "He's been playing." "He playin'" means "He is playing currently." Such nonstandard speech is perfectly reasonable when used among members of a culture. Children with this type of language are not necessarily deficient in the ability to learn to speak Standard English; they are merely the product of their environment. An important issue in children's use of African American Vernacular is that some people, such as teachers, are likely to judge a child's pronunciation as "wrong" and arrive at unwarranted conclusions about the person's intelligence or ability. Children can learn to flexibly move between dialects, based on context, similar to bilingual children.

The Lived Experience feature examines the various challenges refugee children must face to succeed in their new American homeland.

Attitudes, Emotions, and Regulation

In middle childhood, emotional development becomes prominent, especially in the context of social interactions. Many parents seek advice because their child does not respect their authority and expresses "inappropriate emotions." Children in this age group often begin to be seen as more irritable, cranky, and easily provoked. They often strike out at those who are blocking their goals. Or, equally common, children become increasingly uncomfortable with their emotions when relating to peers, becoming embarrassed, or wanting to avoid rejection. Whatever may be the context for interaction, emotional regulation is a key task in middle childhood.

Emotional Competence

Emotional competence is generally conceptualized as a group of skills used to respond to an emotion-eliciting environment, which overlaps with, yet is distinct from, EQ, which more like an internal ability or trait used to deal with an emotion eliciting situation. There are three aspects to emotional competence: experiencing emotions, expressing emotions, and understanding emotions (Denham, Salisch, Olthof, Kochanoff, & Caverly, 2002). In this framework, experiencing emotions refers to both the awareness and the recognition of one's own emotions and the effective regulation of one's emotional expression. When a child is selected by a team to be its soccer goalie, how does she deal with this peer endorsement? Does she simply breathe deeply and concentrate on performance prior to each game? These are efforts at emotional regulation that may or may not work. An important aspect of emotional competence is recognizing that one is experiencing an emotion.

The second aspect of emotional competence is expressiveness. Emotionally competent children are able to express their emotions in a manner that is socially appropriate to the situation. First, you have to be aware that an affective message is needed, and then you have to deliver a convincing affective message. Middle school children often struggle with "being a good sport," which is in part delivering an appropriate affective message while being aware of your emotions. In a parenting context, children must learn how to regulate their anger in the face of negative consequences for a rule infraction.

Lastly, understanding emotions is crucial to emotional competence. A child needs to learn how to read other people's emotions by asking "What is the affective message that this person is sending me?" Without knowing the message, the child cannot respond appropriately. Children also begin to understand that people have different emotional styles.

Social Role-Taking

Social **role-taking ability**, or the reduction of egocentric thought, is viewed as a critical aspect of healthy social development. Based on the early work of Piaget (1929), this concept refers to children's inability to decenter the focus of their conceptual efforts. In other words, children without role-taking abilities just can't see things from another person's perspective. Young children cannot empathize with the feelings of other people; this social cognitive capacity develops as the child grows older.

How does a child develop role-taking abilities? This skill matures through exposure to role-taking opportunities that involve an exchange of differing perspectives. Role-taking is related to moral development, which depends on a person's ability to perceive and comprehend the differing perspectives of other people. Role-taking should be considered a parallel stage to moral development; it is a necessary but not sufficient condition for moral reasoning. The next chapter discusses in greater detail aspects of moral development. For now, let's see why an understanding of role-taking

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Focus on **The Lived Experience**

Refugee Children—A New Life

Imagine traveling, sometimes by bus or boat but mostly on foot, hundreds of miles with your family. This isn't just a hiking trip—you are fleeing your home, village, and country, fleeing from "bad people" who want to hurt you and your family. You are seven years old. You are hungry and tired, but there isn't much food, and there is little time to stop for rest. You are fleeing for your lives. How do you feel? What do you think? When you cross the border you must begin a whole new life.

Within the field of child welfare, refugee children have received relatively little attention. These children have made international migrations because of political oppression in their home countries. Approximately 100,000 refugees are admitted into the United States each year—almost 1.3 million since 1982. Many of these refugees are children who may arrive with family members or as unaccompanied minors who are placed with relatives or in foster care. The majority of these refugees have been fleeing from Southeast Asia, the former Soviet Union, Eastern Europe, Cuba, and Haiti after political upheaval in their respective countries.

On resettlement, refugee children face additional hardships in addition to language barriers. First, for children who are with their families, there are often intergenerational problems. Frequently, children adopt the customs of the new country much more quickly than their parents do, resulting in a role reversal whereby children become translators of language and cultural norms for their parents. This frequently leads to a lack of respect for elders, which is at odds with important values in the original culture. Second, problems may develop with child discipline; some types of discipline used in the native culture may be considered child abuse in the United States. A third source of stress is strong expectations for achievement placed on children by their parents. Many older refugees have given up hope for their own achievement but view their children's opportunity to live a better life as redeeming their own suffering.

Another common issue is posttraumatic stress disorder (PTSD). A significant number of refugee children have witnessed death, torture, rape, and/or imprisonment of family members. Disease and starvation are also common. Many refugees leave their homeland in boats and are at sea for long periods without adequate food, water, shelter, or sanitation. Frequently, when they arrive in the United States, they undergo long stays in refugee camps that have poor housing and shortages of clothing and water. All of these factors contribute to PTSD.

In addition to intergenerational conflicts and posttraumatic stress, refugee children experience difficulties with **acculturation** and cultural identity. At home they are expected to behave in accordance with the native culture. At school, they are expected to behave like Americans. They live a dual life with no role models.

Recognizing unique difficulties refugee children face, the United States developed and implemented legislative policies providing services. Between 1945 and 1980, refugee assistance was provided on an ad hoc basis in response to crises in different parts of the world. The Refugee Act of 1980 and the Refugee Education Assistance Act of 1980 established for the first time a set of comprehensive, permanent, and systematic policies for refugee assistance. These policies guide the provision of cash assistance, medical assistance, and social services to refugees. Services specifically for refugee children include special education, English-language training, child welfare, and health care.

Social workers who work with refugees must continue to advocate for additional policy advances for refugee children and their families, including additional policy advances for refugee children and their families, including increased humanitarian treatment. Policies should develop a long-term outlook in recognition that the achievement of refugee economic stability is a very lengthy process. Supportive services for refugee children should be aimed at promoting long-term adaptation, as opposed to short-term "crisis stabilization." School-based programs for refugee children must address the multiple stressors experienced by these populations—specifically, intergenerational conflict, PTSD and acculturation. One way to do this is through support groups that encourage children to share their feelings and experiences and develop healthy coping strategies. Intervention programs must be tailored to each ethnic group. Soviet and Haitian children, for example, have vastly different experiences.

Like all children, refugee children represent an investment in our nation's future. Equitable and effective policies and programs that improve these children's chances for success in adulthood will strengthen the well-being of the nation as a whole.

—Based on Potocky Tripodi, M. (2002). *Best Practices for Social Work with Refugees and Immigrants.* New York: Columbia University Press.

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Exhibit 6.4 Developmental Stages Across Impersonal and Interpersonal Awareness

	Impersonal	Interpersonal	
Stage	**Cognitive**	**Friendship**	**Peer Group**
0	Intuitive preoperational	Momentary physical playmate	Physical connections
1	Transitional preoperational/concrete operational	One-way assistance	Unilateral relations
2	Consolidated concrete operational	Fair-weather cooperation	Bilateral partnerships
3	Transitional concrete/early formal operational	Intimate-mutual sharing	Homogeneous community
4	Consolidated formal operational	Autonomous interdependence	Pluralistic organization

Sources: Adapted by authors from "Interpersonal Awareness in Children" by R. L. Selman, D. Jaquette, and D. Lavin (1977), *American Journal of Orthopsychiatry, 47,* 264–274; *The Growth of Interpersonal Understanding* by R. L. Selman, Academic Press.

has important implications for understanding and working with children.

Role-taking ability begins to change around 12 years of age, when the ability to think about oneself and one's social relations becomes more advanced (Selman et al., 1977). As children grow older, they can begin to infer others' feelings, thoughts, and intentions. Although cognitive abilities begin to expand during this developmental period, it is still characterized by egocentrism, or the inability to assume another person's role or viewpoint.

Role-taking ability is closely related to the development of social skills in children. Role-taking is a prerequisite for the emergence of many social behaviors, such as cooperation and altruism (Chandler, Sokol, & Wainryb, 2000). Understandings about **social cognition** are increasingly being linked with the development of social skills. The connection is between the variety of social behaviors that are strengthened by a child's ability to take the role of another person. One researcher, Robert Selman, has expanded the concept of social role-taking to help explain how children's friendships and peer relationships develop.

Interpersonal Awareness

Robert Selman's work has focused on what he refers to as interpersonal awareness—how the child conceives his or her own interpersonal relationships, particularly friendship and peer-group relationships. Can distinctive ways of reasoning about such relationships be ordered along a developmental continuum? Furthermore, do children who have social and emotional problems reason at a different level compared with better-functioning peers? These are the questions that Selman sought to answer in his research (see Exhibits 6.4 and 6.5).

As Exhibits 6.4 and 6.5 indicate, children reason differently about trust, depending on their level of

Exhibit 6.5 Stages of Friendship Showing Sample Responses

Stage	Friendship	Sample Responses
0	Momentary physical playmate	Alan, age 4, said he trusted his friend, Eric. When asked why, he said, "If I give him my toy, he won't break it . . . he isn't strong enough."
1	One-way assistance	"I trust a friend if he does what I tell him."
2	Fair-weather cooperation	"Trust means if you do something for him, he will do something for you."
3	Intimate-mutual sharing	Trust is "when they can get it off their chest if they talk with you; things that are going on in your life and in the other person's life."
4	Autonomous interdependence	"Trust means that you've got to grow—the more you hold on to, the less you have. You have to have confidence in yourself as a good friend; then you'll have trust in your relationship."

Source: Adapted by authors based on Selman, R. L., Jaquette, D., & Lavin, D. (1977). Interpersonal awareness in children: Toward an integration of developmental and clinical child psychology. *American Journal of Orthopsychiatry, 47,* 264–274.

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interpersonal awareness. The researchers gathered these sample responses by presenting children with different dilemmas and then asking a series of questions, such as "What is trust?" and "Why is it important for friends to trust each other in order to stay friends?" With this kind of interviewing, they established the different stages of interpersonal awareness.

By studying the levels of interpersonal awareness of typical and children with emotional challenges, Selman hopes he can develop a set of therapeutic and educational goals oriented to developing greater maturity of interpersonal awareness. Selman's research suggests that children who have experienced extremely inconsistent or disruptive interpersonal experiences, and who manifest severe difficulties in their interpersonal relations, do not develop through the domain of social reasoning as steadily as do children with more consistent, dependable, and mutual relations with friends or peers. A 15-year-old who defines a friend as "someone who does what I want him to do" is going to have difficulty establishing friendships with adolescents, who generally perceive friendship as cooperation and reciprocal affection. How can we help children develop better ways of reasoning about friendships and peer relations? The key is providing children with role-taking opportunities and encouraging them to think in ways that expand their social reasoning.

Psychological Strength, Hazards, and Risks

One of the most important psychological strengths of middle childhood is the continuing development and refinement of self-esteem or self-worth. In early childhood, conceptions of self were limited primarily to physical qualities—motor skills, sex type, and age. In middle childhood, conceptions of the self expand to include things such as ideal self, ethnic awareness, and conscience development. In addition to gaining an expanded self-concept, children at this age begin to have a more differentiated self-concept—a more individuated view of themselves—and their self-concept becomes increasingly stable.

Self-Concept in Middle Childhood

During middle childhood, children develop more nuanced self-concepts. Not only are they able to evaluate themselves against others (i.e., "I am the fastest person in my class"), but they are able to differentiate their abilities and skill sets. Children who earlier thought of themselves as "not talented" might now recognize that, although they are not very good at sports, they are better than most children at playing a musical instrument. Related to self-concept is "self-efficacy," which refers to a person's belief in their own capabilities to achieve goals. In many studies, improving a child's sense of self-efficacy is associated with actual, measurable behavioral growth (Larsen, McArdle, Robertson, & Dunton, 2015; Walpole et al., 2013; Zuffianò et al., 2013).

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During middle childhood, children begin to have an expanded and more differentiated self-concept.

Improved feelings of self-efficacy are so strongly correlated to improved behavioral outcomes that many interventions and social programs wish to include self-efficacy as an outcome measure; however, self-efficacy, as a concept, is challenging to capture in a single measure. Noted scholar in the area of measuring self-efficacy, Albert Bandura argues that self-efficacy as an outcome measure should be better tailored to the outcome of interest because "one cannot be all things, which would require mastery of every realm of human life" (Bandura, 2006, p. 307). Bandura provides guidance for developing or tailoring self-efficacy instruments to match outcomes of interest as well as validated instrument that provides insight for a child's sense of self-efficacy in the following domains:

- Self-efficacy in enlisting social resources
- Self-efficacy for academic achievement
- Self-efficacy for self-regulated learning
- Self-efficacy for leisure time skills and extracurricular activities

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Self-regulatory self-efficacy

Self-efficacy to meet other's expectations

Social self-efficacy

Self-assertive efficacy

Self-efficacy in enlisting parental and community support

Scales such as these indicate that children can make distinctions about their competencies in different areas. In some cases, this may lead to conditional feelings of self-esteem. A child may have positive self-esteem in the classroom but a poor self-concept on the playground, where sports games are played. Another important consideration comes from research that indicates that children's evaluations of themselves resemble the way other people perceive them (Harter, 1999). For example, in one study, a child whose self-rating was high on social competence was in fact found to have a lot of friends who considered her to be a good friend. In a similar manner, a child's self-evaluation of cognitive competence was related to how teachers evaluated the child's academic achievements. These research results provide continued support for the idea that how other people perceive us has a lot to do with who we are. In this case, the "looking glass" represents how others perceive a child's self-esteem, and, as the looking-glass theory would predict, it accurately reflects the child's own self-esteem.

These findings also lend support to Erik Erikson's notion that the psychosocial crisis that 6- to 12-year-olds confront is industry versus inferiority. At this age, children measure themselves against their peers to establish a sense of who they are. The focus is on personal and social competence, or according to Harter's research (1999, 2012) on cognitive and social competencies. Children work hard to develop their cognitive skills (writing, reading, and arithmetic), as well as their social skills (cooperation, fairness, and receiving approval from others). Erikson's theory predicts that children who develop these skills will successfully master a sense of "industriousness" and be able to move on to the next stage of development, the identity crisis of adolescence. Exhibit 6.6 shows sample items from a widely used measure of children's self-perception (note that there is a revised version of the self-perception profile for learning disabled students, adolescents, emerging adults, college students, adults, and older adults).

As children enter middle childhood, their self-concepts begin to change as a result of their increasing ability to understand how other people view them. The looking-glass theory helps explain how children's self-concepts begin to change in middle childhood: they have a much better ability to look into that glass and see how their behavior can elicit certain reactions from others. Children begin to control their own actions depending on what kind of social self they want to display. A child who has developed a strong self-concept is sometimes described as having self-esteem. At this developmental stage, high self-esteem in a child looks like a child with confidence, a child who is not afraid to fail, and a child who "bounces back" quickly from setbacks and disappointments.

Exhibit 6.6 Sample Items from the Self-Perception Profile for Children in Grades 3–8

Really true	Sort of true				Sort of true	Really true
☐	☐	Some kids find it hard to make friends.	BUT	Other kids find it's pretty easy to make friends.	☐	☐
☐	☐	Some kids feel like they are very good at their school work.	BUT	Other kids worry about whether they can do the school work assigned to them.	☐	☐
☐	☐	Some kids do well at all kinds of sports.	BUT	Other kids don't feel that they are very good when it comes to sports.	☐	☐
☐	☐	Some kids like the kind of person they are.	BUT	Other kids often wish they were someone else.	☐	☐

Source: Reproduced with permission for children in grades 3–8 from S. Harter (2012), A Revision of the *Self-Perception Profile for Children*, University of Denver, 1985. Six subscales of six items each include the following areas: scholastic competence, social competence, athletic competence, physical appearance, behavioral conduct, and global self-worth,

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Practice Guidelines:

Building a Child's Self-Esteem

Many families take their children in to receive therapeutic services because they feel their child has "low self-esteem." Social workers who assist these families may consider the following strategies to understand the problem better and begin to create a service plan:

- Create an open dialogue with the parent, separately from the child, to understand the parent's expectations for their child. In some cases, this conversation can reveal some unrealistic expectations held by the parents. Social workers can provide psychoeducation around developmentally appropriate expectations. Over time, families may need to confront hypercritical interactional patterns that may have developed that can be impacting their child's self-esteem.
- Encourage parents to find ways to demonstrate warmth and support for their child in a way that matches their child's needs. For example, some children may respond well to lots of physical reinforcement in hugs and high-fives, whereas others feel more supported by verbal praise or special one-on-one time.
- Model ways of communicating with the child that uses lots of reflective listening and empathizing cues, as opposed to lecturing.

Psychological risks and hazards do become more pronounced as children reach middle childhood. Most childhood disorders can be classified into one of two categories: **externalizing problems** and **internalizing problems** (Achenbach & Edelbrock, 1983). Externalizing problems consist of behaviors that reflect a tendency to "act out"—for example, aggressive behavior such as fighting, acting defiantly, and hyperactivity. Internalizing problems consist of behaviors that reflect an "inner state," such as anxiety, loneliness, shyness, social withdrawal, and depression. Two of the most common problems of middle childhood are **attention-deficit/hyperactivity disorder (ADHD)**, an externalizing problem, and **depression**, an internalizing problem. Social workers will frequently confront both internalizing and externalizing behaviors in their work with families and children. Screening instruments can help social workers to understand the various dimensions of problematic behaviors.

Internalizing and Externalizing Problems of Childhood

The following section shows how to use the Child Behavior Checklist and the internalizing and externalizing model developed by Achenbach.

The Achenbach Child Behavior Checklist.

An empirical approach to assessment gathers systematic ratings of children from significant others, parents, teachers, and/or practitioners. One well-known approach to empirical assessment is the Child Behavior Checklist developed by Thomas Achenbach. The Checklist is a standardized rating scale that is typically filled out by parents and teachers. It examines behavior across a number of domains or syndromes, such as depressed, obsessive-compulsive, socially withdrawn, and aggressive. The 113 items include statements such as "Can't concentrate, can't pay attention for long," and "Disobedient at home." The parent circles 2 if the item is very true or often true; 1 if the item is somewhat or sometimes true; and 0 if the item is not true (as far as you know).

The checklist is scored on the Child Behavior Profile (see Exhibit 6.7). Each of the syndromes of the profile (e.g., anxious/depressed and aggressive behavior) was developed through extensive research (see Achenbach, McConaughy, & Howell, 1987). To score the profile, the 1s and 2s under the syndrome are summed to obtain a total score. This score is then charted on the profile. For example, on the profile in the Exhibit 6.8, there were several 1s and 2s under the withdrawn syndrome. When these scores are summed, Catherine receives a score of 10, which is entered on the profile and charted. The Child Behavior Checklist is normed, which means one can compare scores against the scores obtained from a normal population of children. For example, the score of 10 on the social withdrawal scale is around the 97th percentile (the dotted line represents the upper boundary of normal). This means that a score of 10 on the social withdrawal scale is higher than the scores obtained by 97% of the 6- to 11-year-old girls in the normative sample.

The behavior profile for Catherine included the following observations: Catherine's mother completed the Child Behavior Checklist during her intake visit to the Child Guidance Clinic. Two of the scales from the Checklist suggest problems: withdrawn/depressed and thought problems. The withdrawn/depressed scale showed scores on all of the items except one. A score of 2 was listed

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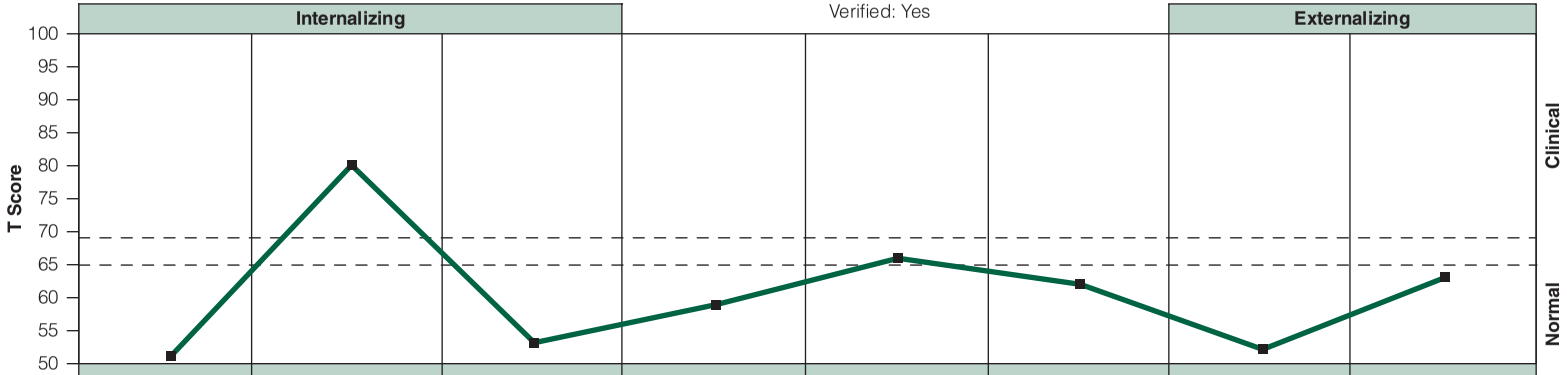
Exhibit 6.7 Revised Child Behavior Check List (CBCL)

CBCL/6-18 - Syndrome Scale Scores for Girls 6-11

ID: 200105-002
Name: Catherine A. Holcomb
Gender: Female
Age: 11
Date Filled: 12/04/2000
Birth Date: 06/16/1989
Clinician: Theresa Lopez
Agency: School
Verified: Yes
Informant: Jane Holcomb
Relationship: Biological Mother



	Anxious/ Depressed	Withdrawn/ Depressed	Somatic Complaints	Social Problems	Thought Problems	Attention Problems	Rule-Breaking Behavior	Aggressive Behavior
Total Score	2	10	1	5	5	7	1	11
T Score	51	80-C	53	59	66-B	62	52	63
Percentile	54	>97	62	81	95	89	58	90
	0 14. Cries	1 5. Enjoys Little	0 47. Nightmares	1 11. Dependent	0 9. Mind Off	1 1. Acts Young	0 2. Alcohol	0 3. Argues
	0 29. Fears	1 42. Prefer Alone	0 49. Constipate	1 12. Lonely	0 18. Harm Self	2 4. Fails To Finish	0 26. No Guilt	0 16. Mean
	0 30. Fear School	1 65. Won't Talk	0 51. Dizzy	0 25. Not Get Along	0 40. Hears Things	1 8. Concentrate	0 28. Breaks Rules	1 19. Dem Atten
	0 31. Fear Do Bad	0 69. Secretive	1 54. Tired	1 27. Jealous	0 46. Twitch	0 10. Sit Still	0 39. Bad Friends	1 20. Destroy Own
	0 32. Perfect	2 75. Shy	0 56a. Aches	0 34. Out To Get	0 58. Picks Skin	0 13. Confused	0 43. Lie Cheat	0 21. Destroy Other
	0 33. Unloved	1 102. Lacks Energy	0 56b. Headache	0 36. Accidents	0 59. Sex PartsP	1 17. Daydream	1 63. Prefer Older	0 22. Disb Home
	0 35. Worthless	2 103. Sad	0 56c. Nausea	0 38. Teased	0 60. Sex PartsM	0 41. Impulsive	0 67. Run Away	0 23. Disb School
	0 45. Nervous	2 111. Withdrawn	0 56d. Eye Prob	0 48. Not Liked	0 66. Repeats Acts	1 61. Poor School	0 72. Sets Fires	0 37. Fights
	0 50. Fearful		0 56e. Skin Prob	1 62. Clumsy	0 70. Sees Things	0 78. Inattentive	0 73. Sex Probs	0 57. Attacks
	0 52. Guilty		0 56f. Stomach	1 64. Prefer Young	2 76. Sleeps Less	1 80. Stares	0 81. Steals Home	0 68. Screams
	1 71. Self Consc		0 56g. Vomit	0 79. Speech Prob	0 83. Stores Up		0 82. Steals Out	2 86. Stubborn
	0 91. Talk Suicide				0 84. Strange Behv		0 90. Swears	2 87. Mood Chang
	1 112. Worries				0 85. Strange Ideas		0 96. Thinks Sex	1 88. Sulks
					1 92. Sleep Walk		0 99. Tobacco	1 89. Suspicious
					2 100. Sleep Problem		0 101. Truant	1 94. Teases
							0 105. Uses Drugs	2 95. Temper
							0 106. Vandalism	0 97. Threaten
								0 104. Loud

Copyright 2001 T.M. Achenbach **B = Borderline clinical range; C = Clinical range** **Broken lines = Borderline clinical range**

Source: From Manual for the child behavior checklist/4-18 and 2000 profile, by T. M. Achenbach. Copyright © 2000 T. M. Achenbach. Reproduced by permission.

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on three items: shy, sad, and withdrawn. The thought problems scale had scores on three items: sees things, sleepwalks, and has sleep problems. These results suggest some serious problems for Catherine, especially in the areas of depression and social withdrawal. The practitioner would want to seek additional information (teacher reports, observations, clinical interviews) to corroborate these results before reaching any conclusions (Achenbach, 1991). Similar caution and thoroughness should be used in assessing for the most common disorder affecting school-age children today, ADHD. The case study in the next section illustrates an approach to diagnosing ADHD.

Attention-Deficit/Hyperactivity Disorder

Carlos was referred to the outpatient mental health clinic by his teacher, who required that Carlos get some help to control his behavior. Carlos, age seven, demanded the attention of almost everyone around him and constantly disturbed the other children in the class. The teacher noted that Carlos could not sit still, concentrate on his work, or complete his tasks. He was always on the move. Even when sitting in his seat, Carlos fidgeted and moved about, which disturbed other students next to him. His mother reported that he was a motor mouth; was unable to stick to any one chore, task, or game; and was often found away from the house where he was not allowed to be. She described several examples of Carlos's poor judgment and weak problem-solving abilities.

Carlos is a typical seven-year-old boy who suffers from ADHD. Carlos has three important characteristics of the disorder: excess motor activity, impulsiveness, and inattention. ADHD is the most common neurobehavioral disorder of childhood (American Academy of Pediatrics, 2022). In fact, it is considered one of the most prevalent chronic health conditions affecting school-age children. ADHD is a serious concern, as in addition to some difficulties with academic and emotional function, it is associated with many psychosocial difficulties in learning, cognition, language, with peers, family problems, mental health disorders, and low self-worth (Rajaprakash & Leppert, 2022). Furthermore, ADHD presents in childhood, but requires management into adolescence and later adulthood. Management largely includes behavioral strategies in early childhood, a combination of behavioral and pharmacologic strategies in middle childhood, and pharmacologic interventions in adolescence. It is estimated that between 7.2% and 15.5% of children have had an ADHD diagnosis (Wolraich et al., Subcommittee on Children and Adolescents with Attention-Deficit/Hyperactive Disorder, 2019). Boys are more than twice as likely as girls to receive an ADHD diagnosis, and girls are more likely than boys to have a comorbid internalizing disorder like anxiety or depression. ADHD is not caused by diet, screen time, parenting, or other social and environmental factors such as poverty, though these factors may exacerbate symptoms of ADHD. Known risk factors include brain injury, prenatal alcohol and tobacco use, low birth weight, prematurity, and genetics.

Although most researchers and clinicians who work with children like Carlos agree that there is a true syndrome or disorder in which you can classify such children, reliable identification of ADHD can be difficult. No one test can diagnose ADHD, and the DSM-5 identifies core symptoms that need to be present, including inattentive (distracted, poor organization), hyperactive impulsive (fidgety, overly active), and functional impairment. Checklists have been developed that can help properly identify children who are likely to suffer from ADHD. Usually parents or teachers are asked to fill out a checklist indicating which behaviors are characteristic of the child. A rating scale is then used in assessing ADHD in children. Many types of rating scales are available. An easy-to-use scale is the SWAN rating scale (Swanson, 2004), which is shown in Exhibit 6.8.

Although rating scales are helpful in diagnosis, multiple sources of information are needed to confirm a diagnosis of ADHD (Felt, 2014).

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ADHD is a common behavior disorder in middle childhood.

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Exhibit 6.8 Assessment Tools: The New SWAN (Swanson) Scale

Name: _____ Gender: _____ Age: _____ Grade: _____
Completed by: _____ Class size: _____ Type of Classroom: _____
Ethnicity (circle one which best applies): African-American Asian Caucasian Hispanic Other
Children differ in their abilities to focus attention, control activity, and inhibit impulses. For each item listed below, how does this child compare to other children of the same age? Please select the best rating based on your observations over the past month.

Compared to other children, how does this child do the following:	Far below avg.	Below avg.	Slightly below avg.	Slightly above avg.	Above avg.	Far above avg.
1. Give close attention to detail and avoid careless mistakes	___	___	___	___	___	___
2. Sustain attention on tasks or play activities	___	___	___	___	___	___
3. Listen when spoken to directly	___	___	___	___	___	___
4. Follow through on instructions and finish schoolwork or chores	___	___	___	___	___	___
5. Organize tasks and activities	___	___	___	___	___	___
6. Engage in tasks that require sustained mental effort	___	___	___	___	___	___
7. Keep track of things necessary for activities	___	___	___	___	___	___
8. Ignore extraneous stimuli	___	___	___	___	___	___
9. Remember daily activities	___	___	___	___	___	___
10. Sit still (control movement of hands and feet or control squirming)	___	___	___	___	___	___
11. Stay seated (when required by class rules or social conventions)	___	___	___	___	___	___
12. Modulate motor activity (inhibit inappropriate running or climbing)	___	___	___	___	___	___
13. Play quietly (keep noise level reasonable)	___	___	___	___	___	___
14. Settle down and rest (control constant activity)	___	___	___	___	___	___
15. Modulate verbal activity (control excess talking)	___	___	___	___	___	___
16. Reflect on questions (control blurting out answers)	___	___	___	___	___	___
17. Await turn (stand in line and take turns)	___	___	___	___	___	___
18. Enter into conversations and games without interrupting or intruding	___	___	___	___	___	___

The 7-point response is scored +3 to −3 (far below avg. = 3, below avg. = 2, slightly below avg. = 1, average = 0, slightly above avg. = −1, above average = −2, and far above average = −3). Subscale scores on the SWAN are calculated by summing the scores on the items in the specific subset (e.g., inattention is items 1–9) and dividing by the number of items (e.g., 9) to express the summary score as the average rating per item.
Source: Swanson (2004). © 1985 by J. M. Swanson, Child Development Center at UC Irvine. Reproduced by permission.

Practice Guidelines:
Assessing ADHD

- When conducting an evaluation of a child for ADHD, consider the following guidelines.
- Determine if the child's symptoms for ADHD occur across contexts and settings.
- Obtain school or community information about symptoms outside of the home by collecting data from an adult such as a teacher or after-school caregiver.
- Examine school performance and assess for learning disorders.
- Review criteria for comorbid conditions (does child's symptoms meet other diagnostic categories?) For example, posttraumatic stress symptoms can resemble ADHD symptoms.
- Conduct child interview to assess impact of symptoms on current functioning and family context.
- Consider referral for physical exam to determine neurological, visual, and hearing screening.
- Use validated ADHD screening from parent, teacher, and self-report.

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ADHD, Medication, and COVID-19

Many people are familiar with the pharmacological treatment of children with ADHD. A high percentage of children diagnosed with ADHD (69% of children ages 6 to 11) take some form of medication (Danielson et al., 2018), typically short- or long-acting amphetamine stimulants (e.g., Adderall, Dexedrine) or methylphenidate stimulants (e.g., Ritalin). In October 2022, the Food and Drug Administration (FDA) posted a notice of a federal shortage of Adderall, reflecting the trend of increasing medication usage. The COVID-19 pandemic was particularly challenging for children with ADHD. Increased social isolation, difficulty managing boredom, and challenges with engaging in online learning all contributed to increased symptom severity (Pollak et al., 2022). After returning to school, children with ADHD found it harder to adapt, including navigating adjusting to a new schedule and needing to use executive functioning skills that they may not have had support for during the period of virtual learning (Abrams, 2022).

Psychostimulants are considered the most effective and safest medication in national guidelines and reviews (Wolraich et al., 2011). The majority of children are helped by medication, which increases the child's ability to sustain attention. A well-known foundational study called the Multimodal Treatment Study of Children with ADHD compared four treatments: medication alone, behavioral treatment alone, combined medication and behavioral treatment, and community care (MTA Cooperative Group, 1999). The study found that across all treatments, behaviors did tend to reduce over time; however, medication management provided the most change in the core symptoms of ADHD. The conclusions of this study paved the way for mass acceptance of medication management alone as a sufficient intervention for childhood ADHD. Critics highlight other findings of the study that demonstrated combined treatment also addressed additional related behaviors for improved global functioning such as oppositional/aggressive symptoms, internalizing symptoms, teacher-rated social skills, parent–child relations, and reading achievement while medication management alone did not.

Although it is clear that medication helps ADHD children in the short term, the long-term benefit of medication has been questioned. In addition, many practitioners are concerned about the side effects of medication on children. Two common reactions to medication for hyperactivity are appetite reduction and sleep disturbance (Smucker & Hedayat, 2001; Hilt et al., 2014). In spite of these problems, medication seems to make children less distractible, and the more self-controlled interactions in school can improve social interactions with peers.

In many instances, medication makes sense for children, but are we overmedicating them? Although the FDA forbids the marketing of antidepressants, such as Prozac, for children, it is hard not to view candy-flavored pills as a move in that direction (Prozac comes in peppermint flavor). Even with the FDA's mandate, physicians have prescribed psychiatric medications to children for a number of "off-label" uses. Much attention has been focused on the profits of the drug industry as a result of sales of stimulant medication being promoted for children (Schwarz, 2013). A recent scoping systematic scoping review of 334 studies indicates that ADHD is overdiagnosed in children and the harms of treating ADHD in children with milder symptoms outweigh the benefits (Kazda et al., 2021; Koplewicz, 2013).

The number of ADHD diagnoses has increased and the treatment of ADHD medication has increased. Potential reasons for this increase include greater diagnoses in children with mild symptoms as well as developmental immaturity being mistaken for symptoms of ADHD. Children are more likely to receive a diagnosis if they are among the youngest in their class. Their behavioral problems may be viewed by teachers as symptoms of ADHD when compared to their peers rather than a less developed skill set. More recent factors at play include the COVID-19 pandemic and the growing influence of social media. The Reddit pager/ADHD has grown from 643,000 subscribers in March 2020 to more than 1.5 million by November 2022. Similarly, on TikTok, videos tagged #ADHD have been viewed more than 11 billion times. The circulation of memes and ADHD comics has led to an increase in awareness of ADHD symptoms; however, these symptoms also look a lot like the struggles of "pandemic brain" (Who didn't have trouble with following through on tasks and multi-tasking?). Many children without ADHD had difficulty with online learning and long periods of social isolation. While ADHD diagnoses have increased, it's important to be aware of the possibility that ADHD may be overdiagnosed in some groups of children while others are misdiagnosed or missed completely. ADHD may be missed more often in girls, people of color, and in children who do well in school and are likeable. What is clear is that children with ADHD have a real neurobehavioral disorder and children with ADHD need treatment. Without understanding the full spectrum of ADHD presentations, children may be held back from becoming their best selves.

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Study Table Psychological Dimension in Middle Childhood

Cognitive Development and Information Processing

- Children at this age operate from concrete operational thought; that is, thought processes are governed by rules of logic. This stage is characterized by becoming less egocentric.
- Children can show reversible thought and conservation skills. For example, they understand that certain transformations do not change the quantitative features of objects.
- Although Piaget's ideas have withstood the test of time, it is now recognized that cognitive changes do not proceed according to predetermined sequences of stages. As a result, "levels" is a better conceptual notion than "stages."
- Information processing is relevant to a child's social relationships. Research has found that skill deficits in how children process information may influence their behavioral interactions.
- EQ describes qualities such as understanding one's own feelings, empathy for the feelings of others, and regulating emotions in ways that enhance life. The concept of EQ is becoming more important for educators, who notice the effect of negative emotions on students' abilities to learn.
- EQ abilities include managing emotions, perceiving emotions, using emotions, and understanding emotions.

Communication

- As children develop their language skills, they become capable of metalinguistic awareness and appreciate humor in jokes, riddles, and puns.
- Children who are deaf learn language in much the same manner as hearing children.
- As communication becomes increasingly important for the social life of children, deficits in communication have social consequences. For example, speech disorders can lead to academic as well as emotional difficulties.
- Bilingual children can have positive outcomes, depending on how the two languages are used. A child's language abilities can be influenced by cultural experiences.
- Children living in poverty may have a restricted vocabulary and construct sentences that are less grammatically correct than those of middle-class students.

Attitudes, Emotions, and Regulation

- Emotional development becomes prominent, especially in the context of social interactions. Middle-age children often are seen as more irritable, crankier, and more easily provoked.
- Emotional competence has three aspects: experiencing emotions, expressing emotions, and understanding emotions.
- Social role-taking is the reduction of egocentric thought, egocentric thoughts being children's inability to decenter the focus of their conceptual efforts.
- Role-taking ability—to see things from another person's perspective—changes around 12 years of age, when children can think about themselves, and social relations become more advanced.
- A child's interpersonal awareness can be ordered along a developmental continuum, and concepts such as friendship and peer groups can be viewed as a series of steps through which children progress. How children think and reason about such concepts can influence their adjustment. Children may benefit from training that helps facilitate this reasoning.

Psychological Strengths, Hazards, and Risks

- One of the most important strengths of middle childhood is the continuing development and refinement of self-esteem or self-worth. The differentiated view of oneself is a less global view than the one held previously and more individuated.
- Childhood disorders can be divided into two categories: externalizing problems of overcontrol and internalizing problems of under control. ADHD is a common externalizing disorder that affects a child's attention and activity levels. Medication alone is commonly used to treat this disorder, but a combination of medication and behavioral treatment is recommended. The most likely cause of ADHD is an imbalance in the brain's neurotransmitters.

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Social Dimension

Groups and Families

Groups

In middle childhood, children increasingly begin to prefer spending time with their peers over adults. Though adolescents spend more time with peers compared to children in middle childhood (Lam, McHale, & Crouter, 2014), peer relationships and reciprocated friendships become critically important during this period, with strong associations to children's self-worth (Maunder & Monks, 2019).

What makes a peer group? Is it just a few children who are similar in age and who hang out together? Apparently not, because researchers have defined **peer groups** as groups of age-mates that are durable and involve interactions based on an established set of social relationships. Peer groups have shared values and goals. Often, children in cliques are identified by their similar social prejudices, speech, and/or clothing styles. Within the group, each individual will have a certain role or status. Although formal groups often elect individuals to certain roles, such as team leader, similar roles emerge naturally in informal peer groups. Let's examine the ways that peer groups are formed, as well as the social interactions within peer groups and their possible influences on members' behavior.

Group Formation

As the number of stable encounters with age-mates increases, children begin to form groups. These groups often start when the child enters school and has increased regular contact with peers. Peer groups are important throughout the life course, but their nature and function change. Preschool children describe friends in terms of reciprocity ("we play"); elementary schoolchildren describe friends in terms of loyalty, trustworthiness, and time spent together; and preadolescents describe friends in terms of sympathy, self-disclosure, and intimacy (Hartup & Abecassis, 2002). Mixed-sex peer groups begin in middle childhood for girls, but is more typical in early adolescence for boys (Lam, McHale, & Crouter, 2014).

In early middle childhood, children are involved in informal groups that lack much structure. Few rules govern the behavior of the members, and there is a high turnover in membership. As a result, the influence of peer groups is limited until the child reaches late childhood. Beginning with the junior high years, group formation becomes increasingly important, and peer relationships take on a new significance. At this age, groups become more formalized and roles emerge more clearly, as do the social rules that govern the groups—for example, "We only allow girls from our soccer group." Children begin to feel a cohesiveness that binds them to the group's values.

The most famous study of group formation was done by Sherif, Harvey, White, Hood, and Sherif (1961), who

Photo credit Little Windows Photography

At 10 years old, Kirk spends less time with his mother and more time with his same-age peers.

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conducted a fascinating experiment with boys in a camp setting. The children were divided arbitrarily into two groups, and many of the boys resented being separated from their friends. As the groups participated in separate activities, group members' cooperation and cohesiveness developed. Soon, each group had developed its own rules of conduct, leadership hierarchy, and status relationships. The children in each group now identified more closely with peers from their own group. The experiment continued by bringing the two groups together for an intergroup conflict phase. The children were exposed to win–lose competition and planned frustration to increase the tension between the groups. These activities increased the level of animosity harbored by the two groups. In the last phase of the experiment, the researchers explored ways to reduce the intergroup conflict. When Sherif and colleagues sought to reduce the conflict, they brought the two groups together under noncompetitive conditions. However, this only heightened the conflict. When the two groups were brought together to work on a common goal that required cooperation (the researchers deliberately broke a water line, so both groups would have to help), the boys were able to reduce the conflict.

This study has many important implications. First, the study illustrated the importance of cooperation and common goals in the formation of cohesive groups. It also showed that groups, independent of any previously shared interest, can develop bad feelings and learn to discriminate against an "out" group. The study found that competition and frustration could increase hostility between groups. Lastly, the study found that such hostility could be reduced when a common goal is introduced and groups are required to work together. Additional studies have supported the notion that cooperative activities can decrease negative social behaviors that sometimes emerge in groups (Richard et al., 2002). Parents can help with this. One study using a national data set found that maternal and paternal sensitivity in third grade fostered greater cooperative behaviors in their children that provided a foundation for positive peer relationships into early adolescence (Blair & Perry, 2019).

The Power of Peers

Early research by Merrill Roff (1963) was groundbreaking in its discovery of the importance of peers for healthy psychological development. Roff conducted a number of follow-up studies that examined children who had poor peer relationships and found that years later, as adults, these people had more than the usual number of mental health adjustments, had more problems adjusting to military service, and had more serious mental health problems.

Peer groups are important throughout a child's development. In early middle childhood, they are informal and lack structure, but by late middle childhood, peer groups become more formalized, with distinct roles and social rules governing them.

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More studies now confirm Roff's early hunches that difficulties in friendship and peer relationships are likely to lead to poor mental health (Rodriguez, Moreno, & Mesurado, 2021). Cowen, Pederson, Babigan, Izzo, and Trost's (1973) well-known study identified first-grade children who had poor peer relationships and found that they suffered disproportionately from psychiatric problems as adults. Research has confirmed that peer acceptance and rejection are integral to group functioning in middle childhood (Cain, 2013; Smith & Hart, 2002).

Even more interesting for social workers was Cowen's finding that assessment of children's social competence by their peers is a more powerful predictor of later behavior problems than assessment by parents, teachers, or mental health practitioners. Indeed, we now realize that peers are crucial to the healthy development of a child—perhaps as important as the influence of parents. Reviews of the literature (Hartup & Abecassis, 2002; Schwartz-Mette et al., 2020) have summarized the importance of friends and enemies on child development and made the following conclusions:

> Poor peer relations are associated with discomfort, anxiety, and a general unwillingness to engage the environment.
>
> Children master their aggressive impulses within the context of peer relations.
>
> Sexual socialization cannot take place in the absence of peer interaction.
>
> Peer relations are related to role-taking ability, empathy, and moral reasoning.
>
> Children who are rejected by their peers are at greater risk for delinquency, school dropout, loneliness, and mental health problems.

Friendships are critical because they provide opportunities for learning social skills and a beginning sense of group belonging. The recent emphasis on peer relationships has stimulated research and program development in two areas: social skills training and social cognition.

Implications for Practice:

Teaching Isolated Children Social Skills for Friendship Making

A well-known study that taught children social skills was conducted by Oden and Asher (1977). This study was designed to assess coaching as a method of training socially isolated children in social skills for gains in peer acceptance. Children (ages 9–10) were selected for this study on the basis of the results of a sociometric assessment that used a roster-and-rating questionnaire. Children rated each other in answers to two questions administered separately during the same session: "How much do you like to play with this person at school?" and "How much do you like to work with this person at school?" The children used a rating scale consisting of five points from 1 ("I don't like to") to 5 ("I like to a lot"). Based on these results, children who were rated as less accepted became the participants in the study. These children were randomly assigned to one of three groups: coaching, peer pairing, or control. The coaching group included instructions from an adult in social skills for friendship making: playing games with peers to practice social skills and a post-play review session with the coach. In the peer-pairing group, isolated children played the same games with the same peers but did not receive instruction or review. In the control group, isolated children were taken out of the classroom with the same peers but did not interact or receive verbal instruction or review. To measure the effectiveness of the intervention, the researchers used the sociometric measure previously described and a "best friends" peer-nomination inventory in which children were asked to name one, two, or three of their best friends in the classroom. The overall results of the research found that the coaching procedure was effective in increasing isolated children's peer acceptance. In particular, the coaching group showed significant increases on the play sociometric rating from pretest to posttest when compared with the peer-pairing and control group. This study points to the potential for enhancing isolated children's peer relationships through direct intervention.

The implications of understanding children's interpersonal relationships extend beyond just isolated children. Children's interpersonal skills are related to the quality of their friendships. A recent meta-analysis of the literature indicates that aggression and withdrawal are associated with negative friendships, whereas prosocial behavior and assertion are associated with more positive friendships (Dryburgh et al., 2022). Ladd, Buhs, and Troop (2002) have described how children's interpersonal skills are also directly related to successful adaptation in school settings. Exhibit 6.9 presents their interpersonal model of school adjustment. The figure suggests that a child's interpersonal relationships—friendships, peer acceptance, rejection, and conflict—relate directly to school adjustment. Such interpersonal skills have been overlooked in their significance for school adjustment.

Interpersonal relationships also can play a role in preventing the development of problems, including drug abuse. For this reason, programs aiming to prevent the development of negative behaviors later in adolescence focus on developing positive peer norms with children in the middle childhood age group.

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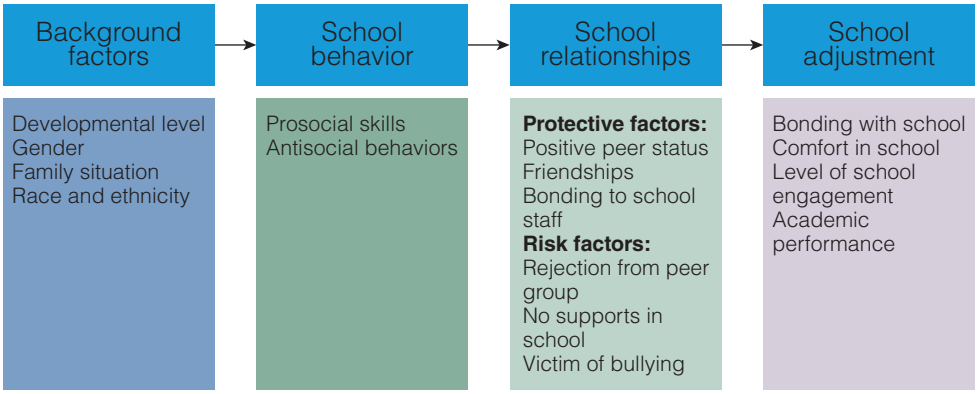
Exhibit 6.9 Interpersonal Model of School Adjustment



Source: Adapted by the authors from G. W. Ladd et al., (2002) Children's interpersonal skills and relationships in school settings: Adaptive significance and implications for school-based prevention and intervention programs, in P. K. Smith & C. H. Hart (Eds.), *Blackwell Handbook of Childhood Social Development* (p. 296). Blackwell Publishing.

Families

Family strength is an important concept that has dramatically influenced social work practice. Social workers are increasingly concerned about offering families opportunities to use their strengths. For too long, social workers did not recognize family strengths and instead were concerned only with a family's pathology. Today, family strength is emphasized because we recognize that the family environment holds the key to unlocking a child's capacity to grow and develop in a healthy manner. Even in environments where significant risks exist, familial warmth can serve as a dynamic and powerful protective factor (Butler et al., 2019; Gorman-Smith, Tolan, Zelli, & Huesmann, 1996).

Focus on **The Lived Experience**

Heritage-Based Rites of Passage for African American Children

In south-central Los Angeles, a six-year-old boy from a family living in poverty walks to school in plastic flip-flops because his family cannot afford to buy him sturdy shoes. A young African American man—who happens to be a member of a street gang—sees him on the street, picks him up, feeds him, gives him a pair of sneakers, and drops him off at school.

This real-life scenario is not what mainstream society would consider typical. The media portray young African American males as drug dealers and killers who do not want to learn to be responsible. The fact is that 90% of young African American men go to school and help their community. A national movement is helping young Black men cope with the difficulties they face from stereotyping and other societal pressures. Rites of passage and mentoring programs are providing new services for African Americans.

These programs have an Afrocentric value system. They promote, for example, "Nguzo Saba"—unity, self-determination, collective work, responsibility, cooperative economics, purpose, creativity, and faith. Nguzo Saba is the cornerstone of the African American holiday Kwanzaa, in which communities give thanks for the past year and prepare for the new one.

Each member spends two years in the programs. On completion, a circle of elders returns as he graduates to the community in a formal ceremony. Each young man presents what he has learned from the program. The community is then asked to accept the young men as new members and support them in their roles. Teaching youth what is needed to make the transition into adulthood successfully is vital to create a sense of responsibility and pride in their heritage and to encourage them to succeed.

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Practice Guidelines:

Developing Positive Family Patterns

Developing healthy and emotionally warm family patterns is a critical element to preventing the development of negative behaviors such as drug and alcohol use, risky sexual behaviors, and gang involvement during the tumultuous adolescent years ahead. Social workers must tailor suggestions to the cultural context of the family. However, the following suggestions may be useful in clinical practice with families who have children in middle childhood:

- Help parents to think about ways that they can emotionally transition from work to time with the family. Often pressures of the day can carry over into tense family interactions and diminish the opportunity to create a distraction-free "reunion time" with their child.
- Encourage the family to consider how they can model positive community involvement (participating in faith-based activities, recreational groups, service organizations), which can be a protective factor for children as they age.
- Family routines can be a powerful way to create emotional safety within a home. This can be challenging for families who are experiencing disruptions in routines (such as during the pandemic) as well as many competing demands. Even simple suggestions such as a weekly shared meals or a family game night can be a positive step.

Parental Discipline

Hoffman (2000) identifies three major parental disciplinary strategies: **power-assertive** discipline, which includes physical punishment, threat of punishment, and physical attempts to control a child's behavior (e.g., threatening to take an electronic device away for not obeying); **love withdrawal**, which involves withdrawing love when the child's behavior is viewed as inappropriate (e.g., refusing to speak to the child); and **induction**, which involves the use of explanation and rationality in attempting to influence the child's actions (e.g., asking children to consider how their behavior has affected others, to cultivate empathy and empathy-based guilt).

What effects do these different strategies of parental discipline have on children? Research studies have shown that parents who use power assertion (punishment) increase their children's aggressive tendencies and is related to the least development of empathy and morals (Hoffman, 2000). There are several possible explanations for why this is likely to occur. As you learned earlier, parents who act aggressively toward their children provide a model of aggressive behavior for the child to imitate. Parents that use this tactic tend to be more neurotic, less empathic, and more extroverted. Parenting difficult children is also more likely to involve assertiveness. Also, children involved in physical confrontations with their parents direct their attention to the parent-child power differential rather than to the potential consequences of the behavior. Have you ever observed a child being physically punished by their parents? You may also have noticed the child is embarrassed and ashamed, and that the punishment demeans the child. Children with low self-worth may be more likely to respond with aggressive behavior in the absence of more appropriate social skills.

Parents who use love withdrawal do so by verbally discounting children, threatening to send them away, and indicating to them that they are not loved because of their actions. Love withdrawal also includes parental actions such as persistently ignoring the children, refusing to talk with them (the silent treatment), and generally not interacting with them. Of course, this behavior is unfair and often makes children fearful. Research has found that this form of parenting can lead to excessive anxiety in children and inhibit needed expression of emotions (Hoffman, 2000).

Consider the difference between these two types of parental discipline strategies: "Chen, get in this house right now! If you don't do as I say, I'll take the paddle to your butt," and "Chen, you need to come in and get ready for dinner. Your aunt is expecting us later tonight and we don't want to be late." How would a child feel in response to these two statements? The first is likely to elicit anger and resentment, whereas the second is more likely to elicit cooperation and understanding. The use of induction helps the child develop an understanding of why he or she should act in the requested manner. Other examples include telling a child, "Please don't climb on that wall. It isn't strong enough to hold your weight" (appeal to prevent injury); "You can't watch TV tonight because you broke our rule about no more throwing temper tantrums" (appeal to fairness); or "Don't chew food with your mouth

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open—that's not appropriate at the dinner table" (appeal to standards of conduct).

Induction is an important parental strategy because it helps children develop internal moral standards (Turiel, 2002; Vozzola, 2014). Children disciplined by induction methods gain experience in exercising self-control and learn to display more consideration and generosity toward others when compared with children who have been disciplined with power assertion techniques (Turiel, 2002). Induction is really a strategy based on principles of moral development. Understanding a child's social, cognitive, and moral development supports successfully using such discipline strategies. An understanding of parental discipline styles is pivotal in helping parents learn effective parenting techniques.

Implications for Practice:

Parent Training

Many social workers are called on to do some form of parent training. They may run parent-training groups for parents of noncompliant children, work directly with foster parents, or conduct parent-training classes to help prepare pregnant adolescents to become better parents. Indeed, parent-training courses have been introduced everywhere—in schools, hospitals, community mental health centers, and churches. Most professionals today rely upon evidence-based approaches to parent training (Christophersen & VanScoyoc, 2008; Forehand & Long, 2010; Kazdin & Rotella, 2014).

The most consistent evidence has supported the use of parent-training models that use social learning theory and behavior modification. The use of behavior modification in parent training involves teaching parents how to apply the principles of behavior to their children. The principles of behavior include concepts such as reinforcement, punishment, extinction, differential reinforcement of other behaviors, and stimulus control. Parent-training programs usually start out by teaching parents to define the behavior they would like to see changed. After learning to define behavior precisely, parents choose a home project to begin to put the principles to work. Parents must choose a behavior, define it, and develop a method of tracking and recordkeeping. If parents are working on reducing the number of temper tantrums, they must define what a temper tantrum is and record this behavior. Often, they chart the behavior for a week or more with graph paper to assess the extent of the problem and to have a comparison after introducing an intervention.

Parents are then taught ways to either increase or decrease behaviors. Most parents choose to implement a reinforcement program based either on praise (social reinforcement) or on a home-style token economy, where points are exchanged for tangible reinforcement (money, prizes, or special privileges). When working to decrease behaviors, parents are taught to use various forms of punishments. For example, a parent working on reducing bedtime crying may use extinction, which involves ignoring the behavior (because the parent's attention was what kept the child crying night after night). Two of the most widely used punishments are time-out and the withdrawal of privileges. Time-out is time without reinforcement, and the child must sit quietly in a chair in the corner of a room for two to six minutes. The strategy is to make the time-out boring and unrewarding to the child. Withdrawal of privileges is often used on older children in conjunction with token economies. When unacceptable behaviors continue, the child loses a predetermined privilege. For example, a parent trying to reduce sibling fights would withdraw the privilege of watching TV that night for any instance of fighting during the day.

Most behavior modification programs work hard to teach parents the skill value of using praise and reinforcement with their children. Parents are encouraged to increase the use of praise dramatically. They are taught to rewrite rules using positive language to record and increase the number of times they use praise, to make and display cards to encourage praise (like "catch your child being good"), and to display charts proudly showing the progress that the child is making.

Assessment tools: measuring compliance with the task analysis questionnaire

The task-analysis questionnaire-home is a 32-item questionnaire that measures problems in the home. The instrument is completed by the child's parents or guardian. The questionnaire can create a baseline of assessment and identify targeted areas for intervention. The instrument includes five domains: morning

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routine, after-school routine, dinner time, after dinner time, and bedtime. The after-school subscale includes the following items (Asher, Gordon, Selbst, & Cooperberg, 2010, p. 34):

After-school routine:

After-school routine questions:	N/A	Never	Sometimes	Very Often
1. Arrives home in a timely manner after school	N/A	0	1	2
2. Brings home all necessary materials from school	N/A	0	1	2
3. Begins homework assignments in a timely manner	N/A	0	1	2
4. Remains on task while working	N/A	0	1	2
5. Competes homework assignments in a timely manner	N/A	0	1	2
6. Puts away materials after completing assignments	N/A	0	1	2
7. Respects others in the house who are working	N/A	0	1	2
8. Writes assignments in agenda	N/A	0	1	2
9. Other (Please write in)	N/A	0	1	2

Marital Conflict and Divorce

Divorce rates have been decreasing in the United States, and hit a record low in 2019 at 14.9%, the lowest rate in 50 years, according to the most recent census data. There's been conflicting evidence on how the pandemic will impact this trend. Some speculate that divorce rates will soar while others hypothesize it will make them stronger. Regardless, marital conflict and divorce constitutes major impediments to the adjustment of children of all ages. Children who are between 7 and 14 years old at the time of their parents' divorce have a 16% increase in risk for behavioral problems (Fitzsimons & Villadsen, 2019). However, most children adjust well within two years following a divorce. A meta-analysis of child adjustment in divorced families indicates that factors that predict positive adjustment, such as fewer internalizing and externalizing problems, social adjustment, and self-esteem, are largely explained by post-divorce parenting (van Dijk et al., 2020). The negative impact of negative parenting (e.g., parental hostility, intrusiveness) is more powerful than the positive impact of positive parenting (e.g., parental support, structure). In addition to these parenting strategies, the researchers recommend that for optimal child adjustment, it is really important that children are not involved in their parents' disputes (triangulation) or put in an adult role (parentification), either practically or emotionally. Although we tend to think of divorce as occurring at a fixed point in time, for the child and family, the reality of divorce looks and feels more like a succession of painful experiences (Heatherington & Kelly, 2002). In fact, children experience a series of stressors when their parents divorce. For example, changing schools, moving to a new house, losing a relationship with the noncustodial parent, potential downward economic mobility, and the addition of a step-parent and possibly step-siblings are just a few of the additional stressors that make divorce difficult.

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Noncustodial fathers are an important source of support and influence for their children.

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Practice Guidelines:

Helping Families with Divorce

- Guide families through the difficult process of securing financial support. Child support can be a critical resource for children.
- Support parents during this stressful time and encourage them to continue their relationships based on warmth and consistent discipline. Encourage families to learn parent-management training that is often offered as a local course. Children will be most successful when behavioral plans and discipline strategies are consistent across every household the child will spend significant time in (i.e., partial and noncustodial parents' homes, grandparents, other adults).
- Promote emotional support from the noncustodial parent. About one-third of divorced children lose contact with their fathers. Promoting regular contact with fathers can help children, particularly sons who have a difficult time adjusting to divorce.
- Encourage the family to obtain additional support from family, friends, and support groups. Parents can attend parents of divorce groups and children can participate in coping with divorce groups.
- Families experience additional stressors such as lower income, moving to a new house and school, legal battles, and conflict in extended family relationships. Coping skills can be helpful as family members make a new adjustment.
- Avoid putting the children in the middle. For example, encourage parents to not speaking poorly about the other parent, or allow other family members to speak poorly about the other parent in front of the children.
- Parents going through a divorce may also soon experience a new life stage of their own, which is dating. Help parents to think carefully about their priorities when considering actions such as introducing children to new significant others.

Communities and Support Systems

School Influences

School is a major socialization agent for our children. Children begin school by age six and spend five hours every weekday interacting with teachers and peers in ways that will affect their social and emotional development. When most of us think of schools, we think of the three Rs—reading, 'riting, and 'rithmetic. However, schools go far beyond academic basics. Children must learn to conform to the rules set forth in their school, respond to teacher demands, interact successfully with age-mates, and manage their day-to-day responsibilities. Schools often invite opportunities such as ganging up on peers, involvement in drugs, and new experiences with sex. Clearly, schools have a major responsibility in the proper socialization of children.

Designing More Effective Schools

What does make for a good school? Most important to a school's effectiveness are its atmosphere and its quality as a social institution (Lezotte & Snyder, 2010). Effective schools and classrooms are likely to do the following:

1. Strongly emphasize academics (demand a lot from students, expect a lot, assign regular homework, set clear classroom objectives)
2. Focus on task-oriented behavior (reinforce good work, provide clear instructions, discourage wasting classroom time)
3. Manage discipline problems effectively (be clear about the rules, use consequences consistently, avoid physical or excessive punishment)

The Center for Research on Education, Diversity, and Excellence has developed a growing body of evidence indicating that effective implementation of five standards promotes positive learning outcomes for students (Doherty et al., 2002): (1) joint productive activity; (2) language and literacy development; (3) contextualization, that is, connecting school to students' lives; (4) challenging activities; and (5) instructional conversation. These standards have been found to reduce the achievement gap between mainstream and diverse learners, and they are universal in nature, allowing for application across all subjects. The center has created a research tool that schools can use to evaluate their progress on the standards.

Self-Expectations and School Performance

As education becomes more reliant on standards and testing, the influence of external expectations for child performance grows more visible. However, increasing studies have also focused on students' self-expectations or motivation in learning (Patrick, Turner, & Strati, 2016). An early researcher on the topic, Carol Dweck has conducted extensive research on motivation and learning. Her work has examined how children develop feelings of helplessness in their learning and how both mastery and performance goals

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influence achievement. Research by Dweck (2007) examined students who could be classified as either mastery oriented, likely to attribute their successes to ability and effort, or helplessness oriented, likely to attribute their failures to luck or the difficulty of the task—causes over which they have no personal control. Studies that have looked at the differences between these two types of students have found that mastery students are confident in their performances on various tasks, whereas helpless students not only see themselves as helpless but also lack confidence in their abilities. They think they will likely confront failure in the future. In one study, the helpless children gave up after a single failure, although they had both the ability and the motivation to perform on subsequent tasks. The study of learned helplessness also has implications for the psychological functioning of children.

Can emotional distress, such as depression and anxiety, color children's view of themselves and the world around them? Research by Pomerantz and Rudolph (2003) suggested that emotional distress can distort how children see themselves and the world. Fourth- through sixth-graders were followed in a yearlong study that measured self-reported levels of depression and anxiety, along with an assessment of the children's views of themselves and the world. They found that distressed children tended to blame themselves for failures and view their successes as based on external factors, two hallmarks of **learned helplessness**. Exhibit 6.10 describes the differences between students that use a *mastery* versus a *learned-helplessness* orientation.

Although many children experience learned helplessness, research has demonstrated that these children can be taught to attribute their failures to insufficient effort rather than to lack of ability. This affects their sense of self-efficacy, and they learn to persist in spite of a failure (Seligman, 2007).

Exhibit 6.10 Examples of Mastery and Learned-Helplessness Orientations

Factors	Learned Helplessness	Mastery
Ability	I'm not good at math	I can do better if I study harder
Attribution for success	It doesn't matter how hard I work—I'm not good at this	When I work hard, I do well
Attribution for failure	I did poorly because I'm not good	I did poorly because I didn't study
Reactions to failure	Give up, perform poorly	Persist, try harder

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Helping students develop a mastery versus a learned helplessness orientation can increase educational motivation.

Learning Poverty and the COVID-19 Pandemic

Learning poverty is a measure of children unable to read and understand a simple passage by age 10. Learning poverty was very high before the pandemic hit; however, with prolonged school closures and unequal mitigation strategies, the pre-pandemic learning crisis was exacerbated and learning inequality among children has worsened. Children from lower socioeconomic families are suffering larger learning losses as a result of the COVID-19 pandemic. Across the globe, schools were fully closed for in-person schooling for approximately 141 instructional days between February 2020 and February 2022. Globally, learning losses have been the equivalent of one-half years' worth of learning, with the poorest children most disproportionately affected. Losses in reading and math have been documented in low-, middle-, and high-income countries.

See Exhibit 6.11 for recommendations from the United Nations Children's Fund (UNICEF), United Nations Educational, Scientific and Cultural Organization (UNESCO) World Bank (2022) for how we can avoid a permanent impact on this generation of children and catch up on learning losses.

The RAPID framework provides countries with recommendations to address COVID-19 learning losses (World Bank, the Bill & Melinda Gates Foundation, Foreign, Commonwealth & Development Office (FCDO), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Children's Fund (UNICEF), and United States Agency for International Development (USAID), 2022).

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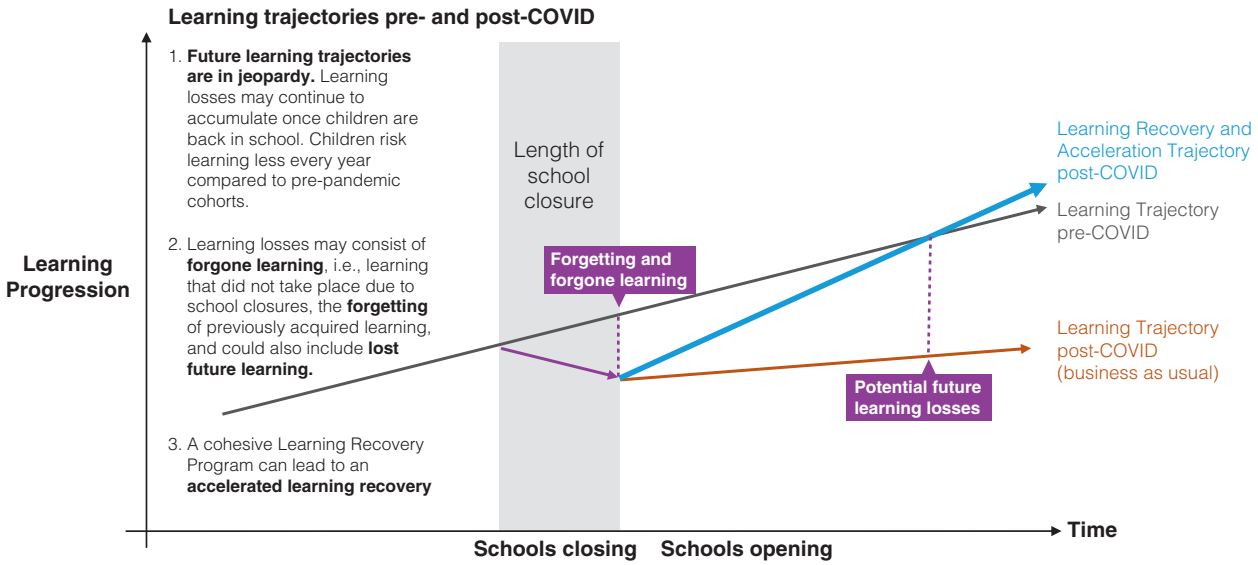
Exhibit 6.11 Learning Trajectories Pre- and Post-COVID



Reach every child and keep them in school.	**Assess** learning levels regularly.	**Prioritize** teaching the fundamentals.	**Increase** the efficiency of instruction, including through catch-up learning.	**Develop** psychosocial health and wellbeing.
Reopen schools safely and keep them open Promote returning to the classroom through back-to-school campaigns Provide cash transfers to poor families Use early warning systems to identify at-risk students	Assess learning losses at national/ subnational level Provide teachers with tools for classroom level measurement	Adjust curriculum across and within subjects Prioritize numeracy, literacy, socioemotional skills Focus instruction on closing the gaps between desired and actual student learning in specific subjects	Use approaches that align instruction with learning needs: targeted instruction; structured pedagogy; tutoring; self-guided learning Support teachers continuously: build practical pedagogical and digital skills Expand instructional time Enhance learning with technology	Build teachers' capacity to support their students' wellbeing and identify students in need of specialized services Support teacher wellbeing and resilience Invest in students' safety, nutrition, and access to water, sanitation, and hygiene facilities

The RAPID framework provides countries with recommendations to address COVID-19 learning loses (World bank, the bill & melinda gates foundation, FCOD, UNESCO, UNICEF, and USAID (2022)

Source: https://thedocs.worldbank.org/en/doc/e52f55322528903b27f1b7e61238e416-0200022022/related/Guide-for-Learning-Recovery-and-Acceleration-06-23.pdf

School Violence and Mass School Shootings

The Sandy Hook Elementary School shooting of 2012 left 28 people dead and two injured. The majority of the victims were six and seven years old. Teachers responded to sounds of gunfire with their previously established lockdown protocols, including concealing their students in closets, bathrooms, and barricading doors with furniture or their own bodies. In the aftermath, the nonprofit organization, Sandy Hook Promise, was founded in dedication to the reform of gun laws and promotion of mental wellness. The group advocates for the expansion of criminal background checks, support for violence and suicide prevention programs in schools, and a ban on high-capacity magazines. On this last point, they argued that 11 children were saved during the Sandy Hook attack, when the shooter stopped to reload. Sadly, in the 10 years that have followed the Sandy Hook shootings, there have been 27 mass shootings at U.S. schools, including 19 elementary schools. Gun control is a sharply divisive issue in the United States, with massive amounts of funding in political campaigns on both sides.

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The history of school shootings in the United States is a relatively new phenomenon. The United States did not have any mass school shootings on record until 1940, in which a junior high school principal shot and killed five staff members before dying by suicide because he thought he was going to be fired (Katsiyannis, Whitford, & Ennis, 2018). There were no subsequent school shootings until almost 40 years later, at which point they slowly grew and fell until the 1990s. The Gun-Free School Zones Act of 1990 imposed criminal penalties for the possession of discharge of a firearm in a school zone. At the time, the introduction of the law resulted in a reduction of gun violence in schools and in fewer students carrying guns. However, mass school shootings took a sharp increase in the 2010s. Typically, the shooters at elementary schools are White, male adults aged 19 to 32 years and are acting alone. Building a cohesive and supportive school environment can help to prevent school shootings. Supportive school environments are ones in which the teachers and staff have adequate support, training, and resources, and the students feel safe and respected. Schools that support the social and emotional needs of children, and not just academic needs, cultivate children that feel respected and connected, and a sense of belonging. Programs that develop skill sets around conflict resolution, stress management, and empathy toward other students can help to prevent fighting and bullying, known risk factors for violent behaviors.

Practice Guidelines:
Promoting Academic Success

Social workers practicing in school settings will regularly be called upon to help children address academic struggles. The following guidelines may assist in helping children manage the challenges of school.

- Assess the child's situation: Does the child have difficulty with organization, an academic skills deficit, language disorder or developmental delay, distractibility (ADHD), or family difficulties?
- Developmentally appropriate cognitive-behavioral restructuring techniques can be very helpful for helping children build tool kits to confront thoughts that prevent them from feeling successful and capable in academic settings.
- Motivational strategies can be used to encourage the child such as a homework contract, extra time with a teacher, and efforts to increase parent engagement in school.
- Social workers can play a vital role in connecting school personnel with families. Social workers can help create behavioral expectations that bridge school and home environments.
- Resist the urge to move too quickly to interventions before you fully understand the child's own experience of school and their performance.
- Advocate for schools to include programs that enhance the social and emotional needs of children and increased feelings of school safety.
- Advocate for schools to have adequate support, training, and resources for teachers and staff.

Motivational interviewing techniques can help ensure that the child is progressively developing their own internal motivations for success, as opposed to simply responding to external punishments and rewards. While simple behavioral interventions such as sticker charts can be very effective in the short term, it is important to continue to encourage conversations about goal attainment and internal satisfaction to ensure long-term growth. A brief instrument that can be used in the schools is the Behavior Rating Index for Children (Stiffman, Orme, Evans, Feldman, & Keeney, 1984) and is described below:

Assessment Tools: The Behavior Rating Index

In general, how often does the child:

1.	Feel happy or relaxed?	1	2	3	4	5
2.	Hide his/her thoughts from other people?	1	2	3	4	5
3.	Say or do really strange things?	1	2	3	4	5
4.	Not pay attention to when he/she should?	1	2	3	4	5
5.	Quit a job or task without finishing it?	1	2	3	4	5
6.	Get along with other people?	1	2	3	4	5
7.	Hit, push, or hurt someone?	1	2	3	4	5
8.	Get along poorly with other people?	1	2	3	4	5
9.	Get very upset?	1	2	3	4	5
10.	Compliment or help someone?	1	2	3	4	5
11.	Feel sick?	1	2	3	4	5
12.	Cheat?	1	2	3	4	5
13.	Lose his/her temper?	1	2	3	4	5

Scoring: Omit items 1, 6, and 10 and add up all the item scores; subtract from the figure the total number of items completed; multiply by 100; and divide the result by the total number of items completed times 4. High scores suggest more behavioral problems.

Children Living in Poverty and the Public School System

The public-school system is a middle-class institution and, as a result, it can have a negative effect on children living

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in poverty. Seligman (2007) outlined three barriers that children living in poverty and children of color face in the school system: low parental expectations for school performance, low teacher expectations for school performance, and lack of culturally relevant educational materials.

Academic expectations may be quite different when we compare parents of middle-class students to parents of children living in poverty or to parents of children of color. Whereas middle-class parents value "getting ahead," other parents often emphasize "staying out of trouble." These varying expectations are likely to influence the academic behavior of children, either to work hard to get ahead or work just enough to get by. Sometimes parents of children living in poverty inadvertently influence school performance; they simply participate less in school activities and, as a result, their children place less value on school. The lower levels of parental involvement may not stem from a lack of a desire to participate in their children's school, but rather from a host of invisible factors such as language barriers, demanding work schedules, not feeling welcomed, or an undertone of racism in the school culture (Lechuga-Peña, & Brisson, 2018). However, when parents do get involved and expect good school performance from their children, their children are likely to do well. Social workers should keep in mind that parental involvement and interest in the child's school performance can make a difference, but should also avoid jumping too quickly to place blame on parents.

The "relevance" of school material can also be a barrier for children living in poverty and children of color. Imagine reading only stories about well-to-do White children when you are an African American who lives in a low-income neighborhood. The stories might not be of much interest, because they lack any cultural relevance. In general, our schools need to do a better job of providing students with culturally relevant material.

Earlier, we presented information about the importance of teacher expectations. If teachers hold negative expectations about children living in areas of low income and children of color, they will build barriers to academic success. Unfortunately, it appears that teachers do have lower expectations for such children (Boser, Wihelm, & Hanna, 2014). A common practice in many schools is to advance students to the next grade regardless of their accomplishments. This action may represent teachers' negative expectations that these children are not going to do well anyway. Such "social promotions" may perpetuate social inequality by depriving children of the opportunity to acquire necessary academic skills.

Practice Guidelines:

Helping Schools Be More Effective

- Identify children or target groups of children needing alternative educational planning or programs and services.
- Consult and collaborate with community representatives to identify the effects of interacting school/community/pupil characteristics and develop resources to meet needs of the child or target group.
- Collaborate with community agencies in the development of alternative education programs and support services.
- Clarify and interpret specific roles and responsibilities of the community in promoting school attendance.
- Set objectives, monitor progress, and measure outcomes of service.
- Advocate for using educational materials that are diverse and representative of the student body.

School social workers often provide a vital link between the community and the school. Often, the child and their family need specialized services from other agencies—for example, health services, counseling, or respite care. Students also are sometimes involved in other major socialization agencies, such as the juvenile justice system or the child welfare system. The school social worker must interact with community agencies in an effort to provide needed planning (Constable, 2002).

Schools and U.S. Public Law 94-142

One of the most significant changes to affect schools was the adoption and implementation of U.S. Public Law (PL) 94-142, the Education for All Handicapped Act. This law has been referred to as a "bill of rights for the handicapped" because it established the right to a free, appropriate public education for all "handicapped" children ages 3–21. This seminal law was amended and renamed the Individuals with Disabilities Education Act (PL 101-476) in 1990. Also, the term *handicap* was replaced throughout the act with the term *disability*. The amended law strengthened the educational rights of children with disabilities and their parents and for the first time addressed transition services, which were defined as a coordinated set of services that promote students' movement from the school environment to postschool activities, such as postsecondary education, vocational training, supported

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employment, and independent living. The law specifically defines "related services" to include "social work services" and "rehabilitative counseling."

Children included under the provisions of this law are evaluated according to a multidisciplinary team that develops their objectives and, together with special education and related services, provides each child with a written **individualized education program (IEP)**. This law guarantees children the right to special education and related services, including any service that helps the child benefit from special education. Services that are recommended in the IEP must be provided to the child and his or her family at no cost. Of particular interest to social workers is the fact that seriously emotionally disturbed children fall under the category of "disabled."

This law has, in essence, provided a legal mandate for school social work services. School social workers become involved in the development and coordination of the IEP required for every student (Bishop, 2002; Raines, 2006). The multiple tasks required of the school social worker point to the importance of understanding the school environment and its influence on children's development. Indeed, it is essential to understand the school as a social organization. School social workers often must act as change agents within the school, working toward organizational change to meet the needs of the students they serve as well as playing a vital role of helping families to navigate the educational system (see Exhibit 6.12).

Lisa F. Young/Shutterstock.com

Public Law 94-142 and other developments in education have contributed to the mainstreaming of children with physical and developmental disabilities.

Multicultural, Gender, and Spiritual Considerations

Imagine a child who turns on the TV Sunday morning and becomes engrossed in a TV series. They begin to identify with one of the characters and imagine being them. The characters on this TV program, though, are all White. The child, unlike the characters, is Hispanic or African American. One day, the child begins to doubt that they can be like the character and to realize that many people will consider them an outsider. The pervasive and subtle effects of racism are beginning to be felt in the child's everyday life.

By middle childhood, racial identity begins to become a very tangible reality for many children. Children begin to think about who they are in terms of similar peer groups, their appearance, and their aspirations. How is the development of a child's self-concept affected in a society that imports negative meanings to being a person of color? Do these children, as a consequence, develop feelings of self-doubt, inferiority, and low self-esteem?

Studies of Mexican American children show that ethnic awareness develops later than gender and race awareness. Researchers (Anfara, Mertens, & Caskey, 2007) have found that young preschool children have limited knowledge of their ethnic identity. As they get older, however, their understanding of their heritage grows broader and more complex. In addition, bilingual Mexican American children were found to be more aware of their ethnic identity than those who spoke only English.

The National Middle School Association (2003, cited in Anfara et al., 2007, p. 7) noted that "successful schools for young adolescents provide multiple learning and teaching approaches that respond to their diversity." **Ethnic identity** development is a critical task for students in middle school, suggesting that the middle-school curriculum is an opportune time for ethnic identity to be strengthened. Furthermore, with an increasingly ethnically diverse population of students in American schools, the need to address students' ethnic identities is greater than ever.

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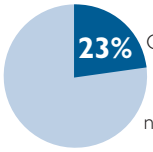
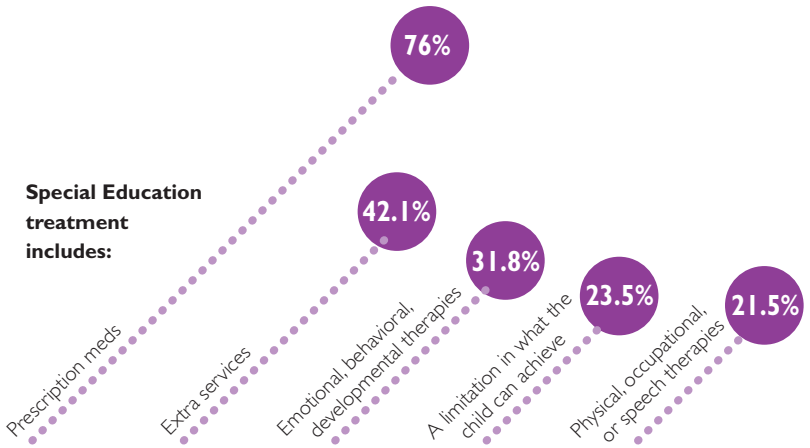
Exhibit 6.12 Children with Exceptional Needs in Education



11.2 million
children have disabilities

Types of disabilities:

physical	Muscular dystrophy, multiple sclerosis, chronic asthma, epilepsy, etc.
developmental	Down syndrome, autism, dyslexia, processing disorders.
behavioral/ emotional	ADD, bipolarism, oppositional defiance disorder
sensory impaired	Blind, visually impaired, deaf, limited hearing.
other health impaired	A child whose strength, endurance, or stamina cannot keep up with school activities.



Relevant policies:

Section 504 of the Rehabilitation Act

- Prohibits schools from discriminating against children with disabilities.
- Requires schools to provide accommodations for disabled students.
- Students with impairments that substantially limit a major life activity can qualify as disabled (learning and social development deficits, too).

The IDEA Act (Individuals with Disabilities Education Act)

- Students with disabilities must be prepared for further education, employment, and independent living.
- If a child's strength, endurance, or stamina cannot keep up with school activities, they can qualify for "other health impaired" special education status.

Americans with Disabilities Act (ADA)

- Schools must meet the needs of children with psychiatric problems.

Sources: http://mchb.hrsa.gov/cshcn0910/more/pdf/pc.pdf; http://www.cdc.gov/nchs/data/databriefs/db97.pdf; http://www.cdc.gov/nchs/data/databriefs/db97.pdf

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Practice Guidelines:

Strengths-Based Focus on Ethnic Heritage

A strong sense of cultural and ethnic heritage has been identified as a protective factor among minority youth (Fishman, 2000; Rapalje, Degelman, & Ashburn, 1986). Social workers can help children to develop positive self-constructs around their family of origin.

- Encourage parents to examine how culture, race, and ethnicity were talked about this to them when they were growing up. Help them consider what they would like to pass on to their own children and what they might want to do differently.
- Parents and teachers can help accentuate the inherent strengths of a child's culture of origin through creative activities, selecting books that celebrate that culture of origin, and talking with the child about what they like about their family and culture.
- Social workers should examine their own upbringing and culture and reflect on that ways that their background may help or hinder their work with families from various backgrounds. Becoming comfortable with authentically presenting one's own experience helps model open dialogue about racial and ethnic diversity with respect and curiosity.

Social Strengths, Hazards, and Risks

As children in middle childhood reach out and become increasingly independent, the neighborhood and community offer opportunities for growth and hazards for healthy development.

Neighborhoods and Communities

The experience of childhood takes place in a social context—in the neighborhood and community where the child lives. The neighborhood is perhaps most critical to the middle-age child in molding experiences and shaping adjustment to the social world. The neighborhood opens up an important arena for exploration and social interaction and contributes to the child's physical and social development (Adelman & Taylor, 2015; Leventhal, Selner-O'Hagan, Brooks-Gunn, Bingenheimer, & Earls, 2004). As the child moves beyond the boundaries of the front yard, he or she is affected by who is in the neighborhood and how safe the neighborhood is. Consider the multitude of neighborhood factors that contribute to the child's development—neighborhood safety, available health and social services, recreational activities, quality of the local schools, and the surrounding economic conditions.

The notion of "community" becomes increasingly important for the child's healthy development. The nature and types of social interactions available influence families' quality of life. Consider the difference between the types of interactions that occur in a housing project in Chicago and in an upper-income suburb in Chicago. As you can see, consideration of the social hazards alerts us to how the community affects the development of the child. Indeed, studies have shown that, when a community's economy is negatively affected, rates of domestic violence increase (Pyles, 2006).

One reality not widely recognized is that children are more prone to victimization than adults. Sadly, in cases of family violence, the odds of child abuse and neglect within the same family is 3.64, according to a recent meta-analysis (Chan et al., 2021). Further, when we add to family violence the frequent occurrence of peer and sibling assaults against younger children, we see a picture in which children are victims of violence far too often. Witnessing intimate partner violence can lead to a number of ill effects for children. In fact, children who witness abuse in the home and children who are abused may display similar effects (Peled, Jaffe, & Edleson, 2012). In general, these children are at greater risk for anxiety and depression and for behaviors such as fighting, bullying, lying, and cheating (Stiles, 2002). Exhibit 6.13 presents some of the potential

Exhibit 6.13 Impacts on Children who have Witnessed Intimate Partner Violence

Age	Impact on children
Infants	Not able to attach properly to adult Poor sleeping habits Eating problems Higher risk of physical injury
Preschool children	Lack feelings of safety Separation/stranger anxiety Regressive behaviors Insomnia
School-aged children	Self-blame Somatic complaints Aggressive behaviors Regressive behaviors
Adolescents	School truancy Delinquency Substance abuse Early sexual activity

Source: Adapted by authors from Jaffe, Hurley, and Wolfe (1990); Rhea, Chafey, Dohner, and Terragno (1996); and Stiles (2002).

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Focus on **The Lived Experience**

Primary Prevention for Traumatized Khmer Children

In an attempt to resettle Khmer refugee children in Tacoma, Washington, Duncan and Kang (Williams & Berry, 1991) created a creative and culturally sensitive treatment program. These children had lived through Pol Pot's atrocities in Cambodia and had been forced from their families when they arrived alone in Tacoma. They experienced trauma and loss that included the separation from families without the resolution of grief and loss. In addition, these children experienced serious acculturative stress. Posttraumatic symptoms emerged soon after their arrival and included sleep disturbances, nightmares involving family members, and disturbing visits by spirits, including those of parents and grandparents.

The primary prevention program included three Theravada Buddhist ceremonies and rituals to honor the children's dead families. These included Ban Skol, a memorial for absent family members; Pratchun Ban, an annual family reunion of living and deceased relatives; and religious observances for absent family members that took place during the Khmer New Year's celebration. Also included was special consultation with Khmer Buddhist spiritual leaders. Last, the program included placements in ethnically similar foster homes.

The Ban Skol ceremony, a joint effort between the foster parents and the social service agency, was held at the child's foster home. A special meal was provided to the monks, family, guests, and agency staff. The child prepared a list of the family members and was instructed to burn it and douse the ashes slowly with water. This symbolic cremation was prepared for those children who had witnessed dead bodies that were simply left to rot, and the refugee child was the primary focus of the ceremony. It was intended to provide protective functions to the child. As Williams and Berry (1991) pointed out, "through the process of the ceremony, the child was able to begin seeing the foster family, their friends, and the agency's caseworkers as sources of support" (p. 637).

During the ceremony, many of the children were either withdrawn or overcome with feelings of loss and grief. This allowed the foster family and others to console the children and offer support. There were anecdotal reports after the ceremony of decreased sleep problems, fewer spirit visits, increased bonding with the foster family, and greater grief resolution.

—Adapted from Williams and Berry (1991).

effects of children who have witnessed domestic violence. Families that live in high-risk neighborhoods and communities face a large number of stresses.

Another instance of children being victimized is the age-old and now widely criticized and researched act of bullying.

Stopping the Bullying Epidemic

The issue of bullying in this country's school systems has gained more attention in recent years, particularly in light of the increased prevalence of school shootings and concern regarding child and adolescent suicides. New research is exploring the various factors involved in bullying, including characteristics of bullies and psychosocial factors present, to assist in the creation of more effective intervention programs.

Bullying typically occurs most frequently between the sixth and eighth grades. In a study by Nansel and colleagues (2001), both bullies and the victims of bullying were found to have difficulty adjusting to their environments and experienced difficulty making friends. Depression and anxiety are found to be experienced more often than average by children who are considered victims of bullying or who both are bullied and bully others themselves (Swearer, Song, Cary, Eagle, & Mickelson, 2001).

The types of interventions or strategies that address bullying have been inadequate at solving the problem of bullying. Relying on adults to identify bullies is typically ineffective, as adults, including teachers, often overestimate their ability to identify bullies (Swearer & Doll, 2001). Group interventions have been used in some schools to address bullying. However, these programs can be problematic for the victims if bullies are included in the same group. The use of peer mediation can be successful as long as the students participating are in equal positions of power. Because bullying is a form of victimization, power equality may be difficult to achieve.

Researchers are now beginning to use more comprehensive approaches to the problem. The focus is on

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three critical aspects of program design (Howe, Marini, Haymes, & Tenor, 2013):

1. Using a schoolwide approach that involves the entire school staff.
2. Implementing life skills training groups in which all students participate.
3. Implementing interventions targeted at individual perpetrators and victims.

These ideas build on the original Olweus Bullying Prevention Program that involved using the school as a community to work together to change the climate of the school and the social norms (Olweus et al., 2007; Olweus, Limber, & Mihalic, 1999).

Developmental Guidelines for Assessment in Middle Childhood

Exhibit 6.14 presents the developmental guidelines for middle childhood. These guidelines are meant to be helpful to social workers, who need to understand developmental aspects when making assessments.

Study Table Social Dimension in Middle Childhood

Groups, Families, Communities, and Support Systems

- In middle childhood, children begin to have an increasing preference for spending time with their peers.
- They begin to form peer groups, which are often referred to as "cliques." The process of group formation can have important implications for peer cooperation and respect, and peer conflict and/or discrimination. Children who are rejected by their peers are at risk for adjustment problems.
- Friendships may provide for unique learning of critical social skills. Children who are rejected by their peers can be taught the social skills needed for friendship making.
- By the time a child reaches late childhood, they are spending much less time with parents and more time with peers. Still, the family provides a safe, authoritative structure that children need.
- Three major parental disciplinary strategies are power-assertive discipline, love withdrawal, and induction. Parent training is recommended by social workers for families that are having problems.
- Schools are a major socializing agent. A good school is a community of parents, teachers, and students. Attributes such as good after-school programs, computers in all classrooms, smaller class sizes, high expectations for students as well as teachers, and opportunities for teachers to continue their education, will contribute to excellent schools.
- Effective schools can be differentiated from less-effective schools on the basis of strong academics, focus on task-oriented behavior, and effective management of discipline problems.
- Teacher expectations and a child's self-expectations can influence school performance.
- Three barriers that children living in low-income areas and children of color face: low parental expectations, low teacher expectations, and a lack of culturally relevant material.
- The No Child Left Behind policy was designed to measure the effectiveness of schools. Schools have not made many accommodations for disadvantaged students. School social workers sometimes must act as advocates in school-community relationships. U.S. Public Law 94-142, the "bill of rights for the handicapped," or people with disabilities, is a case in point.

Multicultural, Gender, and Spiritual Considerations

- By middle childhood, racial identity is beginning to form. Families who identify with their ethnic roots are likely to teach their children about their ethnic background. Children's ethnic identity is related to ethnically based behavior, such as cooperation and respect.
- The effects of racism can influence a child's sense of identity. Rites of passage and mentoring programs are helping young African American men cope with the difficulties they face from stereotyping and other societal pressures. Through initiation rites, the programs reinforce values such as self-respect, responsibility, and dedication to family, community, and one another.

Social Strengths, Hazards, and Risks

- Neighborhoods and communities provide a social context for a child's development.
- Witnessing intimate partner violence can lead to a number of ill effects for children. In fact, children who witness abuse in the home and children who are abused may display similar effects.
- Both bullies and victims of bullying are found to have difficulty adjusting to their environments and making friends. Bullying occurs most frequently between the sixth and eighth grades. As in early childhood, in middle childhood divorce is a significant social hazard.

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Exhibit 6.14 Developmental Guidelines for Assessment in Middle Childhood

Routine Observations	Strengths and Landmarks of Development
Peer relationships and play behavior	Enjoys reading (by third grade)
Adaptation to school	Comfortable away from home/with peers
Family relationships	Development of moral thinking
Interests and skills	Good at catching a ball (5–7 years old)
Physical development (prepubertal changes), interests, and abilities	Can solve simple puzzles (5–7 years old)
TV/movie/computer viewing habits	Friendship development with same sex (8–10 years old)
Sleep and dreams	
Daily routine	
Independent self-care	
Participates in a peer group (9–11 years old)	
Physically active	
Developing preferences for friends and activities (5–7 years old)	
Sexuality awareness	

Development Issues (Not Problems)	Development Observations Requiring Attention
Oversensitive to criticism	Persistent fearfulness
Prefers play to school and home responsibilities	Lying
Short-term fears develop	School failure
Noncompliance with parental requests	Language and speech problems
Doesn't always share	Victimized by bullies
Teacher–child conflicts	Inappropriate sexual behavior
Poor table manners	Overdependence
Excessive aggressive behavior	Running away
Talking back	Fire setting
Moodiness	Persistent thumb sucking
Temper outbursts	Strange, bizarre, or withdrawn behavior
Secretiveness	Lack of communication
Academic achievement and classroom behavior	Cruelty to animals/pets
Reading/literacy skills	Lack of friends
Reasoning abilities	Disturbed sleep patterns, enuresis
	Persistently emotional over small things

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Applying the Framework

Attention-Deficit/Hyperactivity Disorder (ADHD)

Developmental History

Tommy is a seven-year-old African American child who was referred to the Child Guidance Clinic by his teacher. Tommy's mother, Ms. Paul, reports that Tommy's birth was not planned and that Tommy's father was not pleased about her pregnancy. She was upset that Tommy's father did not want the child and concerned about what would happen. Ms. Paul reported that she was in labor for a very long time and that she was given Demerol during the birth process. Complications in childbirth were mostly a result of her failure to dilate properly.

Ms. Paul noted that Tommy developed "normally" and began walking and talking at developmentally appropriate times. She noted that at about age five, Tommy became much more difficult to manage. She began getting complaints about his behavior at school.

Biophysical Considerations

At about age five, Tommy developed problems with his eye muscles. He received optometric treatment for about a year. Ms. Paul reports that she had a very difficult time getting him to do his required eye exercises. Tommy stopped receiving treatment last year when Ms. Paul changed jobs and lost her health insurance.

Psychological Considerations

Cognitive Development and Information Processing

Tommy has difficulties with information processing. In particular, his attention span is exceedingly short. This has led to his diagnosis of ADHD. Teacher reports indicate that constant supervision is required to keep Tommy from talking to the other children. Also, his teachers state that he "cannot sit still" and that he "cannot concentrate." Tommy's school performance has gotten much worse over the last year. His teacher reports that he is at least one full school year behind. Achievement tests suggest this is true but that his poor performance may be caused by his impulsiveness.

The parent interview supported similar conclusions. Ms. Paul has difficulty managing Tommy because he is "all over the place." She also indicated that he lacks judgment. He will apparently do things that disturb other children and not be aware he is offending them. She says that he does not come in from play when he is supposed to and that she cannot get him to take responsibility around the house. Ms. Paul completed a Child Behavior Checklist, and Tommy received an "often true" or "sometimes true" rating in 9 of the 11 items that assess hyperactivity. The items included the following: can't concentrate, can't pay attention long, can't sit still, confused, daydreams, destroys his own things, impulsive or acts without thinking, poor school work, and prefers playing with younger children. Tommy scored well above the clinical cutoff score for hyperactivity.

Tommy was referred for a psychological evaluation, and the psychologist noted that Tommy could not maintain his attention, although he did stay in his seat. During an IQ task, Tommy gave up very quickly, making the assessment difficult. He also had difficulty maintaining his focus in conversations with the psychologist.

The Wechsler Intelligence Scale for Children-III (WISC-III) indicated that Tommy's overall intelligence is in the average range (FSIQ ¼ 98), with similar verbal (VIQ ¼ 101) and performance ability (PIQ ¼ 99). Tommy's achievement scores show he is slightly below average for his age.

Communication

Ms. Paul reports that Tommy can communicate appropriately for his age. She complains that at times Tommy can become a "motor mouth" and will not stop talking after repeated requests for him to do so. Although Tommy has difficulty getting along with peers, he does appear to be able to communicate with them in an age-appropriate manner.

In the clinical child interview, Tommy spoke clearly and loudly to the social worker. Although his language appeared normal, Tommy had difficulty completing his thoughts when responding to questions.

Attitudes, Emotions, and Regulation

Ms. Paul describes Tommy as an unhappy child who has many social problems and gets angry easily. She says that Tommy does have difficulty "controlling his emotions." Ms. Paul reports that Tommy had numerous temper tantrums when he was younger and that he has problems with his anger. As an example, she described a recent incident when Tommy got angry and began throwing his toys against the wall. Ms. Paul noted that it took her at least 20 minutes to get Tommy under control. Ms. Paul reports that Tommy does not easily admit to feelings of sadness; however, he does get into crying spells that

Continued

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Attention-Deficit/Hyperactivity Disorder (continued)

last for a long time. She reports no specific fears, saying that at times he appears "fearless." Ms. Paul believes that Tommy is very upset over his father's leaving the family, although he never wants to talk about it. She feels that much of Tommy's current difficulties stem from her divorce.

In the interview with Tommy, he denied feeling lonely or being sad about anything in his life. When asked if he was sad that his parents were no longer together, he said, "They just want to go off and be by themselves." He agreed that sometimes his anger gets him into trouble. "I can really get mad," he said with some pride. Tommy reported that he did have difficulty in school and that he was "bad at school most of the time. When asked about games and sports, Tommy said, "I am sometimes the best on the team." In general, in many of the domains in Tommy's life, he sees himself as "bad" or "unsuccessful," which is affecting his sense of self-esteem and social competence. Themes in the semi-structured interview indicated problems with anger, low self-confidence, poor peer relationships, and a lack of interest in school.

Ms. Paul reports that Tommy does not have good judgment. Often it appears that Tommy does not think through the consequences of his actions. On several occasions, Tommy has been excessively cruel to their pet dog. Ms. Paul has consistently tried to explain to Tommy that it is wrong to inflict pain on the dog, yet Tommy does not refrain from being cruel toward it. Ms. Paul also reports that Tommy has difficulty getting along with peers partly because he sees them as mean and "always bugging him." Tommy has a difficult time having successful long-term interactions with his peers.

In the interview with Tommy, he recounted an incident that occurred between him and a neighborhood boy. Tommy was asked how his actions might have made the other boy feel. Tommy could not identify the feeling the other boy would have been likely to have. Tommy's social knowledge of others and his sensitivity to other people's feelings are apparently not well developed.

With regard to adaptive and self-help skills, Tommy seems to have no difficulties. Tommy functions well in terms of daily living skills—he feeds himself, brushes his teeth, and cares for his health. Ms. Paul states that sometimes Tommy has difficulty going to sleep at bedtime and has difficulty getting up in the mornings.

In the semi-structured interview, Tommy was presented with a conflicted social situation and asked how he would resolve the problem. He generated two impulsive solutions and could identify only a few of the consequences associated with his solutions. In a role-playing situation that could easily incite a fight, Tommy was asked what he would say or do. His response showed he lacks the skills needed to avoid situations likely to lead to conflict.

Social Considerations

Family Situation

Ms. Paul and Tommy live together in a low-income African American neighborhood. Ms. Paul and Tommy's father divorced two years ago. Tommy is an only child. Tommy sees his father about every two weeks. Ms. Paul states that she believes Tommy and his father have a good relationship. Ms. Paul characterized her marriage before the divorce as always in a conflict or fight over something. She reports that Mr. Paul was not abusive toward her or Tommy. Currently, Mr. Paul is contributing money toward child support, although sometimes his payments are late.

Ms. Paul recently got a new job as a sales clerk. She reports that she is happy with her new job and that she has been in good spirits lately. Ms. Paul reports frequent episodes of depression in the past. She has never been hospitalized or received treatment for depression. Although Ms. Paul is involved with her extended family, she states she feels lonely and without close friends. Ms. Paul says she loves to cook and enjoys having others over for dinner. Weekends often are spent with the relatives, fishing, or other planned activities.

Ms. Paul sees Tommy's problems as a result of his poor adjustment to the divorce. She thinks Tommy may be "hyperactive" but is not sure and does not want to put Tommy on "any drugs." Although she has problems with his behavior at home, she believes the school has not really worked with Tommy to help him. Ms. Paul made it very clear that she is not happy with Tommy's school and how it has treated him. She has become increasingly concerned about her ability to manage Tommy. She feels "completely exhausted at having to deal with him after work" and complains of extreme tiredness.

Ms. Paul and Tommy spend a lot of time with Tommy's grandparents. Ms. Paul's mother has "pitched in and helped a lot." Ms. Paul says she doesn't know what she would do without her. However, Tommy's grandfather is a concern. Ms. Paul reports that he has a long-term drinking problem and that she does not like to see Tommy around him when he has been drinking. Although she has discussed this many times with her parents, her father continues to drink sometimes when Tommy is around.

When Tommy was asked to do a family drawing, he stated, "I don't have a whole family." Tommy drew a picture of his mother cooking and him watching TV. He then drew a solid black line and drew a picture of his father. He stated that he and his father don't get to watch TV much.

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Groups, Social Supports, and Contexts

Ms. Paul describes Tommy as not well liked by his peers, although he does have a few good friends. She believes Tommy's aggressive behavior affects his ability to get along well with peers. Tommy was rated above the clinical cutoff for aggressive behavior on the Child Behavior Checklist. Ms. Paul noted that the following items were of concern: aggressive, brags, cruel to others, demands attention, destroys others' things, disobeys at home, disobeys at school, poor peer relationships, impulsive, shows off, excess talk, teases, temper, and loud. Teacher reports confirm Tommy's difficulty with aggressive behavior.

Ms. Paul and Tommy interact with several social institutions that are of significance. As already noted, Ms. Paul is concerned about Tommy's school. She has gone to a number of teacher conferences, and each time she has felt that the school is unresponsive to her. She believes the teacher is angry because she has not put Tommy on any medication for his hyperactivity. Ms. Paul perceives the school as too large to respond effectively to the needs of the students. Ms. Paul describes Tommy's class as unstructured and too large for one teacher to handle. She also believes that the expectations of students there are extremely low because of where the school is located, in a low-income neighborhood that is well known for having many social problems. Drug abuse is not uncommon.

Ms. Paul and Tommy regularly go to church. Ms. Paul states that this is a very important part of her life. She sees a few of her friends there but wishes she could spend more time getting to know others in the church. Ms. Paul would like to bring better role models into Tommy's life. She is concerned that he will never have a chance at a decent life unless he sees the success some people can attain. Ms. Paul has friends, but without childcare she cannot afford to spend much time away from Tommy.

Multicultural, Gender, and Spiritual Considerations

Ms. Paul and Tommy live in an old house that is badly in need of repair in a poor, urban African American neighborhood. Ms. Paul reports that much of the paint inside and outside the house is cracked and peeling. The paint could be lead-based and might account for Tommy's hyperactive behavior (research has found a relationship between high lead levels and ADHD).

Many of Tommy's peers in the neighborhood have already had run-ins with the law because of drug use and vandalism. This leaves few male peer models for Tommy. Ms. Paul is concerned about his lack of "appropriate friends and acquaintances." Much of Tommy's free time appears to be spent playing aggressive sports or watching violent TV shows. Ms. Paul reports she does not monitor the type of TV programs Tommy watches. Ms. Paul feels that many of the types of activities and games Tommy plays contribute to his problems because there are no "normal recreational activities for him to play in the neighborhood."

Although Ms. Paul and Tommy live in a primarily African American neighborhood, Ms. Paul is concerned about Tommy's experiences of prejudice and discrimination. There have been long-standing conflicts among several of the ethnic groups in the nearby neighborhoods. Tommy has been in a number of fights that have occurred because of racial issues. Ms. Paul is also angry that Tommy's school is underfunded and that the teachers have such low expectations of the students.

Ms. Paul and Tommy have limited access to a number of needed resources. Although Ms. Paul has a full-time job, the minimal pay has not allowed her to obtain needed health care for Tommy. Their house is crowded, and the peeling paint may be a significant health hazard. Ms. Paul's income level does not allow her to meet her and Tommy's needs adequately. Mr. Paul's late and inconsistent child support payments make budget planning difficult.

Summary and Impressions

Tommy has several problems that have become evident from the assessment:

1. Impulsive and overactive behavior—apparently ADHD
2. Aggressive behavior—possibly conduct disorder
3. Poor school progress
4. Poor peer relationships and lack of social skills

Additional difficulties include the following:

5. Inadequate health care for Tommy
6. Inadequate and possibly unhealthful living environment
7. Inadequate recreational opportunities
8. Lack of role models

Continued

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Attention-Deficit/Hyperactivity Disorder (continued)

Ms. Paul and Tommy do have a number of personal strengths and resources. Ms. Paul is clearly concerned and motivated to do her best in providing for Tommy. She displays caring and concern over his difficulties. Ms. Paul has successfully provided for Tommy to the best of her ability. She is perceived as an intelligent, hardworking person who has a lot of concern for others. Ms. Paul has better-than-average parenting skills. Tommy continues to have a successful relationship with his father following his parents' divorce. Ms. Paul also has some social support—especially from the extended family. She is involved in her church and continues to maintain a number of friendships.

Four Ps' Formulation for Integration of the Data

Practice Exercise:

Fill in each of the four Ps for the case that is applying the biopsychosocial framework for this chapter.

Use the results of the four Ps' formulation to:

1. Identify relevant problems, diagnoses, or other relevant judgments about the case described in the Applying the Framework section of the chapter.
2. Describe an appropriate biopsychosocial intervention based on the findings in your four Ps' formulation of the case.
3. Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial integrative data that you identified in your formulation of the four Ps.
4. Describe how you would evaluate your invention based on the data captured in your four Ps' assessment.

	Biological	**Psychological**	**Social**
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

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Reviewing Your Competencies

You should be able to:

1. Describe the key developmental themes present in middle childhood.
2. Understand the key aspects of biophysical growth and development (motor skills, physical activity).
3. Describe the key themes in the psychological dimension for early childhood (industry, Piaget's concrete stage, emotional intelligence, language, social-role taking and interpersonal awareness, Child Behavior Checklist, internalizing and externalizing problems).
4. Describe the key themes in the social dimension for early childhood (peer relationships, parent training methods, effective schools including Public Law 94-142, sex role identification, divorce).

   Five factors help the adjustment to divorce: financial support, adequate parenting by the custodial parent, emotional support from the noncustodial parent, additional social support, and a minimum of stressors.

Key Terms

acculturation
attention-deficit/hyperactivity disorder (ADHD)
bilingual
conservation
depression
emotional intelligence (EQ)
ethnic identity
externalizing problems
individualized education program (IEP)
induction
internalizing problems
learned helplessness
love withdrawal
metalinguistic awareness
peer groups
power-assertive discipline
readiness
reversibility
role-taking ability
social cognition

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Chapter 7

Adolescence

Learning Objectives

1. Describe the key developmental themes present in adolescence.
2. Understand the key aspects of biophysical growth and development.
3. Describe the key themes in the psychological dimension for adolescence (formal operations, use of language, identity, common mental health concerns).
4. Describe the key themes in the social dimension for adolescence (control and autonomy in the family, school influences, peer relationships, identity, common strengths and risks).

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Developmental Themes	Key Concepts
	■ Stage: identity versus identity confusion. Today's adolescents. Independence from parents, increased emphasis on peer-group relations, preoccupation with self, changing body image.
Biophysical Dimension	
Biophysical Growth and Development	■ Adolescent growth spurt. Pubertal process: menstruation, secular trend. Hormonal changes. Psychological consequences of puberty.
Biophysical Strengths, Hazards, and Risks	■ Brain development, nutrition, obesity, dysmennorhea, acne, headaches, sleep.
Psychological Dimension	
Cognitive Development and Information Processing	■ Formal operations, more abstract thinking, hypothetical reasoning, logical consistency.
Communication	■ Increased language ability. Use of metaphors and satire. Writing becomes more meaningful. Young women's and boys' talk becomes more differentiated. Confidentiality.
Attitudes, Emotions, and Regulation	■ Identity formation. Increased emotional intensity and fluctuation. Changes in self-esteem. Foster-care adolescents' self-images. Enhancing adolescents' self-concepts. ■ Identity development: psychological moratorium. Youth of color and adolescent identity. Identity and independence. Regulation: social cognitive monitoring, moral development. Kohlberg's moral development theory. Justice perspective versus care perspective. Overcoming adolescent conformist reasoning. Egocentrism: imaginary audience, personal fable.
Psychological Strengths, Hazards, and Risks	■ Negative images of adolescents. Stress-resistant adolescents. Internalizing and externalizing disorders. Conduct disorder. Delinquency. Self-harm and cutting.
Social Dimension	
Groups and Families	■ Control and autonomy within the parent–adolescent relationship. Parent–adolescent conflict and attachment. Peers and adolescent development. Conformity. Friendship. Social skills training. Peer groups. Gangs.
Communities and Support Systems	■ School influences. High school dropouts. Making family relocations smoother. Runaway youths.
Multicultural, Gender, and Spiritual Considerations	■ Peer relationships and adolescents of color. Adolescent immigrants. The voice of adolescent young women. Body image and depression in young women. The war against boys: suicide rates, schooling. Heterosexuality: oral sex, influences on sexual activity. AIDS prevention and adolescent males. Gay, lesbian, bisexual, and questioning youth. Castration and sexual orientation. Guidelines for adolescents coming out. Harassment.
Social Strengths, Hazards, and Risks	■ Adolescent assets. Adolescents at risk. Victimization of children. Youth employment. ■ Adolescent pregnancy. Social media influences. Sex education. Alcohol and other drug use.

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Developmental Themes[1]

Every night, often well past midnight, C lay in bed with an iPod Touch they received from their grandparents as a 10th birthday gift. (C, who is being identified by their first initial for privacy reasons, is gender nonbinary, and takes the pronoun "they.") On the new device, C made friends on social media and uploaded selfies. Viewers posted compliments on a photo of C standing in an orchard, holding an apple, and "looking like a full adult," C said (M. Richtel, 2022).

America's adolescents attract a lot of attention in their eagerness to establish an identity. Adolescence represents the journey of discovery—Who am I? How am I different from others? What do I want to do with my life? Erikson's theory of adolescent identity recognized this almost universal phenomenon.

But what is life like for today's adolescents? Our society offers a wealth of opportunities—modern technology has brought endless hours of texting, internet connections to the world, better physical health, and improved education. Yet, young people must also face head-on the ills that modern society brings with it: AIDS, violence, alcohol and drug abuse, bombardment of media images, and hopelessness.

In spite of our changing society, the tasks adolescents face has remained stable. And many of the problems young people face do not stem from youth itself but from reduced opportunities and lack of support from a caring adult (Santrock, 2022) and a society overwhelmed by other concerns.

Adolescence is typically defined as the period of growth beginning at about 10 to 12 years of age and ending at around 21 to 22 years of age. Researchers studying adolescent development believe it is important to consider adolescence in terms of three periods: early, middle, and late.

Exhibit 7.1 compares some of the characteristic differences between early, middle, and late adolescence. Early adolescents place great importance on peer approval. Middle adolescence is from ages 14 to 16 and corresponds to the high school years. This period represents the adolescent's reflective and self-discovery journey. Late adolescence begins around the age of 17 and continues up to approximately 22 years of age. During late adolescence, two developmental tasks are considered important: independence from the family and the development of personal identity. Erikson referred to this stage as one of identity versus identity confusion.

Exhibit 7.1 Stages of Adolescence

	Developmental Distinctions of Each Stage
Early 11–14 years of age	Abstract thinking begins; increased emphasis on peers; body image becomes a primary focus; changes due to puberty; beginning of increased parental conflicts
Middle 14–16 years of age	Trying on new roles; advancement of moral thinking; focus on sexual identity; sexual drives; less parental conflicts
Late 17–22 years of age	Increased depth in peer friendships, intimacy; some decrease in peer influence; focus on work or college plans; greater independence

Some key aspects of adolescence as a developmental period are that young people become concerned about their physical appearance and about others' perceptions of how they look. They become aware of the fact that their bodies are developing—young adolescent women will have their first menstrual cycle, and boys may have their first nocturnal emission, or wet dream.

Adolescence is believed to be an important time for the development of identity including gender and racial identity (Mathews et al., 2019). As young people enter adolescence, they seek to answer important questions about themselves. Who am I? What is important to me in my life? These types of questions represent the stage of life that Erikson characterized as identity versus identity confusion. Young people enter what Erikson calls a **psychological moratorium**—a gap between childhood security and adult autonomy. Critical issues for early adolescence identity are gaining confidence in parental support and developing a sense of industry and a self-reflective perspective about the future. Research (Klimstra et al., 2009) is finding that many of the most important identity changes take place in later adolescence.

[1] Madison Rose contributed to this chapter revision.

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Study Table Developmental Themes of Adolescence

Developmental Themes	Establishing one's identity. ■ Erikson's stage of identity versus identity confusion and place in the world. ■ Adolescent development is composed of three periods: early (physical changes and peer approval are prominent), middle (reflection and self-discovery are prominent), and late (familial independence and personal identity are prominent).

Biophysical Dimension

Biophysical Growth and Development

Boys and girls at this stage of development experience what is referred to as an adolescent growth spurt, where there are rapid gains in height and weight. However, the growth spurt occurs two years earlier for girls than for boys. The growth spurt for girls begins at about age 10 and lasts about two years. For boys, it begins at age 12 and also lasts about two years. There is considerable individual variability, so girls could begin the growth spurt as early as age seven, and boys as early as nine. The rate of adolescents' weight gain corresponds with the rate at which they gain height (Herting et al., 2017).

The Pubertal Process

Biologically, adolescence begins with the onset of the pubertal process—the time at which young people can reproduce. **Puberty** is identified by the combination of the growth spurt, maturation of physiological mechanisms, and the development of secondary sex characteristics, such as pubic hair and breasts (Sarpolis, 2011; Herting et al., 2017). Closely associated with a young woman's first menstruation is armpit hair and her need for a bra (Sarpolis, 2011). Although menstruation is one indication of puberty for young woman, there is no clear indication for boys. Menstruation is the cyclic shedding of the uterine lining that leads to vaginal bleeding about two weeks after an egg is released from an ovary and is not fertilized.

Nocturnal emissions and facial hair can indicate puberty in boys. Exhibit 7.2 summarizes the changes that take place for both young men and women in the pubertal period. The onset of puberty for girls has been getting earlier since it was first recorded in the 1800s (Biro, 2005). This trend toward earlier maturity is known as the **secular trend** (a trend likely to move in the same general direction). Each new generation over the past 100-plus years has been taller and heavier and has entered puberty earlier. Records from Norway in the 1840s show that on average, **menarche**, the first menstruation, occurred at age 17, whereas today it occurs at ages 10 to 12. In the United States, the median age for menarche has declined to 11.9 years of age (Martinez, 2020). This dramatic change in the age of menarche has decreased to an average of four months every 10 years for the past century. Why are young women prepared for childbirth at an earlier age today? Although there are no clear answers, most experts believe the earlier onset results from better standards of living, medical advances, and improved nutrition. Body mass is a key factor in menarche; for it to begin and continue, fat must make up 17% of a young woman's body weight. The Focus on Multiculturalism section examines how an Apache ceremony honors the young woman who reaches the childbearing years.

Exhibit 7.2 Physical Changes of the Pubertal Period

Physical Changes	Differences between Males and Females
Apocrine gland development	Similar in males and females
Pelvic changes	Strengthening bones for males; increased diameter of pelvis for females
Growth in gonads	Testes and scrotum for males; ovaries and uterus for females
Breast enlargement	Growth in males; more growth in females
Pubic hair	Similar in males and females
Growth of genitals	Penis for males; labia and vagina for females
External puberty	Nocturnal emissions for males; menarche for females
Puberty	Semen in males; ovulation in females
Body size	Shoulders broaden in males; hips broaden in females

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Focus on **The Lived Experience**

The Apache Ceremony of the Changing Woman

When an Apache girl reaches childbearing years, she is honored with a traditional ceremony of the changing woman. This ceremony comes from the Apache goddess White Painted Woman, who declared this event significant in the lives of the people: "Let all the people come together. Let them eat and dance and have a good time. The Masked Dancers will come forth at night and then the People will dance with each other, side by side and face to face."

The four-day celebration is one of the tribe's most private ceremonies. In preparation, the father sends announcements to friends and family. The girl undergoes instruction from an attendant who guides her in proper behavior. A special dressmaker constructs clothes based on the original garments worn by the White Painted Woman. The garments are dyed pollen yellow, a symbol of fertility. Food is gathered and made to accommodate all the guests.

The ceremony begins in the morning with the washing of the maiden's hair with yucca roots. The attendant gives traditional advice: "Be happy so your people may be happy. Don't talk too much or you'll always be a talker. Don't be cross or you'll always be a nag. Don't laugh too much or your face will wrinkle soon. Don't allow water to touch your lips, or the skies will weep and everybody will not have a good time. Don't think bad thoughts or you'll have evil to the end of your days" (Mildred & Hooper, 1993, p. 6).

The White Painted Woman's holy home, or wickiup, is made of four spruce poles that are lashed together. The maiden enters her home and is now the personification of White Painted Woman. She now has supernatural powers. She lies down on deerskin and is massaged to become supple and possess good health. The shaman and special dancers perform rituals. As the sun rises, the woman faces east and the shaman paints her face with white clay, using an eagle feather. She becomes "White Painted Woman" and is again painted with pollen and runs in four directions. As she leaves the wickiup for the last time, it is pulled down and pushed to the east. Favors are tossed to the children, and her parents can now accept marriage proposals.

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Source: Mildred & Hooper (1993). The ancient Apache ceremony of changing woman. *Southwest Passages, 64*, 5–7.

Hormonal Changes in Adolescence

During adolescence, the **endocrine glands** produce hormones that create different bodily changes in the young person. **Hormones** are powerful chemical substances that regulate various organs in the body.

The endocrine glands that secrete the sex hormones are the pituitary gland and the sex glands, or gonads, referred to as **testes** in the male and **ovaries** in the female. The pituitary gland, or master gland, regulates a number of other glands. Control of the pituitary gland rests with the **hypothalamus**, which "instructs" the pituitary gland on the optimum level of hormone secretion. The hormones secreted by the pituitary gland are known as **gonadotropins**, and they activate the testes and ovaries, which are the parts of the endocrine system called the gonads. The gonads secrete hormones: androgen from the testes and estrogen from the ovaries. Males and females produce both **estrogen** and testosterone, although males produce more testosterone and females produce more estrogen. These hormones have an important effect on puberty in adolescence. Their effect is gradual as the hormones are gradually secreted, and the child moves toward physical and sexual maturity. The hormonal changes take place about a year before changes in the body and sex organs are visible (Peper et al., 2015).

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Implications for Practice:

Physical Changes and Psychological Consequences

Physical changes have psychological consequences for developing young men and women. With young woman, menarche is associated with greater social maturity, improved status among peers, higher self-esteem, greater self-awareness regarding their bodies, and increased self-consciousness (Petersen, 1987). These psychological reactions are convincingly described in this diary entry of Anne Frank (1952):

> I think what is happening to me is so wonderful, and not only what can be seen on my body, but all that is taking place inside. I never discuss myself or any of these things with anybody; that is why I have to talk to myself about them.
>
> Each time I have a period—and that has only been three times—I have the feeling that in spite of all the pain, unpleasantness, and nastiness, I have a sweet secret, and that is why, although it is nothing but a nuisance to me in a way, I always long for the time that I shall feel that secret within me again.

Puberty can be related to both positive and negative emotions; however, more recent research has found that young women do not have intense reactions to menarche but most find it mildly stressful. Most young women receive some information about menarche and that may explain why their reactions are less intense than in the past. One factor that influences whether a young woman's reaction will be positive or negative is early or late maturation.

Studies have found that, in general, it is better to be an early maturing rather than late-maturing boy. Research has found that early maturing boys perceived themselves more positively, had more successful peer relationships, were more athletically oriented, and were more confident when compared with late-maturing boys (Hoyt et al., 2020).

For young women, though, research has found early maturation to be a fairly strong risk factor (Hoyt et al., 2020). Early maturing young women (*maturity* defined as onset of menstruation) did not do as well academically and were more likely to have behavior problems. Early maturity in females is linked to risk for teasing and sexual exploitation. Studies clearly demonstrate that the physical changes that take place in boys' and young women's bodies can lead to positive or negative reactions. An explanation for many of the negative reactions is that the young people were not prepared for the changes they were experiencing (LeCroy & Daley, 2001). Most young women describe their first period as "a little upsetting." Although young women often receive some preparation, boys receive little or no preparation for their experiences of nocturnal emissions and spontaneous erections. What can be done to better prepare young people for these impending changes in their bodies? Information from comprehensive sexual education programs or from parents has shown to be helpful in creating a more positive adjustment for adolescents (Goldfarb & Lieberman, 2020). A cross-cultural perspective indicates that for young women, menarche is a sign of womanhood; therefore, it is surprising that in the United States we do not treat a girl's first menses as a rite of passage. Ritualized recognition may help young people experience their bodily changes as positive. Consider one girl's report of her reaction to her period (Beinggirl.com, 2014):

> I don't clearly remember getting my first period. My mom didn't prepare me, but I don't think I necessarily needed preparation because I had already witnessed my sister going through it. I do recall that I was in sixth grade, and it happened in May. I was pretty ready for it to come. I remember talking to my friends about it, hoping to become "grown up" soon. When it happened, I told my mom, sister, and grandma. Then I told some friends, and soon enough, everyone knew. I didn't really care about them knowing. I wasn't ashamed.

Although puberty clearly has an impact on adolescent development, many researchers are concluding that the effect is not as strong as it was once believed to be (Backes et al., 2019). Looking at this period within the overall framework of the life cycle, it clearly has an impact, but so do other facets of the life cycle. For some young people, puberty is a significant stress, but for most it is not. New challenges result from the biological changes, but there are also cognitive, social, and environmental changes to be dealt with. Biological change may not be the single source of significant change we once thought it was.

Biophysical Strengths, Hazards, and Risks

Increasingly, strengths are being recognized as an important part of the adolescent experience. For example, menstruation was previously perceived as an adverse experience for young women, but today it is known to elicit only a mild reaction. Also, much of the research on adolescent brain development is showing that the adolescent brain is not fully formed and functional but is a changing part of the biophysical development of the young person.

Adolescent Brain Development

Brain research in the past has focused on early childhood because it was believed that the brain had finished

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Physical activity is important for adolescents and can contribute to improved emotional and health outcomes.

its development by puberty. Most researchers now believe that **myelinization**, the process in which neurons surround themselves by a fatty covering called the myelin sheath, continues throughout adolescence. The myelin sheath insulates the wire-like fibers connecting regions of the brain, which allows impulses to travel faster and more efficiently, leading to improved problem solving and coordination, as well as faster reflexes.

An important implication regarding adolescent brain development is that parts of the brain related to emotions, judgment, and problem solving are later to arrive than previously believed. Indeed, a final growth spurt in the brain's gray matter occurs at around ages 11 to 13 in the frontal lobes of the brain—the regions that guide planning, problem solving, and judgment. Recent studies have found that one part of the brain, the amygdala, which governs emotional responses, expands in adolescence (American Academy of Child and Adolescent Psychiatry, 2017). Studies have looked at how teens and adults respond to the same facial images. Looking at photographs of facial expressions depicting various emotions, such as fear, adults identified the correct emotion, but teens surprisingly got it wrong, often saying the person was angry. Conducting functional magnetic resonance imaging of the subjects' brains showed a stark difference in parts of the brain being used. Adults used the advanced prefrontal cortex and the more basic amygdala to evaluate the facial pictures. Younger adolescents relied entirely on the amygdala; older adolescents showed a shift toward using the frontal area of the brain (American Academy of Child and Adolescent Psychiatry, 2017).

The overall implication of this new brain research is that cognitive functions such as problem-solving, maturity, and insight are still developing in adolescence. This helps explain why a 15-year-old might get into a car driven by an older friend who clearly has had too much to drink. This new understanding of the brain also raises new questions about ethics and legalities (Steinberg, 2023). Should teenagers be executed for crimes they committed when they were 15 years old? Many scientists believe that emerging biological explanations that adolescent brains are different mean that young people are less culpable (Ashford, Puzauskas, & Dormady, 2022; Steinberg, 2023). This new understanding about the brain influenced recent Supreme Court's rulings about capital punishment and juvenile life sentences.

Issues in Adolescent Health

Common Health Hazards in Adolescents	
Nutritional Needs and Eating Habits	A proper diet and physical exercise are especially important for young people. The rapid development young people experience causes an increased need for nutrients (Soliman et al., 2022). In general, an average girl needs 2,200 calories per day and an average boy needs 2,800–3,200 calories per day (Soliman et al., 2022). However, an adolescent male who is involved in sports may need as many as 5,000 calories in one day (Soliman et al., 2022). Often, adolescents do not get the proper nutritional diet. They frequently miss a meal, usually breakfast, and may fill up on low-nutrition, high-energy snacks rather than eating a proper meal. (Piernas & Popkin, 2010)

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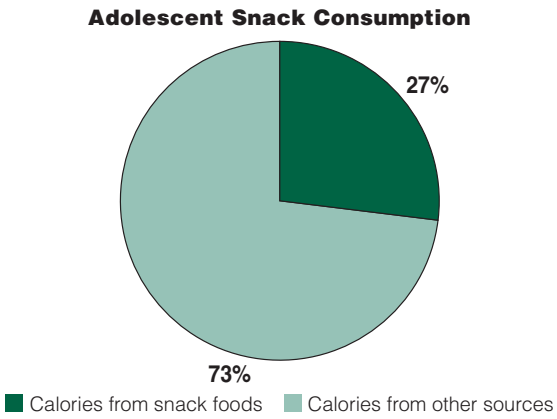

	It is not uncommon for adolescents to be lacking in the proper amount of fluid, protein, iron, and calcium. In addition, adolescents do not eat enough fruits and vegetables. Despite recent national initiatives to encourage healthy eating habits, teens in middle adolescence are eating fewer fruits and vegetables than they did 15 years ago, and one study (Larson, Neumark-Sztainer, Hannan, & Story, 2007) reveals that the situation only worsens as teens get older. The female adolescent's iron levels may be low from blood loss during her menses. An iron supplement is often recommended.
Weight Concerns	Obesity is an increasingly serious problem for adolescents (Saguil & Stephens, 2012). Obesity can be defined as a body weight of 20% or more above the recommended weight for one's height. The rate of obesity among children and adolescents has increased significantly in the last 20 years. In fact, in the United States it has quadrupled in adolescents. Obesity is a serious social problem for adolescents because of the name-calling, stigma, and rejection from peers that many young people experience. In adolescence, it is also important to recognize that many female adolescents develop excessive concerns about body shape, size, and weight. These concerns often lead to unhealthy eating behaviors and use of dietary supplements. Many children develop extra fat in response to the adolescent growth spurt. Once additional cells are formed, they may predispose the adolescent toward obesity in adulthood. In addition, eating behaviors established in adolescence carry into adulthood. Thus, 70% of obese adolescents become severely obese adults (Simmonds et al., 2015).
Dysmenorrhea	**Dysmenorrhea** is defined as cramping pain in the abdomen occurring just before or during menstruation (Estenson, 2015). It is a very common experience, and prevalence rates report it is as high as 90% (American College of Obstrecians and Gynocologists, 2018). *Secondary dysmenorrhea* also occurs, painful menses resulting most often from endometriosis. There is a widespread belief that menstrual pain diminishes either after the female reaches 24 years of age, when the uterus is completely mature, or after the birth of a baby, but this has not been consistently reported.
Acne	Acne, the most common skin disorder in the United States, is the result of increased androgen levels at puberty, which stimulate the production of sebum by the sebaceous glands of the body, usually the face. Acne is associated with genetic predisposition, but it is also related to accumulated oils in the body. Acne occurs in nearly 95% of adolescents with a decline occurring sometime after their 20th birthday (Skroza et al., 2018). Acne can lead to scarring of the tissue and can create embarrassment and social withdrawal. In recent years, oral antibiotics and topical retinoids have been used to greatly control the spread of acne; oral isotretinoin is used for severe acne administered using the iPLEDGE program (Titus & Hodge, 2012). No research has been reported that links diet—foods such as pizza, chocolate, or soda—to acne.

Continued

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Headaches	50% of adolescents who were at least 15 years of age had headaches. "Frequent" headaches were reported in 15% of those who were at least 15 years old (Lewis, 2002). Approximately 10% of adolescents and 20 to 30% of adolescent females experience migraine headaches (Youssef & Mack, 2019).
Sleep	Sleep, or lack thereof, has become an increasing concern among professionals who work with adolescents. The amount of sleep 10- to 18-year-old children get each night declines from about 10 hours in middle childhood to around eight hours by age 16 (Carskadon, 2011). Sleep experts believe adolescents need about 9.25 hours of sleep every night to be in good physical and mental condition. In one study (Dunster, 2019) it was reported that 90% do not get the recommended amount of sleep on school nights. Research has found that adolescents' circadian rhythms change and they are more alert in the afternoons and evenings and not alert in the mornings, when they require more sleep (Carskadon, 2011). Many difficulties emerge when young people fail to get enough sleep, including poor cognitive functioning, increased irritability, anxiety, and depression (Tarokh et al., 2016). Getting up for an early morning schedule leaves adolescents sleep deprived and physiologically unready to perform. Some schools have started the school day two hours later than typically required in order to improve students' academic performance. The widespread use of smartphones has also impacted adolescent sleep with one study stating that 72% of adolescents bring their smartphones to bed and use them while they sleep, and 28% leave their phones on at night and are awakened by notifications such as calls, texts, or social media alerts (Pew Research Center, 2015). This poses a serious issue to sleep quality as the blue light from smartphones at night further alters the adolescent's circadian rhythm (Ritcher, 2015).

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Obesity among adolescents has increased significantly and is a critical health concern.

Practice Guidelines:

Strategies to Prevent Obesity

- Improve the nutritional quality of food provided to children both at home and at school. Reduce reliance on poor quality snack food and soft drinks.
- Promote education in the schools that emphasize how to engage in healthy eating, how to obtain healthy food, programs for increasing physical activity, and promotion of a positive body image.
- Promote individually tailored programs for increasing physical activities and movement throughout the school day. Teach the importance of reducing sedentary time.
- Change the social environment and cultural practices that can support eating healthier foods and being more physically active.
- Teach parents how to support selection of nutritious foods, prepare more healthy meals and snacks, and how to promote alternatives to excessive screen time.
- Provide greater community access to fresh fruit and vegetables.

Exhibit 7.3 presents a model for understanding how to promote positive health choices.

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Exhibit 7.3 Promoting Positive Health Choices

Social Worker Guidelines		Adolescent Characteristics		Parent Behaviors
Initiate discussion of sensitive health topics to promote wellness	⇨	Concrete thinking style	⇨	Uses parental monitoring
Refinforce positive behavior. Encourage responsible decision making	⇨	Risk-taking actions	⇨	Sets limits, promotes responsible actions
Encoruage independent development Protect confidentiality	⇨	Strives for independence	⇨	Practices independence granting based on responsible behaviors
Promote adult thinking	⇨	Develops consequential support, encourages	⇨	Provides relationship with honest discussion

Study Table Biophysical Dimension of Adolescence

Biophysical Growth and Development

- Adolescent boys and young women experience a growth spurt during which they gain in height and weight. Adolescence begins with the onset of puberty, which is identified by the combination of the growth spurt, maturation of psychological mechanisms, and the development of secondary sex characteristics.
- During puberty, young women experience menstruation, which is the cyclic shedding of the uterine lining that leads to vaginal bleeding about two weeks after an egg is released from an ovary and is not fertilized.
- In boys, puberty may be indicated by nocturnal emissions (wet dreams) and facial hair.
- Secular trend is the tendency in young women toward earlier maturity as a result of a better standard of living, medical advances, and improved nutrition.
- The endocrine glands that secrete sex hormones, which produce changes in the young person, are the pituitary gland and the sex glands or gonads (testes in males and ovaries in females). The hypothalamus controls the pituitary gland. The gonads secrete hormones. The testes secrete androgen, and the ovaries secrete estrogen. Both males and females produce estrogen and testosterone, but males produce more testosterone and females produce more estrogen. Hormonal changes occur about a year before changes in the body and sex organs are visible.
- Menarche in young women is associated with greater social maturity, improved status among peers, higher self-esteem, and increased self-consciousness.
- Earlier maturation for boys leads to more successful peer relationships, a stronger athletic orientation, and more confidence. On the other hand, early maturing young women may be more at risk; they do not do as well academically and are more likely to have behavioral problems and a negative body image.

Biophysical Strengths, Hazards, and Risks

- The adolescent brain is not fully formed and functional, and cognitive functions such as problem solving, maturity, and insight are still developing. Myelinization, where neurons surround themselves by the fatty covering called a myelin sheath, continues throughout adolescence. A final growth spurt in the brain's gray matter in the frontal lobes, the regions that guide planning, problem-solving, and judgment occurs at around age 11 to 13. The amygdala, which governs emotional responses, expands in adolescence.
- Adolescents need to increase their calorie intake to match their rate of growth. Adolescents need to consume enough protein and calcium. Female adolescents also may need to take a iron supplement due to blood loss during menses.
- Obesity (a body weight of 20% or more above the recommended weight for one's height) in adolescence is associated with certain diseases, high blood pressure, and social and psychological problems.
- Dysmenorrhea is a cramping pain in the abdomen occurring just before or during menstruation.
- Acne is a result of increased androgen levels at puberty and can lead to scarring, as well as create embarrassment and social withdrawal.
- Adolescents need about 9.25 hours of sleep per night. Adolescents' circadian rhythm changes, and they become more alert in the afternoons and evenings, and less alert in the mornings.

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Psychological Dimension

Cognitive Development and Information Processing

Cognitive development in adolescence is identified with Piaget's last intellectual stage—formal operations. This period of development generally begins at around age 11 or 12. At this stage of development, the adolescent is capable of abstract thought; prior to this stage, the child could use only concrete thinking or concrete operations. Now a whole new world is opened up within the adolescent's mind—flexible and abstract thinking. Adolescents begin to understand abstract propositions and try to reason logically about them. This kind of logical problem solving is referred to as **hypothetical-deductive reasoning**. This problem-solving process uses hunches, or hypotheses, to solve a problem and follows a planned manner to test and evaluate the hypotheses until the best solution is discovered.

In fact, adolescents may begin to ponder the nature of their own thinking. They can think about why they were thinking about certain things. This kind of abstract thinking is also associated with idealism and thoughts about future possibilities.

Why do adolescents often concern themselves with such things as future life plans, their internal life, or developing their own ideology? Piaget (1967) would argue that this thinking is caused by the characteristics of **formal operational thought**. They can now think beyond the real to the possible and reflect on the nature of thought itself. For example, a young adolescent woman might think, "What would it be like if Sam and I were dating? Wait, why do I like Sam, how could a relationship with him be beneficial?" Exhibit 7.4 presents a summary of the major changes that occur with formal operational thinking.

Although Piaget's theory emphasizes a universal understanding of thought, it is important to recognize the individual variations that occur in adolescents' cognitive development. For example, research has found that only one out of three eighth-grade students are capable of formal operational thinking, and by late adolescence only about 60% of young people use formal operations (Steinberg, 2023). A critical factor in such thinking is the adolescent's experience and knowledge in certain areas (Galotti, 2017). In fact, many experts believe that Piaget's stage of formal operations reasoning is applicable only to technological societies where there is a lot of formal education and practice using such reasoning. In this manner, children and adolescents gradually build up knowledge through experience and practice in different areas.

Exhibit 7.4 Examples of Formal Operations and Logic in Adolescence

Major Changes in Thinking	Examples
Thinking about possibilities	"I would like to get to know her even better—she could be a good friend, or I might decide she'd be good as a girlfriend. We like each other. We can work out a closer relationship."
Testing hypotheses	"She told me she wasn't interested in being my girlfriend. After that, I thought young women just don't like me, that I'm not good enough looking or cool enough. But I've had other girlfriends and other young women have shown interest in me. Not all young women are going to like me—I just need to find the right girl for me."
Thinking about the future	"I have a girlfriend now, and we get along really well, but if we stay together, I won't know what it's like to be with other young women. In order to marry the best person, it seems that you need to have a lot of girlfriends."
Thinking about thoughts	"I keep thinking about how much other people like me. Am I really popular with other kids? But even if I'm not that popular, I've got a lot of good friends. I shouldn't worry so much about whether I'm popular and just keep the good friends I have."
Expansion of thought	"I was invited to a party, but my best friend, Tyler, wasn't. John, who's giving the party, doesn't like Tyler. If I tell Tyler, then he'll be mad at John—and John told me not to let him know. But if Tyler asks me, I don't want to lie to him. I don't know if I should keep my promise to John and lie to Tyler."

Communication

Along with an improvement in thinking abilities in adolescence comes a greater capacity for effective communication. The manner of a person's thinking logically relates to their ability to use language. For example, the use of metaphors increases during this time period. To understand metaphors, one must think beyond **concrete operations**. (A metaphor is a comparison of two ideas, such as in the statement "He has a heart of stone.") (Galotti, 2017).

Also, of particular interest in adolescence is the use of sarcasm ridicule (Santrock, 2023). Adolescents typically invent sarcastic labels for teachers, parents, and peers. For

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example, peers may be better known by their nicknames than by their real names.

Writing becomes much more meaningful in adolescence. This is the age when many young people begin a journal to record their inner thoughts and personal experiences. Adolescents can accentuate the important points they are trying to communicate because they can think logically about what they want to say before they write it down.

During adolescence, the nature of young men's talk and young women's talk begins to become increasingly differentiated.

In general, it appears that young men talk more in terms of competitive conversation, comparing knowledge and experience, whereas young women talk more about themselves, their personal feelings, and their relationships. Communicating about problems between gender identifications are also approached differently. While young women tend to offer emotional support, ask questions, and maintain a supportive demeaner, young men tend to approach problems by making jokes and engaging in comedic behavior (Rose et al., 2016).

With regard to communication, one thing is for sure: today's adolescents are more "connected" than ever before, with the widespread use of the internet and cell phones. (See social media section below for more details.) A new report finds teens report using some form of the internet almost constantly (Vogels, Gelles-Wantick, & Massarat, 2022). Often adolescents prefer to spend time texting each other than speaking directly. Although adolescents' use of media may appear extreme and is associated with negative outcomes, research has found some benefits—fostering a sense of connection with others, providing important resources such as adolescent health advice, and even opportunities for developing leadership skills (Plaisime, Robertson-James, & Meja, 2020).

Adolescent Communication and Confidentiality

There is a growing need for social workers to understand the social and legal aspects of communicating consent and confidentiality to adolescents. Because adolescents engage in a variety of health-risk behaviors, they need to access services without facing significant barriers (LeCroy, 2022). Unfortunately, adolescents vastly underutilize systems of care; they seek assistance less frequently than any other age group.

Concerns about confidentiality are becoming more complex, especially for sexually active adolescents and for LGBTQI adolescents. Although information about issues such as family planning and sexually transmitted diseases is protected as belonging to "confidential medical records," separate laws aimed at child abuse may require health professionals to report all sexually active adolescents younger than 18 to authorities.

A growing body of knowledge is making it clear that confidentiality is the foremost barrier in the effective treatment of adolescents. Studies have found that adolescents will not seek care from their physician for sexuality, substance abuse, or emotional issues if their parents have to know about the office visit (American College of Obstetricians and Gynecologists, 2020). More dramatically, one study reported that many adolescents with depressive symptoms cited concerns about confidentiality as their reason for not getting help (Radez et. al, 2020). Some fear parental retribution, lack of understanding, and damage to their reputation or self-worth (American College of Obstetricians and Gynecologists, 2020).

Practice Guidelines:
Adolescents and Confidentiality

- Practitioners should be clear about how confidentiality will be honored when working with adolescents.
- In order to address concerns regarding adolescent behaviors on the part of parents and the community, practitioners should try to encourage the adolescent to involve parents in important decisions as deemed appropriate.
- While every effort to maintain confidentiality should be followed, adolescents should be made aware that situations and circumstances create limits to guaranteed confidentiality.
- Social workers should become knowledgeable of community standards and state laws that can impact confidentiality (in most states where the adolescent has the right to give consent, confidentiality must be maintained).
- Record keeping should be considered in order to maintain and protect adolescent's right to confidentiality.

Adolescents have made it clear that in order for many of them to feel comfortable receiving services, they want clear communication about confidentiality. It is important to recognize that communicating directly with the adolescent alone, clarifying with whom the information will be shared, and creating a comfortable and trusting environment are needed to obtain candid information and offer help.

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Attitudes, Emotions, and Regulation

Adolescence is an important period for the developing self-concept. Young people set out to discover who they are and what they want to become. A significant part of this process results from a focus on self-reflection and thought. And indeed, there is much for the young adolescent to think about. Adolescents obtain greater freedom in behavior and decision making, increased opportunities for both acceptance and rejection by peer groups in dating and the awareness of their sexuality, and major decisions affecting their movement into adult life. If experiences are explored and reflected upon, the adolescent develops a more integrated self (Steinberg, 2023).

The founder of developmental psychology, G. Stanley Hall, is well known for his characterization of adolescence as a time of "storm and stress." In her writings, Anna Freud argued that such storm and stress is simply a part of normal adolescence. Psychoanalyst Peter Blos also believed that adolescence was a period of uncontrolled sexual and aggressive impulses. However, these early notions about the craziness of the teenage years are now considered myths. Experts in adolescent psychology (e.g., Adelson, Douvan, Offer, and Bandura) are increasingly concerned because the widespread idea that adolescence is a normal period of serious difficulty has mischaracterized the lives of millions of healthy adolescents. Although many people find it is difficult to believe, research has empirically supported the fact that the majority of adolescents are well adjusted, get along well with peers and parents, and cope well with their emotions and external environments. Recent changes in our society, like COVID-19, have taken a toll on adolescent mental health with increases in depression and suicides showing many of our youth are experiencing serious problems. For purposes of studying the issues that social workers and mental health professionals encounter most often, this chapter may still seem to focus mostly on the problem behaviors or alternative attitudes of teenagers. It is important to remember that many teens are not like the ones this text uses as examples.

Adolescent Self-Esteem

Self-esteem is a global evaluation of one's self, often referred to as self-image or self-concept (Parise, Caann, Olivan, & Ferran, 2019). What does research on adolescent self-esteem tell us about adjustment in adolescence? In general, we find that self-esteem can vary depending on the stage of adolescence. During early adolescence (ages 11–14 years), self-esteem appears to reach its lowest point (Steinberg, 2023. During these years, young people are highly self-conscious, and their self-perceptions are more easily influenced. This is especially true of young women making the transition to junior high school (Bialecka-Pikul et al., 2019). It is important to emphasize that, overall, most adolescents emerge from this developmental phase with about the same amount of self-esteem as they had at the outset.

Much of self-esteem is tied to how adolescents assess their ability to meet short-term goals. Indeed, an important lesson in adolescence is the understanding that we all fall short of goals—we can't be the best at everything, win consistently in all sports, or get the top grades in every subject. Adolescents can sometimes see such failures as significant setbacks and may interpret such events as devastating failures.

Adolescent emotions can move from extreme happiness to extreme sadness within minutes; mood swings are especially common in early adolescence (Toenders et al., 2022). Adults, by contrast, often take hours to change from one mood to the next. Research on adolescent's moods suggest that adolescents must learn to come to terms with the downs as well as the ups. Instead of allowing the downs to completely overtake them, they need to strive for greater balance and perspective.

Exhibit 7.5 presents some interviewing suggestions to help assess students' sense of themselves and their level of self-esteem and Exhibit 7.6 provides additional interviewing suggestions utilizing the SSHADES screening, a strength-based psychosocial assessment. Although

Exhibit 7.5 Assessment Questions for Interviewing Adolescents about Self-Esteem

Ask about how the adolescent responds to success and failure. Does he or she see small setbacks as a complete failure? Or is he or she able to understand that some setbacks are temporary and that other opportunities will be available?
Ask adolescents about school progress. What positive aspects of school can they tell you about? What negative aspects of school can they tell you about?
Ask about how adolescents feel about themselves. Given a magic wand, what would they change about who they are?
Ask about friends. How many close friends do they have? How would they define a "close" friend? What activities do they like to do with friends? How much time do they spend alone?
Ask about interests and activities. What do they like to do? Are they involved in any sports or after-school activities?
Ask about short-term and longer-term goals? How do they see their future?

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Exhibit 7.6 SSHADESS Strength-Based Psychosocial Inventory

Aspect of Life	Possible Questions
Strengths	What do you enjoy doing? What are you most proud of? How would your best friends describe you? How would you describe yourself? What are your "special skills"? What is your favorite part about yourself?
School	What are your favorite and least favorite aspects of school? What do you want to accomplish when you get older? How do you think you are doing in school? How are your grades? (If school/grades are going poorly, probe for more information about why)
Home	Who do you live with? How well do you get along with people you live with? Do you have anyone in your household you can trust if you are stressed or struggling?
Activities	Do you have a best friend you can trust outside of your family? Do you have a trusted adult outside of your family? Are you still involved in the same activities as last year? Are you spending the same amount of time with your friends as you did a year ago?
Drugs/Substance Misuse	Do any of your friends use drugs, alcohol, or vape? Do they talk about doing drugs, drinking, or vaping? Do you vape? Drink alcohol? Have you ever tried marijuana or other drugs? Have you ever taken a medication to get high? When you smoke, drink, or get high, how does it make you feel? Do you know why you smoke, drink, or get high?
Emotions	How have you been feeling lately? Have you been feeling stressed? How has your sleep been lately? Have you struggled to get sleep? Have you been feeling down, sad, or depressed? Have you had thoughts of hurting yourself or someone else? Have you ever tried to hurt yourself?
Eating	What is your diet like? Would you describe yourself as a healthy eater? Have you been trying to gain or lose weight? What has been motivating you to do that?
Sexuality/Sexual Behavior	(Use gender neutral language) Are you attracted to anyone? Tell me about them. Are you comfortable with your sexual feelings? Do you feel comfortable letting me know your sexual orientation? What kinds of sexual activities have you done? Kissing? Touching? Oral sex? Sexual intercourse? Have you ever been worried about/exposed to/or had a sexually transmitted infection?
Safety	Do you feel safe at your school? (If no, why?) Do you ever carry weapons? (If yes, why?) Have you ever been bullied or bullied someone? Has anyone ever touched you physically or sexually when you did not want them to?

Source: SSHADESS tool is based on Tool and Questions from American Academy of Pediatrics. From *Reaching Teens: Strength-Based Communication Strategies to Build Resilience and Support Healthy Adolescent Development (2014).*

some might think that the challenges posed by growing up as an African American might mean that African American adolescents have lower self-esteem compared with majority of White youth, such an assumption is simply not true. During the period of school desegregation, it was believed that African American children suffered damage to their self-esteem because they were in segregated schools. However, research that examined this issue found there are no differences in self-esteem between African American children in segregated and

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desegregated schools (Twenge & Crocker, 2002). Adolescents of color do experience greater discrimination, poverty, and social and educational barriers than White youth do, and as a result, we can predict larger challenges for African American adolescents. However, as Gibbs (2004) has pointed out, social workers must be careful about overpathologizing and stereotyping all African American youth as victims of their racial identity or class status: The majority of African American youth cope effectively with both. Exhibit 7.7 presents an assessment tool that measures self-liking and competence for youth.

Practice Guidelines:

Enhancing Adolescents' Self-Concepts

There are four main strategies for enhancing adolescents' self-concepts.

1. Encouraging achievement. Adolescents can be guided to emphasize the areas in which they are more likely to succeed. A less physically coordinated young person can become more skilled in playing a game that requires intellectual skills. Studies on assertiveness training with young people have found results that show an increase in self-esteem (LeCroy, 2004). Sometimes adolescents need to work harder at achieving their standards of excellence or to accept a good performance in place of a perfect one (LeCroy, 2022).
2. Promoting competencies in specific areas. Many adolescents begin the process of insisting on irrational standards of behavior. These "shoulds" and "musts" can take the place of recognizing actual accomplishments (LeCroy & Daley, 2022). Adolescents who are taught to recall positive thoughts and feelings about competent behaviors show an increase in self-esteem (LeCroy, 2004).
3. Provision of peer and parental support. Self-esteem can be related to peer-group formation. Studies find that self-esteem is improved when both peer and parental support are provided and by participation in community and school experiences (LeCroy, 2022).
4. Developing coping skills. Coping abilities relate to both enhanced self-esteem and reduced stress (Frydenberg & Oakland, 2010). When adolescents use coping abilities to solve problems, the result is often positive self-evaluations and increased self-esteem. When taught coping strategies, adolescents learn to face problems realistically and honestly (Wingood, Sales, Braxton, & DiClemente, 2008).

Exhibit 7.7 Assessment Tools: Self-liking and Competence Scale

For each statement below, please mark the response that seems most appropriate for *you*. How strongly do you agree or disagree that …

MARK (X) ONE FOR EACH QUESTION

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
A. I feel comfortable about myself.	☐	☐	☐	☐	☐
B. It is often *unpleasant* for me to think about myself.	☐	☐	☐	☐	☐
C. I tend to *devalue* myself.	☐	☐	☐	☐	☐
D. I focus on my strengths.	☐	☐	☐	☐	☐
E. I feel *worthless* at times.	☐	☐	☐	☐	☐
F. I'm secure in my sense of self-worth.	☐	☐	☐	☐	☐
G. I like myself.	☐	☐	☐	☐	☐
H. I do *not* have enough respect for myself.	☐	☐	☐	☐	☐
I. I feel good about who I am.	☐	☐	☐	☐	☐
J. I have a *negative* attitude toward myself.	☐	☐	☐	☐	☐

Source: Adapted from Tafarodi A, R.W., & Swann, W. B. Jr. (1995). Self-liking and self-competence as dimensions of global self-esteem: Initial validation of a measure. *Journal of Personality Assessment, 65,* 322–342.

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Youths of Color, Adolescent Identity, and Critical Race Theory

Identity in adolescence is a significant developmental task, and often it is an even more critical task for the adolescent of color. During adolescence, youths must integrate their image of being from an ethnic group while being exposed to values and images of the mainstream white culture. Young people often perceive a negative image from the White majority and then face the task of developing a positive identity as a member of an ethnic group (Rivas-Drake et al., 2014). Because of their cognitive maturity, adolescents of color are often quite aware of how others evaluate their minority status. By using critical race theory researchers are developing a better understanding of how multiple forms of oppression can intersect with the lives of adolescent youth and the implications of those intersections.

Issues that such youths face as they focus on identity development include racial stereotypes that affect their "looking-glass self," cultural devaluation of the symbols and heroes of their group, and lack of successful role models with whom to identify. Identity development during adolescence leaves many young people making comparisons between themselves and others. Eventually, adolescents of color must reconcile their lives from the standpoint of two contrasting cultural systems—their own ethnic and cultural values, and the cultural values of the White majority. This often leads to three alternatives: assimilation, the youth lets go of their culture of origin while incorporating the norms and ideals of the host country; acculturation, the youth learns how to incorporate both the culture of origin while incorporating the norms and ideals of the host county; and enculturation, where the youth recaptures the culture of origin, learns about it, identifies with it, and reinforces its basic norms and values (Marsiglia, Kulis, & Lechuga-Pena, 2021). The Focus on Lived Experiences presents the voice of an African American girl who identifies with the hip-hop culture.

Ground Picture/Shutterstock.com

In adolescence, youth must integrate their image of being from an ethnic group. This mixed ethnicity youth will become more aware of how others see him.

Focus on **The Lived Experience**

An Open Letter to the World

Dear World,

I am a Black child, a Black child with pride, dignity, strength and courage, and intelligence.

You wonder, "Is it possible for a black child to possess all those qualities?" And, of course, the realization that I do scares you to death. So . . . as you continue in your state of deep, never-ending denial of my will to survive, you deprive me of my heritage, misinform me of my accomplishments, omit my history from your schoolbooks, try to ban my musical education, tear down my community with drugs, disease, police brutality, and more.

I have been oppressed and enslaved for many years. Every time you think you've won, I, and all of my brothers and sisters, rise to the occasion, and you lose again. I'm still here, and I'm still Black.

I am a Black child, here to return my people's dignity, to retrieve my people's history and, most of all, I am today's Black child, striving to become tomorrow's black future.

—Sheila "Da Moon" Rose

Source: Carlip (1995). *Girl power: Young women speak out.* New York: Warner Books, p. 214.

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Implications for Practice:
Identity and Independence

Independence is a related aspect of developing an identity. To help a young person successfully develop an identity, issues of independence need to be carefully reviewed. Young people face many challenges as they attempt to establish an identity—making new commitments to friends, gaining greater independence from parents, developing more intimate friendships and relationships, and confronting social discrimination. Also currently, the young person is increasingly learning to reflect on his or her actions as he or she makes increasingly important life decisions.

Parents can be important influences in the adolescent's development of identity (Santrock, 2022). Research has found that the adolescent's connectedness to parents and the presence of a family atmosphere promote individuation in the adolescent's identity development. *Connectedness* refers both to the adolescent's sensitivity to and respect for others' views and to the adolescent's openness and responsiveness to others' views. *Individuation* has two parts—separateness and self-assertion. Separateness is the expression of the individual's distinct self from others. Self-assertion refers to adolescents' expression of their viewpoints and their clear communication.

Consider the situation in which the adolescent's mother has not "let go" of her daughter. The girl is tied to the mother financially and emotionally in ways that do not let her mature independently. Under these circumstances, the girl could develop difficulties in developing mature intimate relationships and in career choices (Santrock, 2022). She may turn down important opportunities for more responsibility, doubting her ability to be independent. Similarly, rather than confronting difficulties in her intimate relationships, she may turn to her mother for support and comfort. In working with adolescents, social workers need to be aware of their need for independence and help young people chart a course of increased maturity. This may involve working with parents or school staff on independence-granting skills to encourage responsibility and maturity. Too often, society sees the young person as immature and not ready for adult roles rather than systematically encouraging the young person to take increasing responsibility for mature behavior.

It is important to recognize that such notions about individuation and independence are culture bound). Indeed, adolescence has been described as a culture-bound syndrome. In Latino/a/x families, interdependence is a more appropriate concept. Indeed, the one characteristic that many people believe is consistent in most Hispanic cultures is family commitment—based on loyalty, support, honor of the family, and duty to care for family members. These notions are in conflict with the more mainstream emphasis on individualism. Research studies (Naer & Schmitz, 2007) confirm that Hispanic adolescents are more likely than White adolescents to adopt their parents' occupational preferences, lifestyle, and commitment to religious and political beliefs. The implication is that for Latino/a/x adolescents the move to independence may look more like interdependence, whereby the young person is less likely to move away from the family but takes on more responsibilities for the family.

Cognitive Monitoring and Moral Development

A number of theories have been put forward in examining some of the changes that take place in adolescent thinking. Two primary theories are social cognitive monitoring and **moral development**. **Social cognitive monitoring** is a person's ability to monitor and make sense of his or her social thoughts. This development of conscious self-awareness increases during middle childhood and adolescence. Such social awareness is indicated by thoughts like "I don't think I'm easily influenced by others" or "I'm going to have a difficult time talking to and getting to know this person." These kinds of thoughts exemplify how adolescents monitor their social world. As young people develop, they begin to recognize that social thoughts are difficult to assess. Also, experiencing different aspects of others can decrease their accuracy in assessing social thoughts. For example, witnessing another person expressing strong emotions may lead to an inaccurate understanding of that person. As this process develops, children learn that people sometimes do not think accurately about others because they have caught them in a bad mood and have judged their behavior stemming from the bad mood as meaning something more enduring about that person (Galotti, 2017). Moral development is a theory about the stages of thinking that people go through as their sense of morality develops. Kohlberg built on the ideas of Piaget that thinking develops systematically as a person develops. Consider the following moral dilemma:

A woman was dying of a particular type of cancer. However, there was one drug that doctors believed could save her. A druggist in the town where the woman and her husband lived had discovered this drug. Although the drug was expensive to make, the druggist was charging ten times what the drug cost him to make. He paid $200 for the drug and was charging $2,000 for a small dose of it. The woman's husband, Heinz, went to all their friends

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to borrow money for the drug; however, he gathered only $1,000—half the cost. He told the druggist that his wife was dying and asked him to sell it more cheaply or let him pay later. The druggist said, "No, I discovered the drug, and I am going to make money from it." So Heinz got desperate and broke into the druggist's store to steal the drug for his wife. (Kohlberg, 1969)

This story raises a number of difficult moral questions. Does the husband have a duty to steal the drug for his wife if he cannot get it in another way? Did the druggist have a right to charge so much for the drug?

This story and these types of questions are a common method of investigating adolescents' moral judgments. The attempt is to find out how the adolescent thinks about moral dilemmas in which there is no clear right or wrong answer. How a person reasons about whether to steal or not steal the drug is an indication of his or her stage of moral development. Moral development also refers to the rules of conduct people use in their interactions with others. For example, the adolescent could reason that he or she should not steal the drug because stealing is against the law. However, another line of reasoning might be that stealing the drug is acceptable because it is unfair to charge such a high price for the drug, and it is worse to have the wife die from not receiving the drug than it is to steal.

Kohlberg believes that rules of conduct develop as individuals progress through stages. Each stage represents a different way of reasoning about various rules of conduct. In this model, summarized in Exhibit 7.8, there are six separate stages of moral development that begin in the preschool years and continue through adulthood. These stages can be thought of as theories of right and wrong that we carry around with us. Each stage has a different idea of what's right and a different idea of the reason a person should be good (Lickona, 1983). For example, in early adolescence, young people are in a stage of "interpersonal conformity" where "what is right" is to be a nice person and live up to the expectations of others, and the "reason to be good" is to make sure that others will think well of the individual so that they can think well of themselves. As adolescents mature, they are more likely to enter a stage of responsibility to the "system," where what is right is to fulfill one's responsibility to the social or value system and the reason to do this is so that the system doesn't fall apart. As people progress through each stage, they get closer to a fully developed morality. The stages correspond to

Exhibit 7.8 Kohlberg's Stages of Moral Reasoning Showing Sample Responses to the Heinz-and-Druggist Dilemma

Stage of Moral Development	Examples of Moral Reasoning That Support Stealing the Drug	Examples of Moral Reasoning That Support Not Stealing the Drug
Preconventional Reasoning		
1. Punishment and obedience	Heinz should not let his wife die, reasoning: he will stay out of trouble.	Heinz should not get caught because he will end up being sent to jail.
2. Self-interest	If Heinz does get caught, he should give the drug back, reasoning: he will serve a long jail sentence.	The druggist is in a business and he deserves to make money from his business.
Conventional Reasoning		
3. Conformity "good girl, good boy"	Heinz is being a good husband; he is doing this because he loves his wife.	Heinz cannot accept blame if his wife dies; the druggist is being selfish.
4. Law and order	If Heinz did nothing, his wife would die; it is his responsibility if she dies, reasoning: if he steals the drug, he can pay the druggist later.	It is always wrong to steal. Heinz will suffer from guilt if he does steal the drug.
Postconventional Reasoning		
5. Human rights; social contract	There is no law set up for this situation. Although stealing the drug is wrong, Heinz is justified in doing it.	This situation doesn't justify someone taking the law into their own hands. Heinz should not be guided by emotions; he should consider the long-term implications and not lose respect for himself.
6. Universal human ethics	If Heinz steals the drug, he would live up to society's expectations, but he would let down his own conscience.	Heinz should think about other people who might need the drug as well as his wife. His actions should be guided by a universal ethic of the value of all lives involved.

Source: Adapted by authors from Kohlberg, L. (1981). *Essays on moral development, Vol. 1: The philosophy of moral development.* San Francisco: Haper & Row; Lickona, T. (1983). *Raising good children.*

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the preconventional and postconventional stages of moral reasoning described by Kohlberg.

Although Kohlberg's theory of moral development has received considerable support, questions have been raised concerning the link between moral thought and behavior, the quality of the research, and gender bias. To what extent is moral judgment associated with behavior? Do people who reason differently also decide to act on the basis of their judgments? These are difficult questions, and researchers have not found consistent results (Krebs & Denton, 2005). Perhaps moral reasoning does not directly affect behavior but may provide a sense of direction and ethical standards.

Another issue involving moral development has to do with gender bias. Most moral development research has been primarily conducted with males. Carol Gilligan (1982, 1989) is well known for her criticism of Kohlberg. She contends that his theoretical perspective is based on a **justice perspective**, in which the focus is on the rights of the individual. People are characterized as standing alone in their decision making. In contrast, Gilligan offers a theory based on a **care perspective**, in which the focus is on people's connectedness to others. Her theory emphasizes attachments, allowing for both self-sacrifice and self-promotion, with connections being seen as most important. There is more of a focus on interpersonal communication. According to Gilligan, Kohlberg has underestimated the care perspective underlying moral development for both males and females. Recent research suggests most people reason using both perspectives. Although Gilligan's classic criticism of Kohlberg may not stand up to research, her contribution that individuals consider both justice and caring perspectives have advanced the field greatly.

Implications for Practice:
Adolescent Moral Development

To further illustrate how moral development can be used to better understand adolescence, we will use independence as an example. Most young adolescents are in stage 3, interpersonal conformity. At this stage, young people seek to be nice people—so that others will think well of them and they can think well of themselves.

A significant challenge for parents is confronting the typical conformist reasoning apparent at this stage. This is best done by teaching the value of independence and strengthening the young person's ability to be her or his own person and resist the pressures of the peer group (Lickona, 2004). Lickona presents a parent's perspective on how to challenge adolescent thinking at this stage. He presents six ways to help adolescents break free of typical conformist reasoning:

1. Be an independent person yourself.
2. Talk about the value of being independent.
3. Help young people think of words to say.
4. Help young people understand themselves.
5. Help young people put popularity in perspective.
6. Challenge the "group morality" of stage 3.

Lickona (2004, p. 190) presented an example of how parents can help their children move beyond group morality:

Will, who was on the junior high school baseball team, told his mother that the coach had kicked a kid off the team. Kids who thought it was unfair were talking about boycotting practice.

"Do *you* think it was unfair?" his mother asked.

"I'm not sure," Will said. "I just heard about what happened from some other kids. I didn't see it. According to them, Mr. Thompson accused Eric Miller of goofing off when he wasn't doing anything wrong. Then he just told him he was off the team."

"I see," his mother said. "So it's hard to be sure exactly what happened. What do you think of the boycott idea?"

"I don't know," Will said.

"How will you decide what to do?"

"I'll find out what other kids are going to do."

Will's mother tried to get him to examine the inadequacy of this kind of moral thinking. "What will you do then?"

Will sighed and shrugged his shoulders.

"So can you decide what's right on the basis of what the other kids are doing?"

"I guess not," Will said.

"Right," his mother said. "You have to use your own judgment. Think about what's fair, and what's going to help you, the coach, and the team. Would a boycott help matters?"

"No, not really."

"What else can be done?"

Together, Will and his mother came up with the idea that he could go to Mr. Thompson privately the next day and ask if he would call a meeting of the team to talk about what happened.

Moral reasoning is related to egocentrism, discussed in the next section, as both concepts examine in detail how an adolescent thinks and the implication on behavior. Psychological interventions have been developed using both of these concepts with the idea that if we help young people change their thinking it can change how they function.

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Egocentrism

"I hate eating at the swimming pool. Everyone just stares at you. I never know if I've got ice cream all over my face or if guys are just trying to look at my body," Janna said with a sense of desperation. Her friend, Anita, has a similar reaction: "I know, you can never look right at this place. I mean, with wet hair and no makeup I think people are looking at me and saying, gosh, I didn't think she looked that bad. I keep thinking that guys who might think I'm reasonable-looking will come here and see me and never give me a second look."

This conversation between Janna and Anita at the local swimming pool represents what David Elkind (2006) has referred to as adolescent egocentrism. Egocentrism refers to a type of thought that is characterized by preoccupation with one's behavior, feeling, or thoughts in a self-conscious manner. It is the onset of formal operational thinking that is believed to lead to such egocentric thought. Elkind discussed two aspects of egocentric thought—the imaginary audience and the **personal fable**.

The **imaginary audience** is the belief that others are as preoccupied with the adolescent's behavior as they are. Adolescents harbor this notion that they are "on stage" and that everyone is their audience. Adolescents' preoccupation with their own bodies may be a result of their egocentric thinking. In the conversation above, both Janna and Anita believed that everyone's attention was directed at them, and therefore they were very concerned about their appearance.

The personal fable reflects adolescents' sense that they are indestructible and unique. In fact, they are so unique that no one can understand what it is like to be them. In their self-focus, they also come to believe that they are indestructible. Things simply are not going to happen to them.

Antonio Guillem/Shutterstock.com

Egocentric thinking, or preoccupation with one's self, is common among adolescents.

Psychological Strengths, Hazards, and Risks

What is your image of the adolescent in the twenty-first century? Is it an adolescent stumbling around drunk? An emaciated teenage body? A pierced body? A pregnant teenager? Society has fallen prey to a number of negative images when it comes to our young people. Most people don't refer to adolescents as healthy, well-functioning, and serious even as they undergo a number of stressful life changes. Yet healthy adolescents are likely the norm rather than the exception (Belcher et al., 2021). For many years, researchers on adolescence have been arguing that most adolescents develop into independent, healthy, and well-functioning adults!

Why do some adolescents become more negatively influenced by stress than others? This question has led the way for researchers to better understand how risk factors contribute to stress-related problems and how protective factors buffer the negative impacts of stress. Adolescents who do well in spite of the stresses they face are referred to as stress-resistant adolescents (Srivastava, Singh, & Srivastava, 2014). These young people "bounce back" despite enduring intense pressures that would have a negative impact on most young people.

What is the model for stress resilience for young people? Several studies have identified qualities of adolescents and their social environments that lead to better outcomes despite impending stress (Belcher et al., 2021; Masten, 2001). Factors that appear to contribute to adolescent stress resistance include the following:

- Positive and nurturant relationships with others
- Caring relationships with parents
- Easy temperaments, optimism, and a positive perspective about the future
- An internal locus of control and good self-regulation
- An active coping style
- Good social skills and social support
- Positive relationship with parents and extended family members
- Good cognitive skills (problem-solving abilities) and intellectual abilities
- Outside activities and hobbies

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As Masten has noted, there is nothing magical here—stress-resistant adolescents have obtained important resources and use them to cope better with stress.

Adolescent Mental Health Disorders

Social workers interested in community mental health with children and adolescents need to become quite familiar with the mental health problems associated with adolescence. During this developmental time, many mental disorders first begin—in fact more than 50% of all mental disorders begin by age 14 (Child Trends, 2013). Some of the more common disorders diagnosed in adolescence include depression (4.4%), anxiety (9.4%), behavioral problems (including **conduct disorder**) (8.9%), eating disorders (5.2%), and attention-deficit hyperactive disorder (ADHD; 9.8%) (Center for Disease Control and Prevention, 2022; National Eating Disorders Association, 2021. However, youth may not meet criteria for a mental disorder but have significant emotional distress or cause concern from others that lead them to seek mental health treatment. Exhibit 7.9 shows the range of common reasons mental health treatment is sought among adolescents aged 12 to 17.

These results show the significant problem depression is in adolescence.

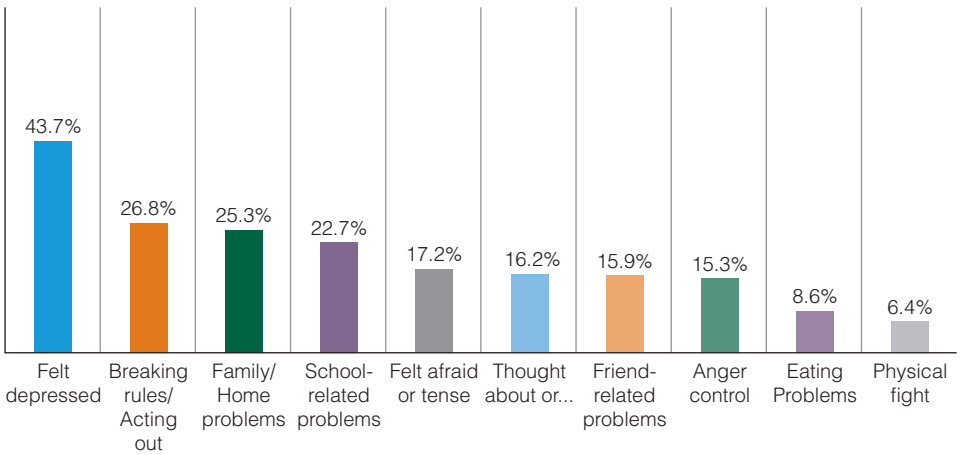
Depression and Suicide

Internalizing disorders such as depression are common in adolescence, and suicide is the third leading cause of death among adolescents (American Foundation for Suicide Prevention, 2020). Additionally, the Youth Risk Behavior Survey (Centers for Disease Control and Prevention, 2022) found that 8.9% of youths in 9–12 grade attempted suicide within the past 12 months with Native American students reporting the highest attempt percentage at 25.5%. Further, between 2010 and 2020, the suicide rate has increased 53% and the recent pandemic has raised even more concerns (Centers for Disease Control and Prevention, 2022). The average onset of depression is between 13 and 15 years of age, and females experience depression two times as often as males. When adolescents experience depression, they suffer emotional distress, problems in daily living and functioning, and often have problems in social relationships. Depression often goes undetected, and it is estimated that 50% of all cases are missed because of absent or poor screening (Corona, McCarty, & Richardson, 2013). In a recent study, it was found that 62% of adolescents with depression have not received follow-up care within one year of diagnosis (Rice et al., 2017). Surprisingly, only 20 to 40% of children who attempt suicide receive follow-up care after getting medical treatment (Chamberlin, 2012). The fact is in-hospital emergency rooms rarely have mental health or social work services available.

Assessment and screening for depression can be facilitated using a number of different questionnaires. The Patient Health Questionnaire (PHQ-9) is free and has been adapted for adolescents; the Beck Depression Inventory and the Children's Depression Inventory are also widely used instruments.

The Patient Health Questionnaire for Adolescent Depression can be used to screen for depression (see Exhibit 7.10).

Exhibit 7.9 Percentage of Common Reasons Adolescents Seek Mental Health Treatment



Note: Estimates are based on different reports and studies, adapted by the authors from Knopf, A. (2008). *The mental health of adolescents: A national profile.* National Adolescent Health Information.

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Exhibit 7.10 Assessment Tools: The Patient Health Questionnaire for Adolescents

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks?** For each symptom, put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like schoolwork, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? [ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes [ ] No

Note: *If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Source: Patient Health Questionnaire Modified for Teens, Spitzer, Williams, & Kroenke, (1999). Scoring: No or minimal depression, 0–4; mild depression, 5–9; moderate depression, 10–14; moderately severe depression, 15–19; severe depression, 20–27. For teens to screen as major depression, these criteria must be met: questions 1 and/or 2 indicated as a 2 or 3, 5 or more symptoms indicated as a 2 or 3 questions 1–8, and a 1, 2, or 3 for question 9. The "how difficult" question should be rated "somewhat difficult."

Practice Guidelines:

Working with Depressed Adolescents

The following tips can be useful with conducting treatment with depressed adolescents:

- As part of routine assessment with adolescents, ask questions that address both depression and suicide; depression may not be apparent in the adolescent's day-to-day behavior.
- Use a depression screening tool as additional data to add to interview data. Specific questions on the screening tool can be followed up in an interview to better understand context.
- Assess risk for suicidal behavior.
- Provide empathy and support acknowledging that discussion of feelings may be difficult and emotionally distressing.
- Assess for comorbid conditions such as substance abuse, ADHD, anxiety disorder, and others.
- Match the adolescent needs and situation with the best approach to treatment, which may be individual therapy, group-based cognitive behavior therapy

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(CBT) for depression, family therapy, or some combination.

- Address concerns about confidentiality and stigma, help the adolescent with peer and family interactions that may be related to their depression.
- Encourage activities that induce "behavioral activation"—getting out and being active, exposure to new experiences, and mastery of skills.

Practitioners should also be direct in their assessment about suicidal thoughts and actions. Questions like the following can be used:

"Have your feelings been so difficult that you wish you were dead?"

"Have you ever had any thoughts about wanting to kill or hurt yourself?"

"Have you ever actually tried to hurt or kill yourself?"

"Do you have a plan for how you would do such a thing?"

"Do you have access to a gun or weapon?"

Identifying Risk Factors for Suicide Attempts among Navajo Adolescents

Suicide is the third most common cause of death in adolescents. The suicide rate for youths has tripled during the past 30 years. Native Americans and Alaskan Natives have the highest suicide rates of all ethnic groups, more than four times higher than for adolescents of all races, and suicide is the second-leading cause of death for Native American youth (Rabasca, 2000). In Native American communities, people often form close groups and experience multigenerational difficulties that originated with efforts to force their assimilation into mainstream Western culture. Many experts believe the repression of Native American cultures has caused a long-term trauma, often referred to as *postcolonial stress disorder*. In this instance, the trauma is caused not by a specific event but by a long-term oppression. Adolescent Native Americans have been raised by parents and grandparents who have experienced this long-term trauma. Recent data (CDC, 2011) show 21.8% of Native American youth reported serious thoughts of suicide and 14.7% reported an attempted suicide. The following factors have been shown to function as protective factors: mental health treatment, social connections, problem-solving skills, and contacts with caregivers. The four key risk factors include prior suicide attempt, drug or alcohol abuse, anxiety disorders, and access to lethal means (Suicide Prevention Resource Center, 2013).

Conduct Disorder

Lauren was very active as a young child. Her parents complained that she was difficult to manage at as early as four years old. At that time, they believed that Lauren

Focus on **The Lived Experience**

Identity and Native American Youths

Consider the following story about a conversation between a Native American and an Anglo youth (Coles, 1986). "In school, I drew a picture of my father's horse. One of the other kids wouldn't believe that it was ours. He said, 'You don't really own that horse'. I said, 'It's a horse my father rides, and I feed it every morning'. He said, 'How come?' I said, 'My uncle and my father are good riders, and I'm pretty good'. He said, 'I can ride a horse better than you, and I'd rather be a pilot'. I told him I never thought of being a pilot."

The boy is clear about the differences between himself and the Anglo youth he knows. "The Anglos I've met, they're different. I don't know why. Anglo kids, they won't let you get away with anything. Tell them something, and fast as lightning and loud as thunder, they'll say, 'I'm better than you, so there!' My father says it's always been like that."

The following poem by a 12-year-old reflects the development of his peaceful identity as a Native American youth (Coles, 1986):

Rivers flow. *The sea sings.*
Oceans roar. *Tides rise.*
Who am I?
A small pebble on a giant shore;
Who am I
To ask who I am?
Isn't it enough to be?

Source: From Political Life of Children by Robert Coles. Copyright © 1986 Robert Coles. Used by permission of Grove/Atlantic, Inc.

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just would not listen and follow their instructions. Both parents used reprimands and spanked Lauren, but to no avail—she was her own boss. As she got older, Lauren became argumentative and increasingly noncompliant. When requested to be home at a certain time or to do a chore, Lauren often would exclaim, "I don't have to if I don't want to." Easily "set off," Lauren would yell at her parents and scream, "I hate you." She has been increasingly absent from school. School officials claim she is involved in a gang that sells and uses drugs. One of her girlfriends is now on probation after having been arrested for shoplifting.

Lauren's pattern of behavior would easily fit into the category of conduct disorder (see Exhibit 7.11), which is a constellation of behaviors that range from oppositional and noncompliant behavior to delinquent behaviors such as stealing, robbery, and physical assault (Pisano et al., 2017).

It is difficult to estimate the prevalence of conduct disorder, because it represents a fairly large heterogeneous group. For example, some researchers distinguish between delinquent and nondelinquent conduct problems, and others refer only to delinquent behavior. The estimate of prevalence is between 2 and 10% in the general population and is consistent among racial and ethnic groups (Mohan et al., 2022; Kazdin & Rotella, 2014; Searight, Rottnek, & Abby, 2001). We know that each year between 4 and 5% of young people are referred to the courts for suspected offenses other than traffic violations. However, twice as many young people come in contact with the police but are not arrested. Also, studies of "normal" children indicate that most (up to 80%) have engaged in illegal or antisocial behavior (Searight et al., 2001).

Exhibit 7.11 Clinical Features Conduct Disorder

Clinical Features Conduct Disorder
Conduct disorder involves a pattern of behavior where the rights of others or social norms or rules are violated as demonstrated by three or more behaviors present for at least six months.
Aggression to People and Animals
Examples: Bullies, threatens, or intimidates others; initiates fights; physically cruel to others or animals; and forced sexual behavior on another.
Destruction of Property
Examples: Fire setting with intent to damage, and deliberately destroyed others' property (other than by fire setting).
Deceitfulness or Theft
Examples: Persistent lying to avoid consequences, burglary, car theft, lying to gain favors, and stealing.
Serious and Repeated Violations of Rules
Examples: Violates parental curfew standards, running away from home; problems with school truancy; problems in social, academic, or work functioning.

Source: Adapted by authors from *Diagnostic and Statistical Manual of Mental Disorders*: DSM 5.

Although many young people may engage in illegal behavior, for some, conduct-disorder behaviors begin early in life and follow them into adulthood. One well-known study Farrington, 2017) found that the aggressive and difficult behavior of 8- to 10-year-olds was a strong predictor of later delinquent behavior. For some, youth conduct disorder or delinquency is strongly related to psychological factors or personality. Seventy-five percent of all children with a diagnosis of conduct disorder will go on to develop antisocial personality disorder (Hagen et al., 2022). Of course, there are many causes of delinquent behavior. Conduct disorder may be related to factors such as temperament or personality, deficits in moral development, family structure and environment (divorced parents, absent fathers, uncaring and abusive parents), and negative modeling. Biological factors could come into play, as conduct disorder may arise from biologically driven arousal deficits that lead to stimulation-seeking behaviors (Mohan et al., 2022; Loeber et al., 2008; Farrington, 2017). What theories do you think best explain delinquency?

Delinquency

A chapter on adolescence would not be complete without a discussion of juvenile delinquency. How many of the individuals in your social work class do you think committed a delinquent act as a youth? If you guessed quite a lot, you are right. An analysis by the Office of Justice Programs examined the leading crimes committed by youths under the age of 18 and found that of the 696,620 juvenile arrests in 2019, 126,130 were for "simple assault," 119,790 were property crime, 44,010 were for violent crimes, and 81,320 were drug related. As of 2019, overall arrests among youths are decreasing, with 58% less arrests in 2019 than 2010, the lowest rate of juvenile arrests since 1980 (Office of Justice Programs, 2019).

A lot of delinquent behavior is related to status in the peer group. Delinquent acts are committed both with

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peers and for peers. Minor delinquent acts are considered normal and appear to be motivated by the desire to be liked by peers and to enhance one's sense of self-esteem. In adolescence, when most delinquent behavior begins, young people feel an increasing pressure to conform with the peer group, beginning around age 13 (LeCroy & Daley, 2001).

When deviant behavior occurs at early ages, the problem is seen as conduct disorder. However, when the behaviors lead to illegal acts by juveniles, then the problem is identified as delinquency. It is important to understand that although most criminals have a history of juvenile delinquency, most individuals with a history of juvenile delinquency do not end up as criminals (Bosick & Fomby, 2018).

Many studies have examined the different predictors of delinquency (Farrington, 2017 ; Loeber et al., 2008). The predictors can be viewed from the multidimensional perspective, examining biological, psychological, and sociological antecedents to delinquent behavior. Exhibit 7.12 summarizes this literature.

Exhibit 7.12 Factors that Predict Delinquency

Predictor of Delinquency
Biological
Early age of delinquency
Males
Developmental disabilities
Psychological
Delinquent behaviors
Peer pressure toward delinquency
Involvement in risky behaviors; for example, drug use and sexual intercourse
Comorbid with other psychiatric conditions: ADHS, anxiety, aggression
Low attachment to school
Social
Living in poverty, low SES
Family conflict, child abuse, domestic violence, family history of mental illness, or substance abuse
Poor school performance and poor verbal ability
Religiosity
Living in high crime area, urban blight
School environment is uncaring, poor control, lacking opportunities

Are criminals getting younger? We know they are, because the number of child delinquents entering the juvenile justice system is increasing, as evidenced by rising arrest rates and court caseloads (Loeber et al., 2008). This is bad news, because child delinquents represent a more serious social problem than do juvenile delinquents. Child delinquents are two or three times more likely than juveniles to become serious, violent, and chronic offenders. They also have longer offending careers than those who are delinquent at a later age, and they represent a greater threat to public safety (Farrington & Welsh, 2007). Depending on the state, some of these youths are being incarcerated in adult facilities.

Some states have lowered the age restrictions for admitting youths to adult prisons, and others have dropped the age restrictions entirely. Also, many states are spending more on prison cells and less on early intervention, family counseling, and treatment. Instead of rehabilitation, incarcerated juveniles will be exposed to deviant peer groups and become more entrenched in the criminal community (Ashford, Sales, & Reid, 2001b). Several studies have found that adolescents of color are disproportionately represented in the juvenile justice system (Hughes-Shaw, Sroka, & Traxler, 2020) What does this say about how we in the United States think of juvenile offenders? The following Implications for Practice section discusses various ways to deal with juvenile offenders.

In general, six treatment methods appear to be the most widely used with delinquent youth: restitution and community service (teaches responsibility through direct or symbolic repayment of the victim); family intervention; token economies; fear, emotional shock, and avoidance training; wilderness training; and social skills training. Family intervention and social skills training appear to have the best results in reducing recidivism (Fonagy, Cottrell, Phillips, & Bevington, 2015).

Self-Harm and Cutting

Self-harm or non-suicidal self-injury has become an increasing concern among professionals who work with adolescents. Self-harm is a process of "self-mutilation" defined as intentional self-injury that may be performed to reduce stress or change feelings. Self-harm has been estimated to occur in 14 to 21% of a community sample with a higher rate for young women than young men. Among the clinical populations, self-mutilation is reported to be as high as 60% (Brown & Plener, 2017).

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Ian Allenden/Alamy Stock Photo

Self-mutilation and cutting often begin in adolescence.

Self-harm is usually performed in secret, and it often begins in adolescence (Muehlenkamp et al., 2018). It evokes many strong feelings, such as shame and guilt, and can take on an addictive quality. Many experts believe self-harm occurs because of emotional expression and control, although the reasons for self-harm vary. The most cited reasons include relief from feelings, coping, preventing dissociation, euphoric feelings, expressing pain, communication, self-nurturing, self-punishment, reenacting abuse, and establishing control. Self-harm has been associated with physical and sexual abuse, compulsive disorders, body image and eating disorders, loss, alcoholism, violence, peer conflicts, and impulse-control difficulties. Working effectively with adolescents to prevent self-harm can be difficult.

Self-harm and non-suicidal self-injury have been increasing in the past decade as more and more youths join social media. Studies have shown that teens who engage in self-injurious behavior have higher attendance on social media platforms. Adolescents who self-harm can also find support in social media circles where they receive support for their behaviors are instructed on how to hide their self-harm more effectively with demonstrations on how to complete self-harming behaviors (Memon et al., 2018). On Instagram, Facebook, TikTok, and YouTube, there have been movements by the platform to block hashtags that link to this content; however, youths have been able to create new hashtags to continue to foster a community (Moreno et al., 2016).

In all mental health issues, it is important to engage adolescents in the treatment process. Exhibit 7.13 presents ideas for how to engage teens in treatment.

The COVID-19 Pandemic: Impact on Adolescents

The COVID-19 pandemic has had a far-reaching impact on our nation's adolescents, from an increase in negative mental health symptoms, increased isolation through

Focus on **The Lived Experience**

One Female's Account of Cutting

I was cleaning my room one day and found a broken piece of glass. I took it to my arm in the midst of me bawling my eyes out over my boyfriend and me, and I proceeded to gash away at my lower arm. I then found a razor blade. I used that instead. I sat there and watched the blood pour out of the newly made cuts, and I just thought to myself, what is my life for? Why am I here? It would be so much better if I weren't. But I didn't want to die. I covered my arm with a towel and let the blood soak through. This was not the first time I cut myself, however. I was in the fifth grade the first time I cut myself. I broke a mirror that time and used the sharp pieces to carve into my leg 'cause I was depressed.

Things with my boyfriend continued to get worse, and whenever I feel like crap, I go and cut myself some more. I do it on the same arm 'cause I promised my boyfriend I wouldn't do it anymore. But feeling the razor go through your skin, and seeing the blood pour out, is oddly soothing. It makes the mental pain go away for some time, 'cause you are too concentrated on the physical pain that's inflicted on you. But this only lasts for so long. I continue to cut my arm up. It's almost an everyday routine for me now. It's addicting, and I wish that I could stop, but honestly, I don't know how I am going to. My home life sucks. My school life sucks. I have no social life anymore 'cause I sit around and cry all day 'cause my boyfriend hasn't taken the time to call me.

Source: Candace. (2003). Physical pain of cutting "relieves" mental pain of depression. n.p.

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Exhibit 7.13 Strategies for Engaging Adolescents in the Treatment Process

Strategy	Description
Respect privacy and space	Adolescents often begin treatment with a sense of mistrust. Empathize with their reluctance to participate in the treatment.
Normalize experiences	Try to normalize the adolescents need for help, for example, "This can be a difficult time and a lot of young people have found talking with someone helpful."
Advocate the adolescent's interest	Be clear about your relationship with the adolescent. Communicate about how you perceive their situation and describe what the benefit is for their involvement.
Link interests and services	Adolescents are more engaged if they see the connection between their concerns, the assessment, and the intervention.
Create optimistic reframes	The extent of an adolescent's engagement in treatment is related to the use of positive reframes.
Keep it brief, start slow	Don't make the mistake of being too friendly or too confrontational, or both, too early in treatment. Adolescents may be better helped in a brief time period such as 30 minutes rather than the standard 50-minute session.

school and event closures, an increase in time spent online, and through the experience of increased social unrest amongst the political division, Black Lives Matter's Movement, and the COVID-19 pandemic in general. Many youths experienced negative mental health impacts from the COVID-19 restrictions as they felt they were "missing out" on activities with their peers, were losing relationships, and experienced the loss of ceremonial events such as graduations, moving to college, and family events (Samji et al., 2022). Additionally, children were found to engage in more conflicts with siblings and parents as a result of increased time at home and a lack of a daily schedule (Evans et al., 2020). In fact, in a systematic review of 116 studies from 2020–2021 on the COVID-19 pandemic and adolescents, Samji et al. (2022) found that the U.S. rates of suicidal ideation among youth rose from 17% in 2017 to 37% during the pandemic. Other mental health implications noted have been an increase in overall depressive symptoms; higher levels of stress, worry, grief, anger, and loneliness; as well as symptoms consistent with post-traumatic stress disorder (Samji et al., 2022). To cope with the pandemic, technology and social media use increased rapidly among adolescents (Evans et al., 2020). Increased use of social media among adolescents is associated with poorer mental health outcomes, and those who self-reported high levels of internet usage were found to have higher average scores on anxiety and depression scales (Liu, 2022). The most impacted groups were noted to be older adolescents, females, youths with pre-existing mental/physical conditions, and youths of color. Young people living in poverty also had unique barriers throughout the pandemic such as increased caretaking for younger siblings, lack of reliable internet access to complete online schooling, and greater household responsibilities (Rinfrette, 2021). Awareness of the differential impact of the pandemic on people of color has increased awareness of how oppressive social structures directly impact the health and well-being of their lives.

The standard suggestions to foster wellbeing among youth including establishing a reliable routine, sleep, nutrition, social connection, and exercise have been impacted by the COVID-19 pandemic; however, as social workers, it is essential to utilize creativity to foster existing supports and encourage the establishment of new ones. For example, social support is associated with positive mental health outcomes so establishing virtual engagement programs for youths can assist to mitigate the level of loneliness and increase social support. Additionally, many students receive their main nutrition from school, as such, locating ways for the adolescent and their family to continue to receive nutritional services is another method to mitigate potential mental health consequences. A main protective factor for youths is possessing a positive relationship with an adult.

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Study Table Psychological Dimension of Adolescence

Cognitive Development and Information Processing

- Piaget's last intellectual stage, formal operations, begins around age 11 or 12. At this stage, the adolescent is capable of abstract thought and logical reasoning.
- Hypothetical-deductive reasoning is characterized by understanding abstract propositions and reasoning logically about them to discover the best solution.
- Formal operational thought includes assimilation: the adolescent consolidates new information into existing knowledge. During middle adolescence, the process of accommodation creates a balance, and by later formal operational thought, adolescents test their reasoning against experience and incorporate their formal operational thinking.

Communication

- Improvement in thinking abilities allows for a greater capacity for effective communication in adolescence. Metaphors increase, as does the use of satire or ridicule. Writing becomes more meaningful because adolescents have developed the type of logical thought processes needed to organize their ideas.
- Boys are more competitive in conversation, and young women talk more about their personal feelings and relationships.
- Social workers need to understand the social and legal aspects of communicating consent and confidentiality to adolescents. Adolescents are more likely to seek help when provided with assurances of confidentiality.

Attitudes, Emotions, and Regulation

- Adolescents develop a more integrated self-concept through greater freedom in behavior and decision making as they move into adult life.
- The idea that adolescence is a normal period of serious difficulty is a myth. The majority of adolescents are well adjusted.
- One problem adolescents may face is low self-esteem, which is at its lowest in early adolescence. This is especially true of young women transitioning into junior high school, who mature early and start to date.
- Adolescents experience a remarkable degree of role diversity and can switch between extreme moods quickly, in contrast with adults, who often take hours to change moods.
- There are four main strategies for enhancing adolescents' self-concept: (1) encouraging achievement, (2) promoting competencies in specific areas, (3) provision of peer and parental support, and (4) developing coping skills.
- There are no differences in self-esteem between African American children and White majority children, but African American children do experience greater discrimination, poverty, and social and educational barriers than White youths do.
- Adolescents enter a psychological moratorium—a gap between childhood security and adult autonomy.
- Adolescent identity statuses or modes of resolution include identity diffusion, identity foreclosure, identity moratorium, and identity achievement.
- During adolescence, youths of color must integrate their image of being from an ethnic group with the values and images of the mainstream White culture. In this process, three options emerge: assimilation, acculturation, and enculturation.
- Social cognitive monitoring, which increases in adolescence, is a person's ability to monitor and make sense of their social thoughts. Moral development refers to the rules of conduct people use in their interactions with others. Kohlberg posited that rules of conduct develop as individuals progress through six separate stages, where each stage represents a different way of reasoning about various rules of conduct. Adolescents are in stage 3, "interpersonal conformity": they are good so that others will think well of them and they can think well of themselves. By late adolescence, most young people move to stage 4, "responsibility to the system." Kohlberg's view is based on a justice perspective, but Gilligan has argued that a care perspective, in which the focus is on people's connectedness to others, has been underestimated.
- Egocentrism refers to a type of thought characterized by preoccupation with one's behavior, feelings, or thoughts in a self-conscious manner. Formal operational thinking is believed to lead to egocentric thought. The imaginary audience (the belief that others are as preoccupied with the adolescent's behavior as he or she is) and the personal fable (adolescents' sense that they are indestructible and unique) are two aspects of egocentric thought.

Continued

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Psychological Strengths, Hazards, and Risks

- Adolescents who do well in spite of the stresses they face are referred to as *stress resistant.* They are characterized by positive and nurturing relationships with others, caring relationships with parents, easy temperaments, an internal locus of control, an active coping style, good social skills, good cognitive skills and intellectual abilities, and involvement in outside activities and hobbies.
- More than 50% of mental disorders begin by the age of 14. Common problems include depression, anxiety, conduct disorder, eating disorder, and ADHD.
- Suicide is the third-leading cause of death among adolescents. Native Americans and Alaskan Natives have the highest suicide rates of all ethnic groups.
- Delinquency can be predicted from behavior displayed at early ages. The leading crime committed by youth is simple assault. Much of delinquent behavior is related to status in the peer group. Treatment techniques emphasize reinforcement for appropriate behaviors, learning new social skills, token economies, modeling, and goal setting.
- For conduct disorder, peer-based group therapy may lead to increases in substance abuse and delinquent behaviors. Family intervention and social skills training appear to have the best results in reducing recidivism.
- Self-harm is a process of "self-mutilation" defined as the deliberate destruction or alteration of one's own body tissue without conscious suicidal intent. Studies have shown that teens who engage in self-injurious behavior have higher attendance on social media platforms.

Social Dimension

Groups and Families

The transition into adolescence involves some stress in most families, for both adolescent and parent (Steinberg, 2023). This stress may be caused in part by the rapid developmental changes that take place—more occur during adolescence than in any other period of the life cycle. Three key developmental tasks for the family are the development of autonomy, resolution of parent–adolescent conflict, and establishment of parent–adolescent attachment (Steinberg, 2023).

Family Influences: Development of Autonomy

Consider the following interaction between a mother and a daughter:

Daughter: Mom, get off my back! I know what I'm supposed to do around this house. I don't need you telling me every second.

Mother: I have to tell you every second or it just doesn't get done. If I could trust you to do it, I wouldn't have to keep after you.

This common interaction reveals an essential theme of the parent–adolescent relationship: control versus autonomy. Much of the stress in parent–adolescent relationships relate to struggles that revolve around control and autonomy. As young people move into adolescence, they begin the process of acquiring more independence, and parents need to begin the process of granting more independence. Because parents have had full responsibility for their children up to now, the process becomes a difficult balance between letting go and maintaining some control. Some parents successfully adapt to the adolescent's need for independence and can grant the young person more decision-making authority. Other parents, though, do not acquire the skills involved in independence granting and are unable to relinquish control over decision making. What is the result of these two different styles of parenting? Parents who hold tightly to their control and are authoritarian in their decision making are more likely to produce young people who have difficulty with autonomy. A democratic family structure, where there is equal involvement of parents and adolescents, with parents retaining the final authority, appears to produce a young person with a healthy sense of autonomy.

Parent–Adolescent Conflict

The parent–adolescent relationship is not viewed as one of stress and storm, rebellion against parents, or a generation gap as it was in the past. Current thinking views the parent–adolescent relationship as a transitional one characterized by some conflicts and disagreements about the details of everyday life (Galambos & Almeida, 1992; Steinberg, 2023), yet most adolescents have satisfying relationships with parents (Santrock, 2023). Also, it may be that perspectives on parent–adolescent conflict vary

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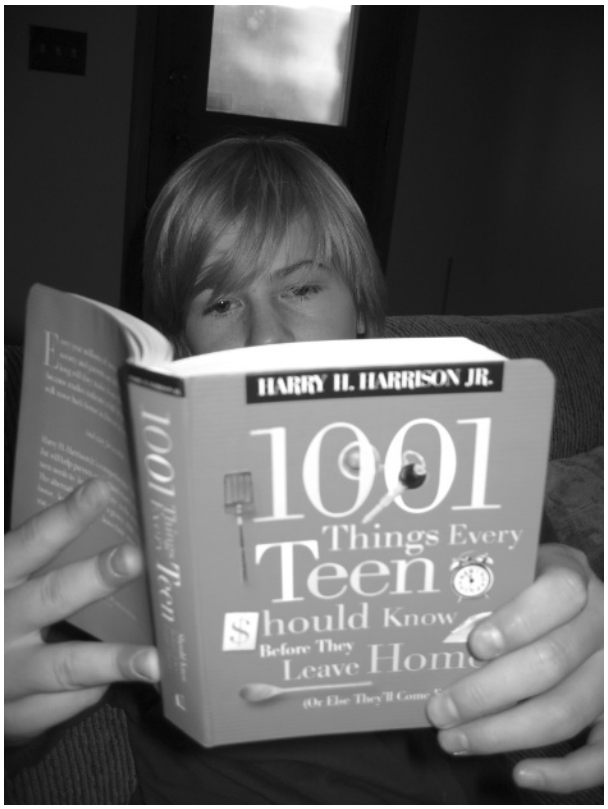

Adolescents become increasingly focused on developing their own autonomy.

depending on who is reporting on the perceived conflict. Adolescents often report that there is little conflict, and they are happy in their relationships with parents. However, parents may not see it this way. Studies (Steinberg, 2022) have reported that the "little" conflicts may not bother adolescents but are a significant source of distress to parents. Adolescent experts believe that parents are both more bothered by the conflicts and generate more negative affect because of the conflicts than do adolescents. Reactions may vary, but parent–adolescent disagreements are in fact common, and they appear to be a normative and adaptive aspect of the transition to adolescence (Branje, 2018).

Conflicts between parent and adolescent arise weekly—twice as often as for a typical married couple (Santrock, 2022). Contrary to many popular notions, conflicts are not about values, politics, or social issues but about mundane, everyday issues such as curfew, chores, and school—the same issues since studies began 60 years ago (Steinberg, 2023).

Is there a functional reason that adolescents and parents have this increase in conflicts? Many researchers believe there is, and they base their ideas on the following theories.

A sociobiological perspective suggests that conflict during adolescence ensures that young people will spend time separated from their family of origin and mate outside the natal group. This theory is based on the observation that conflict intensifies at puberty in other species of primates and that the underlying tension may be derived from evolutionary pressures. The adolescent is forced, through the bickering, to search for intimate companionship outside the family.

From a psychological perspective, the conflict may facilitate the process of **individuation**. Furthermore, this emancipation allows the young person to develop a realistic and mature appraisal of his or her parents, leading to a more mutual relationship with them. The function of the disagreements is that adolescents must come to terms with their parents' fallibility and, as a result, release their dependence on their parents.

From a cognitive-developmental perspective (Smetana, 2000), parent–adolescent conflict can be best explained as a product of the different approaches of adolescents and parents to defining family rules, events, and regulations. Conflict in adolescence is related to the development of social reasoning. For example, instead of seeing an issue as one of social convention ("Everyone in this family must keep his or her room clean"), the adolescent perceives it as a matter of personal choice ("This is my room, and I should decide how clean I want to keep it"). Because parents maintain a conventional stance regarding such issues, conflict results. Also significant is that at this early and middle adolescent period, young people tend to perceive social conventions as arbitrary.

A developmental task in adolescence is obtaining autonomy and independence from parents. However, this can often lead to conflict and difficult family relationships. In order to promote a healthy transition from adolescence to adulthood, practitioners should consider the guidelines presented in Exhibit 7.14

Peers, Peer Groups, and Adolescent Development

The notion of the "teenage" years is practically synonymous with peer relationships and peer groups. If we asked you to picture the first thing that comes to your mind when you hear the word *teenager* or *adolescent*, you'd probably summon one of the following scenes: a teenager texting on a cell phone, two girlfriends sitting and talking with

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Exhibit 7.14 Guidelines for Promoting Positive Family Relationships with Adolescents

Normalize the need for independence and autonomy in adolescence	Help families recognize the importance in autonomy as a developmental task. Help parents accept these changes by noting how they remain a major source of guidance throughout the adolescent years on educational plans and social values.
Discuss adolescent behavior within the context of developmental tasks.	This will and help family members accept changes. For example, early adolescents feel a lot of peer pressure for conformity, but this declines in late adolescence. Point out common issues that adolescents confront as they move from early adolescence to late adolescence.
Appreciate the physical and psychological changes adolescents are going through	This is important that they understand that these changes happen to everyone. However, when normal behaviors become extreme, they may require intervention.
Encourage authoritative parenting coupled with a nurturing relationship	This can promote parental influence, support, and guidance that helps the adolescent develop better self-regulatory skills and promote competence, and the give-and-take of the relationship that engages the child in a process that promotes cognitive and social competence.
Promote independent decision making	This will allow adolescents the opportunity to make choices and learn from them.

each other, a couple out on a date, or a group of peers at the mall or movie theater. Such is the reality of many adolescents, who spend an increasing amount of time in the company of peers [Research has documented that by starting in adolescence the time spent with family members decreases sharply (Santrock, 2023).] An important change related to both the increased influence of social media and the impact of the pandemic is that adolescents are spending less face time with their peers. More specifically, 10th graders go to 17 fewer parties a year than 10th graders did in the 1980s (Merino, 2022). And, high school seniors are spending less in-person social interaction time on a daily basis. The impact—increased loneliness among adolescents (Twenge et al., 2021).

Adolescents are at a point in their development where they need to spend time with peers. This interaction provides important information that is usually not available within the family; peer interaction is a critical source for personal and social competence development. Through interaction with peers, young people learn about sexual relations, compassion, leadership, conflict, mutual problem solving, and more. Locating a

Focus on **The Lived Experience**

An Adolescent's Perspective on Divorce

Suddenly it seemed as if my whole world as I knew it was collapsing around me and I couldn't do anything about it. I'm talking about divorce, affairs, and separations, the whole horrible business rolled into one.

It started when my father announced, with some bitterness I might add, that he was having an affair. It was so unexpected, so devastating even now, looking back, I can't see how my mother managed to hold herself together. She had always been so dependent on my father. Maybe that was one of the pressures, which he tried to explain to me after the initial shock.

They tried desperately to save their marriage, not once but several times, leaving a trail of bitterness and heartache behind them, but it wasn't working. My dad would sometimes leave for a few days in an attempt to gather his thoughts, sometimes returning for me, as we were always close, or maybe to relieve his guilt. Yet each time he was less like the father I had known. It was killing them both, and family life became so unhappy. I can remember many a blazing row: things were hurled, words were so blatantly said, and I was stuck in the middle of them both. I tried so hard to comfort both of them. First my mother, but when I was with her I was laden with guilt for not being with my father. I thought that he might think I didn't love him anymore, and vice versa. Yet as hard as I tried, I was inadequate; he finally left. Sitting at home night after night, wondering if my father was all right. Many a time the thought of my dad, or my mother for that matter, committing suicide came into my mind. Why didn't he phone? I would sit there willing the phone to ring just so that I would know he was OK.

Source: Goodings (1987). *Bitter-sweet dreams: Girls' and young women's own stories.* London: Virago Press, pp. 157–158.

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peer group that is supportive and compatible with one's interests is a psychological task of early adolescence. As discussed in earlier chapters, the impact of peer rejection and isolation can impact the adolescent's healthy development.

Groups offer an organized means of participation, a collective sense of camaraderie, and group support for mastering the tasks of adolescence. Group membership allows young people to assess their individuality considering group pressure and norms. As young people continue their search for identity, choosing to participate in a group helps answer the question "With whom do I belong?" Groups provide experience with difficult social expectations of inclusion and exclusion, as well as conformity and independence.

Peer Pressure and Conformity

As one 15-year-old stated: "Kids need to look at peer pressure and ask, 'Do I want to do this?' Whether the answer is yes or no, they need to ask why" (Costello & Hope, 2016). Peer pressure and conformity are strong processes in adolescence and reach their peak in early adolescence, especially from the sixth to the ninth grade (Steinberg & Monahan, 2007). Adolescent thinking is often characterized by the logic, "If the group is doing it, it must be good and right." Conformity can be negative or positive.

By late adolescence, conformity to antisocial behavior decreases, and parents and peers begin to experience greater agreement. As young people move toward independence, they rely less on peer and family influence. Perhaps this period of strict conformity to peers is a normal and important task of adolescence—to gradually come to terms with the influence of groups (Steinberg, 2023). We all have to learn to balance the need for personal autonomy with the desire for group participation.

Positive conformity and constructive peer pressure are exemplified by Students Against Drunk Driving, where students promise themselves, peers, and parents not to drink and drive.

FG Trade/E+/Getty Images

Adolescents rely heavily on members of their own cliques for clues on how to behave at social events.

Friendships

Consider the following description of a close friendship between two boys:

> I know everything about John, and he knows everything about me. We know where the secret places are in each other's houses, and that my mother cooks better but his father tells funnier jokes …. We always stick together because I'm good at fights, but John's the only one besides my family who knows that I sleep with my light on at night. He can jump from the high diving board but I know he's afraid of cats …. He saw me cry once, and the day he broke his arm I ran home and got his mother for him. We know what's in each other's refrigerator, which steps creak on each other's stairs, and how to get into each other's house if the door is locked. I know who he really likes, and he knows about Mary, too. John is my best friend and I am his. (Zolotow, 1968)

In adolescence, more complete friendships begin to develop. Over time, the concept of friendship expands for young people. When asked to describe friendship, adolescents refer to intimacy, trust, loyalty, and commitment. Perhaps most significant is the capacity for intimacy in friendship. Intimacy in friendship refers to the sharing of personal thoughts. This personal knowledge about others leads to a greater sense of closeness. Gender differences are apparent, with male friendships reflecting more shared interests and female friendships reflecting more supportive and emotional aspects of friendship. Although the intimacy of friendship is highly valued in adolescence, friendship provides other important things, such as companionship, stimulation, interest, and ego support, which begin to emerge as friendship deepens. In the age of social media, the definition of "friend" has also been altered. Many times, adolescents have friends that they have not met in person and have met through gaming, social media, or other online activities. Additionally, youths can more easily stay in contact with friends who have moved or acquaintances they have met at events out in the community.

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Implications for Practice:
Social Skills Training

Because friendships and social interactions are critical for young people's healthy development, social skills can be an important asset for adolescents to possess. We know that some adolescents are unpopular, either rejected by their peers or neglected. Many of these adolescents have poor social skills (Steinberg, 20123; LeCroy, 2022). As a result, an increasing emphasis is being placed on a social skills or social competence model for understanding, preventing, and remediating the problems experienced by adolescents. Social skills training assumes that problem behavior in young people can be understood in terms of not having acquired skills needed to cope with various situational demands. The focus is on discovering effective responses for resolving the demands of problem situations. The treatment model focuses on teaching the prosocial skills and competencies that are needed for day-to-day living, rather than on understanding and eliminating pathological responses. The emphasis is on new learned behavior that leads to positive consequences rather than on past behaviors that may have elicited negative consequences.

Social skills training has been applied to many different problem areas—for example, the specific problems Native American adolescents face (LeCroy, 2022), school adjustment problems (LeCroy, 2016), aggressive behavior (Feindler & Gerber, 2012), life skills for adolescent mothers (Harris & Franklin, 2008), preventing HIV and unwanted pregnancy (Wingood, Sales, Braxton, & DiClemente, 2008), depression (Stark et al., 2004), prevention of substance abuse (Botvin, Griffin, Diaz, & Ifill-Williams, 2001), and withdrawn behavior (Weiss & Harris, 2007).

Depending on the goals of the program and the type of problem situations being addressed, different skills would be appropriate. For example, a program for juvenile offenders might focus on skills such as giving and receiving feedback, negotiating and resisting peer pressure, and problem-solving. A program for pregnancy prevention might focus on skills such as discussing birth control, asking for information, refusing unacceptable demands, and problem solving. All social skills programs break down the skills into component parts for easy teaching. For example, beginning conversational skills might include four parts: greeting the other person, making small talk, deciding whether the other person is listening, and bringing up the main topic

The process of teaching social skills includes seven basic steps that leaders should follow. Exhibit 7.15 presents these steps and outlines the process for teaching social skills (LeCroy, 2008). In each step, there is a request for group member involvement, because it is critical that group leaders involve the participants actively in the training. This keeps the learning process interesting and fun for the group members.

Exhibit 7.15 Seven Basic Steps for Teaching Social Skills

1. Present the social skill being taught.
   a. Solicit an explanation of the skill.
   b. Get group members to provide rationales for the skill.
2. Discuss the social skill.
   a. List the skill steps.
   b. Get group members to give examples of using the skill.
3. Present a problem situation and model the skill.
   a. Evaluate the performance.
   b. Get group members to discuss the model.
4. Set the stage for role-playing the skill.
   a. Select the group members for role-playing.
   b. Get group members to observe the role-play.
5. Have group members rehearse the skill.
   a. Provide coaching if necessary.
   b. Get group members to provide feedback on verbal and nonverbal elements.
6. Practice using complex skill situations.
   a. Teach accessory skills (e.g., problem solving).
   b. Get group members to discuss situations and provide feedback.
7. Train for generalization and maintenance.
   a. Encourage practice of skills outside the group.
   b. Get group members to bring up their own problem situations.

Sources: Adapted by authors from: LeCroy, C. W. (2008). Social skills training manual. In C. W. LeCroy (Ed.), *Handbook of evidence-based treatment manuals* (pp. 99–138). New York: Oxford University Press; LeCroy, C. W. (2016). Teaching social skills in school settings. In R. Constable, C. R. Masset, S. McDonald, & J. F. Flynn (Eds.). *School social work: Practice, policy and research perspectives* (8th ed.). Chicago, IL: Lyceum.

Gangs

Increasingly familiar are the gangs of the big cities—the Crips and Bloods of Los Angeles, or Chicago's Vice Lords and Black Gangster Disciples. Gangs across the United States have received increasing attention from the media, popular writers, and scholars; for example, films such as *Colors*, about the Crips and Bloods, and *The Gangs of New York* put the topic of gangs on the front pages of many newspapers. No longer are gangs associated only with New York, Chicago, and Los Angeles (Howell & Griffiths, 2018).

How can we tell whether a person is a gang member? Defining what constitutes a gang is difficult. For example, what is the difference between a gang and a group? Gangs are usually differentiated from other groups on the basis of their delinquent activity, but the distinction is not limited to delinquency. Huff (2001, p. 4) has provided a comprehensive definition of a youth gang: a collectivity

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consisting primarily of adolescents and young adults who (1) interact frequently with one another; (2) are frequently and deliberately involved in illegal activities; (3) share a common collective identity that is usually, but not always, expressed through a gang name; and (4) typically express that identity by adopting certain symbols and/or claiming control over certain "turf" (persons, places, things, and/or economic markets). Exhibit 7.16 presents the rating of criteria considered important in defining a youth gang by law-enforcement agencies.

Gangs seem to be related to the developmental need for young people to associate with peer groups. Indeed, adolescents who have difficulties with peer relationships are often maladjusted. Because adolescence is a time when intense peer involvement is typical, it is not surprising that gangs are an outgrowth of that involvement. According to the American Academy of Child and Adolescent Psychiatry (2017), because group experience is a normal part of the adolescent subculture, gangs can be considered an extreme manifestation of the need for peer-group involvement and acceptance. Gangs often play a very important function for young people by providing social support, bonding, and protection from rival gangs.

Long-term studies have found that the most important risk factor for gang membership is growing up in a neighborhood with poverty where there is little attachment to people and social institutions (Kubik et al., 2019). Risk factors related to parents include absent parents, lack of supervision, and parental substance abuse. School-related risk factors include low expectations for success in school by teachers, parents, and students, and little school bonding. Of course, peers have a substantial impact, as previously discussed.

Growth in gang numbers is considerable. In Los Angeles, it is estimated that there are approximately 100,000 Crips and Bloods who account for more than 500 homicides every year. These two groups are the most discussed gangs because of their size, the extent of their violence, and their role in drug trafficking. The Crips are the original gang, and the Bloods formed as a means of protection against the Crips. Today, there are more than 25,000 gangs (Youth.gov, 2022) all across America, and it is estimated that they are responsible for an average of 48% of violent crime.

Exhibit 7.16 The Criteria Used by Law-Enforcement Agencies to Define a Youth Gang

Gang Characteristic	Percentage
Commits crime together	50
Has a name	19
Hangs out together	10
Claims a turf or territory	9
Displays/wears common colors or other insignia	8
Has a leader or several leaders	7

Source: Youth Gang Survey, Office of Juvenile Justice and Delinquency Programs, 2000.

Gang members range in age from 15 to 30 years old, with the majority of gang members between ages 14 and 18 (Howell, 2019). Gangs are not limited to males. Although females account for under 10% of overall gang involvement, they comprise 25 to 50% of youth gang affiliation (Youth.gov, 2022). In a national survey of youth, the National Crime Victimization survey asked youth aged 12 to 18 about gang presence in their schools. In 2019, only 9% of youth reported there being a gang presence in their schools, down from 20% in 2009 (National Center for Education Statistics, 2022).

Gangs have received increased attention from the popularity of the book Freakonomics, which presented an economic analysis of a drug-selling gang's finances. In examining the financial activity of gangs, Levitt and Dubner (2006) report that the average earnings in the gang are just a little above the labor market rate. As a result, gang members participate in a high-risk gang without a lot of financial benefit. The authors propose that it is the future prospect of higher earnings that partially explains participation in gang activities.

One interesting approach to reducing gang violence has been promoted by physician and epidemiologist Gary Slutkin. Shifting from the traditional approach of policing and longer prison sentences, Slutkin has started a program called CeaseFire based on his work to reduce infectious diseases in Africa. The theory suggests the following: treat violence like an infectious disease. Therefore, to treat the disease, you have to go after the most infected and treat the infection at its source. Kotlowitz (2008) quotes Slutkin's description: "for violence, we're trying to interrupt the next event, the next transmission, the next violent activity . . . and violent activity predicts the next violent activity like HIV predicts the next HIV" (p. 36). In this respect, the idea is to treat violence like a public health issue rather than a moral issue. Slutkin's is a unique approach to violence reduction: most approaches focus on either environmental factors such as gun purchases or individual behavior change emphasized in antiviolence curricula. Slutkin's theory is based on research suggesting that peer or social pressure is the most effective way to change behavior. CeaseFire hires former gang members with credibility to deal with disputes at the front end—to intervene before

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things get worse. Violence is often the result of efforts to seek revenge, which is where CeaseFire tries to intervene. The gang workers are referred to as "violence interrupters," and they focus exclusively on preventing shootings. In a recent report, CeaseFire reports that the program reduced the number of shootings by 30% in Oakland, CA (CeaseFire, 2022). In Brooklyn, the city went 27 months without a killing, and in New Orleans the city went for more than 200 days without a homicide (CeaseFire, 2022, 2016).

Communities and Support Systems

School Influences

A functional match between schools and the adolescent is increasingly recognized as an idea that needs attention and reform. Indeed, many researchers and professionals believe that middle schools and high schools could be more effective institutions for young people. For example, Eccles, Barber, Jozefowicz, Malenchuk, and Vida (1999) argued that a serious mismatch exists between the organization and curriculum of middle schools and the intellectual, social, and emotional needs of young adolescents. Studies (Borman et al., 2019) have found that when there is a mismatch there is a decline in students' academic motivation and their attitudes toward the subjects being studied, and an increase in conduct disorders. To address many of the educational issues of adolescents, we will examine various perspectives on schools in today's society.

The primary function of schools is to provide a comprehensive curriculum to prepare young people for the diverse aspects of life. The structure of this "comprehensive curriculum," however, is a source of debate. For instance, the back-to-basics movement has gained prominence, but opponents argue that schools must also be responsive to young people's social and emotional lives. The extent to which schools address the social emotional aspects of development continues to be debated. Recently, the Department of Education has recognized the significant gaps in our school's ability to support emotional well-being and has implemented project AWARE across the country. Funding is provided to school districts to promote wellness and resiliency and develop sustainable infrastructure for school-based mental health programs and services.

Whatever the curriculum, the numerous hours that young people spend in school expose them to significant and life-changing events and experiences. Their identity formation, competence in social and academic abilities, career paths, and social relationships are all affected by their experience in school. One of the major organizational factors that influences the relationship between school and adolescent development is the transition from elementary school to middle school and from middle school to high school. The transition from elementary school to middle school is often a stressful one. This transition often represents a move from a small neighborhood school and the stability of one classroom to a large, impersonal institution, often more complex and bureaucratic, and a period class schedule with multiple teachers. This shift may disrupt important support and comfort from peer groups and caring relationships from school teachers and staff. This transition can be particularly difficult for middle school girls (LeCroy & Daley, 2001). Furthermore, this transition occurs in tandem with puberty and other emotional and social changes (e.g., concerns about body image, decreased dependency on parents, and changes in social cognition). Despite the trend toward creating separate middle schools, there is no good evidence to support this change; in fact, some research suggests it would be better to keep the old school system of grades K–8 and 9–12.

Middle schools fall short of meeting many of the educational, health, and social needs of young adolescents. Three essential qualities schools need to improve learning: (1) schools need to be restructured to a more human scale, which means creating smaller learning environments; (2) schools need to create a small group of caring adults who work with each other to develop coordinated, meaningful, and challenging educational experiences and provide some stability with peer groups; and (3) schools need to create opportunities for each student to interact with at least one adult who can provide the youth with advice about academic matters and personal problems and emphasize the importance of succeeding in the middle school.

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Schools can influence adolescents' identity, their social and academic abilities and their career choices.

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Some researchers (Aronson, 2000) believe problems like those experienced at Columbine (the mass killing in Colorado of high school classmates) directly relate to the impersonal and negative environments that exist in high schools. Aronson (2000) wrote that schools must work harder to create environments where understanding and compassion exist. In his book, *Nobody Left to Hate*, he outlined a series of interventions that can transform schools. He included targets such as reduction of bullying, promotion of social skills, conflict resolution, empathy training, and structural changes in the schools. In Aronson's view, we must break down existing peer barriers through the use of cooperative learning strategies. One approach to helping schools increase their effectiveness is making community-based support resources more accessible to students. Exhibit 7.17 provides a list of topics and resources that schools could use.

Exhibit 7.17 Community-Based Supports for Adolescents

Topic	Description	Resource and Website
Mental Health Services	Nationwide suicide call/textline	9-8-8
	Government-sponsored treatment locator.	www.findtreatment.samhsa.gov
	Journal article reviewing state laws about what parents can do regarding decision making for adolescent mental health treatment.	https://www.tandfonline.com/doi/abs/10.1080/1067828X.2013.777380?journalCode=wcas20
Substance Abuse Services	Government-sponsored treatment locator	www.findtreatment.samhsa.gov
	Journal article reviewing state laws about what parents can do about decision making for adolescent substance abuse.	https://www.tandfonline.com/doi/abs/10.1080/1067828X.2013.777380?iournalCode=wcas20
Information Privacy and Protection	Guidance on pediatric healthcare information privacy and protection.	https://www.hhs.gov/hipaa/for-professionals/faq/personal-representatives-and-minors/index.html
Family Planning Clinics	List of federally funded family planning clinics.	www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/
Sexual and Reproductive Health Services	State-specific fact sheets with sexual and reproductive health policy.	www.guttmacher.org
Contraception	Resource describing contraceptive methods including emergency contraceptives.	www.bedsider.org
	Resource with birth control method descriptions and interactive quiz to find individual specific birth control options.	https://www.plannedparenthood.org/learn/birth-control
Sexually Transmitted Infections (STIs) Testing and Treatment	Free online search tool for where to get tested for HIV or other sexually transmitted infections.	https://gettested.cdc.gov/
Sexual Orientation and Gender Identity	Informational resource on gender identity and sexual orientation.	https://www.plannedparenthood.org/learn
State Specific Minor Consent Laws	Comprehensive guide to state-specific minor consent laws.	www.cahl.org
Sexual Assault	Resource for information about sexual assault, including safety and prevention tips, consultation, and training, and help line number.	https://www.rainn.org/about-sexual-assault
Statutory Rape Reporting	Resource on clinician reporting requirements based on state law.	https://aspe.hhs.gov/system/files/pdf/75531/report.pdf
Cyber Stalking, Harassment, and Bullying	Resource providing cyberbullying information, laws and regulations, and advice for schools and peers on prevention and intervention.	www.stopbullying.gov
Partner Abuse	Confidential resource for information about dating abuse, boundaries, healthy relationships and includes call, chat, and text line.	www.Loveisrespect.org

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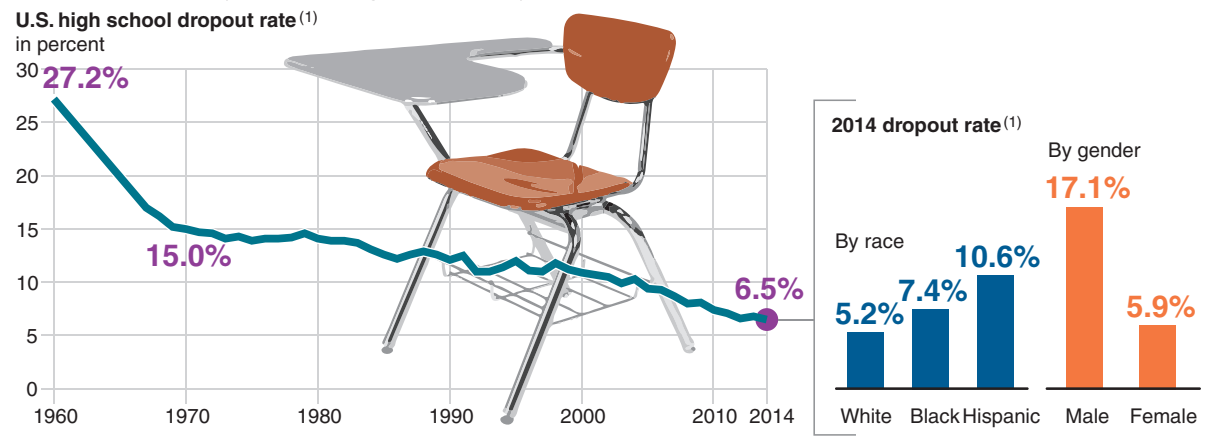
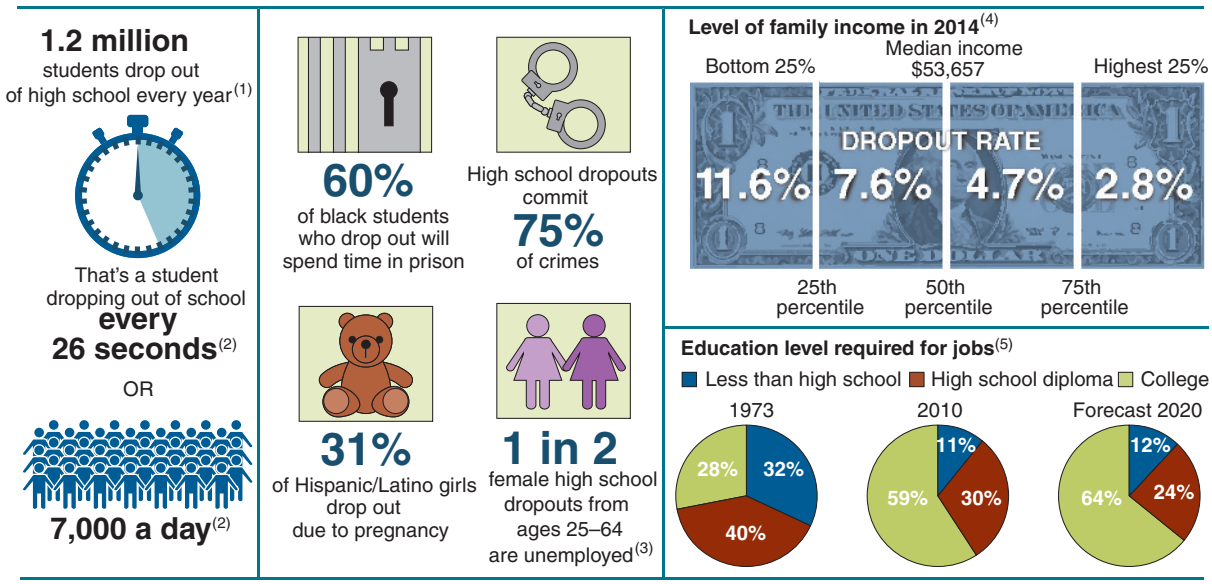
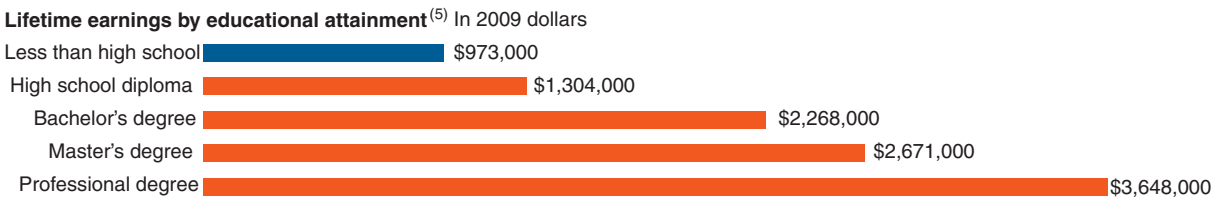
High School Dropouts

Although high school dropouts remain a serious problem, the percentage of youths who do not finish high school has decreased considerably over the years. The dropout rate, the percentage of 16- to 24-year-olds who are not enrolled in school or earned a GED certificate, was 5.1% in 2019. More specifically, the dropout rate for Whites was 4.1%, for African Americans it was 5.6%, and for Hispanics it was 7.7% (National Center for Education Statistics, 2022). The poor academic preparation and disadvantaged economic background of students of color appear to account for their higher dropout rates. Dropout rates also vary dramatically depending on the city and region of the country. Exhibit 7.18 summarizes this information in an infographic.

Exhibit 7.18 The Impact of the High School Dropout Rate







Sources:
(1) U.S. Department of Education
(2) Banchero, *The Wall Street Journal*, 2014
(3) Travis Smiley Reports, Fact Sheet: Is the Dropout Problem Real?
(4) U.S. Department of Commerce, Census Bureau
(5) Georgetown University, The College Payoff

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Studies of the characteristics of dropouts have found several factors that predict dropout: poor attendance, lack of interest in school, living in poverty, single-parent families, parents who do not participate in decision making concerning the student, conduct problems in school, grade retention, low grades, pregnancy, more than 15 hours of work per week, and urban lifestyle (National Education Association, 2016). Dropping out is not usually a response to a lack of ability—these students have average intelligence scores. In general, the pattern that emerges is one of students who disengage from school. Dropout prevention programs have focused on targeting at-risk students and improving academic performance, changing attitudes about school, and reducing absenteeism (Stevenson et al., 2019). In fact, as of 2017, increasing student engagement is the only practice which has been demonstrated by the "What Works Clearinghouse" to have strong evidence for dropout prevention (Rumberger et al., 2017). Increasingly, a primary effort in the schools is to increase school attendance. Truancy, chronic absenteeism, and class cutting are critical concerns that most schools are attempting to address (Kim & Streeter, 2013). Very few dropout prevention programs have been evaluated for their effectiveness. However, the trend is to begin dropout prevention strategies earlier than high school by focusing on middle schools and elementary schools. Also, because dropout rates in some schools are so high, the strategy is to improve the school overall to prevent dropout. An individualized approach is no longer feasible. The current focus of prevention is on school-wide practices that can reduce alienation from the educational process and increase motivation and interest in learning.

Runaway and Homeless Youth

Tim, at age 16, knows what it is like to be homeless. He's lived that way for the last five years. Where would you be most likely to find him? Look in abandoned buildings in downtown Phoenix, under highway overpasses, or in alleys filled with homeless men and women in the worst parts of the city. Tim is only one of an estimated 4.2 million homeless youth and young adults. youth (Housing and Urban Development, 2016). What kinds of difficulties do these young people face? Do most runaway youth share common problems?

This section includes information on children who are gone from their homes either because they have run away or because they have been thrown out by their caretakers. According to a series of national studies, such homeless youths are frequently afflicted with drug and alcohol abuse, sexual or physical abuse, criminal activity, and thoughts of suicide. The most prevalent characteristic of the runaway episode is that the young person had been physically or sexually abused at home in the year prior to the episode (see Exhibit 7.19).

Juiced Up Media/Shutterstock.com

Homeless youth are a serious problem in today's society.

Clearly, runaway youths face many health and social problems. Unfortunately, very few of them have the needed resources to address the problems they face. Most have no medical coverage. Although many of these young people are in state care, many have fallen out of care and are not receiving benefits they are entitled to through the state. Runaway shelters provide a limited means of protection. Many young people stay for a short time and end up back on the street, where they again face issues of substance abuse, unprotected sex, isolation, and feelings of hopelessness. The Lived Experience section presents the voice of homeless youths.

Multicultural, Gender, and Spiritual Considerations

There are many multicultural and gender considerations in adolescence (Gibbs, 2004). As young people experience a broader world, they become more aware of their unique qualities—what it means to be a person of color; an immigrant from another country; a boy or a girl; or a heterosexual or a gay, lesbian, or transgendered person.

BIPOC Adolescents

In adolescence, young people of color begin to interact with a more heterogeneous population, becoming more

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Focus on **The Lived Experience**

Homeless Youth

Day in the life …

Gwen looked back at her situation in the past two weeks. It began one morning when she woke up early and left home with $250, some clothes, a backpack, and food. Already after 15 minutes, $70 were gone because it was used for bus fare to the city. Thinking back, Gwen realized that that air-conditioned bus ride was the best part of her life as a runaway. From there, things went downhill.

Stepping off the bus, a bunch of problems attacked her at once. A young girl near the station saw Gwen, immediately grabbed her backpack of food and clothes, and disappeared into thin air. Upset, Gwen began to cry helplessly, until a boy her age walked up to her and spoke.

"Hey, listen if you're going to live on the streets, you have to learn a couple of things. Lesson #1: Never cry. It'll just make you look more vulnerable. By the way, my name's Razor Blade. Well, not really, but it's my street name."

"I'm Gwen." As she spoke, she dried her eyes.

"Well, hey Gwen, you seem nice so I'll cut you a deal. If you give me $150 I can get you a nice place to stay. A whole bunch of us have this place fixed up and you can live with us, too."

Gwen was relieved to know she had a place, so she gladly handed over the money.

"Thanks, Gwen. By the way lesson #2 is—don't trust anybody." With that, Razor Blade ran down the street. Gwen was now left with $30. Since she hadn't eaten all day, so she decided to go to the donut shop to grab some cheap food.

Four days later, Gwen was cold, out of money, dirty, and hungry. She'd been staying under a bridge by a river, although she couldn't sleep much at night out of fear of what could happen—rape, theft, murder. During the day, she would go to stores to see if she could get a job but no one would hire a 15-year-old runaway. She'd also hang out in fast-food restaurants to keep warm and hope that some kind soul would buy her food. No such luck. So she finally decided to go to a shelter to clean up and get a meal.

At the shelter, a girl her age introduced herself. "Hi, I'm Star. Listen, me and a couple of guys found a squat a couple of blocks away. It's damp and smells like a reservoir, but it's abandoned. You wanna come with us?"

Eventually, Gwen gave in and she, Star, and four guys—Weed, Butted, Trick, and Fireball—headed down the street to their new "home." It was infested with rats, dark, and smelly, but that didn't seem to bother the others. In fact, they were celebrating with hits of acid. Gwen refused to join them that time, but she has since experimented with drugs, something she used to swear she'd never do.

Gwen had faced other problems in those past two weeks. She witnessed one runaway kill another in a fight over a stale muffin. She saw Weed overdose on drugs. She spent her days panhandling for whatever she could get and sometimes had to steal to survive. And her worst experience—when she started prostitution. It was her first time, and it was to a 50-year-old, overweight man who rented a cheap, dark room. What did she get out of it? $50.00, a packet of ketchup, and a lot of pain and discomfort.

She confided in Star about this experience and Star began crying. Star, who resorted to prostitution months before, confessed. "I think I'm pregnant. And worse, I think the father had AIDS."

That did it for Gwen. In two weeks, she had faced every problem imaginable—and she began to look back, wondering, "What did I ever run away from to begin with?"

Source: http://library.thinkquest.org/3354/Resource_Center/Virtual_Library/Runaways/runaways.txt.

aware of their ethnic status as a result. Adolescents from BIPOC groups begin to develop an ethnic or racial identity. Such an ethnic identity is important because it relates to a stronger sense of purpose, self-confidence, and social competence (Marsiglia & Lechuga-Pena, 2021).

BIPOC youth often confront living in two different cultures—the dominant culture and a culture shaped by their ethnic or racial status. Living in two cultures is a challenging background for development, especially when the two cultures clash. For example, one culture may value individual achievement, whereas the other may focus more on group-oriented achievement (Steinberg, 2023).

Adolescents of color often have two sets of peer relationships: one at school and another in their neighborhoods (Santrock, 2022). Neighborhood peers are more likely to be from their own ethnic group. In a study by Brown and Mounts (2000) of multiethnic high schools, between one-third and one-half of students of color were associated by peers with ethnically defined

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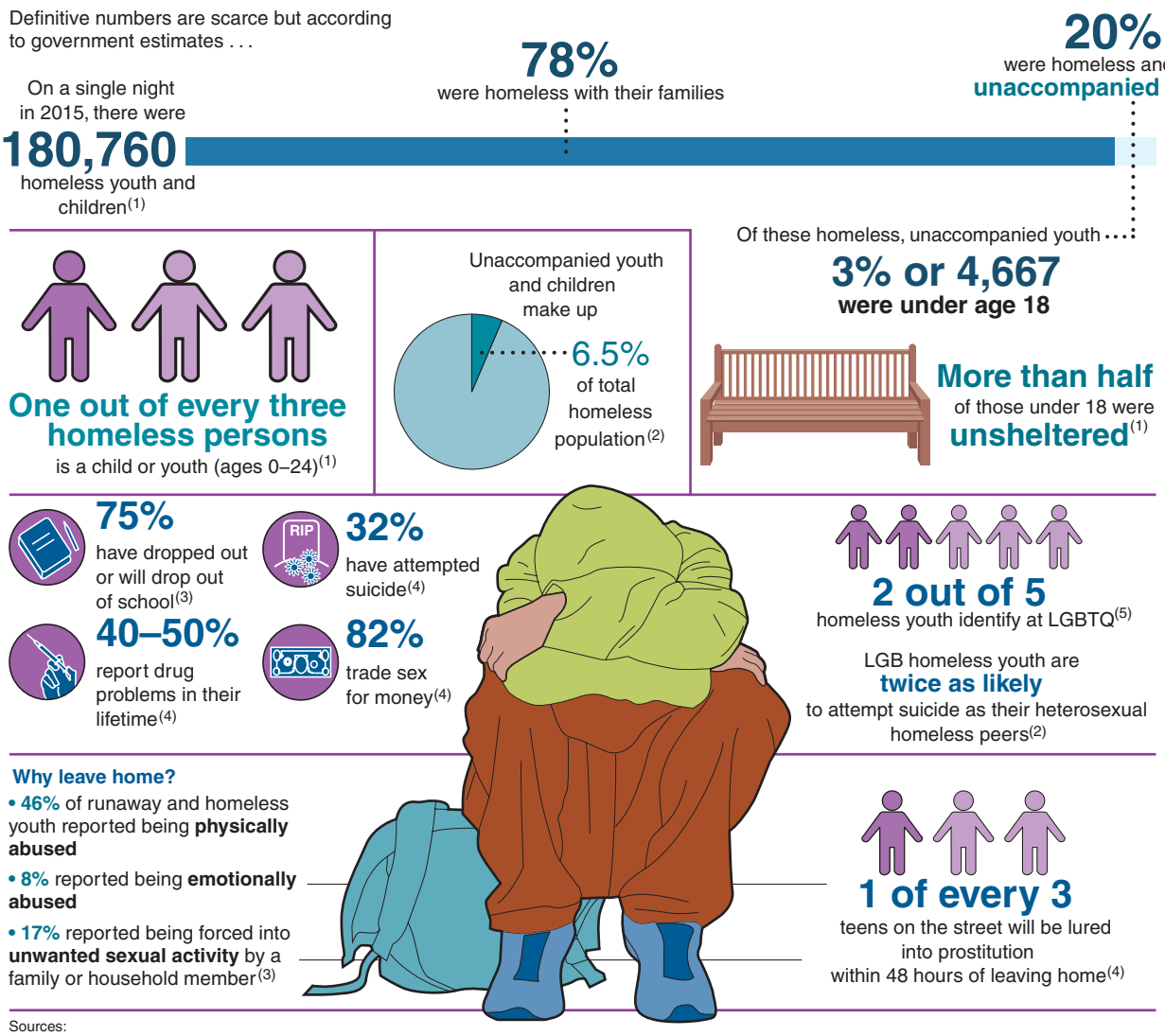
Exhibit 7.19 Homeless Youth



Sources:
(1) U.S. Department of Housing and Urban Development
(2) National Alliance to End Homelessness, 2015
(3) National Conference of State Legislatures
(4) U.S. Department of Health and Human Services
(5) dosomething.org

crowds—for example, rappers. The remaining students, two-thirds to one-half, were classified into reputation-based groups, such as those considered "popular" or "new wavers." Because adolescents of color may have two sets of peers, it is important to inquire about relationships both in the school and in the neighborhood. Adolescents who may be isolated and rejected in school could be neighborhood stars (Masiglia & Lechuga-Pena, 2021).

The Adolescent Immigrant

Thousands of adolescents immigrate to the United States with their families each year, from countries all over the world—Mexico, Thailand, Vietnam, and Haiti, to name a few. How does immigration affect their long-term adjustment to a new country? Several factors are important for their satisfactory long-term adjustment (Masiglia & Lechuga-Pena, 2021). Adolescents must address the

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Adolescent immigrants face discrimination and struggle with belonging and estrangement.

issue of belonging versus estrangement. Many adolescent immigrants get quick exposure to racial and ethnic discrimination. Their status as an immigrant is heightened by differences in appearance, dress, and language. A sense of belonging can be developed through participation in their immediate community or in educational and political activities. Critical to their adjustment is reliance on their earlier primary group's cultural values, which can provide a foundation for their adjustment. By using their identification with earlier values, they can make new accommodations without the need to reject basic values. Last, supportiveness of family relationships is necessary to provide positive expectations about their new adjustments to a different way of life. Encouragement that they can be successful and achieve reduces the sense of self-doubt and feelings of being marginal, providing a basis for them to realize their aspirations. Immigrating adolescents face many unique challenges in successful acculturation.

Gender and Identity

What does it mean to be a young man or a young woman in today's society? In the past, there were more clear indications about what a young man did compared with a young female—young men played rough and got dirty, whereas young women played quietly and kept clean. In today's culture, there is greater diversity in gender roles, both conforming and nonconforming and an increasing emphasis on equality or role sharing. Much of this change in gender roles is characterized as a move toward androgyny, which is the combination of masculine and feminine behaviors in the same person (Bem, 1974). An androgynous male adolescent is someone who is both assertive and sensitive to others; an androgynous female is dominant and assertive, as well as nurturing. Various research studies on gender roles suggest that, in general, changes are taking place in the direction of greater role sharing.

There are four major gender-role classifications: androgynous, masculine, feminine, and undifferentiated. We have already defined androgynous, and you are familiar with the notions of masculine and feminine; the undifferentiated classification refers to a person who has neither masculine nor feminine characteristics. Although androgyny is a useful concept, researchers have had a difficult time specifying the concept. Also, we must consider how the concept reflects the developmental level of the child (Santrock, 2022).

There has been an increase in adolescents identifying as non-binary meaning that they do not conform or identify with the traditional male or female gender. Youth who identify as nonbinary or one of the other commonly used terms will prefer to use pronouns such as "they/them" rather than "he/him" or "she/her." This transition to identify as nonbinary generally occurs in adolescence but also occurs in other periods such as childhood or young adulthood.

The feminism movement has gained ground among adolescents in today's society. Fourth Wave Feminism began in roughly 2013 and focused on the true equality of both men and women, extending the movement to include men. The goal of the movement is not solely focused on women gaining equality, but instead allowing men who express female characteristics with freedom from judgment such as painting their nails, expressing their feelings, and engaging in any stereotypically female activity while also further encouraging the rights of women to be equal.

Adolescent Depression and Young Women

In childhood up to puberty, more boys than girls are depressed. Suddenly, in late adolescence, the number of young women experiencing depression is twice that of boys—a disparity that continues through adulthood (Albert, 2015; Zhao et al., 2020).

Research has examined a number of possible factors that could account for such differences, including life events, popularity, and sex roles. However, the most significant factor related to depression is body image. Young women interpret their maturing bodies negatively, whereas boys perceive their own body changes as positive—as the development of more muscles.

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Media exposure can have a profound effect on one's body image especially in the age of social media where youths are profiling the highlights of their lives. Young women and young men are equally likely to be depressed because of life events, by young women unhappy with their body images are more likely to be depressed than boys. Also, young women who spend more time in "feminine activities"—such as makeup, cooking, and shopping—are more inclined to be depressed. Furthermore, because stereotypically feminine activities tend to be passive and may provide less mastery and autonomy, they may contribute to a tendency to depression (LeCroy & Daley, 2001).

Implications for Practice:

A Prevention Program for Adolescent Young Women

The "Go Grrrls" program (LeCroy & Daley, 2001) seeks to address the unique challenges early adolescent girls encounter by providing them with practical instruction and skill-building exercises. The target population is seventh graders, and the hope is that the program will provide a sort of inoculation of knowledge and skill early enough that young women may resist some of the common hazards of growing up in a culture that seems, in many respects, to be toxic to females. The program includes topics such as being a girl in today's society, establishing a positive self-image, developing an acceptable body image, assertiveness, problem solving, friendship skills, finding help, and planning for the future.

Some of the group sessions (such as the session on problem solving) emphasize skill building in areas equally pertinent to young men and young women, but the examples and role-plays used to illustrate the skills emphasize young women as the major actors. Other sessions (such as the session on being a girl in today's society) are designed to address areas of special concern to adolescent young women—the profusion of negative images of women in popular media, and the ability and confidence to critically challenge these cultural stereotypes. A randomized control-group experiment found the program enhanced the skills and abilities of the participants significantly (LeCroy, 2004). These same themes have been translated into a program designed specifically for young men and include understanding sexual consent, role boundaries, and sexual risk reduction skills (LeCroy, 2021; LeCroy, Mllligan-LeCroy, & Lopez, 2021).

Adolescent Sexuality

No discussion of adolescence would be complete without a section on adolescent sexuality. In adolescence, formation of a sexual identity is a major developmental task. From adolescence to young adulthood, young people begin the process of sexual exploration—a search for their sexual identities. How sexually active are adolescents? Recent data suggest that they are active with 42% of high school females and 38% of males engaging in sexual intercourse. The percentage of high school males engaging in sexual activity has declined 17% since 2002 (Centers for

Focus on **The Lived Experience**

The Difficulty of Being a Young Woman in Today's Society

I cannot stop crying. Why won't the tears stop flowing? When I was little I'd just think of something and then I'd be ok, but no happy thoughts pop into my mind at the moment. Crying is pointless. It gives me a headache, makes my eyes burn, makes my nose run, and causes people to ask, "What's the matter?" What do you expect me to say? Where would I begin?

How could I possibly explain how awful I feel about myself; how I can't remember the last time I was actually proud of myself; how I can't stand any of the people I used to call my "friends"; how I feel guilty about everything I do; how I hate being fat but wish I were thin; how I wish boys would like me even though I'm fat so I'd be happy with myself; how I wish I didn't depend on boys to raise my self-esteem; how I hate boys but want them anyway; how I know you don't really care what's the matter with me. Nobody cares. Maybe that's why I'm crying. Would you understand this? No, because you're self-confident, popular, and thin! You have no idea what it feels like to be so inferior to everyone around you! So shut the fuck up, walk away from me, and let me cry in peace!

Source: Carlip (1995). *Girl power: Young women speak out.* New York: Warner Books, p. 53.

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One of the most important factors in adolescent depression is poor body image.

Disease Control and Prevention (CDC, 2019)). Most people believe the statistics underestimate the extent of adolescent sexual behavior. Of particular attention recently has been the number of adolescents engaging in oral sex.

Recent media reports have popularized the notion that adolescents are engaging in oral sex because it isn't "real" sex. Data on 15- to 19-year-olds finds over 40% of both young men and women report having received oral sex (CDC, 2015). Many of the reports focused on what was labeled a fad among suburban middle school students. Because of the complexity in conducting research on such sensitive topics with young adolescents, there is little data to verify these media reports. Although it would appear that there is an increase in such sexual behaviors, it is difficult to know the extent of the behavior. As one expert put it, "Middle school young women sometimes look at oral sex as an absolute bargain—you don't get pregnant, they think you don't get diseases, you're still a virgin and you're in control since it's something that they can do to boys" (Roffman, cited in Remez, 2000). There is also the perception that oral sex is something you can do with someone you are not intimate with, intercourse being reserved for that special person. Adolescent health professionals will need to address these issues as they continue to work on improving the health status of young people. If nothing else, oral sex has helped everyone recognize that we need a broader definition of sex—it is not just a single act but a wide range of behaviors. Many aspects of adolescent sexuality have undergone rapid and considerable change, yet many other aspects have remained unchanged (Exhibit 7.20).

The accompanying The Lived Experience presents several adolescents' viewpoints about sex.

Focus on **The Lived Experience**

Adolescents' Views on Sex

Santrock (2013, p. 384) has quoted several adolescents about their sexual experiences:

> I am 16 years old and I really like this one girl. She wants to be a virgin until she marries. We went out last night and she let me go pretty far, but not all the way . . . It's getting hard for me to handle . . . I feel I am ready to have sex. I have to admit I think about having sex with other young women too . . . (Frank C.)

> I'm 14 years old. I have a lot of sexy thoughts. Sometimes just before I drift off to sleep at night I think about this hunk who is 16 years old and plays on the football team. He is so gorgeous and I can feel him holding me in his arms and kissing and hugging me . . . (Amy S.)

> Is it weird to be a 17-year-old guy and still be a virgin? Sometimes I feel like the only 17-year-old male on the planet who has not had sex. I feel like I am missing out on something great, or at least that's what I hear. I'm pretty religious and I sometimes feel guilty when I think about sex . . . (Tom B.)

> I'm 15 years old and I had sex for the first time recently. I had all of these expectations about how great it was going to be . . . We were both pretty scared about the whole thing. It was all over in a hurry. My first thought was, "Is this all there is?" It was a very disappointing experience. (Claire T.)

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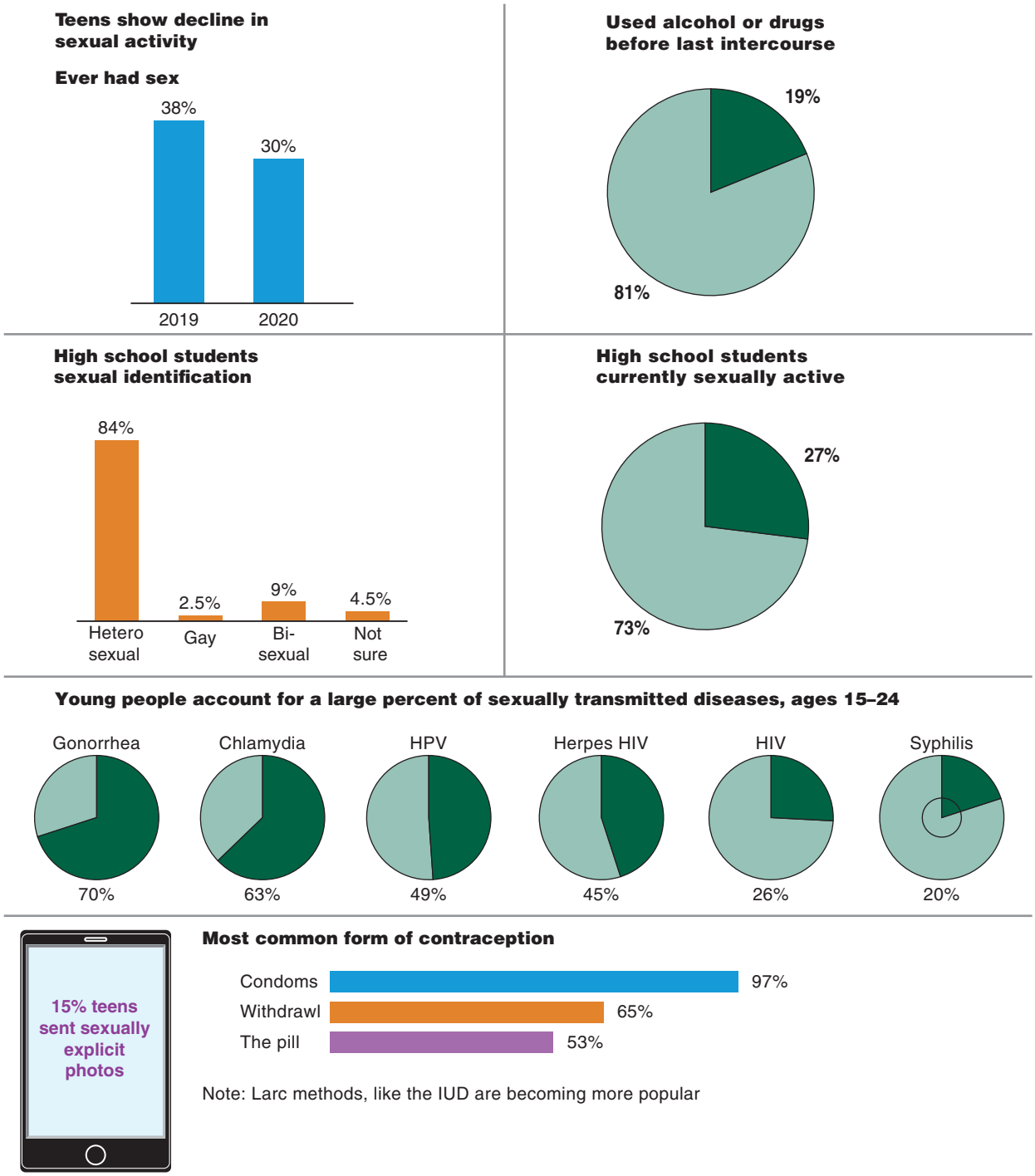
Exhibit 7.20 Adolescent Sexual Behavior



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Gay, Lesbian, Bisexual, Transgender, and Questioning Youth

Consider the following quotations from LBGTQ adolescents (from Myers, K., & Evans, K. R., 2020)

As a queer person of color who traces my heritage to a country in which homosexuality is punishable by death, I want to use my privilege as an American citizen with a supportive family to raise awareness and fight for the people who can't.

By my teens, I was looking hard to find anyone who was like me. I didn't fit the stereotype of a gay woman, but I knew my sexual identity was outside the norm.

Hi. I'm Corey. I'm 14 years old. I might look happy now but I haven't always been. I've known I was different all my life. When I was little I loved to play with dolls and play dress up. I loved painting my nails too. Wearing my mom's high heels was my favorite! But only in the house. NEVER outside. Because I was born a BOY.

The only way I will rest in peace is if one day transgender people aren't treated the way I was, they're treated like humans, with valid feelings and human rights. Gender needs to be taught about in schools, the earlier the better.

Please, BE WHO YOU ARE… Do it for yourself, Do it for your happiness. That's what matters in YOUR life. You don't need approval on who you are. Don't let people or society change who you are just because they're not satisfied with your image.

These are the words of gay and lesbian (LGBTQ) adolescents. The term *gay* refers to both men and women whose sexual orientation is toward members of the same sex. The term *lesbian* is used to describe women. The term *bisexual* is used to describe sexual behavior that is directed to members of both the same and the opposite sex. The word *transgendered* refers to a person whose identity differs from conventional expectations for his or her physical sex. Transgendered people can include transsexuals, drag queens/kings, cross-dressers, and so forth, and transgendered people can be gay, lesbian, bisexual, or straight. Often, gay and transgendered people are referred to together as LGBT (lesbian, gay, bisexual, and transgendered) or LGBTQ (with the addition of "questioning"). The word *homosexual* refers to both gay men and lesbians but is often not the preferred language, as homosexual has been associated with negative stereotypes. These labels are also words of secrecy and fear—a world that gay adolescents must learn to live within. Life can be difficult, if not dangerous, for many gay adolescents, who experience violence because of their sexual orientation. Indeed, gay adolescents present our society with many challenges. As Hersch (1999) aptly put it, "to a culture already uncomfortable about adult sex, worried about adolescent sex, and downright hostile about homosexual sex, gay and lesbian adolescents pose a compounded threat—children who are sexual and deviant."

Society has a difficult time accepting adolescents as sexually active and would rather deny the existence of LGBTQ adolescents. Even sex education programs fail to address gay adolescents' needs or acknowledge their sexuality although this is starting to change.

Teens are disclosing their homosexuality with increasing regularity and doing so at a younger age. According to Savin-Williams (2006) in *The New Gay Teenager*, the gay person comes out just before or after graduating high school. Whereas in 1997 there were 100 gay-straight alliances—clubs for LGBTQ and LGBTQ-friendly kids—currently, there are thousands of gay-straight alliances in high schools. While some schools have tried to stop these alliances, the federal Equal Access Act guarantees that students at public schools have a right to form GSAs (gay-straight alliances). The internet and other communications media have fueled increased exposure of gay teens with websites such as younggayamerican.com and outproud.org, new novels such as *Rainbow Road* about three gay teens, and gay teens who are out on mainstream television shows such as *Desperate Housewives*.

A Gallup poll found that 5.6% of the adult population identify themselves as LGBT in 2020 with 0.7% identifying as lesbian, 1.4% as gay, 3.8% as bisexual, 0.6% as transgender, with 0.2% identifying as "other" (Gallup, 2021). As of 2020, the prevalence of adolescents within the LGBTQ community identifying as nonbinary was 26% (Trevor Project, 2022). The basis for homosexuality is debated. However, it is likely to have a genetic component: when one twin is gay, the other twin is gay more than 50% of the time. No matter what the origin of homosexuality, the estimated 4 million LBGTQ adolescents in the United States must confront many social difficulties.

Perhaps of most concern among LGBTQ adolescents are isolation, depression, and potential for suicide. These young people are two to three times more likely to attempt suicide than other youths (Steinberg, 2023). A significant number of the suicide attempts relate to personal turmoil about being gay. Many of these young people have a difficult time confronting the social isolation they experience, their concern about secrecy, and their fear of violence. Other risks include low self-esteem, substance abuse, and harassment.

Several authors have explored the unique developmental challenges faced by LGBTQ youth in relation to the

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coming-out process. Adaptation to a gay identity is commonly conceived to span four stages, often sequentially, though progression may cease at any stage. It is important to remember that although frameworks provide a helpful generic description of the developmental transition, the process is highly variable and rarely unfolds in an orderly, linear fashion. It is characterized by diversions and detours and by individual differences, sex differences, and the historical context. Troiden (1989) has referred to the first stage of adaptation as *sensitization*, during which the individual becomes aware of feelings that make him or her different according to social definitions. The next stage is *identity confusion*, where the person struggles with the implications of a LGBTQ identity. At this stage, individuals often try to make sense of their feelings without the advantage of accurate information and are informed only by the negative and erroneous stereotypes of the dominant culture. Eventually, the strength of the feelings associated with sexual attraction leads to some degree of self-redefinition that may be associated with behaviors consistent with a LGBTQ identity. Troiden referred to this stage as identity assumption and described the final stage as commitment, which involves a restructuring of the individual's social life to include a sustained, positive association with a community of like others.

Unfortunately, many LGBTQ youths do not learn to accept or feel comfortable with their sexual identity. In addition to the concern about depression and suicide, gay adolescents face a number of increased risks, such as destructive alcohol and drug abuse, being victims of crime, sexual diseases including AIDS, and school dropout. These risks can be compounded if the youth is a person of color. LGBTQ youths of color live within three communities: their ethnic community, the LGBTQ community, and the majority community. They are thus susceptible to two types of prejudice: racism and homophobia. A LGBTQ person lives in a number of different worlds—and too often none of the worlds provides the support that is needed. Social workers can support the positive development of LGBTQ youths following the suggestions shown in Exhibit 7.21 (Myers & Evans, 2020).

Implications for Practice:

Guidelines for Adolescents Who Want to Consider Coming Out

Many LGBTQ adolescents will confront the decision about whether or not to come out and discuss their sexuality. This is a difficult decision with a lot of serious consequences. More than 20 years ago, Sauerman produced a pamphlet for the Federation of Parents and Friends of Lesbians and Gays (PFLAG) about coming out, and Pope (2004) has updated these guidelines for coming out to one's parents:

1. Be clear yourself. Tell them when you have accepted your own sexual orientation and are comfortable and happy with it. Then it is important to express this to your parents. If you are not comfortable or happy, they will perceive this incongruity between your words and feelings, and they will want to try to change you.
2. Tell them about your sexual orientation when things are going well for both you and them, or during a period when there is relative tranquility in your lives.
3. Do not come out during an argument, because this knowledge may then become a weapon to be used to cause pain to everyone.
4. It is okay to tell only one parent initially if that is easier or more comfortable for you. It is important that both parents know eventually.
5. Begin by telling your parents that you love them. If you do not usually say these things, then find other positive thoughts to share.
6. Be prepared for your parents to be upset and hurt by this news. Your parents may respond with anger, but try not to be defensive and angry also. Be prepared also for your parents to say, "I've known this for many years," or to say nothing. Different parents react differently.
7. Give them the time and distance they need to assimilate this information.
8. Tell them that you are still the same person and you hope they will continue to love you.
9. Try to maintain open lines of communication. Your parents are going to go through a period of adjustment as well—feelings of guilt, lost dreams, and greater uncertainty about the future. Sometimes they just need time.
10. Get reading material and share it with your parents. Get the address and phone number of the local Parents and Friends of Lesbians and Gays (PFLAG) and give it to your parents.
11. Coming out to your parents is probably more important for you than it is for them. Do not force the discussion further if your parents are not ready to continue the dialogue at this time. Sometimes they just need some time and space to process this information and gain some perspective.

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Exhibit 7.21 Suggestions to Assist LGBTQ+ Youth

Be vocal	Make your support well known. Help support LGBTQ youths and create safe spaces for youths to be self-advocates.
Be visible	Show visible support. Post a rainbow flag, have books that are inclusive and visible. Use models of LGBTQ people in your work.
Be respectful	Honor people's name and pronoun choices. Show respect for their choices and identities. Accept and reflect their language.
Honor confidentiality	LGBTQ young people face risks when their identities are disclosed. Only do so if given permission. Provide resources that can be used by young people and that protect their confidentiality.
Be trauma informed	Understand the role that trauma may play in a young person's life. Promote trauma-informed approaches.
Listen carefully	LGBTQ youth can feel judged, so it is important to allow them to direct the conversation. Learn how to communicate in a manner that doesn't reinforce hetero normative language.
Educate yourself and others	Learn about LGBTQ identities. Reference networks and organizations such as the Trevor Project and the Gay Lesbian & Straight Education Network.

Source: Based on Myers & Evans. (2020). Narratives from the closet: Stories of LGBTQIAP+ youth, *Children, Youth and Environments.*

Harassment

Harassment is becoming an increasing concern among school officials. On average, around 56% of young women and 40% of boys experienced sexual harassment (National Sexual Violence Resource Center, 2022). In the AAUW report, "Hostile Hallways: Bullying, Teasing and Sexual Harassment in Schools," one-third of students said they fear being sexually harassed in school, whereas less than half reported never being afraid when they go to school. More than a quarter of the students surveyed reported they often experience sexual harassment. The report discussed the negative ramifications of harassment for young women, who described feeling self-conscious, embarrassed, and less confident when experiencing sexual harassment. Other research indicates that students with disabilities are more likely to be sexually harassed than their peers and that LGBTQ youth can experience intense harassment (Kiekens, 2021). Surprisingly, much of the harassment is taking place in front of teachers and school officials, despite the fact that since Title IX of the 1972 Education Amendments, schools are legally liable when they know of sexual harassment but do not act on it.

Focus on **The Lived Experience**

Being Gay in High School

"DYKE!"

From behind my back, I hear the slur for the umpteenth time. "I'm not going to let it go this time," I think to myself. "Let's see who's so tough and brave now." I whip around to face four boys who like to think of themselves as men.

"Who said that?" Four heads bow dumbly at their desk. "I asked you, who said that?" Not one of those pairs of "tough" eyes dares to look into mine. "You're all a bunch of cowards," I say with exasperation and walk away.

As soon as I walk away, frustration, disappointment, and anger well up inside of me and I explode with unanswerable questions. I'm a good person and I don't try to hurt other people. Why can't they just leave me alone? Do they hate themselves so much that they hate me too? Do they fear me? What do they know about the real me? They don't even know who I am.

This was not an isolated incident. I've experienced this harassment throughout high school. I have always been able to stand up for myself, but I've always been left with a vague angry feeling …

Source: Carlip (1995). *Girl power: Young women speak out.* New York: Warner Books, pp. 93–94.

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What needs to happen to curb the incidence of such harassment? Experts agree that social workers should first become aware of any existing policies in the schools; if there are none, policies need to be created. Second, make sure the school has a plan for what to do when an incident is reported to a school official and that everyone is clear about how a student can file a complaint. Third, all school staff need to be trained in sexual harassment policies and principles. Fourth, whenever harassment occurs, it should be addressed immediately. Lastly, build a supportive community of parents who can help ensure that policies and practices are consistently implemented.

Social Media

The 2010s and 2020s truly are the "age of social media," with social media becoming ingrained in youth society. Common Sense Media reported that those between ages 13 and 18 spend an average of 8 hours and 29 minutes a day on social media websites such as TikTok, Instagram, Snapchat, and Reddit and video streaming services such as Netflix and Hulu. Between 2019 and 2021, screen time among youths increased by 17%. This online environment has created a wave of new issues for adolescents today including negative influences on self-esteem, an increase in acceptability of drug use and access to drugs and is changing how adolescents today view friends as well as how much time they spend with them face to face. Screen time was reported to be highest among youth from low-income families and youths of color. This discrepancy can be explained by the COVID-19 pandemic, with lower-income families being impacted more substantially by school closures and a lack of afterschool activities. See Exhibit 7.22 for a social media discussion guide for adolescents.

Exhibit 7.22 Adolescent Social Media Use Discussion Guide

Questions	Recommendations
Which social media sites do you use?	Discuss privacy settings and the importance of utilizing them. Discuss digital literacy, boundary setting, and critical thinking. ■ How to evaluate if content is inaccurate or factual ■ Discuss personal privacy and protection ■ Discuss how to respond to unfamiliar or unknown individuals Inform that nothing on the internet is private, even if they have strong privacy settings and to think about potential risks before they post.
How long do you spend on social media each day?	Limit leisure screen time to 1 to 1.5 hours per day. Achieve 8 to 12 hours of sleep a night; avoid electronics.
How do the apps you consume affect you emotionally?	Assess mental health risk. Facilitate discussion about risks and benefits of social media usage. If mental health is negatively impacted, brainstorm interventions with youths such as unfollowing accounts or limiting time on specific apps.
Do you use your electronic devices before bed?	Assess the frequency of use before bed and reasoning. Suggest alternatives. Avoid electronic devices in the bedroom and one hour prior to bedtime.
Have you experienced cyberbullying?	Facilitate communication between adolescent and caregiver about online citizenship and safety. Inform adolescent and parents on cyberbullying intervention methods. Advise to treat others with respect online. Be wary of online solicitation. Avoid communications that compromise personal safety and privacy.
Has someone ever pressured you to send explicit videos, pictures, or messages?	Inform about child pornography laws. Discuss consent. Discuss the risk of sending explicit material including the possibility of legal ramifications, distribution, and hacking.

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Cyberbullying

When most people envision bullying, they picture a scene in the schoolyard involving physical or verbal threats and/or violence. As elementary, middle, and high school students become adept at using internet and phone technology, bullying has taken a new form. Cyberbullying can be particularly cruel, largely due to the offender's anonymity and the potential to have a large crowd of virtual witnesses (e.g., sending messages through online social media). While traditional bullying is often limited to the schoolyard and bus, cyberbullies can leave threatening messages at any time. Statistics about cyberbullying note that 37% of youth have been bullied online in 2019 compared to 17% in 2007, with reports being the highest among middle school students. Females tend to experience cyberbullying in the form of rumors being spread about them, while boys experience physical threats (National Bullying Prevention Center, 2020). The most common form of cyberbullying occurs through instant messaging, with most victims in middle school (Kowalski, Limber, & Agatston, 2012).

Are cyberbullies different from traditional bullies? One study found that more young women admitted to cyberbullying (13%) than boys (9%), which is consistent with other research suggesting that young women prefer using indirect forms of aggression (Kowalski et al., 2012). Cyberbullies also experienced higher levels of social anxiety than traditional bullies, though cyberbully victims experienced even higher levels of social anxiety. This is not surprising, as half of cyberbullying victims report that they do not know the perpetrator (Kowalski et al., 2012).

The act of cyberbullying is distinctly different from traditional bullying. In a face-to-face encounter, the victim can communicate emotional cues to let the bully know what effect their behavior has on the victim. This may help the traditional bully decide when to stop, knowing that they've made an impact. Cyberbullies do not have this kind of feedback and may continue bullying past the point of making this impact. Similarly, victims of cyberbullying are not able to read the faces of their perpetrators. A wink or slight smile might communicate the bully's intention, and the cyber equivalent of the emoticon often fails to communicate whether the bully is really "just kidding."

Also, bullies are likely to say and do things in a message that they would not do in a face-to-face encounter. This creates an opportunity for more frequent and vicious threats, taunts, and other forms of aggression.

As children have access to instant messaging at an increasingly younger age, parents and school staff need to be aware of the potential for this new breed of bully. The effects of cyberbullying may be more dramatic than traditional bullying, as bullies now have increased access to their victims and are able to remain anonymous. Research suggests that it may require unique forms of intervention and treatment (Kowalski, et al., 2012).

Social Strengths, Hazards, and Risks

Building "Assets" for Youths: A Strength- and Community-Based Approach

Peter Benson, president of the Search Institute, has led a nationwide effort to promote positive youth development. His work began with research describing assets and their impact on the at-risk behavior of youth. His work has been used to promote strategies to build the assets of children and adolescents (Benson & Galbraith, 2012;). This approach attempts to shift the current emphasis on the crisis and problems of youth and concentrate on building assets for and with young people. According to Benson, too much focus has been placed on trying to stop or prevent problems rather than on increasing young people's exposure to positive and constructive activities as a way to build stronger communities. The research on ASSETS comes from more than 600 communities and is based on almost 50,000 young people. The research focused on the presence of 30 assets.

The findings are revealing: high school students with only 1 to 10 of the 30 assets in their lives are involved in an average of 5.8 of 20 risk behaviors. However, youth with between 11 and 20 assets are involved in half as many risk behaviors, only 3.4. Furthermore, youth with 26 to 30 assets show very little risk behavior at all. Exhibit 7.23 shows that young people with the smallest number of assets have the highest alcohol use and that youth with the most assets represent a small percentage of youth with alcohol problems.

The asset-building approach is a growing movement across the country (Shek et al., 2019; Benson, 2003; Lernerf, et al., 2008).

Many communities, schools, and task forces are working together to develop a vision for positive youth development and to implement ways to build assets for youth.

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Exhibit 7.23 Developmental Assets for Youth

External Assets
Social
Family support
Caring neighborhood
Parent involvement in school
Empowerment
Safety
Youth as resources
Community values
Boundaries and Expectations
Positive school environment
Adult role models
High expectations
Use of Time
Youth programs
Social-recreational activities
Time at home
Internal Assets
Commitment to Learning
School bonding
Reading
Achievement motivation
Positive Values
Caring
Responsibility
Integrity
Social Competencies
Planning and decision making
Resistance skills
Conflict resolution
Positive Identity
Self-esteem
Sense of purpose
Positive view of future

Adapted by the authors from 40 developmental assets. The Search Institute, Minneapolis, MN.

Adolescent Risk and Protective Behaviors

How can we understand the various factors that play a significant role in leading to adolescent risk behaviors or lifestyles? For several years, Richard Jessor (1992, 1998) has been studying adolescent problem behavior. Jessor's theory identifies five protective and risk factors that influence adolescent risk behavior: biology/genetics, social environment, perceived environment, personality, and behavior. Within each of these categories is a set of risk and protective factors. For example, in the social environment, the risk factors are poverty, normative anomie, racial inequality, and illegitimate opportunity; the protective factors are quality schools, cohesive family, neighborhood resources, and interested adults. It is important to point out that the influence of these concepts is bidirectional. Studies have found that a single risk in early adolescence is related to increased levels of school dropout and criminal arrests and the more risk factors an adolescent experiences increases the rate of school dropouts and criminal arrests further (Gubbels et al., 2019). Some researchers (Ellis, Del Giudice, Dishion, et al., 2012) have suggested that adolescent risk behaviors can be understood from an evolutionary model. Within this framework, adolescent risk behaviors have an evolutionary function and rather than perceiving these behaviors as maladaptive they are better understood as adaptive within an evolutionary model. Exhibit 7.24 presents the prevalence rates for selected behavior problems.

Exposure to Violence

Before we begin to address various social hazards of adolescence, it is important to recognize that many children and adolescents today are growing and developing in a violent world. Almost half of all adolescents believe their schools are becoming more violent. Some young people are afraid of being hurt or shot by classmates who have weapons (10%), and twice as many youths (20%) fear going into restrooms (Safe Schools, 2020). In 2019, 8.2% of high school students reported experiencing physical and/or sexual violence in their dating relationships (Center for Disease Control and Prevention, Interpersonal Violence, 2019)). Violence in schools is a significant concern, but the incidence of violent deaths, though always tragic, remains small with only 2% of youth homicides occurring on school grounds (Centers for Disease Control and Prevention, 2021).

Because people are in schools for a significant portion of their childhood, this research suggests that children are potentially subjected to much more violence than adults. In fact, rates of assault, rape, and robbery against those aged 12 to 19 years old are two to three times higher than for the adult population as a whole.

Homicide is the only violent crime to which teens are somewhat less vulnerable than adults. Yet there are huge racial disparities—for African Americans aged 10 to 35, the homicide rate has been found to be up to 13 times higher than their White counterparts (Sheats et al., 2018)

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Exhibit 7.24 Prevalence Rates for Selected Behavior Problems and Disorders

Behavior Problems and Disorders	Prevalence Rates
Drug use[1]	Reported drinking in the past 30 days: 13% of 8th graders 27% of 10th graders 40% of 12th graders By high school graduation: 50% have used illicit drugs
Substance-use disorders[2]	11% of youth meet the criteria for a substance-use disorder (10% of adolescent females and 12% of adolescent males). Rates of drug abuse/dependence are 9% and for alcohol abuse/dependence are 6%.
Sexual behavior[3]	Birth rates for 15- to 19-year-old females: 34 per 1,000 (56 per 1,000 for Hispanic adolescents) In 2010, 740,000 adolescent pregnancies per year About half of adolescents are sexually active before they graduate from high school.
School dropout[4]	*Status dropout rate:* the percentage of an age group that is not enrolled in school and has not earned a high school diploma. Approximately 8% of 16- to 24-year-olds (who were out of school without a high school diploma).
Suicide[5]	Overall suicide rate of 7% for 15- to 19-year-olds (2% of adolescent females and 11% of adolescent males).
Depression[2]	Depression rates range from 3% for bipolar disorder and 12% for major depressive disorder or dysthymia.
	When any kind of mood disorder is included, the rate is about 14% (18% of adolescent females and 10% of adolescent males). Rates among 17- to 18-year-olds are double that of 13- to 14-year-olds.
Anxiety disorders[2]	Overall rate for any kind of anxiety disorder is 32% (38% of adolescent females and 26% of adolescent males). Rates of social phobia are 9% and specific phobia is 19%.
Eating disorders[2]	About 4% of the adolescent female population (2% of the adolescent male population) suffer from eating disorders.
Behavioral disorders[2]	Overall rate for any kind of behavioral disorder is 20% (16% of adolescent females and 24% of adolescent males). Rates of oppositional defiant disorder are 13% and conduct disorder are 7%.
Autism spectrum disorder[6]	Rates have shown increases in the last 30 years. Recent estimates are 1 in 88 (1 in 252 girls and 1 in 54 boys)

1) Johnston et al, 2012; 2) Menkangas et al., 2010; 3) Centers for Disease Control and Prevention; 4) Chapman, Laird, and KewalRamani, 2010; 5) Center for Disease Control and Prevention, 2011; 6) Centers for Disease Control and Prevention, 2012b.

and African American youths are 17 times more likely to witness violent crime than their White counterparts (Sheats et al., 2018). This is believed to be due to the low levels of opportunity, low education, and high levels of urbanization and poverty that exist in many African American communities.

So, who is hurting our nation's children? Sadly, it is their families. Adults report that they inflicted almost twice as much severe violence (which included beating up, kicking, and hitting with fist or object) against a child in their household than they did against their adult partner. Taking into account that many acts of family violence go unreported, this is shocking. Child prostitution is another national shame, and it is estimated that at least 100,000 American children are trafficked for sex each year (Fang, 2013).

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After-School Programs

Researchers and practitioners working with youth have recognized the importance and value of providing them with access to quality programs, activities, and opportunities during nonschool hours (Durlak, Weissberg, Pachan, 2010). These Ies are increasingly deemed essential to the healthy development of youth. In a meta-analysis of studies (Durlak et al., 2010), it was determined that participation in after-school programs was associated with improved school performance—more specifically, with higher grades and achievement test scores. Increasing focus is being placed on the development and evaluation of such programs. For example, The National Institute on Out-of-School Time publishes the journal *Afterschool Matters*, the Harvard Family Research Project maintains an out-of-school time-evaluation database, and Child Trends regularly publishes papers on strategies for promoting quality out-of-school time programs.

Youth Employment

Youth employment has dropped dramatically in the past 20 years and currently about 17.6% of adolescents between 16 and 19 are while enrolled in school (Butts, 2022). In today's world, adolescents juggle school, friends, boyfriends or girlfriends, family, and work (Steinberg, 2023). But is it good for teenagers to work? Recently, Paul (2022), writing for the *New York Times*, revisited the topic of adolescent work and argued that an after-school job is the best extracurricular experience. Research has found that the number of hours involved in work can have positive or negative effects on adolescents. In general, working 15 to 20 hours per week improves a student's self-esteem and school satisfaction, and working students' grade-point averages are higher than those of nonworking peers and is promoted by many youth-based organizations (Youth First, 2017). Research has found that adolescents working more than 20 hours per week face negative effects. Adolescents who work this much show elevated levels of psychological distress, including low self-esteem (Steinberg, 2023). These youth are more likely to get in trouble with the police and use drugs and alcohol. In conclusion, adolescents who are involved in some work derive benefits that may encourage responsibility and autonomy and may provide important new opportunities in the future.

Adolescent Pregnancy and Childbirth

A significant social hazard of the adolescent years is teenage pregnancy—a topic discussed by many people in our society. Teenage pregnancy has remained a national concern for many years.

Being sexually active can take a young person down many new roads. Once an unplanned pregnancy occurs, there are many difficult decisions to confront: Should I have this baby? Should I give this baby up for adoption? Should I consider an abortion? An unplanned pregnancy has many implications for the future of the young woman: involving the father, getting married, finishing school, parent relationships—all of these things must be attended to. It is as if the young person is thrusted into a completely new reality. This section will examine the prevalence of adolescent pregnancy, the consequences of adolescent pregnancy, the adolescent father, and implications for reducing adolescent pregnancy.

Prevalence of Adolescent Pregnancy

When examining the prevalence of adolescent pregnancy, several factors come into play. First, how many adolescents are sexually active? Second, how many sexually active adolescents are using contraception effectively? Third, if early pregnancy does occur, how many adolescents are obtaining abortions? Given all these factors, it is easy to understand that many factors can influence birth rate statistics. Exhibit 7.25 shows the prevalence of various sexual behaviors of 12th graders from 2013. The birth rate for female adolescents has declined almost continuously over the past 20 years. As shown in Exhibit 7.26, birth rates are higher among Hispanic and Black adolescents compared to their White counterparts.

Still, about 16% of American adolescent young women between the ages 15 and 19 will become pregnant each year (Centers for Disease Control and Prevention, 2021), contributing to the nearly 1 million teen pregnancies. Even with the recent decline in pregnancies, the United States has one of the highest teen birth rates of all developed countries. And once a young woman becomes pregnant, the risk of a second pregnancy increases. About one-third of adolescent mothers have a repeat pregnancy within two years (Steinberg, 2023). This sobering fact suggests the ongoing need to address birth control among young people.

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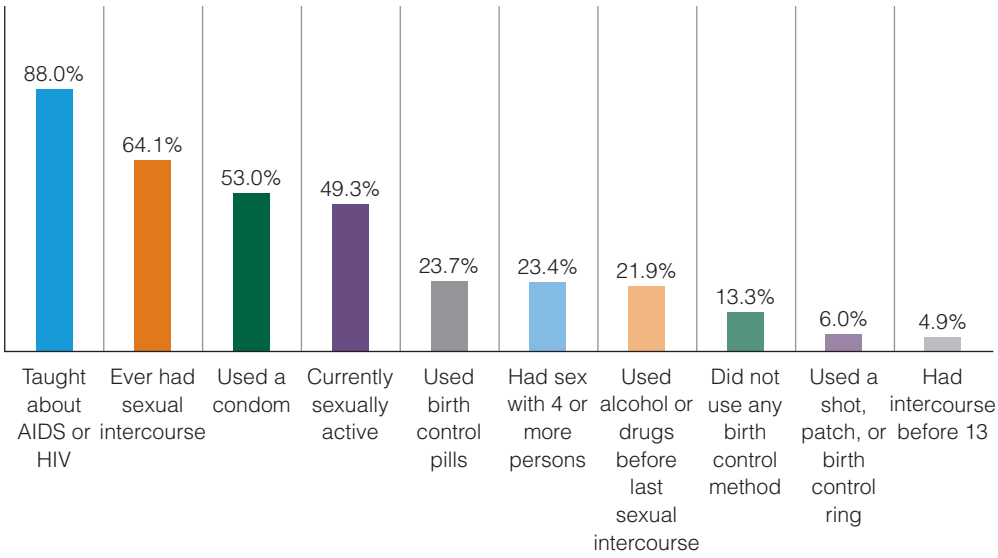
Exhibit 7.25 Trends in Sexual Behavior of 12th Graders

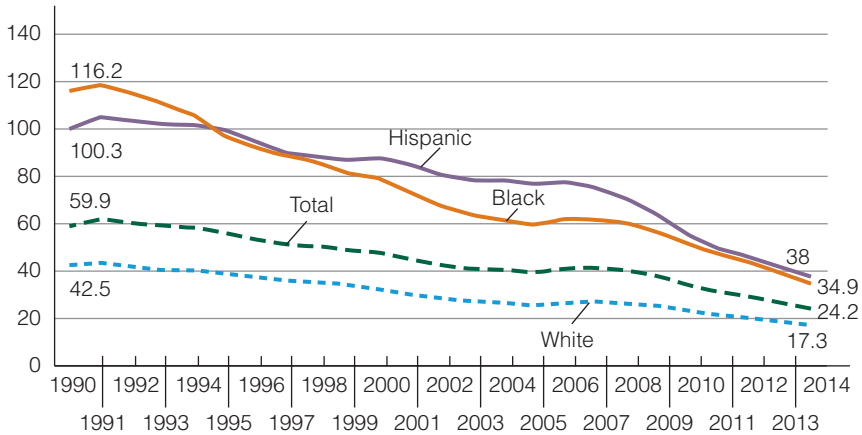


What is the greatest risk factor for a teenager becoming pregnant? If you guessed poverty, you are correct (Centers for Disease Control and Prevention, 2021). With poverty comes less education, poor medical care, less opportunity, higher dropout rates, a sense of hopelessness and isolation, and a greater likelihood that the age of first intercourse will be younger. And, not surprisingly, the younger the age at first intercourse, the less likely a teen is to use contraceptives.

Consequences of Adolescent Pregnancy

The consequences of early pregnancy affect both the mother and the child. For the infant, low birth weight and an increased likelihood of infant mortality are consequences. Prenatal care is obtained by only one out of every five of all mothers during the critical first three months of pregnancy. For the mother, especially young mothers, there are increased risks of complications and mortality. There is also a greater likelihood for young mothers to experience complications such as toxemia, anemia, and prolonged labor (World Health Organization, 2020) because of the long-term consequences of early pregnancy, teenage mothers suffer many critical disadvantages, including reduced educational achievement, due mostly to early dropout from school. This may contribute to the additional problems of low-status jobs, lower

Exhibit 7.26 Birthrates Among Adolescent Mothers



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income, and welfare dependency. They face equally critical disadvantages in social relationships—high divorce rates, unstable relationships, and more subsequent unintended births. Long-term consequences for children of adolescents can include lower educational achievement, behavioral and emotional problems, a greater likelihood of themselves becoming teenage parents, and an existence based in poverty (Centers for Disease Control and Prevention, 2021).

Young women who terminate their pregnancies experience few negative consequences, although the later in the pregnancy an abortion occurs, the greater the risk of complications. The literature has not found significant psychological consequences associated with abortion. Similarly, there appear not to be any serious psychological consequences associated with adoption, although adoption is rarely an alternative selected by teenage mothers.

Jason Stitt/Shutterstock.com

Adolescent pregnancy is an important risk factor because it decreases the likelihood that the mother will complete school and significantly reduces her chances for economic self-sufficiency.

Implications for Practice:
Reducing Adolescent Pregnancy

The consequences of adolescent pregnancy point to the need for a more effective means to reduce its incidence. How can it be done? A comprehensive approach at several levels is needed. The following are a few of the suggested approaches:

1. *Expanded sex education efforts.* The best model for sex education and the best data supporting the influence of the model on rates of pregnancy come from efforts outside the United States. The adolescent pregnancy rate in this country is the highest in the Western world—twice as high, for example, as in England or Canada, and three times higher than in Sweden. Yet, U.S. adolescents are not any more sexually active than those in other countries. In fact, Swedish adolescents are more sexually active at an earlier age and are more exposed to sexual activities through television. One difference may be that all children in Sweden, beginning at age seven, are exposed to a sex education curriculum. The majority of parents in the United States appear to favor sex education in the schools. In addition to sex education, there is the need for a specific emphasis on decision-making skills, life skills, and life planning. Many school-based curricula are available and emphasize the need to teach young people problem-solving and assertiveness skills for situations where there is risk for pregnancy.
2. *Increased access to birth control.* Many people believe that increased access to contraceptive devices would likely reduce the number of unwanted pregnancies. School-based clinics appear to be ideal, because they can be community based, they can reduce stigma by providing a wide range of services, and their staff can work closely with other school officials and outside social service workers. A well-known example is Health Start, a program in which primary and preventive services (physicals, emergency care, mental health care, and social work counseling) are offered during school hours at schools.
3. *Provide greater "life options" for young people.* Because a lot of adolescent pregnancy is associated with social disadvantage, the implication is that changes in the social environment may be needed in order to expand "life options." Increasingly, professionals are recognizing that adolescents have to become motivated to reduce their risk of pregnancy (Santrock, 2022).

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4. *Enhance community involvement and support.* Too often, sex education and advice are seen as the responsibility of parents and schools. Studies have shown that very little sex education comes from parents (Steinberg, 2023). We know that contraceptive use increases when there is greater communication between parent and adolescent about sex, but our efforts must be directed on a community-wide level. If we can change attitudes about sex education, we can enhance access to family planning services. In European countries where sex education is more open and without such conflict, adolescent pregnancy rates are much lower.

Sex Education and Adolescent Development

Does the adolescent's cognitive development have an influence on the success of sex education? Adolescent contraceptive use may not be enough. What does matter is adolescents' acceptance of themselves and their sexuality, and this acceptance depends on their emotional and cognitive development, or maturity. The prevention of adolescent pregnancy embraces some very complicated features, including the ability to approach problem solving in a planned and organized way, to anticipate consequences, to delay gratification, and to communicate in a direct manner.

However, many of these capabilities require the capacity to solve problems and anticipate consequences—cognitive skills that many adolescents are just beginning to develop. As a result, much of the current content of prevention programs may not be appropriate for early adolescents. In late adolescence, there is some realistic and future-oriented thinking about sexual experiences. In middle adolescence, there is often much romanticizing of sexuality. And in early adolescence, sexuality is depersonalized in a manner that gives way to anxiety and denial.

Some researchers (LeCroy & Daley, 2001) have recognized these differences in sexual maturity and asserted that prevention programs should address sexual readiness and emerging sexual identities and orientations in order to be effective. Programs that teach "abstinence only" may be effective only for adolescents who refrain from sex anyway. Abstinence-only programs also fail to educate sexually active students about responsibility. Precisely because adolescence is a time of sexual awakening, sexual feelings should be discussed, rather than ignored. Educators should acknowledge that pubescent children need to understand their sexual feelings and changing bodies. Otherwise, unexplored, ill-defined sexuality can lead to frustration and irresponsible sexual behavior.

Alcohol and Other Drug Use

No discussion of adolescent social hazards would be complete without a section on alcohol and other drug use. For many—parents, teachers, and human service professionals—this is the primary social issue young people facing today. Drinking is a big part of being an adolescent in today's world. The most recent data from the Youth Risk Behavior Survey (YRBS), a national survey administered to high school and middle school students showed that 29% of high school students have consumed alcohol in the last 30 days, with 13.7% of students reporting binge drinking in the last 30 days. This is an important finding since binge drinking, particularly if frequent, is an important health-compromising behavior. It makes one vulnerable to ongoing problems with alcohol, as well as other health-compromising behaviors, such as violence, use of illicit drugs, unprotected or unwanted sex, and driving while intoxicated, and it may reflect difficulties with the transition into young adulthood. The 2019 YRBS found 36.8% of high school students had ever consumed marijuana with 21.7% consuming marijuana within the last 30 days.

Data from the 2019 study found the use of ecstasy, heroin, synthetic marijuana, alcohol, and cigarettes all declined. Cigarette use by adolescents reached an all-time low for the study in 2019. However, in the 2010s, e-cigarette usage, also known as vaping, had increased exponentially with 50.1% of youth reporting vaping in their lifetime, 32.7% in the last 30 days, and 10.7% using e-cigarette products on 20 or more days of the month. Many believe that vaping is less dangerous than conventional cigarettes and have less risk of long-term health effects but vaping consumption research is still too new to have conclusive data regarding its safety. Heroin use continued to show a gradual decline.

Fentanyl, an opioid 50 to 100 times more potent than morphine has been found in cocaine, heroin, Xanax, and counterfeit opioid pills. Between 2019 and 2021, fentanyl overdoses tripled among teens, and increased fivefold among African American Youth (Harvard News, 2022), with more than 77% of youth overdose deaths being caused by fentanyl in 2021.

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Social Media and Drug Use

Drug use is going down; however, drug overdoses are increasing rapidly among adolescents, with some areas of the United States having drug overdoses as the leading cause of death for adolescents between the ages of 12–18. One suggested factor for this increase is how youths secure substances to misuse. Snapchat tends to be an area where adolescents locate and secure substances to misuse with three out of four youth expressing that they have secured illicit drugs via Snapchat. Securing substances to misuse online has an appeal to youths due to the perceived anonymity and the ease of access. A unique consideration with securing substances online is whether the substances are safe and are accurately identified and described. Many news articles since the COVID-19 pandemic have covered overdose deaths among youths with the substances being (1) counterfeit and (2) secured online through social media platforms such as Snapchat or Instagram.

Substance-Use Prevention

What is the best method of prevention? A variety of approaches reflecting different theoretical orientations have been utilized in the prevention of youth substance abuse, including knowledge-based, affective, social skills; family skills training; and peer refusal approaches, and a number of these have been identified as effective (LeCroy, 2022; LeCroy & Mann, 2004). Typically, the targets of these prevention approaches have included the individual, the peer group, the school, or the community. Although no single best prevention approach exists, research has demonstrated that effective prevention involves strengthening protective factors such as social skills, family bonds, and attachment to school while reducing risk factors that increase vulnerability to drug use. Reviews of prevention research underscore that risk and protective factors should be the primary targets of intervention and that a risk/protective factor–enhancement model provides an important framework for the prevention of adolescent substance abuse.

Developmental Guidelines for Assessment in Adolescence

Exhibit 7.27 presents the developmental guidelines for adolescence. These guidelines are meant to be helpful to social workers who need to understand development when making assessments.

Exhibit 7.27 Developmental Considerations in Assessment for Adolescence

Routine Observations	Development Issues (Not Problems)
Brain development and abstract thought	Excessive concern with body image
Peer groups	Spending too much time alone
Body image	Negative peer influence
Sense of morality	Decreased interest in school
Independence	Academic difficulties
Sexual identity	Moodiness
Romantic involvements	Sexual behavior
Focus on physical appearance	Transition to middle school
Increased caloric intake	Parent conflict
Hormonal changes	Late-maturing young women
Menstruation (girls) and nocturnal emission (boys)	Risk behaviors (e.g., automobile safety)
Strengths and Landmarks of Development	**Development Observations Requiring Attention**
Increased resilience	Eating disorders
Development of autonomy and independence	Depression (stability of moods)
Increased influence of peers	Pregnancy
Enhancing parent–adolescent relationships	Sex abuse and rape
Peer support	Substance use
Egocentrism	Violent behaviors and exposure to violence
	Firearm exposure/use
	Conduct disorder and delinquency

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Study Table Social Dimension in Adolescence

Groups and Families

- The transition into adolescence involves some stress in most families. Three developmental tasks for the family are (1) development of autonomy, (2) resolution of parent–adolescent conflict, and (3) parent–adolescent attachment.
- Parents and adolescents often struggle over control and independence. Parents who hold tightly to their control and are authoritarian in their decision making are more likely to produce young people who have difficulty with autonomy. A democratic family structure appears to produce young people with a healthy sense of autonomy.
- Negative interactions, mostly conflicts about everyday issues between parents and adolescents, begin in early adolescence, around the time of puberty.
- Authoritative parents are warm and involved, but firm and consistent.
- Adolescents are at a point in their development where they need to spend time with peers, because this interaction provides important information about sexual relations, compassion, leadership, and conflict that may not be available within the family.
- Peer pressure is strongest in early adolescence and decreases as the young person moves toward independence.
- Male friendships reflect more shared interests, whereas female friendships reflect more supportive and emotional aspects. Social skills training emphasizes new learned behavior and focuses on teaching the prosocial skills and competencies that are needed.
- Cliques are small, interaction-based groups with close relationships. Crowds are larger, reputation-based collectives of similar young people who do not necessarily spend a lot of time together.
- Gangs are differentiated from other groups on the basis of their delinquent activity. The most important risk factor for gang membership is growing up in a neighborhood with poverty where there is little attachment to people and social institutions. Gang interventions must start at an early age and must be focused on the family and community.

Communities and Support Systems

- The transition from elementary school to middle school may be stressful due to a new impersonal school environment and the top-dog phenomenon. Middle school may not be an effective institution for young people, because a mismatch exists between the organization and curriculum of middle schools and the intellectual, social, and emotional needs of adolescents.
- To create a community for learning, schools need to be smaller learning environments, include caring adults who work together and provide some stability with peer groups, and create opportunities for each student to interact with at least one adult who can provide the youth with advice about academic matters and personal problems.
- High school dropout rates have decreased. Factors that predict dropout include poor attendance, lack of interest in school, living in poverty, single-parent families, conduct problems, low grades, and pregnancy.
- Homeless youth who have run away or who have been thrown out by their caretakers are more likely to engage in drug and alcohol abuse, experience sexual or physical abuse, participate in criminal activity, and have thoughts of suicide. Runaways are likely to have been physically or sexually abused at home in the year prior to running away.

Multicultural, Gender, and Spiritual Considerations

- In adolescence, young people of color become more aware of their ethnic status and begin to develop an ethnic identity.
- Ethnic identity is related to a stronger sense of purpose and increased self-confidence and social competence.
- BIPOC adolescents begin to solidify a racial identity. They also often have two sets of peer relationships: school peers and neighborhood peers.
- Several factors affect adolescent immigrants' long-term adjustment to a new country. Relying on their earlier primary group's cultural values can provide a foundation for their adjustment.
- Adolescents are becoming increasingly identified with their gender roles; however, there is more acceptance of androgyny. There has been an increase in adolescents identifying as non-binary meaning that they do not conform or identify with the traditional male or female gender. Fourth Wave Feminism focuses on the true equality of both men and women, extending the movement to include men. The goal of the movement is not solely focused on women

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gaining equality, but instead allowing men who express female characteristics with freedom from judgment such as painting their nails, expressing their feelings, and engaging in any stereotypically female activity while also further encouraging the rights of women to be equal.

- Adolescent young women may lose their "voice" or sense of self. Depression is more common for young women and often revolves around body image. Sexual identity is a major task during this period. Boys face critical issues around schooling and education.
- Although there has been a decrease in the number of adolescents having sexual intercourse, about half are sexually active at the end of the adolescent years.
- Some key factors related to sexual activity in adolescents include (1) living in a single-parent household, (2) early dating experience, and (3) parental discipline—either too permissive or too strict. Factors that have been found to discourage sexual activity are (1) attending church, (2) doing well in school, and (3) good parent-adolescent communication. Four major influences on early sexual behavior are biology, sexual abuse, problem behavior, and normative expectations.
- Many gay adolescents experience social difficulties and even violence because of their sexual orientation. Acceptance of gay adolescents is growing, as evidenced by the growing number of gay-straight alliances. Still, many gay adolescents experience risk factors and are likely to feel isolated and depressed, and they are two to three times more likely than heterosexual youths to attempt suicide. Adaptation to a gay identity has four stages: sensitization, identity confusion, identity assumption, and commitment. On average, 80% of adolescents report being sexually harassed by their peers.
- Social media has created a wave of new issues for adolescents today including negative influences on self-esteem, an increase in acceptability of drug use and access to drugs and is changing how adolescents today view friends as well as how much time they spend with them face to face.

Social Strengths, Hazards, and Risks

- A focus on assets is an alternative to the current emphasis on crisis and problems of youth. Prevention efforts have sought to increase the number of assets youth possess.
- Children are potentially subject to more violence than adults, and homicide is the only violent crime to which teens are somewhat less vulnerable than adults. Huge racial disparities exist in the experience of violence, particularly for African American youth.
- Working 15 to 20 hours per week may improve a student's self-esteem,
- Birth rate for female adolescents has declined. The greatest risk factor for a teenager becoming pregnant is poverty.
- Infants born to young mothers have low birth weight and an increased likelihood of infant mortality. Young mothers have increased risks of complications, such as toxemia, anemia, prolonged labor, and mortality. Teenage mothers also face reduced education achievement, low-status jobs, lower income, and welfare dependency.
- Efforts to reduce adolescent pregnancy include expanding sex education efforts; specifically emphasizing decision-making skills, life skills, and life planning; increasing access to birth control; providing greater "life options"; and increasing community involvement and support.
- Overall, drug use among adolescents has declined over the past 20 years. Adolescents become involved in drugs at an earlier age, and substance use has increased substantially for young adolescents in sixth through ninth grades.
- Binge drinking, defined as having five or more drinks in a row, is a common problem during adolescence and young adulthood. Between 2019 and 2021, Fentanyl overdoses tripled among teens, and increased fivefold among African American youths, with the majority of youth overdose deaths being caused by Fentanyl in 2021. Snapchat tends to be an area where adolescents locate and secure substances to misuse with three out of four youths expressing that they have secured illicit drugs via Snapchat.
- Effective prevention involves strengthening protective factors such as social skills, family bonds, and attachment to school while reducing risk factors that increase vulnerability to drug use.

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Applying the Framework

A Depressed Adolescent

Developmental History

Susie Lee, a 13-year-old Chinese American young woman, was brought to the agency by her biological parents. Susie's parents are third-generation Chinese Americans and live according to American cultural norms and values. Susie has two brothers and one sister, all younger than her.

Susie's parents discussed her early development, including pregnancy and childhood illnesses. Susie's mother reported that her pregnancy was normal with no complications. She also states that she was very careful throughout her pregnancy to avoid food, drink, medication, or illegal substances that could harm her developing fetus. The only medical problems out of the ordinary were Susie's seizures at the age of five as a result of influenza. Her mother reported no developmental delays and that Susie crawled, walked, and talked at the appropriate times.

Biophysical Considerations

Susie often has trouble sleeping at night and reports periodic nightmares (one or two per month). She experienceed night eating syndrome—being unable to sleep at night, she eats. In the morning, she does not feel like eating breakfast. She has a tendency to consume a large amount of food quickly and feels bad about having done so afterward. She does not eat a balanced diet. She denies any self-induced vomiting. This sequence of events often leads to severe self-criticism. Susie was an early maturing female who had her first menses at 11 years of age. She has been diagnosed with dysmenorrhea (painful menstruation) and often complains about having stomachaches.

Psychological Considerations

Cognitive Development and Information Processing

Susie appears to be of average intelligence and performs well academically. Last year she had above-average grades of As and Bs. In discussing her self-criticism, Susie demonstrated abstract thinking ability as she commented introspectively about her own thought processes. She demonstrates complex thinking about the psychological peril she is experiencing. However, Susie is often unable to make simple decisions because she is literally thinking too much about a decision. Susie believes she is invulnerable—that no harm can come to her. Although this is an aspect of normal cognitive development, it can lead to negative outcomes if her thinking influences her behavior.

Communication

One of Susie's strengths is her ability to communicate her thoughts and feelings clearly and directly. She expresses concern about her eating habits and about feeling down and irritable much of the time.

Attitudes, Emotions, and Regulation

Susie expresses intense emotions that range from extreme anger to hopelessness. She describes feeling sad, irritable, touchy, "on edge," and depressed. She described some of her feelings: "I feel like I'm falling into a dark tunnel that I cannot climb out of; screaming all the way down but no one hears me." Sometimes she's deeply sad and spends a lot of time crying. Other days she's extremely irritable—everybody and everything bothers her. When asked about how she perceives herself, she reports feeling like the ugliest girl at school. She often looks in the mirror and sees a fat, ugly person. She is extremely preoccupied with how "bad" she thinks she looks. "I hate my body," she reports. A lot of her self-criticism is related to her binge eating and her negative body image.

Susie scored in the depressed range on the Beck Depression Inventory. She admitted that she thought about suicide previously after a friend had committed suicide. At present, she denies any thoughts of suicide. She does not have access to a gun.

Susie expresses strong egocentric thoughts. She is preoccupied with her feelings and behaviors in a self-conscious manner. This is demonstrated in her body perceptions—she is very concerned about how others are going to view her body and looks. She compares herself excessively to peers she sees on social media outlets like TikTok. She feels self-conscious about not having a boyfriend at the present time. This style of thinking is an entry to more intensely self-critical statements. She reports being quite concerned about what her peers are saying and doing and has difficulty expressing any independence around them. Her parents report that she "gives in to peer pressure all

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the time and that this gets her into a lot of trouble." Her mother expressed specific concern that she would not be able to say no to sexual advances by boys. In the one-to-one interview, Susie discussed having been sexually active with a previous boyfriend. She reports inconsistent use of birth control methods.

Social Considerations

Family Situation

Susie experiences serious family conflict, including a highly conflict-ridden relationship and lack of closeness with her father—her father still spanks her. Furthermore, Susie suffered a major loss when her favorite grandfather died last year of cancer. In addition, she started junior high school this school year, which has been a difficult transition for her.

Susie expressed concern over her inability to get along with her family. In particular, fairness is a big issue with Susie. She reports that her siblings are treated more fairly than she is. Her parents describe situations where Susie feels she is being treated unfairly and throws a temper tantrum. For example, last week she found a box from a fast-food meal that had been her brother's lunch, stating it wasn't fair that he got one and she did not. She threw things around the living room, started yelling, and ran to her room crying. Susie reports being gruff and harsh with family members on a daily basis. Her oppositional behavior is also evident on a regular, but not daily, basis when she lies, loses her temper, argues with her parents, fights with her siblings, or refuses to do her chores. She says she "feels unimportant to this family" and that everyone sees her as a "bad" kid. She is angry at her father and believes he mistreats her—especially by spanking her. She also believes that her parents, particularly her father, do not love her.

Groups, Social Supports, and Communities

Susie feels like an outsider at school, although she has three or four friends she regularly interacts with. Recently Susie has found it difficult to go to school. When she is in school, she feels empty and dull. Although she used to be involved in after-school activities, she has no extracurricular activities now. When asked if she has an adult, she is close to, she said there was no one for her to talk with, especially since her grandfather died. Her parents are frustrated with her and do not provide her with much emotional support.

Multicultural, Gender, and Spiritual Considerations

Susie disclosed concern regarding her identity. Although her family is very acculturated, she has recently been questioning the significance of her Chinese American background since meeting a student at school who is very involved in Chinese culture. She has expressed concern about how others view her. For example, at school she believes teachers expect more from her than other students when she turns in assignments or takes exams. She resents the additional pressure she feels from her teachers and her parents. She wants to be treated "just like everyone else." Her parents fear that they are losing control over her, and Susie complains that her parents are not giving her enough freedom. Despite their acculturation, they are having a difficult time reconciling their family values with the values and norms of the dominant society.

Summary and Impressions

As a result of assessment, it is apparent that Susie has several problems that need to be addressed:

1. Depression
2. Irritable, with extreme mood swings
3. Resentful behavior toward siblings
4. Uncontrolled anger outbursts
5. Poor family relationships
6. Possible unresolved grief
7. Adjustment issues involving her developmental stage (e.g., identity concerns)
8. High-risk behaviors such as unprotected sexual intercourse

Although the family members are experiencing difficulties, they do provide a stable, predictable living situation for Susie and her siblings. Susie's father earns a steady income that provides adequate resources. Susie's mother works part-time while the children are at school, and she states that she is usually home when they return from school. They have lived in the community for five years and have established a network of family friends and church support. In addition, both parents appear genuinely concerned and willing to evaluate their parenting techniques in order to work toward a positive outcome. Susie's strengths include her intellect and thoughtfulness, her good communication skills, and her desire for improved family relationships.

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Four Ps' Formulation for Integration of the Data

Practice Exercise:

Fill in each of the four Ps for the case that is applying the biopsychosocial framework for this chapter.

Use the results of the four Ps formulation to:

1. Identify relevant problems, diagnoses, or other relevant judgments about the case described in the Applying the Framework section of the chapter.
2. Describe an appropriate biopsychosocial intervention based on the findings in your four Ps formulation of the case.
3. Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial integrative data that you identified in your formulation of the 4 Ps.
4. Describe how you would evaluate your invention based on the data captured in your 4 Ps assessment.

	Biological	**Psychological**	**Social**
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

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Reviewing Your Learning Objectives

You should be able to:

1. Identify several common health hazards in adolescence.
2. Discuss the five major changes in thinking that emerge in formal operations.
3. Identify the four main strategies for enhancing adolescents' self-concepts.
4. Define Erikson's concept of a psychological moratorium.
5. Define and discuss social cognitive monitoring.
6. Describe how to promote adolescent moral development.
7. Explain cognitive changes in adolescence.
8. Describe changes between the adolescent and parent relationship.
9. Discuss assessment strategies for adolescent depression.
10. Identify and discuss common social problems in adolescence.
11. Discuss the concept of an androgynous person.
12. Identify and discuss influences associated with early sexual behavior and subsequent pregnancy.
13. Discuss some common concerns among LGBTQ youth.
14. Describe the ASSET model of prevention.
15. Describe a few of the suggested approaches to reducing the incidence of adolescent pregnancy.

Key Terms

androgen
androgyny
care perspective
concrete operations
conduct disorder
dysmenorrhea
endocrine glands
estrogen
formal operational thought
gonadotropins
hormones
hypothalamus
hypothetical-deductive reasoning
imaginary audience
individuation
justice perspective
menarche
moral development
myelinization
ovaries
personal fable
psychological moratorium
puberty
secular trend
social cognitive monitoring
social skills training
testes

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Chapter 8

Emerging and Young Adulthood

Learning Objectives

1. Describe the key developmental themes present in emerging and young adulthood, including theories of adulthood and the concept of "emerging adulthood."
2. Understand the key aspects of biophysical growth and development (brain development).
3. Describe the key themes in the psychological dimension for young adulthood (formal operational thought, communication, intimacy and independence, serious mental illness and depression).
4. Describe the key themes in the social dimension for young childhood (marriage, homophobia, parenthood, fertility, work, racism, gender, intimate partner violence, substance use).

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Developmental Themes	Key Concepts
	■ Stage: intimacy versus isolation. Economic independence independent decision making. Emerging adulthood.
Biophysical Dimension	
Biophysical Growth and Development	■ Peak of physical development, loss of muscle and increase in fat weight, and development of health patterns. Changes in reproductive systems during early adulthood. The impact of hormones on women.
Biophysical Strengths, Hazards, and Risks	■ Physical endurance. Cancer and self-examinations. Health disparities, health equity, and men of color.
Psychological Dimension	
Cognitive Development and Information Processing	■ Formal operational thought.
Communication	■ Miscommunication. Gender and communication. Styles of communication. Communication skills. Nonverbal communication. Communicating with the deaf. Virtual communication.
Attitudes, Emotions, and Regulation	■ Intimacy. Love: myths and other beliefs. Triangular theory of love. Possibility of isolation and loneliness. Cognitive attitudes that lead to loneliness.
Psychological Strengths, Hazards, and Risks	■ Major life decisions. Serious mental illness. Anxiety. Depression. Depression in women.
Social Dimension	
Groups and Families	■ Marriage: selecting a partner, adjustment to marriage, expectations and myths. Empowering African American families. Remaining or becoming single. Gay relationships. Homophobia; internalized homophobia. Transition to parenthood. Gay and lesbian parents. Voluntary childlessness. Infertility. Miscarriage.
Communities and Support Systems	■ Work life. Women and work. Volunteerism and social services.
Multicultural, Gender, and Spiritual Considerations	■ Career and multicultural challenges. Blending religions. Gender roles. Motherhood mandates.
Social Strengths, Hazards, and Risks	■ "Social capital." Extension of young adulthood: earnings losses, supporting a family. Welfare reform. Families with a disabled member. Divorce. Sexual harassment. Sexually transmitted diseases. Rape and sexual assault. Intimate partner violence. Social workers in managed-care systems. Alcohol, tobacco, and other drugs. Alcohol use among college students.

Developmental Themes

Young adulthood is a critical period that spans the ages of 23 to 39 years and is considered to be a major life transition. In young adulthood, significant life roles become established. Young people move from a preoccupation with the self to a focus on intimacy that often leads to marriage, children, and the need to establish a stable career path. In many ways, everything that has taken place before this stage can be considered preparation for adulthood.

Perhaps two of the most critical developmental tasks associated with making the transition to adulthood are economic independence and independent decision making.

Often these two aspects are considered hallmarks of the transition from adolescence to young adulthood. Economic independence occurs as young people move from high school or college into the workforce on a full-time basis. This shift entails major life changes because living independently carries new responsibilities. Many of these new responsibilities lead to independent decision making:

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where to work, where to live, how to budget income, what kind of dates to go on, when to get married, and so forth. The challenges associated with this transition to adulthood in modern times have created an in-between process that has been characterized as a new stage of development known as ***emerging adulthood*** (Arnett, 2014b).

Emerging Adulthood

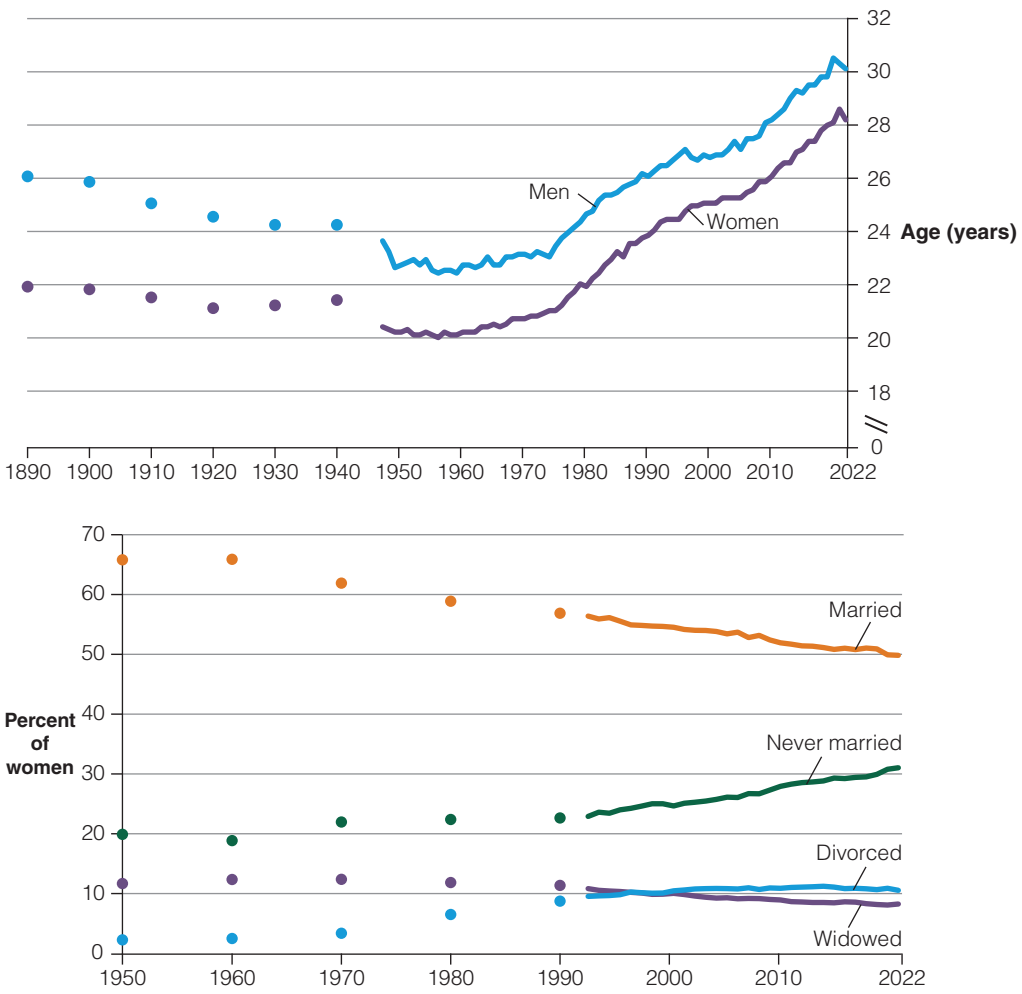
When our mothers were our age, they were engaged . . . they at least had some idea what they were going to do with their lives. . . . I, on the other hand, will have a dual degree in majors that are ambiguous at best and impractical at worst (English and Political Science), no ring on my finger and no idea who I am, much less what I want to do. . . . Under duress, I will admit that this is a pretty exciting time. Sometimes, when I look out across the wide expanse that is my future, I can see beyond the void. I realize that having nothing ahead to count on means I now have to count on myself; that having no direction means forging one of my own.

—Kristen, age 22 (in Arnett, 2014b)

Does this quote sound more like an adolescent or a young adult? It may be difficult to tell. Today, the field of young adulthood is being challenged by definitions of what constitutes the transition into adulthood. Is young adulthood defined by age, or by social and economic factors? Many experts adhere to the traditional notions set forth by G. Stanley Hall (who gave us the popular notion of adolescence) and Erik Erikson, who established the psychosocial stages of development.

For Erikson, young adulthood was a stage of intimacy versus isolation, which assumed that a person reached psychosocial maturity after leaving home and taking on new

Exhibit 8.1 Historical Marriage Trends



Source: https://www.census.gov/content/dam/Census/library/visualizations/time-series/demo/families-and-households/ms-1b.pdf

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adult responsibilities. Today, the transition into maturity and leaving home looks quite different. Young adults in 2022 were getting married for the first time at 28.2 for women and 30.1 for men compared to two years later than just 20 years ago (U.S. Bureau of the Census, 2022). Historical trends indicate that fewer people are getting married, and these rates have particularly changed in the last 30 years (see Exhibit 8.1).

Also, a larger percentage of young adults live at home with their families. During the COVID-19 pandemic, the majority of people aged 18 to 29 were living with their parents (Pew Research Center, 2022). Though this phenomena was largely the result of university students who moved back home and then were out by the end of the pandemic, the U.S. Bureau of the Census (2021) reports that 38.4% of young people aged 25 to 34 live in a shared household with another adult (not a spouse or cohabiting partner), and 17.8% live in their parents' households. These trends are up from 2019. One reason? Fewer people are living in poverty when living with their parents. In 2019, 36.3% of those aged 25 to 34 years would have been considered living in poverty based on their individual incomes, as well, poverty rates for parents are improved with their adult child's income (U.S. Census Bureau, 2020). Have these young people entered adulthood, or are they in an extended period of adolescence? Regardless of how one answers this question, the point is clear: Many "young adults" are still in a transition stage from adolescence to adulthood. This transition is being increasingly recognized. For example, the Federal Fostering Connections to Success and Increasing Adoptions Act of 2008 amended the title IV-E foster care program to extend foster care beyond the age of 18 up to age 21 (as the state elects) in recognition that most 18 year olds are not fully prepared for self-sufficiency (Child Welfare Information Gateway, 2022).

Overall, the period of transition is known as emerging adulthood. According to Arnett (2014b), who is a leading proponent of this conceptualization, emerging adulthood is neither adolescence nor young adulthood but is theoretically and empirically distinct from both of these stages (Arnett, 2014b). It is characterized by a period of transition into adult roles but constitutes a distinct period of the life course that emphasizes change and exploration of possible life directions in love, work, and worldviews.

At this stage, the most common response to the question "Do you feel you have reached adulthood?" is "In some respects yes, in some respects no." Indeed, when Arnett asked college students when they felt like an adult in his research, he found that entering work or getting married had nothing to do with feeling like an adult. Arnett wrote (2014b, p. xiv), "The most important criteria for adulthood to these college students were more intangible and psychological: accepting responsibility for one's actions, making independent decisions, and becoming financially independent." Thus, he found that transitions to work, marriage, or parenthood had less to do with feeling like an adult than the psychological terms reported by college students, and in subsequent research, by noncollege students.

Arnett's research is calling into question the emphasis placed on conceptualizing this process merely as a transition rather than as an extended psychological process. In his view, the transition to adulthood consists of a longer road or journey than previously assumed in the adult development literature. He has argued that it takes a lot longer to grow up today than it did in the 1960s, and this is due to four revolutions. First, the *technology revolution* has resulted in our economy being a knowledge technology rather than a manufacturing economy. A knowledge technology requires an education beyond high school which pushes everything else back, such as getting a career-related job, moving away from home, and getting married. The *sexual revolution* and the advancement of contraception has broken the link between sexuality and reproduction, as well as between sexuality and marriage. As previously described, ages at first marriage are getting older, while first sexual relationships are happening in adolescence. The *women's movement* has resulted in more women pursing further education in contrast to the pressure of past generations to find a man and get married. Women in their 20s today are more focused on their education and career than women of past generations. Finally, the *youth movement* has prolonged a period of entry into adulthood. The realities of Western societies are that it takes longer to prepare oneself for a knowledge economy, and for women and people of color, there is a new range of opportunities. Though there are concerns over the delay into adulthood, there are notable strengths: later ages to first marriage mean potentially choosing a better marriage partner and being older when having children may bring greater emotional maturity and parenting skills.

Theories of Adulthood

Whereas adolescents are preoccupied with the self, young adults turn outward and focus on social and intimate relationships with others, as described by Erikson (1974):

> In youth you find out what you care to do and who you care to be—even in changing roles. In young adulthood you learn whom you care to be with—at work and in private life, not only exchanging intimacies but also sharing intimacy.

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In adulthood, however, you learn to know what and whom you can take care of. (p. 124)

Erikson was astute in his observation that in industrialized countries, many young people experience a prolonged adolescence represented by role experimentation. For Erikson (1959), "issues of identity and role confusion fade into the background for most young adults who have achieved a sense of identity, as issues of intimacy followed by generativity come to the fore" (Kroger, 2007, p. 148). Erikson concluded that issues surrounding intimacy becomes the primary psychological preoccupation of young adults with issues of generativity versus stagnation emerging as equally important challenges as young adults' approach middle adulthood. He assumed that as individuals develop a sense of who they are and are comfortable with this identity, they are more likely to enter into intimate relationships (Kroger, 2007).

This emphasis placed on tasks of intimacy and generativity ignores another task that accompanies these other tasks that other theorists felt was not given sufficient attention by Erikson—the task of career consolidation (Kroger, 2007; Vaillant & Milofsky, 1980). In achieving this important task, many young people are experiencing major difficulties in urban and nonurban contexts across the globe, committing to a career or developing a connection to employment, advanced schooling, or relevant training. Bloom wrote, "the transition to adulthood is likely to be perilous and rocky for young people who drop out of high school" (Bloom, 2010, p. 9). Indeed, it is even more difficult for individuals to transition to adulthood who do not obtain postsecondary education or training (Ashford & Gallagher, 2014; Bloom, 2010).

One in six young individuals between the ages of 18 and 24 are neither in work nor in school (National Center for Education Statistics, 2022). This group of youths is referred to in the United States as the "disconnected." They are isolated from our society's key social structures for constructing ways of making a living. Thirty-one percent of disconnected youths (compared to 16.5% connected youths) are living in poverty (Lewis, 2021). For Black or American Indian Alaska Native (AIAN) disconnected women, approximately 42% are living in poverty. AIAN youths have the highest disconnection rate of any U.S. racial and ethnic group at 22.1%. In the United Kingdom, they are described as a NEET: a young person who is not employed, in education or any kind of training, who are between 16 and 24 years of age. The overall rate of NEET in the United Kingdom for young people between 16 and 24 years of age was 10.4% in 2022 (Office for National Statistics, 2022). In Japan, on the other hand, the age range of disconnected youths is between 15 and 34 years of age. These youths not connected to major social structures associated with career development are inhibiting their ability to build what Daniel Levinson has defined as a life structure.

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Many young adults are disconnected from society—especially when they are not employed or involved in school.

Daniel Levinson (1986) developed a different theory of adult development that consists of young adult subphases not covered in Erikson's theory. He describes young adulthood (ages 17–33) as focusing on choices in love, occupation, friendship, values, and lifestyle and identified the novice phase of development as the phase where young people move into the adult world and begin to build a stable life structure. In accomplishing this life task during the novice phase, the young person experiences change and instability. This emphasis placed on experimentation in Levinson's theory mirrors Erikson's ideas of role experimentation. Exhibit 8.2 presents a summary of Levinson's eight stages of adult development. Experimentation is a well-recognized aspect of young adulthood, but we are seeing an extended period of experimentation from what was previously assumed by Erikson and Livenson that was previously described by Arnett.

Carl Jung, like Arnett, assumed that maturity was not associated with the transitional events stressed by many developmental theorists. In his view, there were two stages of development: the first lasts from birth until a person reaches middle age at around 40 years. This first stage involves efforts at integrating intrapsychic dynamics and conflicts with the external environment. After resolving the psychological tasks associated with this stage, the person moves to a second stage of development that involves the task of self-realization or consolidation. For Jung, the first stage of development is considered a prelude to what

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Exhibit 8.2 Levinson's Eight Stages of Adult Development

Levinson (1978) was instrumental in developing a theory of adult development. On the basis of intensive interviews with adult men at different stages in the life cycle, Levinson set forth his ideas about the stage's adults go through. He then expanded his theory to include adult women (Levinson, 1986); Levinson outlined eight developmental stages in young and middle adulthood. Fundamental to his theory is his notion of "life structure." A life structure represents a basic pattern of an adult's life at a particular time. A person's life structure reflects the choices a person makes, such as marriage, childrearing, career, and so forth. According to Levinson, the stages of the adult life cycle alternate between stability and turmoil and transition. The stages are summarized as follows:

1. Ages 17–22: Leave adolescence; make preliminary choices for adult life.
2. Ages 22–28: Initial choices in love, occupation, friendship, values, and lifestyle.
3. Ages 28–33: Change in life structure, either a moderate change or, more often, a severe and stressful crisis.
4. Ages 33–40: Establish a niche in society; progress on a timetable, both in family and in career accomplishments.
5. Ages 40–45: Life structure comes into question; usually a time of crisis in the meaning, direction, and value of each person's life; neglected parts of the self (talents, desires, aspirations) seek expression.
6. Ages 45–50: Choices must be made and a new life structure formed; the person must commit to new tasks.
7. Ages 50–55: Further questioning and modification of the life structure; men who did not have a crisis at age 40 are likely to have one now.
8. Ages 55–60: Build a new life structure; can be a time of great fulfillment.

Source: Adapted by the authors from Levinson (1986). A conception of adult development. *American Psychologist*, 41, 3–13.

he considered "the real work of life" (Okun, 1984). For Jung, maturity referred to "the discovery of a meaning and purpose in life, the gaining of a perspective of others, the choosing of values and activities in which one is willing to invest energy and creativity, and the preparing for the final stage of life, death" (Okun, 1984, p. 6). Unlike other theorists, Jung placed significant emphasis in his theoretical approach on issues of spirituality. He opined that people overcome inner conflicts, anxieties, and feelings of alienation from life roles and other experiences in the second stage through experiences with the transcendent or spiritual component of a person's humanity. This viewpoint differed from Freud, who assumed that maturity was achieved when a person successfully negotiated the psychosexual stages of development.

Clearly, there is no consensus in the current counseling and theoretical literature on what constitutes maturity. For this reason, a critical issue affecting current and future social policies affecting the lives of young people is the question of when we should assume that a person is mature enough to be considered an adult. Different counseling theories have offered different psychological conceptualizations of maturity and of the kinds of factors that contribute to the development of a psychologically mature individual. Some developmentalists have argued, however, that there is a difference between psychological maturity and the term *adult* (Okun, 1984). However, this begs the question of whether we can define the term *adult* without defining the term *maturity*. The upshot is the definition of what constitutes a mature adult has changed over time and is heavily influenced by advances in research and other forms of knowledge resulting from philosophical disputes about determining the best philosophical foundations for defining the achievement of adult status.

What Is Maturity?

Maturity is defined as the state of being fully grown. The application of the term *mature* has been differentially applied to males and females. Do males and females achieve maturity at different points in time? Should maturity only be limited to physiological states? Is the notion of psychosocial maturity an outdated concept? New neuroscience evidence is indicating that the brain is not fully mature until around 25, but females appear to mature earlier in the prefrontal cortex than males.

While some of the prior questions have not been resolved about maturity, there continues to be some agreement that females tend to achieve maturity earlier than males, but the actual ages when this occurs has varied over time. For instance, very early legal definitions established that boys reached maturity at age 14 and girls at age 12. The age of majority in law refers to the age at which a person is considered an adult. Eventually, it was assumed in legal institutions that girls achieved adult status at age 18 and males at age 21. Nonetheless, most laws and social

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policies today consider young people an adult when they reach age 18, but research is suggesting that they do not reach full maturity until age 25. Definitions of maturity based on current brain research differ from other ways of considering issues of maturity, including issues of psychological maturity previously identified by Jung and other psychoanalysts.

A study in 2013 by the Nickelodeon channel in the United Kingdom found that men matured psychologically at approximately age 43, which was about 11 years later than women. Some have argued, however, that these findings are considering other considerations for when we should assume that a person is "fully grown-up." Today, responses to questions about maturational differences and appropriate legal definitions of an adult are turning more and more to evidence from the biological, psychological, and social sciences. Biological, psychological, and social factors contribute to our understanding of what the terms *adult* and *maturity* mean and a broad array of empirical findings with implications for understanding these issues are discussed throughout the remaining sections of this chapter.

Practice Guidelines:

Promoting Transitions to Adulthood

- For children who have been living in foster care, the transition to life outside of care can be especially difficult. Finding affordable housing, pursuing higher education, and job searching can be especially daunting for these young people who may not have the embedded networks of adults to cushion their transition. Research has found that these youths are more likely to succeed if they become involved in community organizations such as volunteer organizations, campus advocacy groups, and organized community activities. Social workers can help by providing community resources to develop social networks.
- Help young adults to think about career goals and ambitions. Discuss long- and short-term benefits of steps toward independence.
- In working with a young adult who is applying for jobs and educational opportunities, it can be tempting to complete a lot of tasks oneself. Social workers must strike a careful balance of providing resources and support and encouraging skills development.

Biophysical Dimension

Biophysical Growth and Development

Physical development in young adulthood represents both the peak of physical development and its slow decline as the body gets older. Our physical performance is usually the strongest during the early 20s. An easy way to assess the body's performance is to examine the average ages of Olympic gold medalists. Only about 15% of Olympic medalists are over the age of 30 (Santrock, 2023). The peak of muscular strength occurs between age 25 and 30 years and decreases about 10% between age 30 and 60 years. As a result, the mid-20s are a good age for speed and agility. However, professional athletes perform well into their 30s if they are competing in endurance sports, such as long-distance running and weightlifting.

In young adulthood, many individuals begin a pattern of health-conscious behavior. Indeed, the workout frenzy is very popular in this age group. This phase of development is a particularly good time to begin a healthy lifestyle. Many individuals at this age realize their once-teenage metabolism is slowing down, and they start putting on weight and may struggle to avoid excessive weight gain and obesity. During early adulthood, the percentage of body weight composed of muscle decreases. This represents not a loss of muscle but an increase in fat weight. According to the *American Journal of Clinical Nutrition*, it is recommended that for people ages 20 to 39, body fat be 8 to 19% for men and 21 to 32% for women. Women have a higher body fat percentage than men and it will also increase with age. Women typically have more fat deposits in the buttocks, thighs, breasts, and shoulders, whereas men distribute their fat more evenly. Body composition reflects an individual's overall physical health.

Fat in the body is stored in adipose cells. As these cells fill, your hunger is satisfied. If the cells are empty, you will be hungry. As people gain weight, they increase the size of fat cells in the body—and at this point, it becomes difficult to make them shrink. Obese people have an excessive amount of fat cells in their bodies. One reason that we gain more weight as we age is that our ***basal metabolism rate***, which is the minimum amount of energy that we use in our resting state, decreases. The implication of the decrease is this: To maintain the same weight we had in the past, we must eat less.

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Study Table Developmental Themes in Emerging and Young Adulthood

Emerging Adulthood: Psychological Process Between Adolescence and Young Adulthood

- Economic independence
- Independent decision making
- A psychological phase of transition

Young Adulthood: Intimacy Versus Isolation

- Involve life decisions that go beyond adolescence in the process of identity formation.
- New sources of identity beyond religion and politics identified by Erikson.
- Less self-absorbed and more focused outward toward establishing intimate relationships.
- Achieving career consolidation.
- Building a life structure that reflects a person's choices in love, occupation, friendship, values, and style of life.
- Generativity emerges as a developmental task as individuals approach middle age.
- Carl Jung established two stages of development. The first stage lasts from birth to age 40, which involves the integration of psychic dynamics and conflicts with the external environment.
- *Maturity* is a term that is not without controversy.
- Young adulthood involves role experimentation with choices involving love, occupation, friendship, values, and lifestyle.

Although restrictive diets are popular, exercise combined with proper diet is a more effective means by which to lose weight. Exercise is important because it burns up calories and continues to raise the metabolic rate for several hours after exercising. Exercise can be effective in weight loss because it lowers the body's set point for weight and makes it easier to maintain a lower weight. The most effective means to lose weight is to exercise and eat a healthy diet. The American Dietetic Association recommends the following: 25 grams of fiber per day for women (38 grams for men), limiting intake to 30% of daily calories from fat, and increasing to 50–60% the daily calories derived from complex carbohydrates such as fruits, vegetables, and grains. To prevent deficiency, it is also recommended to eat 0.8 grams per kilogram of body weight in protein (10–35% of daily calories). For example, an average 165-pound (or 75-kilogram) sedentary adult should be eating 60 grams of protein daily. People who exercise regularly require more protein (but no more than 2 grams per kilogram of body weight each day). The percentage of protein should increase to about 1–1.2 grams per kilogram in middle adulthood in order to prevent the loss of muscle mass.

Exercise not only helps deal with issues of weight gain in young adulthood, but also helps with cognition, learning, and performance. There are also clear benefits of exercising and better mental health (Chekroud, 2018). Important changes in the prefrontal cortex are taking place in the early phases of adulthood, when key areas of the prefrontal cortex are achieving full maturation. Many of these structures are not fully achieved until a young person reaches about 25 years of age. Exercise has a positive effect on the development of these areas, whereas cumulative alcohol and marijuana use in this phase of development are associated with decreased cortical thickness and other negative effects on brain structure.

Brain Development in Emerging and Early Adulthood

During emerging adulthood, the brains of young people are growing more and more overlapping branches of axons and neurons. These neurons fire and communicate with other branches at synapses. Branches or twig-like branches near other branches in the brain that are not used very much will wither. This process of withering is referred to in the neuroscience literature as pruning. Indeed, the brain is making and breaking connections in this phase of development and glial cells around the neurons wrap around the neurons with a fatty white matter known as myelin. The myelin increase is associated with corresponding speed in connections among relevant neural networks.

The brains of very young adolescents lack relevant connections with other neural networks in areas of the brain with implications for judgment, and risk-taking behavior places these adolescents at a significant disadvantage (Steinberg, 2023). Youths during emerging adulthood develop stronger connections between the emotional and motor centers of their brains and the prefrontal cortex, which is the part of the brain that is associated with the inhibition of impulses and strongly experienced emotions (Fallon, 2013). The prefrontal cortex completes its development in the mid-20s. This part of the brain is the "region most important for the elaboration of personality

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and character, and the control of impulse, obsessions, and antisocial behavior" (Fallon, 2013, p. 52). It is also associated with executive functions "such as the ability to make and carry out plans, switch between tasks, and maintain attention and focus, and connects with other key brain structures that are involved with emotion" (Cavanaugh & Blandchard-Fields, 2019, p. 38).

Smooth flow of information from one part of the brain to another is dependent on the integrity and maturity of pathways associated with white matter (Paus, 2005). Volume increases in white matter are noted in early adolescence and start to stabilize in emerging adulthood (Mills et al., 2021). However, loss of gray matter occurs in a nonlinear manner across the brain. This preliminary evidence of changes in the brain is consistent with changes observed in cognitive capacities, "such as to think abstractly, consider multiple dimensions of problems, process information and stimuli more efficiently, and reflect on the self and life experiences" (Zarrett & Eccles, 2006, p. 16). An important finding, however, is that there is substantial variation between people in brain changes, particularly in the transition from adolescence into young adulthood. That is, there are large differences in how much decrease of gray matter volume, cortex volume, mean cortical thickness, and in white matter surface area occurs in the transition to young adulthood (Mills et al., 2021). The age at when these structures begin to stabilize is a measure of maturity for structural brain measures, and this varies across people. For example, adolescents with a thinner cortex are more mature than their same-aged peers with a greater cortical thickness.

During late adolescence or early stages of adulthood, the brain undergoes considerable maturation. Unfortunately, many of these changes in brain development coincide with escalations in both alcohol and marijuana use. Neuroscientists are now trying to understand how these exposures to substances during this phase of development influence brain growth and structural developmental processes in the brain. Growing evidence indicate that marijuana use during development is linked to long-term, and in some cases permanent, brain changes (National Institute on Drug Abuse [NIDA], 2021). Included in this list are cognitive impairments, structural and functional changes in the hippocampus, and an altered reward system that increases the likelihood of using other drugs in the future.

Indeed, drug and alcohol use have a clear onset that is identified with the adolescent stage of development (Lisdahl, Gibart, Wright, & Shollenbarger, 2013); however, emerging adulthood (18–25 years) is the period with the highest prevalence of alcohol and drug use (Baumer, Dennis, & Estrada, 2018). The two most commonly used substances among emerging and young adults are alcohol and marijuana. Of those aged 19 to 30, 82% reported using alcohol and 42% reported using marijuana at least once in the past year (Schulenberg et al., 2021). Of those aged 18 to 25, in the last month, 39% report binge drinking and 21% report using marijuana (Baumer et al., 2018). Research is showing that usage of these substances during these phases of development produce neurodevelopmental changes in both gray and white matter (Lisdahl et al., 2013). These changes are also associated with slower psychomotor speed, sequencing ability, sustained attention, and rates of errors in cognitive inhibition (Lisdahl & Price, 2012). Further, those who use both at the same time, experience more negative consequences (e.g., getting into legal trouble, having heated arguments, getting injured; Subbaraman & Kerr, 2015).

Reproductive System during Early Adulthood

This stage of development is considered the best time biologically for a woman to become pregnant. A woman in her early 20s has a mature reproductive system and is likely to produce fertile eggs. Also, her hormone production is relatively regular. Because her physical abilities are at her peak and her uterus is receptive to a pregnancy, this is an ideal time for a safe and healthy delivery of a baby.

Although biologically this is an ideal time to have babies, many young adults and professional social workers are not aware of the critical significance of birth spacing (that is, the time between births). Birth spacing is an important factor that can improve the health and well-being of children and mothers. The probability of dying is much higher with less than two years of birth spacing, and this finding is highly consistent across regions of the world (Molitoris, Barclay, & Kolk, 2019). Although traditionally two-year spacing has been identified as a healthy interval between births, new research has shown that longer intervals are even better for both infant and maternal survival and health (Molitoris et al., 2019). How long is the ideal time to wait before having the next child? The largest improvements in the probability of survival comes from increasing spacing until at least 36 months, and in some cases, there is continued decline at intervals longer than 48 months. Further, there is no evidence that longer birth intervals are detrimental for mothers or infants (Molitoris et al., 2019). The public campaigns state it thus: Three to five years saves lives.

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Effect of Hormones on Women

Although hormones influence both men and women, their effect on women is stronger. As women progress through the ***menstrual cycle***, their hormones fluctuate. Estrogen levels rise to their highest point when a woman is ovulating and then begin to decline as she approaches her menstrual period. After ovulation, progesterone levels begin to increase. When progesterone production is at its highest, about 10 days before the beginning of the menstrual cycle, a majority of women (85%) experience the set of symptoms known as ***premenstrual syndrome*** (PMS; Dickerson, Mazyck, & Hunter, 2003). PMS is associated with breast tenderness, a bloated feeling, irritability, and negative moods occurring just before the menstrual period (see exhibit 8.3).

Although 70 to 90% of women are affected by some premenstrual discomfort, one in three meet the criteria for PMS (Mishra et al., 2023). However, some women (3–8%) include ***premenstrual dysphoric disorder*** (PMDD), a severe form of PMS. PMDD is listed in the DSM-5 as a separate entity under Depressive disorders, including some of the following symptoms:

1. depressed mood, feelings of hopelessness, or self-deprecating thoughts;
2. anxiety, tension, feelings of being "keyed up" or "on edge";
3. affective lability;
4. persistent and marked anger or irritability or increased interpersonal conflicts;
5. decreased interest in usual activities;
6. difficulty in concentrating;
7. lethargy, easy fatigability, or marked lack of energy;
8. change in appetite, overeating, or specific food cravings;
9. hypersomnia or insomnia;
10. feeling overwhelmed or out of control;
11. other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain.

Putting it into perspective, women in the United States have about 481 menstrual cycles in their lifetime. If we

Exhibit 8.3 Example of a Daily Symptom Calendar for PMS

Name _____ Month _____

Daily Symptom Calendar

	Day of month												
	1	2	3	4	5	6	7	8	9	10	11	12	1
Depression or sadness													
Tension or irritability													
Anxiety or nervousness													
Anger, aggression or short temper													
Crying spells													
Swelling of hands or feet													
Tenderness or fullness of breasts													
Abdominal bloating													
Lower abdominal cramping													
Generalized aches and pains													
Low backache													
Headaches													
Fatigue													
Increased appetite or decreased appetite													
Cravings for sweet or salty foods													
Insomnia													
Other (specify)													

No symptoms = A
Mild symptoms = B
Moderate symptoms = C
Severe symptoms = D

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account for approximately two pregnancies, the average women may experience 459 cycles. If women with PMDD experience approximately 6.4 days of severe symptoms per cycle, that means they are experiencing around eight years of debilitating symptoms in their life. Thus, PMDD can cause significant distress and functional impairment, making it an important health concern.

Biophysical Strengths, Hazards, and Risks

As discussed in the "Biophysical Growth and Development" section, a clear strength for anyone in this age group is physical endurance. During this age, important health behaviors and interests can be established and have an influence throughout the life course. Becoming physically fit and developing an interest in fitness, exercise, and sport activities can be important biophysical tasks in young adulthood.

Cancer

An important health hazard of the reproductive system for both women and men is cancer. Cancer is the fourth-leading cause of death in this age group (behind accidents, suicide, and homicide; American Cancer Society, 2020). Cancers that start in childhood and adolescence are different than the types that start in adulthood, because they are often the result of gene changes that take place early in development. That means they are less strongly linked to environmental factors. In young adulthood, the types of cancers are a mix of the types that can develop in childhood as well as later adulthood, including breast cancer, lymphomas, melanoma, sarcomas, cervix/ovary, thyroid, testicular, colorectal, and brain/spinal cord tumors. Breast cancer is more often diagnosed in older women (it is rare before age 30); however, the outlook is worse for those who are younger at the time of diagnosis. The young adult years are a good time to develop the habit of breast self-examination. The exam is easy; women should choose the same time each month to conduct the exam, preferably after the menstrual period has ended. This time frame is important because the breasts vary in size and texture during the menstrual cycle, but after the menstrual period they are not swollen. Health professionals can instruct women how to conduct the exam, and the American Cancer Society has brochures that describe the procedure. Detection of a breast mass is common; however, approximately 90% of masses are caused by benign lesions.

Men are encouraged to conduct a self-examination of the testes. Testicular cancer is a common disease for men between 15 and 35 years old and is the leading cause of cancer death among young adult males. Self-examination is important because, when detected, testicular cancer is second only to skin cancer in terms of successful cure rate. Men should be taught by a health professional how to perform the exam.

Health Disparities and Men of Color

One fact stands out when looking at healthcare statistics: Men of color living in poverty have the worst health outcomes, including higher rates of illness and mortality. In general, men are sicker and die sooner than women, in virtually every country worldwide. This disparity is especially true among African American men. One of the strongest determinants of health is poverty. Research has shown that smoking, alcohol and drug use, and unprotected sex are all less common among those with higher income and education. Stress, which is also linked to health, is higher when living in poverty. Race reflects multiple dimensions of social inequality (Williams et al., 2010).

Race and racism also play an important role. The difficulty in finding well-paying and meaningful work is more pronounced for men of color. Research has shown that even when men have the same job titles and advancements, men of color are more likely to experience occupational hazards and stress. Men of color face a complex social structure that affects their health. For example, smoking can provide relief from stress. As communities of color experience higher levels of stress, it is not surprising to see higher rates of smoking in them. Low-income and neighborhoods of color are also targeted by billboard advertisements for cigarettes and alcohol and by small businesses that provide such goods.

Lastly, cultural beliefs such as gender norms can affect health (Manandhar et al., 2018). Gender is distinct

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Racism is an important factor in health disparities

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from, though is related to, the categories of biological sex. Gender includes norms for behaviors, activities, characteristics, and opportunities that include different levels of power. Gender is considered a social determinant of health, a driver of health behaviors, and impacts how people respond to health systems. These issues will be discussed later in the chapter. However, it is important to note that in understanding health outcomes, gender matters. Women are more likely than men to seek and use health care, are more effective in making use of coping mechanisms and social support, and are likely to prioritize health (especially health-promoting activities) before they are seriously ill. Too often, men postpone their health care, compromising health outcomes later in life. In the two years following the COVID-19 pandemic, Congress improved access to public and private health insurance, which according to the U.S. Census Bureau (2022), contributed to lower uninsured rates in 28 states in 2021.

Critical Issues in Studying Health Disparities

In assessing the influence of biological systems on behavioral and health outcomes, we have known for quite some time that race and racism are potent predictors of various types of health risks. Racism includes structural and interpersonal factors that cause health inequities and health disparities. Many people of color, such as African Americans, Latinos, and AIAN, consistently demonstrate disadvantages in certain health areas. For instance, there are marked differences in hypertension, type 2 diabetes, obesity, asthma, and heart disease between people of color and White Americans (CDC, 2021). Another example of enduring health disparity was the disproportionate impact the COVID-19 pandemic had on people of color. Where people live, work, play, and worship are considered ***social determinants of health*** because they are conditions that impact health risks and outcomes. See Exhibit 8.4 for six key areas in which there are long-standing inequities that influence a wide range of health risks and outcomes (CDC, 2021).

According to the CDC, in order to achieve ***health equity***, social workers need to:

- address historical and contemporary injustices,
- overcome economic, social, and other obstacles to health and health care
- eliminate preventable health disparities

Social workers are in a position to prevent health disparities by bringing together communities of employers, healthcare systems and providers, public health agencies, community- and faith-based organizations, and

Exhibit 8.4 Social Determinants of Health

1. Social and Community Context (including Discrimination and Racism)	The types of racism people can experience within their community include structural or systemic racism, personally mediated or interpersonal racism, and internalized racism. Racism impacts stress, which impacts people from attaining their highest level of health.
2. Healthcare Access and Use	Structural barriers like difficulty with transportation or getting time off work can make it hard to go to the doctor. Cultural or language differences can also impact patient-provider relationships and healthcare quality.
3. Neighborhood and Physical Environment	Finding affordable and quality housing is particularly challenging for people of color. Historical discrimination practices have results in people of color living in neighborhoods with higher crime rates and school districts with inadequate funding.
4. Workplace Conditions	Work-related health problems disproportionately impact people with social, economic, and environmental disadvantage (e.g., temporary work arrangements, lack of safety measures, no health insurance benefits).
5. Education	Residents of lower-income neighborhoods have less access to high-quality education. Policies that tie public school funding to the tax base of a neighborhood limit the available resources to schools in those areas. Lower literacy and numeracy levels create barriers to attending college.
6. Income and Wealth Gaps	Limited higher-paying job options with good benefits contribute to barriers to wealth accumulation and greater debt. The historical practice of denying mortgages to people of color (redlining) has also denied opportunities for home ownership, and subsequently wealth accumulation due to an ability to pass down property and build wealth. Financial challenges make it difficult to pay bills and buy nutritious food.

Source: CDC, 2021

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Study Table Biophysical Dimension in Emerging and Young Adulthood

Biophysical Growth and Development:

- The period of development that reflects both the peak of physical development and the onset of a slow decline in physical processes and functions.
- A woman in her early 20s is when she has a mature reproductive system and is likely to produce fertile eggs.
- In the latter phases of young adulthood, the metabolism slows down and individuals are at greater risk for gaining weight.

Biophysical Strengths, Hazards, and Risks

- Increased endurance is a major characteristic of this phase of development.
- Early adulthood represents the phase of full maturity of brain functions.
- In late adolescence and early adulthood, cortical volume increases and refinement in cortical connections takes place in the brain.
- Cancer is the fourth-leading cause of death (behind accidents, suicide, and homicide).
- Increased rates of young adults who are involved in risky sex, substance abuse, and other health-related concerns cannot overlook the factors associated with these health disparities in men of color.
- Understanding racism, rather than race, as a biological risk factor.

policymakers to work toward creating policies, programs, and systems that are inclusive of community needs and a health equity framework.

Psychological Dimension

Cognitive Development and Information Processing

Formal Operational Thought

According to Piaget, the formal operational thinking that occurs in adolescence is the last stage of cognitive development. Therefore, young adulthood is characterized by the same mechanisms of formal operational thought. You will recall that Piaget (1967) believed that formal operational thought consists of conceiving abstract concepts, systematic thinking, and step-by-step logic. In late adolescence and young adulthood, it is currently assumed that people refine their formal operational approach to problem solving. The cognitive changes that take place in adulthood consist of operations applied to increasingly complex situations and problems.

Adults are better able to harness formal operational thinking because of their reduced egocentrism, and therefore approach problems with greater objectivity. Adults also are able to access past experiences and education more effectively in using available cognitive operations. Gisella Labouvie-Vief (2015) has suggested that a new integration in thought occurs in adulthood, but she believes that adulthood carries a pragmatic adaptive strategy that leads to decreased emphasis on the logical approach characterized in adolescence. Perhaps this pragmatic approach provides experience for adults in generating and considering an increased number of options and realistically hypothesizing the potential effects of each option—a facet of multidimensional thinking.

Many people do not achieve the level of formal operational thinking. This could be the result of many factors, such as genetic limitations on their cognitive abilities or poor cognitive stimulation as children. Studies have shown that only 60 to 75% of adolescents can solve any formal operational problems, and no more than 30% of adults ever complete the transition to the highest levels of formal operational thought (Kuhn, Kohlberg, Langer, & Haan, 1977). These findings suggest that formal operational thinking is not universal and instead is achieved only by certain people who are perhaps trained in this type of thinking.

Development of Post-Formal Thought

What is the difference between adolescent thought and adult thought? Researchers who study post-formal thought look at cognitive development beyond Piaget's formal operational stage. One well-known theory of adult cognition is represented by Labouvie-Vief (2015),

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who has looked at the development of pragmatic thought, where logic becomes a tool for solving real-life problems. In her original research, she used a scenario to examine the differences between adolescent and adult thinking.

The scenario introduces a married couple, John and Mary. John is known to be a heavy drinker, especially when he goes to parties. Mary warns him that if he gets drunk one more time, she will leave him and take the children. Tonight, John is out late at an office party. He comes home drunk (p. 13).

Does Mary leave John? How certain are you of your answer? Below are the adult and adolescent responses to the scenario (Labouvie-Vief, 2015). How do they compare? How is the thinking different?

The adolescent response is as follows (Labouvie-Vief, 2015):

It's a good chance that she would leave him because she warns him that she will leave him and take the children, but warning isn't an absolute thing. . . . And, I'd be absolutely sure that, well let's see . . . I'm trying to go all the way. I'm trying to think of putting everything [together] so I can be absolutely certain of an answer. . . . It's hard to be absolutely certain. "If he gets drunk, then she'll leave and take the children." I want to say yes 'cause everything's in that favor, in that direction, but I don't know how I can conclude that she does leave John. (pp. 93–94)

Here is the adult response (Labouvie-Vief, 2015):

There was no right or wrong answer. You could get logically to both answers [yes or no]. . . . It depends on the steps they take to their answer. If they base it on what they feel, what they know, and they have certain steps to get an answer, it can be logical. (p. 96)

Which response seems more characteristic of formal operational thinking? In the adolescent response, there is an understanding of the ambiguity of the situation but also the need to search for the correct answer. The adult response does not search for a correct answer—there is tolerance of the ambiguity. It also presents a combination of logic and feeling in understanding the situation.

As Labouvie-Vief (2015) pointed out in this example, the adult would be scored as not having reached formal operational thought in this example. Does this mean that there is a decline in formal operational thought as one gets older? Perhaps it is not so much a decline as a qualitative shift toward a more reflective way of thinking, which recognizes that norms and rules are relative to context. Due to this qualitative change, adults are more likely to have conflicts with young adolescents who consider norms and rules as absolute, rather than relative to context (Cavanaugh & Blanchard-Fields, 2019.

Communication

In young adulthood, perhaps what is most pronounced about communication is the notion of miscommunication; young men and women can become quite focused on the differences between the ways they communicate. Indeed, this notion is reflected in popular culture. For example, Deborah Tannen's (1991) classic book *You Just Don't Understand: Women and Men in Conversation* and her more recent *That's Not What I Meant! How Conversational Style Makes or Breaks Relationships* (2011) point out many of the significant ways in which women and men differ in their relationships with each other. Yet although gender differences do exist, much of our understanding of the differences between men and women boils down to sexual stereotyping. Often, the so-called differences are reduced to two conclusions: Men are in pursuit of power, and women are in pursuit of relationships. Such generalizations have yet to be supported by good studies.

Regardless, the social construction of gender matters and it is important to understand how gender intersects with communication. For example, Hilary Clinton lost the Electoral College vote in 2016 after winning the Democratic nomination for the presidency, which was believed to reflect sexism in the United States. Preelection, polls were concerned over Clinton's use of personal emails but not Trump's use of personal emails postelection (Palczewski, McGeough, & DeFrancisco, 2022). In 2020, Senator Elizabeth Warren was criticized for being unlikeable, and Vice President Kamala Harris was scrutinized for a romantic relationship early in her career. Research supports that the public views power-seeking female politicians as uncaring and their male counterparts as assertive, strong, and tough (Palczewski et al., 2022). Other events that have occurred in our history since then have only underscored the importance of gender, race, and intersectionality in communication. For example, activist Brittany Packnett was compelled to create the hashtag #BlackWomenAtWork in response to two prominent Black women who were publicly belittled by White men, including the scrutiny of Black women's facial expressions. Her movement underscored the ways in which whiteness is imposed at work, including standards for nonverbal communication and women's bodies, and what is viewed as professional.

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Styles of Communication

Some researchers identify men as using an instrumental style of communication and women as using an expressive style of communication. ***Instrumental communication*** refers to having a focus on identifying goals and finding solutions. ***Expressive communication*** involves the expression of emotions and having a perspective that is sensitive to how others feel. In general, men are more interested in having rational discussions and solving problems, and women are more interested in expressing emotions and feeling listened to and provided with support. The following scenario is a typical example of this kind of mismatch.

A young mother describes her worries and frustrations concerning appropriate childcare for her son. She is using an expressive style and is most interested in having her partner listen to her and provide some support. However, the husband, using an instrumental style of communication, assumes she wants to solve a problem and begins to search for solutions. This mismatch in communication leads to serious problems. Because her husband is not listening to her and hence not providing her with the support she desires, she assumes he doesn't have any sympathy for her concerns. He is frustrated by what he perceives as her complaining and her inability to simply solve the problem.

This situation represents a classic mismatch. Each person is attempting to respond appropriately. However, each is frustrating the other; she wants his sympathy, and he wants to help her solve a problem. In this context, each partner assumes that he or she knows what the other person wants, but this is clearly not the case.

Other differences in communication, according to Tannen (2011), include women's use of ***rapport talk***, which involves discussing similarities and matching experiences, and men's use of ***report talk***, which involves discussing knowledge and displaying skill. A research study comparing speech acts found that generally political leaders use report talk but there are important gender differences. When comparing speeches by presidential candidates Donald Trump and Elizabeth Warren, Trump's report talk was more varied but Warren's rapport talk was more varied (Nabila, Mujiyanto, & Rukmini, 2020). What men and women talk about also varies considerably. Women usually prefer discussions about their personal lives and feelings, whereas men seem to prefer discussions about activities and events (see Exhibit 8.5).

Differences also emerge in mixed-sex conversations, where women are more often listeners and men are more often lecturers. Tannen explains these differences by suggesting that they parallel games learned in childhood. For men, the game is "Do you respect me?" and for women, the game is "Do you like me?" According to Tannen, mixed-sex conversation places a woman in a double bind, because she will be evaluated negatively if she adopts either a male or a female style. Tannen (2005) explains that "if they speak in ways expected of women, they are seen as inadequate leaders. If they speak in ways expected of leaders, they are seen as inadequate women" (p. 244).

AzmanL

Communication differences between men and women at the office can be challenging. It is useful to understand your own communication style.

Communication Skills for Women

Often, in a discussion among men and women, men dominate the discussion. Women may need to "jump in" to the conversation more forcefully than they are accustomed to doing. Good use of nonverbal behavior can be critical: making eye contact, using appropriate vocal tone and pitch, and maintaining good posture and orientation in space will command attention. When the content of a spoken message is inconsistent with the nonverbal message, the nonverbal message will have the greatest effect. Because nonverbal behavior can be so powerful, women should use both nonverbal and spoken messages to convey positive responses and should rely more on oral communication to express negative responses. Use of personal space also can influence the effect of a message. Many women need to become more visible by obtaining a good position for interaction with others.

Women are often less comfortable than men in talking about themselves and their accomplishments. Women for whom this is a problem might want to script a short biography that describes their specific accomplishments and states their areas of expertise. To feel more comfortable

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Exhibit 8.5 Communication Differences between Men and Women

Men	Language	Women
Show knowledge and skill	Rapport talk	Discuss similarities and differences
Talk about activities and events	Report talk	Discuss personal lives and feelings
Lecture	Conversations with others	Listen
Let's solve it!	Problem talk	Provide understanding

Source: Adapted from Tannen (1991; 2011).

about sharing their point of view, women also can practice expressing opinions on a variety of topics.

Communication Skills for Men

Because men often tend to dominate a conversation, they should observe their patterns of communication and evaluate their tendency to dominate. If this is a problem for them, they can learn to catch themselves interrupting and politely encourage the other person to continue with his or her thoughts. Men can sometimes be difficult to talk with because they don't "carry" enough of the conversation; for example, they might provide only short answers to questions. Some men also need to work at being more conversational. A good technique to use for improving conversational skill is the two-question rule. This rule keeps the conversation focused on the other person. It requires a speaker to ask an opening question and then to follow up that question with another inquiry. Often, people ask just one question, such as, "How did you feel about that meeting?" and then proceed with their own analysis and reaction to the meeting. By contrast, asking a second, follow-up question demonstrates good listening and helps to keep the dominant person from launching into a lengthy monologue. Too often, women feel "talked at" by men rather than "talked with." Many men need to practice being good listeners. Good listening requires concentration and sustained effort, but a balance of conversational give-and-take will facilitate good communication between men and women.

Men who do not usually use an expressive communication style can practice discussing their interests, feelings, and thoughts. To do so, rather than approaching a conversation as an interaction about events and activities, men can focus on their feelings about various subjects.

Nonverbal Communication

In well-known studies of nonverbal communication, three dimensions are represented in nonverbal expressions. (1) The like–dislike dimension is expressed through closeness or distance—for example, looking at or away from a person; (2) the potency dimension is expressed through one's expression—for example, standing straight rather than slumped, or using rapid versus slow movements; and (3) the responsiveness dimension is expressed through one's facial movements, voice tone, and voice volume. Mehrabian (1972) is often noted for his observation that, of a total feeling conveyed in a message, 7% is verbal feeling, 38% is vocal feeling, and 55% is facial feeling. What's important about this observation is that even though we may restrict what we say in words, it is often more difficult to restrict our feelings from influencing our nonverbal responses. Therefore, nonverbal responses may contradict our verbal message. It is the nonverbal part of the message that will qualify what we are attempting to communicate verbally.

Problems in communication are of particular concern to couples. Communication problems are one of the most frequently identified issues of couples seeking counseling (Gottman, 2011). Research has also found that happy and unhappy couples can be distinguished on the basis of three aspects of communication: comfort in sharing information with the other person, willingness to recognize and resolve conflicts as they occur, and quality of the couple's sexual life.

In a study that attempted to predict the likelihood of divorce, Gottman, Gottman, and Declaire (2006) studied communication and interaction styles as the couples discussed problem areas. Primarily on the basis of how the partners related to each other, the researchers were able to predict, with an accuracy rate of 94%, which couples would be divorced three years later.

Communication is the center of many of the issues critical to good social work practice. Indeed, practitioners need to understand communication with a diverse range of clients. The following section looks at communication with deaf individuals.

Communicating with People Who are Deaf

Social workers who work with clients who are deaf know that just using an interpreter does not address the whole picture: communicating with the deaf requires more than

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just signs. People who are deaf represent a linguistic minority with a separate language—American Sign Language (ASL). Research in psycholinguistics has found that signing is not just gesticulation, but has its own syntax and is well formed like other languages. What makes social work practice with clients who are deaf difficult is that one is working in a language that is not one's own. Also, many cultural, educational, and service issues are specific to people who are deaf. For instance, a common error in the assessment of individuals who are deaf lies in not understanding that they often read and write English at a much lower level than do hearing students at the same age level. For example, a high school graduate who is deaf may have only a fourth-grade reading level, in which case a social worker needs to know how to evaluate a person with poor reading skills. Writing is also very different for the deaf, because ASL and English have very different structures, styles, and syntax. As a result, people who are deaf can appear mentally disoriented when in fact they are not. There is a need for social work professionals who specialize in deafness; however, few programs offer a subspecialty in deafness.

Virtual Communication

Though communication through the virtual world is becoming more of the norm than the exception, particularly in response to the COVID-19 pandemic which made face-to-face contact outside of the home almost nonexistent for nearly two years, research indicates that most young adults prefer human over virtual contact, though Gen Zers are more comfortable communicating virtually compared to the older Generation Y (Strnadová, Voborník, & Provazníková, 2019). *Social media* is a collective term for websites or applications that focus on communication, community-based input, interaction, and content-sharing. Many people use social media to interact with friends near and far, but more and more businesses and organizations are using social media to market and promote their products/services and interact with customers/clients. Social media is global and is used most frequently by young adults. According to the U.S. Media Consumption Report, the total time spent using digital media is increasing every year. It hit an all-time high of eight hours and five minutes a day in 2021, not including voice calls, but including listening to audio, using social networks, and watching videos. In the same year, approximately 60% of young adults visited TikTok daily (YouTube was 61%) and both Instagram (56%) and Snapchat (52%) were more popular with young adults than older adults. However, only 28% of young adults used Facebook daily (compared to 57% of Baby Boomers and 68% of Generation Xers). Online gaming was used by 82% of young adults daily, 44% streamed three or more hours of video content daily, and 60% listened to online music daily. Only 22% visited news websites and 11% listened to a podcast daily. Traditional media, conversely, is on the decline across adults, with only 20% of young adults watching one to two hours of TV daily and 19% listening to the radio daily. Consequently, the young adults of this generation are increasingly media savvy, with a better awareness of what is communicated through digital messaging tactics.

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The primary mode of communication for many young adults who are deaf is using American Sign Language.

Attitudes, Emotions, and Regulation

A major psychosocial task in young adulthood is the development of intimacy with others. Erikson referred to this stage as intimacy versus isolation or self-absorption. In order to successfully negotiate this stage of development, one needs to have a good understanding of oneself and to develop appropriate ways of interpreting the needs and actions of others. Intimacy in this context refers to the ability to share one's true self—both the good and the bad parts. Developing intimacy involves taking a risk, sharing things about yourself while knowing that the other person can make judgments about what you share. Kiefer (1988, p. 131) described the complexities involved in intimacy: "Any close relationship involves the exchange of demands and expectations, some of which are difficult and unpleasant. More importantly, getting to know someone

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intimately always involves hurt when illusions are dashed or expectations unfulfilled; and it always involves unpleasant insight into one's own weaknesses."

Love

One of the most prevalent emotions in young adulthood is love. Love takes on particular significance for the young adult, who begins to experience many meaningful emotional relationships (and emotions of love are likely to lead to marriage in young adulthood). Erik Erikson identified the core task of the early adult years as intimacy. As the task of identity is addressed, the individual moves toward preparation for intimacy. Those who cannot effectively resolve the tasks of intimacy are left to isolation and lack the ability to form reciprocal exchanges based on understanding, empathy, and support. A major developmental task of the young adult is to develop emotionally satisfying relationships—to experience love.

But what is love? This is a critical question asked by many young adults. A typical young adult scenario could be the following: Two young people meet and they begin seeing each other. As their interest and excitement grows, each becomes increasingly obsessed with the other. They want to spend increasing amounts of time with each other, and their sexual desires cannot be entirely fulfilled, no matter how much they try. Yet, although they are sharing what seem to be immense parts of themselves with each other, they do not know if this is really love. They realize that to keep the relationship going entails a certain amount of sacrifice and personal risk. They are unsure whether they should take the plunge and exclaim "I love you" to each other. They face extremely difficult questions that young adults commonly ask: Is this love? How can I tell?

Is love something we can define and study? In the last 20 years, many researchers have set out to study love and achieve a more exact understanding of this emotion. Most researchers begin by differentiating romantic love from "true" love. Robert Solomon (2006) described three characteristics of romantic love: (1) it is sexual in origin and motivation; (2) it is spontaneous and voluntary—and not directly under our control; and (3) it is an emotion appropriate only between equals (e.g., not between a mother and child).

Bartels and Zeki (2004) examined the effect of love on brain activity. Interestingly, this research supports the old adage "Love is blind." It appears that feelings of love suppress the activity in the brain that is responsible for controlling critical thought. Both romantic love and maternal love produced the same effect on the brain. This function may make it easier for people to "couple," and at the same time the emotions of love bond individuals through the brain's "reward system" of positive emotion. Still, some would argue that emotions are evaluative judgments and that we in essence choose our emotions (Solomon, 2006). Whatever the process that leads us to love, many individuals do not cope very effectively with this age-old emotion, in part because of the many myths that surround it.

Some common myths that have resulted from our idealized concept of love include the following:

Myth 1: When you fall in love, you'll know it.

Myth 2: You have no control over love.

Myth 3: Love is a completely positive experience.

Myth 4: True love will last forever.

Myth 5: Love can conquer all problems.

Some new theories of love may shed light on how we can better understand this elusive concept. Sternberg's triangular theory of love (1986) suggests that love has three components: intimacy, passion, and commitment. In this theory, intimacy refers to the warmth and closeness shared in a relationship; passion refers to the intense feelings (both positive and negative) experienced in love relationships, including sexual desire; and commitment refers to the decision and intent to maintain a relationship in spite of the difficulties encountered. Young adults desire intimacy but at the same time, are working on establishing independence and identity development. Williams (2014) shares an example of these competing desires from one young woman's experience:

> I think it is confusing. I think that for me the main thing is, I want to be in this like long-term relationship with someone I really care about and have, but it's like a favorite old piece of clothing or something. You always wear it and you love it, but like, you still love new clothes.

The triangular theory of love posits multiple types of relationships that emerge from the presence or absence of the three components of love (see Exhibit 8.6; based on Sternberg,1986).

Sternberg believes that in any given relationship, the components of love take different courses. For example, in a long-term relationship, passion often decreases but intimacy keeps increasing. Furthermore, two partners may not emphasize the same elements at the same time. Of course, a successful relationship means resolving these differences.

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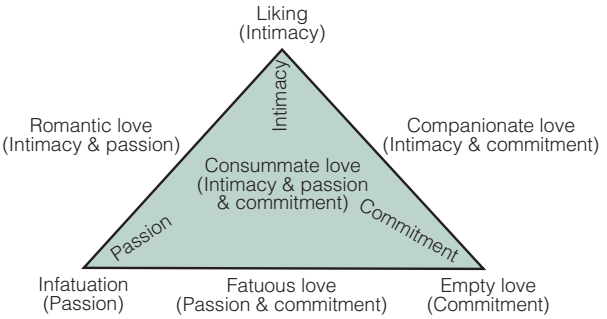
Exhibit 8.6 The Triangular Theory of Love
The triangular theory of love includes three basic components: intimacy, passion, and commitment. The figure shows the three basic components and possible combinations.



Source: Adapted by authors from Sternberg (1986).

Young adults desire intimacy within the context of a close romantic relationship and also independence and identity exploration through trying on different roles. According to Williams (2014), these developmental goals manifest in romantic relationships in two distinct ways: the search for an exclusive, committed, and emotionally involved relationship (intimacy), and the search for a non-exclusive, low-commitment, and less emotionally intense relationship (exploration). The conflicting and competing nature of these goals is seen when young adults are asked to describe love. They want to experience love in an intimate and close romantic relationship, yet may not want to remain committed to the same person. These two feelings are difficult to reconcile because they know that in order to fully experience love, they need passion, intimacy, and commitment within their relationship. A young woman from Williams's study explains this distinction:

> You know how they say, "What's love got to do with it?" …Marriage is a lot more than love and like these [young] relationships because you can really care about something, but you have to have more than that. You have to have more, like, there's got to be another part of you that is willing to commit. It's not just the caring part. Like you can care about somebody, but not be able to be with them because you just can't make that final jump over.

Intimacy and Independence

Although intimacy is a primary focus in young adulthood, independence also is an important developmental task. Young adults are exploring aspects of intimacy and they are also recognizing their need for independence and freedom. Maturity and growth are reflected in the ability to experience both intimacy and dependence, and freedom and independence.

In adolescence, young people are working to develop their identity; in young adulthood, they are trying to establish their identity. This establishment often takes place as young adults begin to strengthen their own inner identity and clarify their beliefs and values (Coté, 2000). The key issues revolve around vocational directions. For example, they may be concerned about career choices or relationship commitments they are making. In moving from early to mature adulthood, goals and values may change frequently. Coté (2000) has referred to young adulthood as "arrested adulthood," given the changing nature of identity commonly experienced by young people.

This process of developing one's identity is often facilitated when the young adult begins to shape a "dream." According to Levinson (1986), such dreams reflect what a person would like to accomplish as an adult. These dreams often start out being concrete and overly simplistic, and then mature into clear and realistic visions. Some people may focus more on occupational goals, whereas others prioritize love and family.

Problems can occur, however, when people fail to establish their own identities. How can young people develop independent identities when they are still dependent on their parents for financial, personal, and emotional needs? Such dependency may lead to problems in developing intimate relationships with others or in developing independent career opportunities. Exhibit 8.7 shows the steps to build independence in young adulthood.

Isolation and Loneliness

The counterpoint to intimacy is isolation—the inability to share intimately with others. With a lack of such exchanges, you are robbed of the experience of having another person understand you from your point of view, as well as insight and understanding of yourself, and support and encouragement concerning your actions and thoughts. Such isolation may lead to a deep sense of loneliness.

Although many young adults actively seek emotionally satisfying friendships and romantic relationships, many others experience feelings of loneliness. In fact, research on the prevalence of loneliness (1) identifies adolescents and young adults as the loneliest age groups and (2) finds that loneliness decreases with age, at least until late adulthood, when marriage partners and friends

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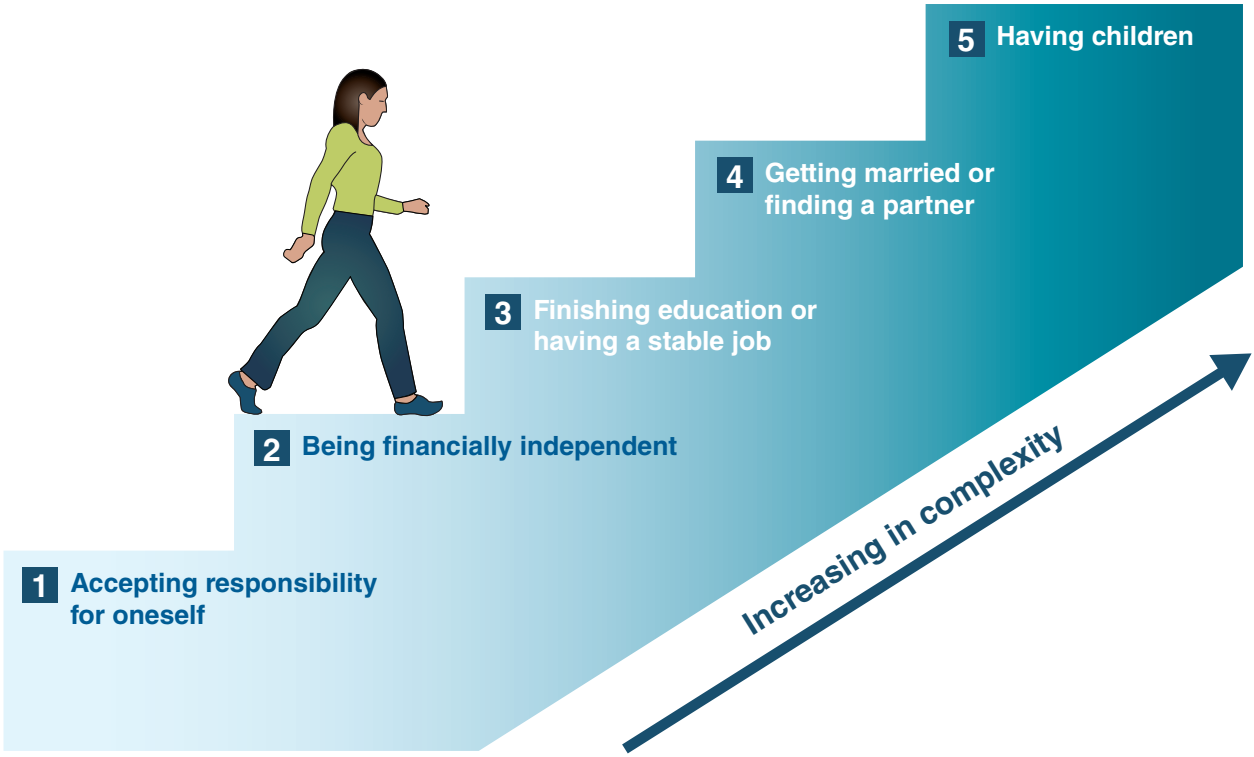
Exhibit 8.7 Building Independence in Young Adulthood



begin to die (Beam & Kim, 2020). The COVID-19 pandemic sparked a loneliness epidemic and, according to new research, older adolescents and young adults were hit the hardest (Beam & Kim, 2020). Between April 22 and May 11, 2020, 65% of young adults reported their feelings of loneliness had increased. Further, loneliness was associated with increased alcohol and drug use, anxiety, depression, and decreased feelings of connectedness (Horigian, Schmidt, & Feaster, 2021).

Loneliness is a subjective feeling, and it is not the same as social isolation, although the two are associated. ***Loneliness*** is best defined as a distressed feeling that one's social needs are not being met by the quantity and quality of one's social relationships (Hawkley & Cacioppo, 2010). Loneliness, therefore, is not the same as spending time alone. Many people experience loneliness even though they may have many personal "friendships." However, many people desire solitude and want few personal relationships.

Loneliness is also not the same as ***existential isolation***. Existential isolation is related to an insecure attachment in infancy and results from feeling like your personal experience can never be truly known by another person (Helm et al., 2020). Existential isolation is considered a trait that can be sparked during specific situations; for example, not finding funny a comment that everyone else is laughing at. Existential isolation is related to loneliness but loneliness correlates positively with a need to belong, whereas existential isolation does not. Another related but distinct concept is ***alienation***. People who feel alienated feel powerless, meaningless, and isolated from others or from society in daily life. Loneliness, existential isolation,

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Young adulthood can be an intense period of loneliness.

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and alienation all result in feeling a degree of disconnection from others, but existential isolation is due to interpersonal causes, whereas alienation stems more from societal ones.

Loneliness is not one dimensional; it appears to occur in different areas of one's life. For example, you could be satisfied with your relationship with your partner but not with your friendships. There are different areas where loneliness can be a problem: (1) romantic relationships, (2) friendship relationships, (3) family relationships, and (4) community relationships. Therefore, knowing what areas of loneliness are particularly problematic suggests a different focus for learning how to best address feelings of loneliness.

Practice Guidelines:

Reducing loneliness

Most of the interventions developed to help people cope with loneliness focus on four areas: cognitive restructuring or changing negative self-talk; providing social support; enhancing social skills; and enhancing social interaction.

- Help individuals reduce anxiety and increase comfort and set goals to promote people staying engaged in social situations.
- Teaching people social skills, such as how to start and maintain a conversation.
- Encourage the person to obtain additional social support during their time of loneliness.
- Help individuals recognize how their cognitions lead to loneliness; for example, if they say, "I'm not an interesting person," they may avoid friendships or if they say "I don't know how to act around others," they may avoid social situations.
- If lonely individuals live alone, this increases their risk of suicide. Make sure they have someone to check in on them.
- Lonely people often do not sleep well so helping them increase the amount and quality of their sleep is important.
- Make a connection to one person that you are concerned might be lonely once a week.
- Programs that match young adults with older adults foster Intergenerational connection (Beam & Kim, 2020).
- Attachment styles are moderately stable over the life span. However, romantic and peer relationships can shift attachment styles. Particularly, it is in young adulthood that people shift their attachment figure from parents to peers or relationship partners. Attachment styles can also be changed in therapy.

The appropriate intervention depends on the particular cause of the loneliness. Young (1982) identified a variety of different kinds of cognitions or self-talk that contributes to feelings of loneliness. His research identified six clusters of cognitions that lead to different kinds of irrational cognitions and subsequent behaviors. For example, cognitions related to avoidance of friendships might be, "I'm undesirable," or "I'm dull and boring." Cognitions related to avoidance of potentially intimate relationships might be, "I won't risk being hurt again," or "I'd screw up any relationships."

Understanding a client's thinking processes can be helpful in planning different intervention strategies.

Psychological Strengths, Hazards, and Risks

Young adulthood is an interesting combination of true psychological strength and risks. In many respects, young adults are at the top of their game. They are physically strong and capable, cognitively advanced, and often seizing upon career advancement. Young adults are in the process of achieving their long-term goals. As they move toward psychological and economic independence, their decisions have an enormous impact on the trajectory of their functioning into late adulthood. However, on the other side of these strengths are growing responsibilities that can create stress and problems for the young adult.

Robert Havighurst (1972), a researcher who studied adulthood, has noted that the young adult years are one of the most difficult periods in a person's life. Young adults must make major decisions that include career and job choices, selecting a mate, extending education, and bearing and rearing children—these are major responsibilities for someone who is just entering adulthood. Many young adults become easily frustrated because they have not been adequately prepared for the life challenges they now face. The large number of frustrations, coupled with immense responsibilities, often cause psychological problems.

Excellence in Performance Development as a Strength

As pointed out earlier in the chapter, the development of a career is an important adult task and the extent to which a person embarks on practices associated with the achievement of excellence in a career is associated with certain psychological processes that are documented in

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positive psychological research—these include resonance, passion, and grit. Newberg, Kimiechk, Durand-Bush, and Doell (2002) created the concept of resonance, which is a process that is associated with the achievement of excellence in several different areas of expertise. They discovered that people who are capable of achieving excellence in their performances are individuals who become fully engaged in what they are doing (Compton & Hoffman, 2013). This outcome is achieved because these individuals "consciously identify unique feeling[s] they want to experience in their daily pursuits and palace themselves in situations and environments that elicit these feelings" (Newberg et al., 2002, p. 257).

The model developed by Newberg and colleagues consists of four stages: the dream stage, the preparation stage, obstacles stage, and a fourth stage that involves revisiting the dream. It is obvious that in order to achieve a dream that one must engage in consistent practice in order to realize one's dreams. Barriers are obvious, but how one responds to the barriers is what distinguishes their model from others. For them, simply trying harder to overcome the barriers is not necessarily the solution. Instead, people who achieve excellence either revisit the dream, or "reconnect with the feelings that gave spark to their dream. This reconnection with original feelings allows them to embrace the obstacles, to avoid the trap of 'trying harder and enjoying it less,' and thereby to move forward" (Compton & Hoffman, 2013, p. 157).

The Resonance Performance Model (RPM) is consistent with other research that documents the importance of passion. Passion represents an inclination toward activities that help to define a person (Vallerand, 2012). In fact, they are so self-defining because they reflect the key characteristics of an individual's sense of identity. The important role that passion plays in adult achievement was also recognized as a positive contributor and Duckworth, Peterson, Matthews, and Kelly (2007) combined the concept of passion with the concept of persistence to characterize what they called ***grit***. They found that "people who are very self-disciplined and score high on measures of persistence and passion toward their goals are high in grit" (Compton & Hoffman, 2013, p. 157). Moreover, a review of the science on grit indicates that grit increases with age and is associated with success and well-being, including greater academic achievement, career outcomes, work-related functioning (i.e., less burnout), physical health, happiness, less stress, and fewer problems with drug and alcohol use (Datu, 2021). Advances in neuroscience have implicated the prefrontal cortex as an important region associated with grit, as well as the distribution of gray matter volume and white matter pathways. From a prevention perspective, supporting the development of grit may buffer the impact of psychological hazards, particularly, it can diminish suicide ideation and feelings of hopelessness. There are many reasons behind *why* grit is so beneficial, including people with more grit also have greater cognitive resourcefulness, fulfillment of psychological needs (e.g., autonomy, competence), positive cognitions, emotion regulation, and are also more likely to have other positive interpersonal characteristics such as gratitude. There are not as many studies of grit conducted outside of non-Western cultures; however, there are enough to suggest that grit is cross-culturally positive, with links to positive performance in Japan, China, Hong Kong, mainland China, the Philippines, South Korea, and Thailand, among others.

Serious Mental Illness

Many of the major mental illnesses—in particular, schizophrenia—become evident in late adolescence and early adulthood. **Schizophrenia** is a prominent thought disorder that includes delusions, inappropriate affect or silly affect, and disorganized speech. Those who suffer from schizophrenia can be grouped into three broad categories: (1) treated successfully with a full recovery, (2) partial recovery with a reasonably normal life, and (3) little or no recovery with repeated hospitalizations.

What leads a person to develop a serious mental illness like schizophrenia? Most of the evidence points to heredity as the major explanation (Kendler & Klee, 2022;). Studies have shown that relatives of a person with schizophrenia have an increased risk for developing schizophrenia, and the closer the relationship, the higher the risk. There are many cultural beliefs around schizophrenia as well. For example, a recent study of Mexican families revealed that although hereditary factors are understood to cause schizophrenia, emotional trauma in childhood was believed to be the primary cause, with emotional problems, head trauma, mistreatment, and divine will playing a role as well (Audiffred-Jaramillo & Alba-García, 2022). There are several risk factors that increase schizophrenia vulnerability, including genetics, childhood trauma, and regular cannabis use (Lemvigh et al., 2021). The role of cannabis is promising, as it is an avoidable environmental risk factor that appears to play a substantial role in schizophrenia pathology.

What physical mechanisms are involved in schizophrenia? Many researchers now look to the influence of

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Serious mental illness—from which people can suffer throughout their adult life—often makes its first appearance in young adulthood. Proper care and treatment for people with mental illness are enhanced through case management services.

neurochemical factors. Schizophrenia and other mood disorders are accompanied by changes in neurotransmitter activity, and most of the drugs that are effective in controlling the symptoms of schizophrenia act to restrain dopamine activity in the brain. Therefore, abnormality in dopamine function is believed by some to be the most likely cause of schizophrenia and all pharmacological treatments affect the dopamine system (McCutcheon, Abi-Dargham, & Howes, 2019). Dopamine has been implicated as the neurotransmitter linked to psychosis; however, we have learned that psychosis is a condition that involves the dysregulation of multiple transmitters in multiple pathwaIcluding serotonin and glutamate systems (Stahl, 2018). Current research proposes that schizophrenia is caused by a genetic vulnerability coupled with environmental and psychosocial stressors, the so-called diathesis-stress or vulnerability-stress model.

The National Alliance In Mental Illness (NAMI) has become a powerful advocacy group that promotes the well-being of people with schizophrenia and their families. Formed from a grassroots organization in 1979, today, NAMI has chapters in most cities across the country. The organization's mission is to serve in an advocacy role, bringing problems and issues to the attention of local, state, and federal agencies. For example, NAMI is particularly interested in research that would identify new ways to help clients readjust to the community, using the least restrictive environment as a guiding principle. NAMI is also involved in finding ways to help families function more effectively and with less overall stress.

Assessment Tools:

Assessing Clients with Mental Illness

Social workers often are called on to provide necessary services for clients with mental illness. Understanding the multifaceted nature of mental illness is critical in designing and coordinating services. Some of the factors that social workers might want to consider in assessing the clients and their social situation are as follows:

- Physical health status
- Physical functioning
- Ability to perform activities for daily living
- Extent of bodily pain
- Quality of sleep
- Level of energy and fatigue
- Quality of life
- Access to resources and opportunities
- Fulfillment of life's roles and tasks
- Overall well-being or life satisfaction
- Family and peer relationships

Ability to maintain and develop relationships with others
Ability to maintain and develop relationships with family members

- Extent of the family's burden
- Rehabilitation status
- Social skills
- Vocational status
- Independent living skills

Although not complete, the preceding assessment list gives some idea of the complexity involved in working with people with mental illness. Understanding and helping these clients requires assessing multiple aspects of the social environment. There is also growing evidence that hope, or positive expectation, has an influence on the person with mental illness and his/her adaptation to living with mental illness.

Depression and Anxiety in Young Adulthood

For young people, depression and anxiety are common psychological hazards—so common that today's universities are focusing on ways to combat the problem.

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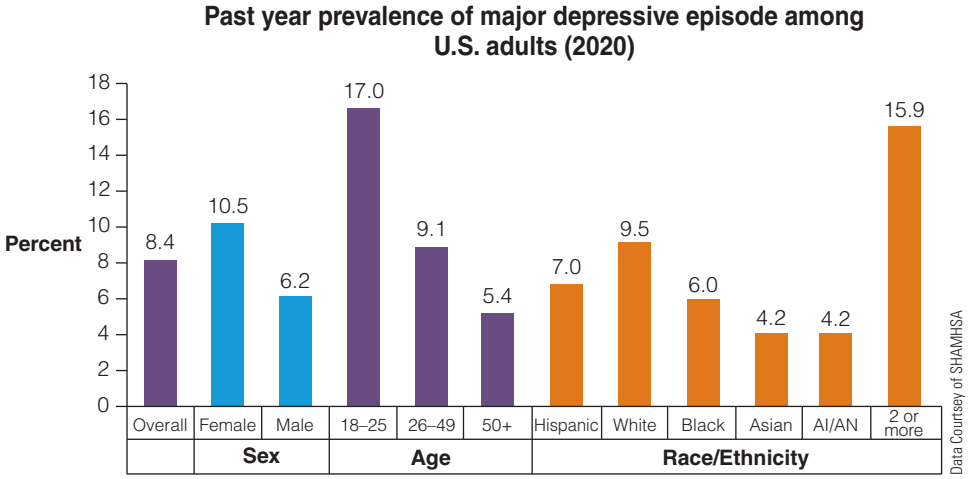
Attending college is a major transition. It is often the first time away from home, which requires increased independence and responsibility, and can be stressful and challenging. A growing number of college students are suffering from depression, and now, anxiety has surpassed depression as the most common mental health diagnosis among college students (Pedrelli et al., 2015). Notably, the conditions around the COVID-19 pandemic only exacerbated mental health challenges for young adults (Beam & Kim, 2020). Longitudinal studies that surveyed adolescents and young adults before and after the pandemic, saw increases in both depression and anxiety symptoms, particularly among females (Hawes et al., 2021). During lockdown, young adults experienced the most psychological distress and intolerance to uncertainty than any other age group (Glowacz & Schmits, 2020). They reported less living space, occupational activity, social contact, and higher anxiety, depression, and uncertainty about the future compared to older adults. Social workers should be mindful that in times in which confinement is necessary, that young adults are more sensitive to lockdown conditions and psychological distress.

Even in pre- and post-pandemic times, for whatever reason, college students appear to be feeling increased pressures that are taking their toll. The academic pressure combined with personal freedom may compound many comorbid issues such as depression, anxiety, and substance abuse. College students make up the largest group with major depressive disorder; however, their use of mental health services is lower than other adults. Despite being highly treatable, only about one-third of those with anxiety seek treatment (Hart Abney et al., 2018). Reasons for not seeking services include not knowing where to go, not believing the treatment will help, believing their symptoms are just typical stress associated with going to college, and worry about stigma. It is important to note that contact through digital media can be anxiety-provoking for young adults; young adults were the least likely to seek treatment via telehealth during the COVID-19 pandemic (Glawacz & Schmits, 2020). A promising intervention, "Creating Opportunities for Personal Empowerment" (COPE) Program for Young Adults, uses a Cognitive Behavioral Therapy framework over seven 30-minute one-on-one sessions (Hart Abney et al., 2019). It includes different ways of coping with life challenges and can be incorporated into first-year university programs to promote fewer symptoms of depression and anxiety at a critical transition point.

Depression and Women

Depression is one of the leading mental health problems for women in the United States (see Exhibit 8.8). According to SAMHSA, 10.5% of adult women had a diagnosable major depressive episode in the United States in 2020; indeed, depression was highest among adults aged 18 to 25 (17%), and it was twice as likely to impact women (SAMHSA, 2022). Depression has been called the most significant mental health risk for younger women of childbearing

Exhibit 8.8 Prevalence of Major Depressive Episode in the United States



* Persons of Hispanic origin may be of any race; all other racial/ethnic groups are non-Hispanic | AI/AN = American Indian/Alaskan Native.
Note: The estimate for Native Hawaiian / Other Pacific Islander group is not reported in the above figure due to low precision of data collection in 2020.

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and child-rearing age (Brogan, 2016). Pregnancy, the postpartum period, perimenopause, and the menstrual cycles are all associated with dramatic physical and hormonal changes that uniquely impact women. Unfortunately, many of these women will go without proper treatment, despite new treatment technologies that have reduced depressive symptoms in women by 80 to 90%. A further complication is that depression in women is misdiagnosed about 30 to 50% of the time (Brogan 2016).

Why do women experience such high rates of depression? This question, as you might imagine, generates a number of explanations. Most experts now agree that depression in women can be explained only from a biopsychosocial perspective. Research has identified a multitude of factors that influence the prevalence of depression, such as personal styles characterized as avoidant, passive, and pessimistic (LeCroy & Daley, 2001). These characteristics are related to sex-role expectations and socialization experiences. Also, women who suffer from depression often focus on their feelings, neglecting to take action to gain a sense of control over the conditions that may be leading to the depression. Although men are more likely to distract themselves, women tend to ruminate on their mood. This rumination is believed to amplify negative emotions and reinforce the negative mood state. This internal attributional style can also lead to increased feelings of helplessness.

Additional research has found that being unhappily married increases the chances for depression. For women, being in an unhappy marriage increases the likelihood of depression threefold. When there are young children to care for in the home, women are more likely to be depressed. Similarly, the more children a woman has, the greater the likelihood of depression.

Other factors for depression include any physical and emotional abuse that a woman may have experienced. Also, many women in this country live in extreme poverty, and such adverse economic conditions contribute to persistent depression. Other women may be further marginalized or socially stigmatized by their age, ethnicity, or sexual orientation, or by drug dependence.

Assessment Tools:
Assessing Depression

Purpose of the Assessment

- Identify the young person's chief complaint.
- What is the reason the client is seeking care or an assessment at this point in time?
- Was the person referred for an assessment by another professional or agency? Establish the reasons for the referral.

History of the Present Illness

- Identify symptoms of depression the client is displaying (changes in mood, in sleep, appetite, libido, concentration, memory, loss of interest or pleasure, significant weight gain or weight loss, lack of energy, or suicidal thoughts).

Mental Health or Psychiatric History

- What is the history of past illness episodes—diagnosed or not?
- Prior treatment and the client's response to this treatment.
- Was the client ever previously hospitalized for a psychiatric condition?
- What prior clinical records for her prior assessments and treatment are available?

General Health History

- Any history of prior illnesses, or undiagnosed illness causing distress or impairments in social functioning?
- Is the client taking any medications for other health conditions?

Substance-Abuse History

- Licit and illicit substances used by the client? Type of substance, mode of administration, and dosages or quantities used.
- Is there a history of substance-abuse problems in the family?

Developmental History

- Major events in the person's history, including any traumatic precipitating events?
- History of trauma?
- History of coping strategies and history of difficulties adjusting to problems in living.

Social Dimension

Groups and Families

Marriage and the emergence of the "family" become one of the most significant life changes in young adulthood. Decisions regarding whether to get married and whether to have children are fundamental struggles in this period.

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Study Table Psychological Dimension in Emerging and Young Adulthood

Cognitive Development and Information Processing

- Piaget assumed that formal operations was the last stage of cognitive development.
- Labovive-Vief identified post-formal thought, which shifts from an emphasis on logic to a more pragmatic way of thinking about an issue.
- In post-formal thought, less emphasis is placed on the correct answer and more emphasis is placed on pragmatic consequences.

Communication

- Men are more likely to rely on instrumental styles of communication and women tend to be more likely to adhere to an expressive style.
- It is easier to constrain the expression of our emotions verbally than nonverbally.
- Difficulties with communication increase the likelihood of couples experiencing problems when they are not comfortable sharing information, do not resolve conflicts when they occur, and the quality of a couple's sexual relations are poor.

Attitudes, Emotions, and Regulation

- Three characteristics of love: (1) sexual in origin and motivation; (2) voluntary; (3) an emotion appropriate only between equals.
- Triangular theory of love.
- Common myths of love.
- Isolation and loneliness—the inability to share intimately with others.
- Loneliness can be a problem in four areas: (1) romantic relationships, (2) friendship relationships, (3) family relationships, and (4) community relationships.

Psychological Strengths, Hazards, and Risks

- The onset of serious mental illness in young adulthood.
- Depression and anxiety are common hazards for young adults.
- Biopsychosocial explanations for the higher rates of depression in women.
- Excellence in performance development associated with resonance, passion, and grit.
- Passion reflects the key characteristics of an individual's sense of identity.
- Grit increases with age.

Newman and Newman (2014) have described the importance of these decisions:

> The most important social factors contributing to the creation of a lifestyle are whether one marries, the characteristics of one's marriage or intimate life partner, whether one has children and the characteristics of those children, and one's work. The extent to which one has a choice about each of these factors depends on cultural values and restrictions, societal norms and barriers, and socioeconomic factors, especially educational attainment. Each factor interacts with personality, interests, and life goals to shape a lifestyle. (p. 523)

Marriage

Although the institution of marriage has changed considerably over the past 30 or 40 years, most Americans still opt for marriage at least once in their lives. However, recent data show that 34% of adults ages 15 and older had never married (up from 23% in 1950). About one-third of men and 42% of women aged 25 to 34 were living with a spouse in early 2021 (U.S. Bureau of the Census, 2022). The historical trend of rising numbers of people who never marry coincides with more people choosing to live with an unmarried partner; 17% of young adults did so in 2021. At the same time, over half of young adults (58%) were living in their parents' home.

Indeed, there are some other distinctive changes that have taken place with regard to marriage. Perhaps most significant is that young adults are postponing marriage until almost 30. The median age for first marriage is 28.6 for women and 30.4 for men. However, after a relatively long period of stable divorce rates in the United States, divorce rates are starting to decline. The average length of a marriage in the United States is currently just under 20 years and currently, the divorce rate is 2.3 people per 1,000. Divorce rates among same-sex couples are no different than different-sex couples. However, the divorce rates among those 50 and older are still rising. Called the "gray divorce rates," national divorce rates have doubled for this population and have tripled for those aged 65+. Interestingly, older adults are more likely to get divorced

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now than ever before while millennials have the lowest divorce rates. Millennials are waiting longer to get married or choosing cohabitation over marriage. With less pressure to settle down early, young adults further in their development may have better skills and life experience to select a good partner. According to the Institute for Divorce Financial Analysis, the number one reason for divorce was basic incompatibility, more common than infidelity and money issues. Some research indicates that millennials may be less likely to have unrealistic expectations for marriage and are generally more cautious about marriage. Churches have been a catalyst in supporting the use of marriage myths inventories. For example, the PREPARE/ENRICH inventory examines four relationship issues: personality, intrapersonal, interpersonal, and external (Knutson & Olson, 2003). Example items include:

My partner and I have a very close relationship.

My partner has habits I dislike.

I can share positive and negative feelings with my partner.

We have some important disagreements that never seem to get resolved.

We have similar styles of spending and saving.

I sometimes feel pressured to participate in activities my partner enjoys.

I am very satisfied with the amount of affection I receive.

A small percentage of couples break their engagement after taking the inventory. Adjustment to a new marriage requires a multitude of new tasks for each person. Among the many tasks that couples must master are establishing new routines for daily living, building new friendships as a couple, creating common goals, learning how to negotiate, and establishing a family budget.

See Exhibit 8.9 for addressing marital myths that still pervade pop culture.

Exhibit 8.9 Marital Myths

Myth	Fact
Your true love will automatically know what to say and do to make you happy	Communication is essential for successful relationships. Especially when there is conflict or disconnection. Your partner cannot read your mind and resentment can build if you are quietly hoping the other person will figure out what they did wrong.
There is one clear path in marriage, such as having kids	Couples should establish their own norms and sense of marital culture that works for them. There are no rules for marriage other than what the couple agrees upon. That includes making lifestyle decisions such as whether or not to have children.
Having kids brings couples closer together	Having children can bring couples closer together through a shared understanding and intimacy but having children also brings stress and other challenges, such as potential differences in parenting styles.
Differences will ruin your marriage	It is not the differences that destroy relationships but how you respond to your differences. At some point, couples will realize that there are differences between you, but you don't have to agree with your partner on everything. An important framing is to be curious about it, and try to understand where the other person is coming from.
Happy couples don't argue	Miscommunications are bound to happen, after all, a marriage of two people means two different family upbringings and expectations for relationships. In fact, when couples don't argue, they are more likely making emotional compromises that erode feelings of trust. It is important to use active listening skills and avoid power struggles to resolve arguments and move on.
Happy couples have to do everything together	Having shared interests is great but having your own interests is also great. It is important to feel supported in pursuing your own interests and goals in order to avoid feeling resentful or trapped.
Monogamy means boring sex and kills the passion	The intense lust at the beginning of the relationship is not the same as the excitement of a long-term relationship. However, emotional openness and the ability to express love in a secure relationship enhances sexual physical pleasure and can result in a deeper and more satisfying sex life.

*PscyhCentral 2016. Medically reviewed by Psych Central's Scientific Advisory Board

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In spite of these trends, many people still have an idealized notion of the "nuclear" family: a married couple with two or more children, the husband as the primary breadwinner and the woman as the homemaker. Yet it has been estimated that very few American families live this life. Our image of the American family needs to change. We need to recognize the influence of single-parent families, childless families, unwed parents, LGBTQ+ couples, dual-career families, and multicultural families, which reflect the reality of the diversity of families in the United States. Also, it is important to recognize that this diversity may be related to the larger influence of the economy and broader social changes.

Selecting a Partner

Finding a partner to whom you are willing to make a serious commitment is usually a gradual process. This process involves moving through a series of phases that leads to a deepening attraction and commitment (see Exhibit 8.10).

In phase I, opportunity plays a critical role in determining who is available to choose from as a partner. Opportunity will be influenced by the values of the young person's culture, family, and place in the social structure. For example, such cultural influences may produce opportunities for selecting a partner based on attendance at private schools, church groups, sporting events, or local neighborhood events. In the early stages, physical attraction and behaviors that are valued (e.g., being outgoing) are also important determinants in the selection process. According to the Pew Research Center (2020), online dating and finding a partner through dating apps is becoming more common. Almost half (48%) of adults aged 18 to 29 said they used a dating site or app in a survey conducted among 4,860 U.S. adults in 2019. Rates were higher among LGBTQ+ adults (55%). Almost one in five young adults (17%) said that they married or stayed in aIed relationship with someone they met online. Although there are other challenges associated with online dating, the majority of people felt it was at least somewhat easier to find potentially compatible partners.

Our culture now accepts more diverse notions of marriage, and weddings. These women are bringing gifts to a couple during a Cambodian wedding procession.

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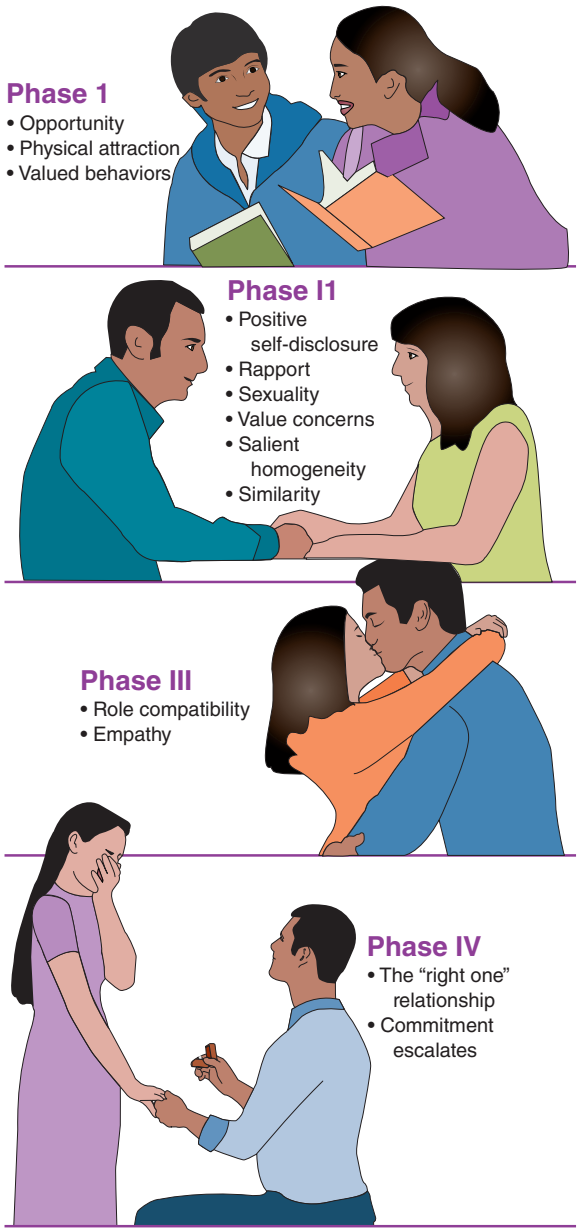
Exhibit 8.10 Phases Involved in Committing to Marriage



By the time young people move to phase II, they are focusing on a process of more intimate discovery. They might reflect on such questions as, "Who is this person, really? Is he or she similar to me?" Through reciprocal self-disclosure, each person learns more about the other. The information gained often is assessed in terms of similarities. For example, many people would consider similarity in religious faith to be an important factor in selecting a mate.

The transition to phase III is similar, but involves a deeper level of disclosure. Couples may share aspects about their sexual desires, personal fears, and life's dreams. In this phase, there is more trust and a greater level of risk as one shares increasingly intimate aspects of the self. This sharing leads to two central processes: role compatibility and empathy. The couple learns about the extent to which they are truly compatible and deepen their level of understanding about each other.

Finally, the couple reaches phase IV, where each partner is persuaded that this is the "right" relationship and each person takes steps to deepen his or her commitment to the other. Each partner has developed comfortable feelings and predictability. Furthermore, the couple is socially defined as being "together," so the costs of ending the relationship become much greater. Once a person has found the "right" partner, both must come together and begin the process of making an adjustment to marriage.

Empowering African American Families

To increase their effectiveness in working with African Americans, social workers need to recognize the potential of the client's extended family, spirituality, religion, and the African American community as a whole. Many practitioners who work with African American clients are treating the wrong people. The people who come into therapy, women and children, may be the least likely to effect change in the family. Instead, members of the extended family—the grandmothers and grandfathers, aunts and uncles, and fathers and boyfriends—should be targeted for change. For practitioners to increase their effectiveness, they must work with the people who traditionally have the

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Adjusting to marriage is a critical life task for many young adults.

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power in African American families. Unfortunately, many African Americans view therapy as something that "crazy, sick, White, or rich people" do—everyone but them. The challenge for social workers is to demonstrate to African Americans that they have something to offer them. How can this be done? Two approaches are bringing spirituality and religion into practice and bringing families together as a key source of help.

For many African American families, the psyche and the spirit are one. Therefore, some African Americans view psychotherapy as anti-spiritual because its theories do not include spirituality. Exploring religion in therapy and using it to help clients cope with trauma can be a key to working effectively with African American families.

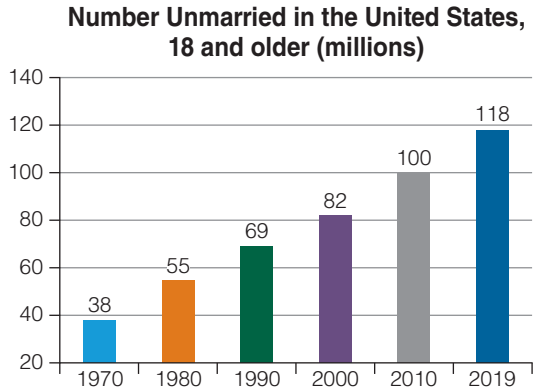
The pervasive threat of crime in low-income African American communities is a crisis that leaves people feeling increasingly vulnerable and isolated. It is not enough for practitioners to do family therapy one family at a time. The challenge for social workers is to find a way to bring families closer together and capitalize on the strengths of the African American community (Martin, 1995a). Black Emotional and Mental Health Collective (BEAM) is a national training, movement building, and grant making institution to help remove the barriers that Black people experience related to their emotional health care and healing. They use a healing justice framework to intervene and respond to generational trauma and violence facing Black and marginalized communities. According to their report in 2021, BEAM reached thousands of people all over the world through social media platforms and virtual offerings.

Remaining or Becoming Single

Many adults will remain single throughout their lifetime. Schwartzberg, Berliner, and Jacob (1995) validated the life stage of always single in their now classic book *Single in a Married World: A Life Cycle Framework for Working with the Unmarried Adult*. Although some young adults remain single throughout their lives, many become single after being widowed, separated, or divorced (see Exhibit 8.11). For whatever reason, being single has increased dramatically over the last 60 years. In the last 30 years, the percentage of men and women who remain single has doubled (more than doubled if we look at only young adults).

Many young adults who are single face difficult stereotypes and pressures. When the majority of the population marries, the question many single adults must confront is, "Why haven't you married?" There are many stereotypes about remaining single as an adult. For example, people often assume either that single people are uncommitted so they can pursue promiscuity or that they were not "good enough" to attract a mate. However, a Pew survey in 2019 found that half of single people (those without a committed partner, either married or unmarried) were not interested in a romantic relationship or even a date. The stereotyping, stigmatizing, and marginalizing of single people has been called out as rampant in the United States. As a result, "Singles Week" was created as an opportunity to celebrate unmarried and single people during the third week of September.

Exhibit 8.11 A Historical Look at Never-married Adults in the United States (U.S. Census Bureau, 2020).



Studies have attempted to examine the differences between single and married people. Although research has shown that single adults are worse off than married people, research has found that it is attributed to, at least in part, to less social support as well as more social discrimination and mistreatment compared to coupled adults (Girme et al., 2022).

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In recent years, the percentage of men and women who remain single has doubled.

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Being single may require some special adaptations. For example, socializing often occurs in couples, and the single person may be left out. Many single people feel lonely because they lack the constant companionship available in a marriage or a committed relationship. Single people may not want to go places or do things alone. A good network of friends can help eliminate these concerns. Lewis (2000) outlined the tasks that identify predictable issues for single adults, such as meeting basic needs, deciding about children, intimacy, making peace with one's parents, and preparing for old age.

LGBTQ+ Relationships

In the late 1940s and early 1950s, Alfred Kinsey reported the sexual histories of thousands of Americans. His research found that 8% of men and 4% of women were exclusively homosexual or gay (*gay* refers broadly to gay men and lesbian women) for at least a period of three years. In addition, 4% of men and 2% of women were exclusively gay after adolescence. A much larger percentage of the population had some previous experience with gay behavior—37% of the men and 20% of the women reported at least one gay experience that led to orgasm.

The myth exists that individuals are either gay or heterosexual. Kinsey's sexual-behavior studies, however, showed that one should view homosexuality and heterosexuality as a continuum. Exhibit 8.12 illustrates Kinsey's original idea that sexual orientation represented a seven-point scale.

More representative studies of the general population have estimated lower rates of gay behavior than did the early Kinsey studies. For example, Gallup polls (Jones, 2019) indicate that 7.1% of U.S. adults identify as lesbian, gay, bisexual, transgender, or something other than straight or heterosexual. Additionally, LGBTQ+ Americans are as likely to be married to a different-sex spouse (11%) as to be married to a same-sex spouse (10%). This is because bisexual adults are more likely to be married or living with a romantic partner of a different sex (32%) rather than someone of the same sex (5%). Over half of LGBTQ+ adults (53%) are single/never married and not living with a romantic partner. Many experts believe that these estimates are low because the tremendous amount of social prejudice that precludes many from self-reporting (and even self-acknowledging) same-sex attractions. Many experts place the estimate of the incidence of same-sex attractions as high as 10% for both sexes. Furthermore, the way one defines same-sex or homosexual behavior is going to have a large influence on how the prevalence is estimated. Individuals who do identify themselves as gay tend to be well educated. In fact, twice as many college-educated as high-school-educated men, and eight times as many college-educated as high-school-educated women stated they were gay. This difference may reflect the more liberal orientation among more educated individuals.

What determines sexual orientation? Some therapists believe it is biologically based, dependent on, for example, hormones and neurological factors. Other researchers have focused on genetic factors as determinants of sexual orientation, and they have shown that the concordance rates for homosexuality in identical twins far exceed that of fraternal twins or adoptive siblings (see Exhibit 8.13).

Research on the sexual abuse of children has not found an increased frequency of homosexual perpetrators, though LGBTQ+ perpetrators are more likely to be convicted and receive longer prison sentences (Meyer et al., 2022). Conversely, there is a plethora of research to indicate that LGBTQ+ people are at greater risk of being victims of sexual assault (Farahi & McEachern, 2021). None of these findings support the view that homosexuality is caused by trauma in early childhood or poor parenting; rather, it is a complex interplay of genetic, hormonal, and environmental influences. It is a normal and natural variation of human sexuality that is not a source of negative psychological effects; rather, it is the pervasive and systemic poor treatment of people who are

Exhibit 8.12 Continuum of Heterosexuality and Homosexuality

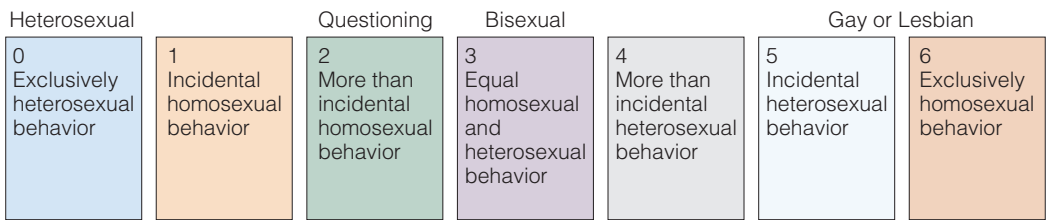

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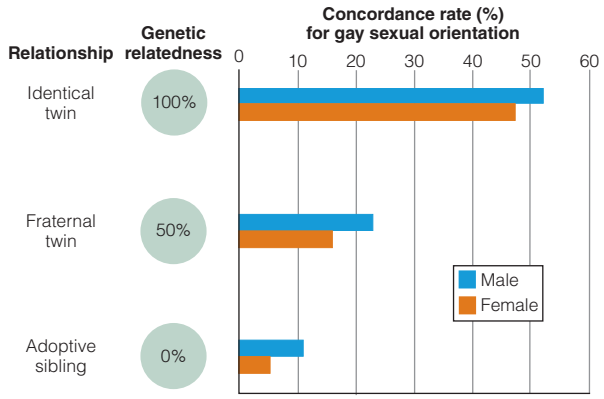
Exhibit 8.13 Concordance Rate for Sexual Orientation



LGBTQ+ that result in increased incidence of poorer mental health (Schulman & Erickson-Schroth, 2019). There may be as many as 25 million gay people in the United States. How do gay couples differ from their heterosexual counterparts? In *Gay Marriage*, Jonathan Rauch (2004) reports that gay men and women and heterosexual men and women are quite similar in what aspects of intimacy they value.

Gay couples do, however, have to face a different reality concerning their relationship. The Defense of Marriage Act was signed into law in 1996, defining marriage by the federal government as between a man and a woman. Marriage law touches nearly every aspect of monogamous relationships, including domestic partner benefits, rights of visitation, medical decision-making, survivorship, child custody, immigration, and funerals. However, the *Obergefell v. Hodges (2015)* landmark decision by the U.S. Supreme Court held that same-sex couples have the fundamental right to marry. Previously, most employment benefits for domestic partners did not provide for full equity, and child custody and inheritance also were not available for gay couples. As a result, gay couples were denied many economic benefits and rights available to heterosexual couples because they lacked the rights and privileges that are associated with marriage. The overturning of *Roe v. Wade* in 2022 generated concern for other rights, such as those for LGBTQ+ people. As of the end of 2022, legislation was advancing that would provide federal protections for same-sex and interracial marriages. Called the Respect for Marriage Act (RFMA), it would repeal the Defense of Marriage Act and require that all states recognize same-sex marriages performed in other states and would create additional federal protections for such unions.

The White House released the statement: "The right to marriage confers vital legal protections, dignity, and full participation in our society. No person should face discrimination because of who they are or whom they love, and every married couple in the United States deserves the security of knowing that their marriage will be defended and respected."

Homophobia

Homophobia is an irrationally negative attitude toward gay people. LGBTQ+ people often are depicted in terms of negative stereotypes. Factors that appear to be related to homophobia include authoritarian perspectives, highly religious views, being with others who share negative views toward gays, and not having had any personal contact with LGBTQ+ people. In recent years, homophobic attitudes, as well as the fear of AIDS, which increased the visibility of gay people, have led to many gays being harassed or even assaulted.

Homophobia exists in all aspects of society. Many gay professionals, including doctors, social workers, and lawyers, believe that they need to conceal their gay identity (Gabrani & Pal, 2019). Gabrani and Pal's letter to the editor explains, "Many LGBTQ physicians still report social ostracization in the workplace, as well as harassment by colleagues and patients/the community… [Workplace] incidents are a nagging reminder of how LGBTQ people continue to be perceived as different, as somehow diminished, on account of their sexuality" (p. 753).

The good news is that there is movement federally that would enhance protections for LGBTQ+ people. The Equality Act was passed by the House in 2021 (117th Congress, available at https://www.congress.gov/bill/117th-congress/house-bill/5) and would prohibit discrimination based on sexual orientation, sex, and gender identity in all aspects of employment, public accommodations and facilities, education, housing, credit, and the jury system. More than 80% of Americans support the Equality Act, according to a 2020 survey from the nonpartisan Public Religion Research Institute. The same survey found that the majority of Republicans, Democrats, Independents, and people from all major religions support laws that protect LGBTQ+ people from discrimination.

Internalized Homophobia

Why do some lesbians, gay men, and bisexuals seem to easily ignore society's prejudices toward their sexuality, whereas others absorb the bigotry to the point of

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self-loathing? This self-loathing, called ***internalized homophobia***, exists when a gay man or lesbian has negative feelings about their own homosexuality or bisexuality. It can be associated with depression, low self-esteem, or extreme defensiveness, and it can impair a person's capacity for intimacy. Researchers have identified populations that have lower rates of internalized homophobia. They are (1) people who are more open about being gay or bisexual with their friends and acquaintances, particularly with heterosexuals; (2) women who have told their partners about their sexual orientation; (3) people who have a strong support system both within and outside the LGBTQ+ communities; and (4) gay and bisexual men who told their mothers about their sexual orientation. Researchers note that internalized homophobia may actually be a common, albeit painful, path of development for LGBTQ+ people living in a homophobic society.

A revised five-item version of the internalized homophobia scale was developed to assess the internalized stigma related ones on sexual orientation that is inclusive of gender (Huynh, Sheridan, & Lee, 2020). Renamed the internalized heterosexism scale, it is associated with LGBTQ+ people's mental and physical health, as well as their overall psychological adjustment. The measure can be used by social workers to assess progress in treatment, with the goal of adopting more positive views toward one sexual identity. Clients respond to each statement on a four-point Likert scale (strongly agree to strongly disagree):

1. Wish to not be L/G/B
2. Tried to stop having same-sex attraction
3. Would be heterosexual if given a choice
4. Being L/G/B is a personal shortcoming
5. Want to get professional help to change sexual orientation

Practice Guidelines:
Working with Homophobia

How can social workers help clients with internalized homophobia? Some approaches may include the following:

- Discuss the patient's early experience and the ways they adapted to or repressed their gay feelings.
- Challenge the client's assumptions or beliefs about gender roles.
- Examine your own assumptions about gender roles to make sure you are not presenting a traditional role as the only acceptable alternative for the client.
- Be a role model. If you are part of the LGBTQ+ community and have dealt with and overcome your own internalized homophobia or self-contempt, you provide a positive model for a LGBTQ+ client struggling with similar issues.

Researchers admit that more research is needed to explore ethnic, cultural, and socioeconomic differences in internalized homophobia, as well as the role it plays in substance abuse, domestic violence, and suicide among LGBTQ+ people.

Transition to Parenthood

Carrying the baby horizontally across my chest like a football usually calms him and often puts him to sleep. But not tonight. He's still crying, cycling through his whole repertoire: the screechy fear cry; the lower, throaty demand cry; the pitiable gasping interspersed with slobbery whimpers. Kapa nursed him an hour ago at midnight, so he isn't hungry. Teething—always a suspect—doesn't seem to be the problem tonight: he isn't drooling much, nor is he clawing at his ears. I may give him a dropperful of Tylenol anyway, to help me relax.

—C. Goodrich

As this scene depicts, the transition to parenthood brings many changes and new challenges. Consider all the adaptations the new parent must make. Parents must now accommodate changes in priorities, as they have less time to spend on career and personal interests. Indeed, the loss of free time appears to be the most difficult adjustment for parents. How will the new household tasks be divided between the parents? Many parents struggle to find the time and energy needed to keep their own relationship satisfying in terms of intimacy and companionship. The transition also must include their adaptation to a new role—that of parent. What makes a good parent? What kind of parents do they want to be?

These life changes are usually accompanied by a significant increase in stress (Kuersten-Hogan & McHale, (2021). and may shape health trajectories in midlife for both mothers and fathers (Saxbe, Rossin-Slater, & Goldenberg, 2018). The crying baby and the new demands of diapers, bottles, and laundry combine to create a stressful environment for many new parents. Mothers can

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be uniquely affected, and they often enter parenthood exhausted from the birth process. For older mothers and working mothers, the transition to parenthood often is more difficult and stressful (Oyarzún-Farías et al., 2021). Women are particularly vulnerable to distress when they are the infant's major caretaker and when they have babies with difficult temperaments. Physical and mental health problems often peak in the transition to parenthood (obesity rates, depression) and are exacerbated for parents that do not have sufficient access to protected and paid time off work (Saxbe et al., 2018). Curran (1985) surveyed married couples and single mothers to identify what parents perceive to be the most stressful aspects of their lives. There is a remarkable consistency in what parents view as stressful almost 40 years later. He identified the following top 10 stressors, listed in order of priority:

1. Economics, finances, budgeting
2. Children's behavior, discipline, sibling fighting
3. Insufficient couple time
4. Lack of shared responsibilities in the family
5. Communicating with children
6. Insufficient "me" time
7. Guilt for not accomplishing more
8. Spousal relationships (communication, friendship, sex)
9. Insufficient family playtime
10. Overscheduled family calendar

The Perceived Stress Scale is the most widely used psychological instrument to evaluate perceived stress., and can be used to help parents assess their stress levels during this transition time The four-item version (PSS-4) takes less time to complete than the original 10-item version, and asks clients to reflect on how often the following thoughts and feelings occurred over the last month on a scale from 0 (never) to 4 (very often). Higher scores are correlated to more stress (Cohen et al., 1983).

1. In the last month, how often have you felt that you were unable to control the important things in your life?
2. In the last month, how often have you felt confident about your ability to handle your personal problems?
3. In the last month, how often have you felt that things were going your way?
4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Preparing for the Transition to Parenthood

How can we make the transition to parenthood less stressful? Jay Belsky and John Kelly (1995) have recommended that parents be helped to reach realistic expectations about parental responsibilities. This recommendation is based on the finding that stress is highest in new mothers who have overestimated the benefits of their new mothering role and underestimated the difficulties associated with their new role. Mothers with optimistic perspectives about what it is like to be a parent tend to experience more distress, because their expectations need the greatest amount of realignment. Prospective parents could be greatly helped by better education about what parenting is like. Once they understand that although children are "bundles of joy," they can also be "bundles of stress," parents can develop more realistic expectations and be in a better position to cope effectively with their new role as parents.

One factor that is particularly powerful during this time is social support. When a mother has a good supportive relationship with her husband or partner and he shares the burden of care and household responsibilities, stress is significantly lower than when the mother has no partner or an unsupportive one (Demo & Cox, 2000). Social support from family and friends is also a buffer to the stress new parents experience, which can be a challenge for families living long distances from extended family.

LGBTQ+ Parents

An increasing number of parents do not fit the stereotypical mold of "mom" and "dad." Today, several million LGBTQ+ people are parents. Many have children from a previous heterosexual relationship that did not work out, but an increasing number of LGBTQ+ parents have emerged because of adoption and new reproductive technologies. In addition, the practice of divorce judges giving custody automatically to the heterosexual parent is decreasing, as many states have issued opinions that sexual orientation is not relevant in making custody decisions (Berk, 2013).

Much debate has centered on whether LGBTQ+ parents could be adequate parents because of their sexual orientation. With increased acceptance of the LGBTQ+ community, this question is being asked much less frequently. Research studies have shown that LGBTQ+ parents are as committed to and as effective with children as are heterosexual parents. Children of LGBTQ+ couples are no more likely than children of heterosexual parents to develop a gay or bisexual orientation—more than 90% of

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Increasing numbers of gay and lesbian couples are becoming parents.

the children of LGBTQ+ couples are heterosexual (Golombok & Tasker, 1996). One study (Bigner & Jacobsen, 1989) found that gay fathers were more responsive to their children's needs than were heterosexual fathers. The authors theorized that the gay men's less traditional gender identity allowed for a greater involvement with the children.

In summary, parenting by LGBTQ+ people is similar to that of heterosexual parents. However, LGBTQ+ parents do experience less social support for their parenting (Berk, 2013) and their children may experience stigma.

Of course, regardless of sexual orientation, not all couples are interested in having children. A large number of couples choose not to have children.

Choosing to Be Childfree

An increasing number of married couples choose not to have children. This change is most likely the result of women seeking career opportunities, marrying at a later age, and concerns about climate change and the environment. However, the most common reason people say they don't want to have kids is that they just don't want to. Over half (56%) of nonparents aged 18 to 49 said that this is the reason they probably won't have kids, according to Pew Research data in 2021. Fertility rates were at a record low in the United States, even before the pandemic began, which was associated with a "baby bust." The overall birth rate in the United States was 4% in 2020, which was an 8% decline from the previous year. The percentage of women who never expect to bear children is about 16.5%, according to 2020 U.S. Census data. Given that a large number of couples decide to be voluntarily childfree, how do they compare with couples who have had children? Overall, they do quite well. A systematic review of the literature finds that childfree people generally have a positive life satisfaction (Stahnke et al., 2022). Stigma toward childfree adults still pervade and people with children, or people who want children, tend to view childfree people less positively (Watling Neal & Neal, 2021). Therefore, it is important for social workers to use strengths-focused language such as "childfree" rather than "childless" adults.

Infertility

Infertility is defined as the inability to achieve pregnancy after one year of sexual intercourse with no contraception. It is estimated that about one in five women are unable to conceive after one year of trying to become pregnant (CDC, 2022). The chances for a pregnancy in healthy couples who are both under the age of 30 and having sex regularly is 85% within one year. A woman's peak fertility occurs in her early 20s. As a woman ages beyond 35, the likelihood of her getting pregnant drops to 66% (44% at the age of 40) within one year (Delbaere, Verbiest & Tyden, 2020). Some of the recent rise in infertility is attributable to an increase in sexually transmitted diseases, which can result in pelvic inflammation and adhesions, and to the fact that couples now delay childbearing into their 30s. Female fertility decreases after age 30, and male fertility drops after age 40. Thus, couples who delay childbearing may pass up their most fertile years and later experience difficulties conceiving.

Infertility has several causes. Male abnormalities contribute to 40% of the cases of infertility, and female problems constitute another 40%; in the remaining 20% of cases, there is no ascertainable reason the couple cannot conceive. In males, the problems of infertility involve having a low sperm count, having abnormally formed sperm, or having sperm with low motility (i.e., the sperm are unable to make the journey through the cervix and uterus to the fallopian tube). Heavy alcohol use, smoking, cancer treatment, trauma to the testes, and certain medical conditions, such as diabetes, may contribute to this.

In females, menstrual cycles can result in infrequent or absent ovulation. Cervical mucus, which is hostile to sperm, can prevent migration of the sperm through the cervix. The fallopian tubes may become blocked from a past pelvic infection or inflammation from *Gonorrheal salpingitis*, or from the pelvic adhesions of endometriosis

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(a condition that arises when pieces of the lining of the uterus become attached to structures in the abdominal cavity, including the fallopian tubes). Uterine problems such as fibroids, congenital malformations, and intrauterine adhesions can keep a fertilized egg from implanting. Similar to male infertility, smoking, excessive alcohol use, being under- or overweight, and stress can contribute to infertility.

Miscarriage

Mei Ling and Kim were thrilled when they learned that Mei Ling was pregnant. Mei Ling told everyone—her coworkers, friends, neighbors, and family—that she was pregnant. The couple began to look at baby items in stores and to plan how they would decorate the nursery. Eleven weeks into the pregnancy, however, late one afternoon at work, Mei Ling experienced some lower abdominal cramping. After dinner that night, she felt increased cramping and began to have vaginal bleeding. Mei Ling called her doctor, who told her to go to the hospital. There, later that evening, Mei Ling miscarried. Mei Ling and Kim were devastated by the loss, but their doctor assured them that they were young and could try again soon. The nurses gave Mei Ling a booklet about coping with fetal death, the number of a support group to call, and a satin-covered box containing a small gold ring. The couple was encouraged to name the baby and to have some kind of memorial. They hardly had time to cry. Kim returned to work two days later, and Mei Ling took a few days to recover. Two weeks after the loss, friends and family stopped asking Mei Ling how she felt. One month later, the couple had a major argument after Mei Ling accused Kim of not caring about their baby. After this blowup, they decided to attend the support group. Their first question was, "How long does this pain last?"

Often in a hospital or a clinical setting, a social worker is called on to support families who suffer a fetal loss. To many couples, an early miscarriage can signify the loss of a child. Even at the beginning of pregnancy, most couples have dreamed of and planned for their expected child. The mother, especially, has fantasized about the baby she will have, and the loss of that dream is very real and painful. At any stage of pregnancy, mourning a perinatal loss is difficult, though, because there is so little concrete evidence of the child's existence. It is hard for a mother to identify with a child she has only interacted with through fantasy. It is hard for friends and family to understand the pain of the loss of someone they never knew. It is difficult to grieve for someone who never lived. As a consequence, many couples who experience a fetal loss lose not only their dream but also their right to mourn.

Often, because this situation involves coping not only with one's own grief but that of one's spouse, partners experience at least one episode of intense conflict following perinatal loss (Kersting & Wagner, 2012). Men and women grieve a fetal loss in different ways. Fathers report less intense grieving and for shorter periods than their partners. Because of the shorter period of intense grief that fathers experience, mothers may believe that their partner is unfeeling and not adequately mourning the loss, and fathers may conclude that their partner is dwelling on her grief instead of getting on with life.

The couple needs to recognize that the fetal loss is the loss of a real baby and all the dreams and fantasies surrounding it. The couple should be encouraged to mourn adequately before attempting another pregnancy. Attempting to have a second pregnancy to replace a perinatal loss is likely to result in unresolved grief. First, the couple should be encouraged to see the body, name the baby, make a book of memories, and have a memorial service (DuBois, 2006). The hospital can attempt to provide the family with evidence of the child's existence by providing a photograph, a lock of hair, a footprint, or whatever the couple wishes to keep. Most important, the couple should be allowed the time and opportunity to express their feelings about the loss. They should be helped to understand and accept that each person grieves loss in his or her own way. But for some who ask, "How long will the pain last?" the answer is often, "A long time." The March of Dimes and Now I Lay Me Down To Sleep are two national nonprofit organizations that specialize in helping families grieve the death of a baby.

Communities and Support Systems

Work Life

In young adulthood, a person's career or job can become a significant part of the person's self-identity. Often, a person's self-definition is related to what he or she does. Levinson (1986) describes the process of young adults entering an occupation whereby they must develop an occupational identity and establish themselves in the work world. Each job carries with it a set of components that

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must be adapted to for successful adjustment in the workplace. Newman and Newman (2014) describe four of these components: the use of technical skills, the development of authority relations, the adaptation to special demands and hazards, and the development of interpersonal relationships with peers. As young adults make important inroads in their careers, they may also be starting a family. Achieving a balance among one's career, leisure, and family lives is a developmental task that needs to be addressed during this period.

The psychological importance of what people do vary, and it is important to understand the difference between a job and a career. Many people pursue a job in order to earn a living. Therefore, their job may not have much value to them from a psychological perspective. Other people pursue a career more as a way of life. Their career may have significant value to them because it is a central aspect of their identity. Not everyone has the opportunity to pursue a career, so adapting to young adulthood can be very different depending on whether one is entering the workforce for a "job" or a "career." However, job security is important to young adults. Using U.S. Census Bureau data of 18- to 26-year-olds during the COVID-19 pandemic (June 15–June 30, 2020), Ganson and colleagues (2021) found that employment loss, or expected employment loss, was associated with poorer mental health. That is, feeling uncertain about work and employment in young adulthood elevates symptoms of anxiety and depression (Ganson et al., 2021).

Women and Work

The role of women in the workplace has changed dramatically in recent decades. The majority of married women with children under the age of six work outside the home. Although the role of women has changed dramatically, the reality is that the workplace is still quite different for men from what it is for women, for whom discrimination and inadequate opportunities remain significant obstacles. Particularly significant is the fact that women still experience job segregation on the basis of gender. Some jobs are considered "male," and some are considered "female." Many of the major professions—computer programming, electrical engineering, accounting, and law—are dominated by men. Of course, employees in female-dominated professions earn less than employees in male-dominated professions, even when skill levels and responsibilities are similar. The separation between men's and women's work evokes many questions about larger issues. Is this a result of the economics of capitalism? Or is it, as some assume, part of the need for women to be a part of an underclass that supports our current economic structure?

George Rudy/Shutterstock.com

Roles for women in the workplace have changed dramatically

Currently, the percent of women in the U.S. labor force is 57.5%, the lowest it has been in the last 30 years, according to U.S. Census data (see Exhibit 8.14). Women were much more likely to drop out of the workforce to take on the burden of additional childcare responsibilities when day cares and schools closed during the COVID-19 pandemic, and it is unclear how many will come back. If they do return, they face the potential of earning less than they did before they left, similar to what happens when women take off time to have a baby. Those periods of nonparticipation contribute to the gender wage gap. Black and Hispanic women, and women in low-wage jobs, are facing the greatest difficulties returning to the workforce and are least likely to have access to federal supports.

Housing

Many young adults are interested in buying a home, and many buy their first home in the young adult period. However, fewer people are able to afford it. According to the National Association of Realtors, the median age of first-time home buyers in the United States in 2019 was 33 years old, five to six years later than first-time home buyers in 1981. Based on a Bankrate survey of 2,530 adults in March 2022, 65% of Millennials and 59% of Gen Zers viewed owning a home as a top sign of success, as important as having a successful career (60% of all U.S. adults). Both a lack of affordability and rising home prices contribute to fewer young people owning homes today. One-quarter of Millennials also said that their credit scores

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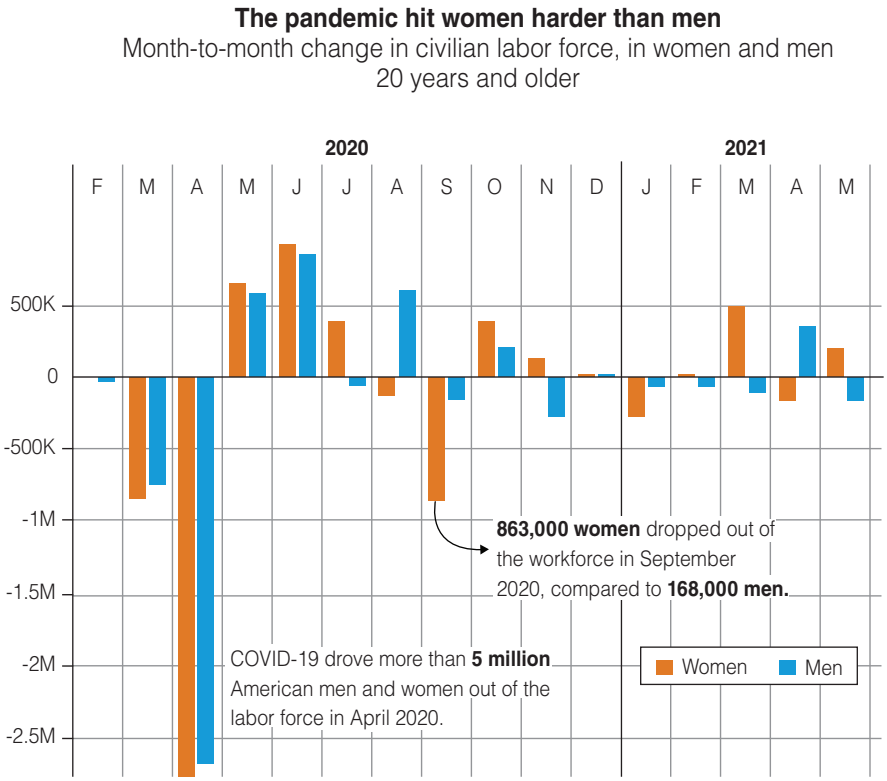
Exhibit 8.14 The Impact of the Pandemic on Women in the Workplace



Source: U.S. Bureau of Labor Statistics

were a barrier to securing a mortgage loan for a house. See Exhibit 8.15 for profiles of owners and renters based on the 2021 U.S. Census data.

Volunteerism and Social Services

Have you ever felt the satisfaction of knowing that you helped someone by your volunteer efforts? You are not alone. Over 1 billion people volunteer worldwide and an estimated one in four Americans are volunteers. Volunteering confers many acknowledged benefits. It helps build a sense of community, breaks down barriers between people, and often raises the quality of life for all involved. Some types of volunteer activities seem consistently successful; the most obvious example being the outpouring of help that occurs after natural disasters. It is estimated that the COVID-19 pandemic resulted in around 11% of volunteer operations in the United States closing their doors.

But we have to ask: If there are really over 60 million volunteers in our country, why are our cities in worse shape than they have ever been? Few of those millions of volunteers, just 8.4%, work in "human services," a broad category that includes aiding the unhoused, family counseling, and serving as tutors or mentors. But the problems of troubled children, needy seniors, and those with low income require exactly this kind of volunteering. It must be performed one on one, over a long period of time, and often in low-income neighborhoods. And for this type of assistance, there is a shortage of volunteers.

Why are supply and demand so misaligned? The simplest explanation is that volunteers sign up for reasons other than the urgency of social problems. Volunteers say they participate because (1) they were asked by someone, (2) they learned of an opportunity through an organization to which they belonged, or (3) a family member or friend would benefit as a result.

Economic realities also shape the choices volunteers can make. The backbone of volunteer involvement in the past was stay-at-home mothers with flexible schedules. Now many families have both parents working, and whatever spare time is left over must go to the kids. "I don't think it is a question of people not wanting to volunteer; it is a question of how, where, and can I do it in a way that fits in my schedule," according to the vice chairwoman of

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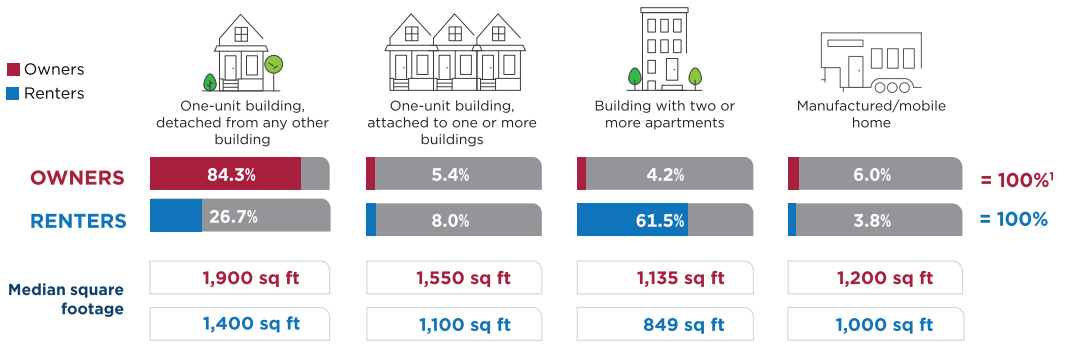
Exhibit 8.15 Profile of Homeowners and Renters

PROFILE OF OWNERS AND RENTERS

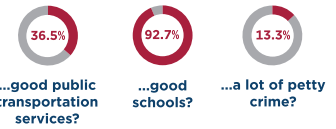
AMERICAN HOUSING SURVEY

What kind of homes are owners and renters living in?

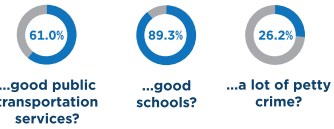


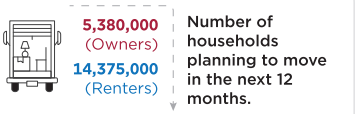
[1] Percentages may not add to 100 percent due to rounding.

Do owners agree that their neighborhood has...

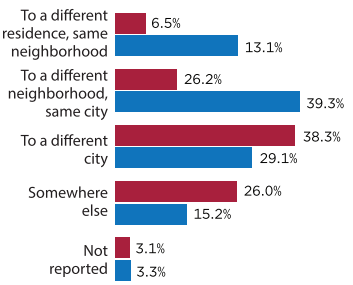


Do renters agree that their neighborhood has...





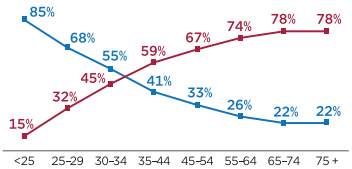
Where are owners and renters planning to move?



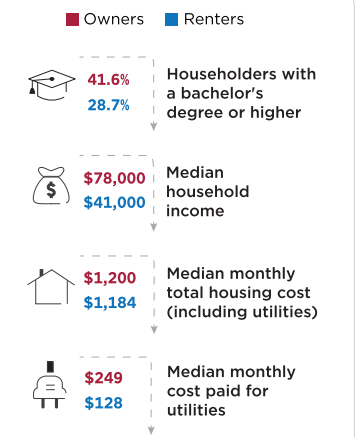
What do we know about owners and renters?

Demographic and housing cost data collected in the American Housing Survey make comparisons of household characteristics and costs of owning versus renting possible.

Percentage of owners and renters by age of householder[1]



[1] Percentages rounded to the nearest whole number.



Note: Information on confidentiality protection, methodology, sampling and nonsampling error, and definitions is available at <www.census.gov/ahs>.
Source: https://www.census.gov/library/visualizations/2022/demo/2021-profile-of-owners-and-renters.htm

United States Census Bureau
U.S. Department of Commerce
U.S. CENSUS BUREAU
census.gov

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

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City Cares of America, a group that matches busy people with appropriate volunteer opportunities. Baby Boomers are more likely to be volunteers than any other generation.

Partly because the number, 100 million volunteers, is so impressive and inspiring, some politicians think that churches and charities, not government, should provide more of the social safety net for welfare reform. Supporters of turning over social programs to churches and charities say their plan will reawaken American passion. Religion, they say, is often crucial to turning lives around, and charitable organizations are often more efficient and effective than government programs. Furthermore, Americans give billions of dollars to charities, and the amount of giving has increased over the past decade. Opponents contend that counting on charity would ignore history. The social safety net grew precisely because churches and charities could no longer deal with the entrenched poverty. Additionally, charities are already overburdened trying to respond to existing cuts in government spending for people living in poverty or for people with disabilities Finally, nonprofit organizations are not a substitute for government, because government provides about one-third of the funding for charities.

It is one thing to celebrate volunteers. It is another thing to depend on them to fill the gaps in welfare and other government programs. In this light, it is not the thought that counts. Volunteerism is often understood as a virtue, but now it should also be understood as a market. And viewed that way, it is an inefficient one. Most volunteers are not deployed effectively to solve the hardest and most critical problems. In fact, the majority of the 60 million volunteers do informal volunteering: babysitting for a neighbor, baking cookies for a school event, singing in the church choir, or serving on community boards. Volunteer management is often poor, and amazingly little is known about which volunteer programs really work. To an extent rarely acknowledged publicly, the volunteer sector is not ready for the responsibilities politicians want to thrust upon it.

Multicultural, Gender, and Spiritual Considerations

Multicultural aspects of young adulthood are many and varied across different cultures. However, the development of one's career or livelihood is an important task that has clear multicultural aspects. In particular, unemployment rates are critical among African Americans, Hispanics, and AIAN. Many young adults in these groups value the family but are frustrated in their attempts to provide for their families because of limited opportunities. Additional issues among different cultures as their members face adulthood include alcoholism among AIAN, acculturation for Asian Americans, the stereotype of the African American as violent, and the increasing significance of African American females as the heads of households. Exhibit 8.16 presents some of the unique challenges that may confront AIAN, African American, Hispanic American, and Asian American adults.

Exhibit 8.16 Challenges Confronting People of Color

Ethnic or Racial Group	Unique Challenges Confronting Adults
Native Americans/Alaska Natives	Many of their unique problems stem from a history of discrimination, broken treaties, and prejudice. Poor academic attainments (only 57% are high school graduates). Extremely high unemployment rates. Language problems have affected progress. Stereotypes promoted by TV and movies.
African Americans	Dialect differences have challenged them. The stereotype of the "violent Black" is influencing their social progress. Poor academic progress and lack of social progress. Social conditions that are detrimental to self-improvement such as discrimination, racism, and lack of opportunities.
Asian Americans	Language problems have been a challenge. The "model minority" stereotype. With acculturation, family roles and expectations can conflict with the White American culture. Value changes in family relationships can lead to a schism between younger and older generations.
Hispanic Americans	Language problems are critical because many Hispanics speak only Spanish. Poor academic progress and lack of social progress. Improvement in middle-paying and high-paying jobs. Lack of appropriate skills for coping in the dominant White society and with discrimination and prejudice.

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Blending Religions

The variety and abundance of the world's major religions seems to show that there are many paths to God. For the last 2,000 years, when most people lived in villages, if those paths crossed, a holy war was more likely to break out than a wedding. But in America today, we have a unique society in which the person next door may believe in one of many religious beliefs; our "paths" are crossing more than ever. For example, the proportion of Jews who married Gentiles—about 1 in 10 around the first half of the 20th century—doubled by 1960, doubled again by the early 1970s, and in this decade has leveled off at around 50%. Millennials are more likely to have been raised in households with two different religious identities than previous generations (27% compared to 20% of Gen Xers and 19% of Baby Boomers, Pew Research Center, 2016). And as these couples raise their children, they are, in effect, creating a new form of religious identity in America.

Expecting children to choose either their mother's or father's religion may put them in the position of rejecting one of their parents. These children also may feel inferior to their cousins or friends whose families share a single religion (Adler, 1997). To remedy these dilemmas, some couples choose one religion to raise their children in, others expose the children to both or to a variety and let the children choose, and still others blend their religions to make a third one. Research shows that children are more likely to identify with their mother's religion as their own, though this may not be that surprising given that mothers are also more likely to be responsible for the religious upbringing (Pew Research Center, 2016).

A complicated aspect of parenting is finding how to integrate what both parents believe religiously into an agreeable plan for the whole family.

Gender Roles

In young adulthood, women confront two significant role expectations (Weiten, Dunn, & Hammer, 2015): the marriage mandate and the motherhood mandate.

The marriage mandate says that to be a successful heterosexual female, you must find a marriage partner. In fact, part of being a young adult is having gotten married. Some researchers believe that the fact that a significant number of lesbians previously were married to a man is evidence of the power of the marriage mandate.

The motherhood mandate says that a successful adult woman also must bear children and become a mother. The mandate further suggests that it is important to have two children, with one of them being a son. The woman also should be a "good mother."

What is it like for women who do stay home to take care of the house and children? Higgins and colleagues (1964), in their classic work, referred to this scenario as the "intelligent-housewife syndrome." Professionals misleadingly characterized women's unhappiness as female neurosis rather than oppression (Adams, 2020). In general, women who stay at home have greater psychological adjustment problems compared with either employed husbands or employed wives (Durak et al., 2022). Stress, loneliness, and burnout have been implicated in this relationship.

Two other factors may help explain why women are less happy when they occupy the homemaker role. First, these women are socially isolated. It may be difficult, especially in our postmodern world, for them to find meaningful connections with others on a day-to-day basis. Second, the important role of homemaker and mother, rather than being highly valued by our society, carries a negative connotation, and therefore the status of the homemaker is low.

Gender expectations and stereotypes can be negative and destructive for women and men. Many young adults are committed to discarding such expectations, focusing instead on qualities that are valued by everyone. For example, Carol Tavris (1992), in her book *The Mismeasure of Woman*, has examined the dominant male viewpoint and challenged this as a standard for what is normal for both men and women. She argued for an expanded view of what it means to be human and recommended a move away from the typical "us/them" perspective used when discussing gender issues.

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Women who stay home to take care of their children face special challenges.

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One consistent expectation: women do most of the childcare and housework. Because the roles men and women play in the family have changed dramatically in the last 30–40 years, many experts look to changes in childcare and housework when assessing the significance of the changes—for example, are men doing more of these activities than in the past? Studies have found that, yes, husbands have increased the amount of time they spend doing family work, by about 25%. However, husbands' participation in family work continues to be about one-third that of their wives.

Social Strengths, Hazards, and Risks

Young adults embrace many aspects of their social world. Building stronger friendships, establishing intimacy and perhaps marriage with another person, engaging in the world of work, and forming families: these are all important social strengths. Young adults can build good communication skills that will help them obtain stronger and longer-lasting marriages, and form friendships and mentorships that will lead to a stronger positive sense of self. Erikson's notion of intimacy versus isolation provides a guideline for consideration of strength. Much can result from reaching out to others and building relationships that help young adults confront many of the demanding tasks that lie ahead of them. The "social capital" of this life stage comes from such relationships, as they provide individual, psychological, and social benefits.

This chapter on young adulthood began with a description of a new phase in the life cycle—emerging adulthood, or early adulthood. It is fitting to end the chapter's section on social hazards with some information about one of the main reasons why young adulthood has been extended. Work by economists Smeeding and Phillips (2002) found that 70% of American men aged 24 to 28 earned enough income to support themselves, but fewer than 50% earned enough to support a family of three. The social significance of this is clear: to obtain a decent standard of living requires a college education. One of the main reasons for a prolonged early adulthood is that it takes longer to secure a full-time job that will provide enough income to support a family (Furstenberg, Kennedy, McCloyd, Rumbaut, & Settersten Jr., 2004). Over the past 30 years, research has turned attention toward how well American young people are making the transition from school to adult roles in work and family life, and the conclusions are that the transition is particularly difficult for the forgotten half—non-college-bound youths. There is declining economic fortunes of young adults, and people of color are substantially worse off than Whites. This decline in earnings is a result of changes in the economy that have created a deterioration in real earnings.

How can there be earnings losses for Americans? This happens when the amount of money someone earns does not keep up with living costs. It simply costs a lot more to live today than it did 10 to 40 years ago—and how much you can buy for your money is substantially less. For example, 40 years ago a lower-income family spent about 35% of their income on rent and utilities, but today those essentials cost families about 50% of their family income. The same is true for those who can afford a house—whereas mortgage payments used to cost about 25% of one's income, today 50% or more of one's monthly income may go to the mortgage.

These facts mean that supporting a family is a lot harder for a larger percentage of American society today than it was in the past, particularly for young people who are not college bound. Coupled with this loss of earnings is the fact that good job opportunities are shrinking for young people, and this is especially true for youth of color. Decline in earnings is the primary reason the percentage of families of color that live below the poverty line has increased so dramatically.

American society needs to work toward better compensation for non-college-educated youth. The William T. Grant Foundation has concluded that "the American people should set as a conscious goal of public policy the improvement of employment and earnings levels for all workers, not the least those lacking college education." This point is even more urgent today, because in addition to a loss of buying power come longer work hours to make up for lost income, fewer total jobs because of outsourcing, and fewer good jobs for those who lack a college education.

Welfare Reform

Millions of American families hold two or three jobs but still cannot afford necessities, and they see little relief ahead. "Welfare reform" is on many people's lips, but those working with low income (i.e., those working at least 27 weeks a year but whose income still falls below the poverty level) receive little or no attention from politicians or policies. Although welfare reform has lifted millions of people off the dole and into the workforce, many will join the 10 million Americans who hover one

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rung above poverty on the nation's ladder of opportunity. The difficulties of living on a low income were well described in Barbara Ehrenreich's (2001) book *Nickel and Dimed: On (Not) Getting By in America*. She set out to experience how to get by on a low-income wage. The bottom line: It wasn't easy. People with low income must stretch groceries from one paycheck to another and have no savings. They ride the bus to discount stores and do not bother to clip coupons because the generic products are still cheaper. And, because they cannot afford health insurance, they can be wiped out and pushed into poverty by even a minor medical problem. (Two-thirds of the over 40 million Americans with no health insurance live in families with full-time workers.)

In some cities, one-quarter of the people who call local hotlines for the unhoused are employed: they include schoolteachers, chefs, computer maintenance workers, and airline flight attendants. The standard recommendation is that a family should budget 30% of its income for housing. Among those working with low income, 70% is more typical. The working poor may not expect much from government, but at a minimum, they wish the government would not make their hard lives even harder. Unfortunately, many of those working with low income say that they are too discouraged to go out and vote because it is so easy for politicians to ignore them. As some people feel, "Now everything goes up except people's wages. Either you're rich or you're poor" (Gibbs, 2004, p. 17). Unfortunately, most people fail to recognize that poverty affects us all.

Social Workers in Managed Care Systems

Managed care, as a cost-containing system of healthcare administration, is here to stay. However, this leaves the most vulnerable populations—people living in poverty, people of color, women and children, and seniors—on the periphery. The populations in greatest need are often selected out of managed care systems because their high-risk status (poor nutrition, inadequate income, lack of prenatal care, substandard housing, minimal preventive care, and so on) ensures increased costs of care. Specific communities (certain rural and urban areas) are less likely to be served.

So what can social workers do? Primary care visits often involve the medicalization of presenting problems that are frequently psychosocial in origin. Physicians spend an excessive amount of time dealing with patients' psychological, social, and environmental concerns, when their preference is to refer nonmedical issues to mental health practitioners. Physicians could make more effective use of their time by referring clients with the appropriate issues to social workers. Some of these issues Ie those related to family, resources, mental health, behavioral problems, and medical noncompliance. Other issues involve children, older adults, and people with intellectual disabilities. In sum, social workers can play many vital roles as interdisciplinary team members working in community clinics under a managed healthcare system. Redirection of emotional, psychological, familial, and social concerns to social work professionals relieves other primary-care staff from dealing with issues that may not besIir area of expertise. Additionally, social work screenings and case findings lessen the inappropriate use of valuable interdisciplinary professional time, thus increasing patient satisfaction.

Families and Children with Disabilities

Families that have a child with a disability often face especially trying financial circumstances. The care of a child with a disability often restructures the family's intentions and plans. The mother, who perhaps was looking forward to returning to work, may now decide that she needs to stay home to provide special care for the child. This decision, in turn, affects the financial status of the family and may compel the father to seek additional work to compensate for the loss of income. However, the father may also feel a need to be more available to the family. The family may decide that services are not adequate in the area where they live and may seek a new location that can better provide for the child. Many sacrifices are made as the family attempts to adapt to the new demands placed on it.

The mother is often under enormous pressure and may become physically exhausted. She is often the person who must spend hours traveling to doctor's offices, following up on health insurance claims, seeking special education programs, and so forth. Going on a simple outing may require taking special equipment such as a wheelchair, special eating utensils, and medications. Caring for a child with a severe disability is demanding and often leaves the mother stressed, socially isolated, and exhausted from the hard work. Much of the stress results from the mother's inability to develop interests beyond the child's care. Critical to successful adjustment is the emotional support she can receive from her spouse.

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Parents of children with disabilities can benefit from respite service, so the parents can leave the child with others and get some time away. However, these services are not always available. However, some parents have had so little time to themselves that, when they do get away, they do not know what to do. The parents may spend their time fighting, because they have not had any opportunity in their regular schedules to address their problems. For adjustment to take place, parents need to recognize their responsibilities to each other as a couple, as well as their responsibilities to the child as parents.

Does the increased pressure result in a higher divorce rate among couples with a child with a disability compared with couples without such children? Although it would be logical to assume so, this is not the case. When divorce does occur, it is usually because of preexisting problems. A common response among parents of children with a disability is a strengthening of their relationship and a perception that the experience of raising a child with a disability has helped them grow as individuals, as well as, their children can become partners and self-advocates in their own lives (Lee et al., 2015).

Divorce

The emotional consequences are often dire for both men and women. It is a dramatic change in one's life to go from being married to being divorced. Consider the following statement from a divorced man in Weiss's (1975) well-known study on marital separation: "And then all of a sudden every goddamn thing, I'm back to zero. I have no house. I don't have a child. I don't have a wife. I don't have the same family. My economic position has been shattered. And nothing is recoverable. All these goals which I had struggled for, every goddamn one of them, is gone" (p. 75). Indeed, we now know that divorce is not a single event; it is a series of stressful events for the entire family and encompasses life changes and ongoing efforts for family members to reorganize their lives (Amato, 2000).

Research supports the negativity of divorce on husbands, wives, and their children. Chapter 6 discussed the impact of divorce on children, but how does divorce affect husbands and wives? The overall reaction from both husbands and wives is that divorcing leads to overwhelming stress. It is a period of disruption that lasts at least one and often two years (Amato, 2000). The husband and wife often have similar feelings of anger and depression, but for different reasons. The wife often feels anger for having to take on all the custody responsibility and depressed and overwhelmed by the responsibilities. The husband is angry, especially if he did not want the divorce, and depressed over not having access to his children at all times. For both men and women, adjustment to divorce involves redefining themselves as single individuals and discovering new ways to relate to the former partner, especially if children are involved. Both are likely to feel isolated, alone, and unsure of themselves as they explore new relationships. Divorced women with children will most likely struggle to get by with considerably less income (Amato, 2000). A review of 50 years of research confirms that women are economically disadvantaged relative to men after a divorce or a separation from a cohabiting partner, across geographic regions and historical time periods (Thadathil & Sriram, 2020).

However, financial loss is not the only consequence of divorce. All of these stressors put divorced adults at higher risk for depression, psychological distress, physical health problems, and substance abuse (Amato, 2000). Outcomes are worse for individuals who did not initiate the divorce, have little income, and do not find any new supportive relationships (Wang & Amato, 2000). Of course, there are positive aspects of divorce—many individuals feel more in control of their lives and less miserable on a day-to-day basis.

Why do people divorce? Answers to this complex question must take into consideration a multitude of factors. One explanation has to do with the social changes that have occurred regarding the stigma associated with divorce. Divorce is not the evil phenomenon it was 50 years ago. Society as a whole has become increasingly tolerant of divorce—partly because of the increasing numbers of people who have experienced it. The institution of marriage underwent a particularly dramatic shift when women entered the workforce. People no longer necessarily have to stay married because of economic forces. According to researchers, we are in the midst of trying to renegotiate what the marriage contract is—what men and women are supposed to do as partners. Families have changed, as well: The decline in fertility rates and the trend toward smaller families enhance the likelihood of divorce when problems arise. Legal barriers to divorce have been reduced, and men and women are more likely to seek their own self-fulfillment rather than make sacrifices for each other.

However, not all couples are calling it quits at the first sign of marital stress. As couples see the havoc divorce wreaks on divorced friends and acquaintances, many are

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now asserting a new effort to fight for their marriage. Also, many younger couples have lived through their own parents' divorce and are now less likely to pursue divorce themselves. There is a growing recognition that marriages are not to be entered into—or dissolved—lightly, because of the enormous social and economic costs.

Almost no one disputes the many valid reasons for divorce—among them, intimate partner violence, child abuse, and substance abuse. Mere incompatibility can be reason enough. However, the past few years have seen a rise in the number of couples doing more to preserve and strengthen relationships. Recent reports indicate that almost half of all married couples attend counseling at some point in their marriage, typically using some form of Cognitive Behavioral Therapy, the Gottman Method, Emotionally Focused Therapy, Positive Psychology Therapy, or Solution Focused Therapy. A recent systematic review of the literature found that African American couples benefit from the inclusion of culturally relevant components, such as storytelling and oral tradition, discussion of historical sociocultural factors, cultural values and racial identity, strengths of the African American family and children, and the use of Africentric principles and curriculum content (Mikle & Gilbert, 2019). The integration of these components improved relationship satisfaction through building relationship skills and more positive communication.

Intimate Partner Violence

Intimate partner violence (IPV) is a serious problem in the United States. Families, often suffering from intense stress, conflicts, and maladaptive coping, fall prey to acts of violence. It is estimated that 41% of women and 26% of men experiences at least one physical assault by an intimate partner during their lifetime (CDC, 2022). In many cases, the battering is life threatening; the National Organization for Women estimates about 1,400 women are beaten to death every year by their husbands or boyfriends. Women are more likely to be killed by a husband, ex-husband, boyfriend, or acquaintance than by a stranger. Also, spouses and ex-spouses commit a much larger percentage of the homicides than do strangers. Women aged 19 to 29 and women with incomes below $10,000 are more likely than other women to be victims of violence by a spouse or intimate. Such violence often leads to being unhoused when women flee violent home situations.

What would cause spouses and partners to resort to such gross mistreatment of each other? Of course, many factors relate to family violence, including intergenerational transmission of violence, poverty, social pressure and stress, social isolation and a lack of community involvement, serious personality problems, and psychopathology. When multiple risk factors are present, the family is vulnerable to maladaptive coping behaviors, and the family's welfare becomes threatened. Increasingly, researchers find that the minor, mutual slaps, kicks, and shoves depicted in the media are an all-too-common feature of real-life love and marriage. Even though such acts may seem trivial compared with the type of assaults that force women to seek safety in battered women's shelters, they are still abusive—to the psyche, if not to the body. This initial type of aggression may lead to outright battering, in which the man usually has the physical advantage. Yet shockingly, many couples regard such actions as innocuous, even normal, in any loving relationship. Even for mutually violent partners, therapy should focus first and foremost on ending the man's violent behavior, mainly because he can usually inflict more physical and psychological harm than the woman can. However, a practitioner should never question the spouses' strong bond with each other. The couple often still shows evidence of mutual affection, empathy, and commitment.

If we could look back in time, we would see that many of couples started exchanging shoves and slaps long before they exchanged vows. For this reason, reducing violence in dating relationships should be a focus for researchers and practitioners. Young people need to know how to resolve conflicts peacefully, become intolerant of physical abuse in romantic arguments, and minimize dominating and jealous behaviors toward a partner.

In addition to providing shelter to protect women from violence, many communities are attempting rehabilitation of perpetrators.

Sexual Harassment

Sexual harassment is defined as unwelcome sexually oriented behavior. The behavior in question may be glares or "checking someone out," or it may involve physical touching, pressuring someone into sex, or sexual assault. The #MeToo social media movement in Fall 2017 and Time's Up campaigns have brought increased attention to a historical problem. It is recognized as a problem, and it extends beyond the work setting—although this is where it usually occurs, despite that it is illegal under Title VII of the Civil Rights Act of 1964.

It is difficult to obtain accurate information about the prevalence of sexual harassment because many people

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don't recognize it and thus hesitate to report it. However, national polls in the United States estimate that 21 to 35% of women, and 7 to 14% of men, have experienced sexual harassment on the job (Raj et al., 2020), and it is higher by certain occupations, such as female firefighters and women in the military. ***Workplace sexual harassment*** falls into three categories: unwanted sexual attention (such as, ongoing romantic attention or requests), gender harassment (such as, verbal or nonverbal sexual objectification), and sexual coercion (such as, forced sexual contact or exhibitionism through technology). This can include ***quid pro quo harassment***, in which a person in a position of power subjects a person of lower status to unwanted sexual advances and behaviors in exchange for a job, a promotion, a higher grade, and so forth.

The impact of workplace sexual harassment is clear, including loss of productivity, financial costs, physical health issues, substance misuse, depression, psychological distress, and suicide ideation (Raj et al., 2020). These effects are more pronounced when the perpetrator is in a position of authority or power relative to the coworker. Those most vulnerable to harassment are younger females in subordinate positions, migrants, or temporary workers. In other words, those with social vulnerabilities are more at risk for harassment at work, as well as other forms of gender-based violence.

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The majority of women have experienced sexual harassment on the job.

Sexual harassment is not limited to sexual acts such as intercourse. It includes a wide range of unsolicited and unwelcome actions such as flirting, comments about another person's clothing or anatomy, intrusive questions about another person's personal life, and descriptions of the harasser's own sexual experiences. Unwanted physical contact also includes a wide range of unwelcome behaviors, such as touching, hugging, pinching, and slapping. Fundamentally, sexual harassment is an abuse of power by someone in a position of authority.

Rape and Sexual Assault

There is no justification in this world for hurting me, for taking away what he tried to take away from me. . . . I cried, I know what rage lives inside of me. It's always been there—it always will be. It's OK. I went out and danced and got plowed last night. . . . I was drained the rest of the day and felt cruddy cuz of my hangover. . . . Tonight is my first night alone and I battle the "caged in" feeling. . . . I screamed in a loud voice in my front yard, "I am mad at the whole world."

—From the diary of a 26-year-old rape victim

The prevalence of rape is so high that it is likely to touch everyone. It is now estimated that one of every six women has been raped in her lifetime and people aged 18 to 34 years are at the highest risk of sexual violence (Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, National Crime Victimization Survey, 2020). Ninety percent of adult rape victims are female and women aged 18 to 24 who are college students are three times more likely than women in general to experience sexual violence. Transgender, genderqueer, and nonconforming female college student are at even higher risk. More than 70% of these women are raped while they are too intoxicated to give consent.

The fear of rape has a direct effect on the quality of all women's lives. In their daily lives, women must take precautionary actions because of the possibility of rape. In particular, women often must isolate themselves, by not going out after dark and certainly not going out alone at night.

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Although victims of rape are predominantly women, men can be victims. Men raped by men suffer traumatic and long-term consequences, especially because they have never thought of themselves as possible rape victims. Also, rape is usually discussed in a heterosexual context, but gays are also victims of rape. However, increasingly, men have reported being raped by women.

Two of the more common types of rape are acquaintance rape and date rape (Weiten & Lloyd, 2014). ***Acquaintance rape*** occurs when a woman is raped by someone she knows; ***date rape*** occurs when she is raped by someone she is dating. Date rape is different from the act of seduction. Seduction occurs when a woman is persuaded and agrees to have sex. Date rape occurs when a woman is forced into sexual intercourse without her consent.

Both men and women often fail to acknowledge that date rape has occurred. In one study (Koss, Gidycz, & Wisniewski, 1987) of men who admitted forcing a woman to have intercourse, none perceived this act as rape. Of the women who indicated sexual aggression that constituted a legal definition of rape, only 27% actually said that they had been raped. Thus, this kind of rape has been referred to as a "hidden crime." Why is there so little recognition that rape has occurred in these instances? Part of the answer lies in the myth that, for rape to occur, it has to be perpetrated by a stranger; this myth helps men deny their responsibility and causes women who have been raped. However, stranger rape is less frequent than rape by an acquaintance or by a person the victim is dating.

Rape Trauma Syndrome

Regardless of the type of rape women experience, a common reaction is ***rape trauma syndrome***. As the quote at the beginning of the previous section reveals, women experience many intense emotions and reactions about being physically forced to have sex against their will. The crime may be life threatening; the victim is helpless. She experiences a loss of control, and she has become the object of another person's rage. These reactions lead to overwhelming feelings of fear and stress. Women may develop a number of fears: fear of being alone, fear of men, inability to trust a dating partner. Common feelings associated with rape include depression, anger, guilt, shame, and anxiety. Most rape survivors experience some of the following clusters of symptoms (Matsakis, 2003):

- **Disorganization phase:** This phase reflects the woman's immediate expressed or controlled physical and emotional reactions to the trauma. Common feelings in this phase are most likely fright, anger, and disbelief. A common reaction is "second guessing"; for example, asking, "What could I have done to avoid this?" Such questioning can lead to intense feelings of guilt and self-blame.
- **Controlled reaction:** In this phase, the rape victim achieves a more composed and calm perspective following the trauma. Although some women react in a physical manner, by crying, shaking, and behaving hysterically, other women do not. Even though the woman is experiencing a controlled reaction, she is still suffering from the trauma.
- **Reorganization phase:** This phase reflects the adjustment and adaptation necessary following the rape. In one study (Burgess & Holmstrom, 2015) of rape victims four years after the rape, 75% of the women felt recovered. Half the women felt recovered after several months; the other half indicated it took them years to recover following the trauma. An important finding is that a quarter of the women still did not feel recovered after four years. Reorganization needs to take place as women attempt to regain equilibrium in physical, psychological, social, and sexual areas.

Guidelines for Practice:
Helping Victims

The recovery process follows a pattern similar to that of people who must adjust to grief. Matsakis (2003) has identified four issues that are important to the rape victim during the reorganization process:

1. Regaining a feeling of physical well-being and safety
2. Working through fears and phobias
3. Coming to terms with losses, such as loss of trust
4. Redefining a new sense of self

For many women, being in a support group is helpful because they can "tell their story" and begin the process of accepting what happened to them and learn how to assimilate their experience into their sense of self. However, many family therapists believe that the family can critically affect a rape victim's ability to recover from a trauma. Some emphasize that trauma survivors tell their story to someone who matters to them and who is willing to validate their pain. Often, that person is a family member.

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Sexually Transmitted Diseases

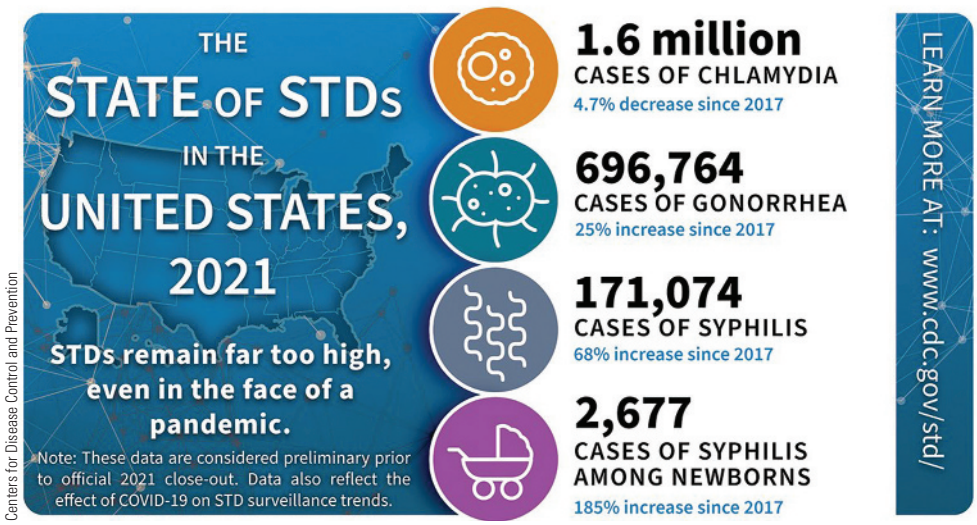
Sexually transmitted diseases (STDs) are illnesses that are transmitted through sexual contact. STDs are being increasingly recognized as a serious social problem for adolescents and young adults. Many people think of STDs as one of three diseases: AIDS, syphilis, and gonorrhea. Actually, there are approximately 20 sexually transmitted diseases. Some can be easily treated; others cannot. Most, but not all, are transmitted through genital, oral-genital, or genital-anal contact; some do not require intercourse for transmission. The overall rate of STDs is higher among women than men. This is because it is twice as easy for a man to infect a woman with any STD, including AIDS, as it is for a woman to infect a man (Centers for Disease Control and Prevention, 2021). The rate of STDs is increasing, and they continued to increase during the second year of the COVID-19 pandemic, with no signs of slowing. In 2021, there were 2.5 million reported cases of chlamydia, gonorrhea, and syphilis; half of new infections were among youths aged 15 to 24. It is estimated that one in five Americans has an STD (see Exhibit 8.17).

AIDS is no longer the disease it used to be since highly active antiretroviral therapy (HAART) became the treatment of choice over 20 years ago. However, since 60% of infected youth are unaware of their status, they could unknowingly pass the virus on to others. According to the CDC, about one quarter of new HIV infections are under the age of 25 and 85% of all youth infections are spread through sexual contact. With medication advances, the disease that was once a clear death sentence is now a chronic illness. However, getting AIDS clients to comply with the medication is a difficult and often-overlooked task of therapy. It is recommended that adherence rates of 95% are needed for the medication to work. Critical to this demand is the fact that failure to adhere to medication can cause the virus to multiply rapidly and become drug resistant. Yet a 95% adherence rate is difficult to meet under any circumstances. Recent work has centered on developing interventions to improve medication adherence including using technology advances.

Alcohol, Tobacco, and Other Drugs

In studies nationwide, alcohol, more than any other drug, has been closely associated with violence and aggression. In one study, respondents reporting either physical abuse or neglect of children were five times more likely to report alcohol abuse or dependence than were those who did not often report physical abuse or neglect. Alcohol also is involved in more than half of all rapes. Substance abuse brings out the worst in people and makes victims of us all. Social workers need to learn much more about the effects of drugs and become increasingly skilled in prevention and rehabilitation efforts involving alcohol, tobacco, and other drugs. Research has found that early use leads to higher chances of addiction. One study (SAMHSA, 2014) found that among adults who had first tried alcohol at age 14 or younger, 17.8% were classified as alcohol dependent

Exhibit 8.17 STDs in the United States in 2021



Centers for Disease Control and Prevention

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Focus on **The Lived Experience**

Spiritual Growth in Women with AIDS

By failing to recognize the personal growth experienced by some women with HIV, social work professionals can inadvertently minimize the strengths and power of their clients. This mind-set tends to keep clients as victims and may impede ethical social work practice, which includes primacy of clients' interests, rights, and prerogatives.

When asked whether they had discovered any unexpected positive outcomes in the face of this very serious illness, 82% of infected women answered yes. These women spoke of rebuilt relationships, newfound values, a new sense of meaning and purpose, profound self-awareness and self-acceptance, and discoveries of connections with nature, God, and higher powers. They reported being able to use the pain and despair of the HIV diagnosis as an opportunity for self-awareness and growth, and some women described a profound healing in their lives that made room for a richer existence.

Five themes emerged: reckoning with death, life affirmation, creation of meanings, self-affirmation, and redefining relationships. The following are some quotes that express these themes (Dunbar et al., 1988):

Life affirmation: "I went through a process where I would see beauty in real simple things: flowers, a rainbow, these mountains, a rainstorm, a pond, a river. I never stopped to notice these things before. Yeah, you saw a rainbow, but now a rainbow represents to me the entire life force. It's a deeper appreciation. . . . I think I've been on a steady course of becoming less materialistic. . . . [T]hat is just not important anymore."

Creation of meaning: "Well, we're in a body, here on this earth. We have some sort of purpose for being here; it may not be clear to us in this whole lifetime what the purpose is, but we have a purpose. And it may not be some huge purpose. It may be only to learn patience, virtue, kindness."

Self-affirmation: "You know, I think as a mother, as a woman, as a wife, I am always taking care of everybody else. . . . But I finally realized that . . . if I don't start taking care of my own self, then I am not going to be around to take care of anybody else."

Source: From Dunbar et al., "Spiritual Growth in Woman with AIDS" Copyright © 1998 National Association of Social Workers, Inc. Reprinted with permission of the National Association of Social Workers, Inc., 750 First Street, N.E., Suite 700, Washington, D.C. 20002-4241, USA.

or alcohol abusers, compared with only 3.9% of adults who had first used alcohol at age 18 or older. Exhibit 8.18 shows the clear relationship between age at first use and later substance-abuse problems.

Alcohol Use among College Students

Loaded. Plastered. Tanked. Smashed. College entrance exam vocabulary words? Guess again. These are colloquial terms for the all-too-familiar collegiate phenomenon of getting drunk. Although research indicates that most students successfully mature past the period of heavy drinking, the college period is one of heightened vulnerability to the pressures associated with alcohol consumption. Research has shown that college students drink more than similarly aged noncollege students and participate in binge drinking and heavy drinking. In fact, young adults made up the highest percentage of binge alcohol users in 2020, significantly higher than both adolescents or adults aged 26 or older (SAMHSA, 2022). Traditional prevention efforts have relied on educating the population about the potential dangers of abusing alcohol, assuming that the individual will apply this information to his or her own personal situation. Recently, prevention has taken on a new focus: affecting people's motivation and desire to drink. This approach is being implemented on college campuses and in small towns.

From laboratory data collected over more than 10 years, researcher Alan Marlatt has found that peer pressure and expectancies about sexual behavior could increase the reported amount people drink. Marlatt also found factors that could decrease the reported amount people drink: exercise, meditation, and participation in community activities (Bowen, Chawla, & Marlatt, 2010). Marlatt is now using the information he discovered in his field research. His energies are aimed not at preventing drinking but at preventing development of drinking

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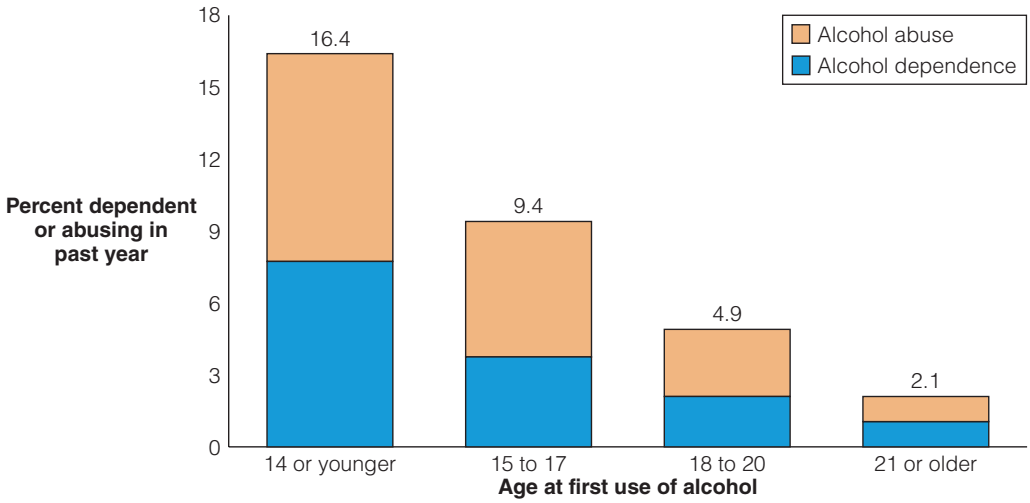
Exhibit 8.18 Alcohol Dependence or Abuse in the Past year Among Adults Aged 21 or Older, by Age at First Use of Alcohol.



Source: Substance Abuse and Mental Health Services Administration (2006). Results from the 2005 National Survey on Drug Use and Health: National Findings. Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194. Rockville, MD.

problems and ensuing injuries in those individuals who already drink.

With these goals in mind, Marlatt developed a six-week cognitive-behavioral program that (1) challenges the glamorous portrayal of the effects of alcohol; (2) emphasizes awareness of one's drinking habits as a safety precaution; and (3) suggests plausible alternatives to drinking—exercise, nonalcoholic parties, and community work. A one-hour motivational interview emphasizing these areas was effective in reducing binge drinking among small groups of college students.

On the basis of this success, Marlatt and his colleagues began a longitudinal study in which they followed 500 college students identified as high risk for problem drinking when they were high school seniors. Half the sample received no treatment, and the other half underwent the one-hour motivational interview when they started college. Students whose drinking problems persisted received the six-week program, and any students who showed signs of severe drinking problems were taken out of the study and given a referral for treatment.

Annual evaluations, even after three years, show that the program makes a significant difference in helping to accelerate "maturing out of drinking behavior" (Marlatt, Larimer, & Witkiewitz, 2011). Marlatt has now targeted fraternities and sororities with the hope that the group format will foster group pressure toward behavior change.

Additional strategies for substance-abuse prevention on the college campus include the use of social-marketing ideas. Social marketing uses advertising messages and images, carefully developed as in commercial advertising, to popularize positive ideas and alternative behaviors to substance use. Taking into account that knowledge about alcohol and other drugs does not impact substance use, the goal of social marketing is to impact the environmental influences that draw students into substance use. In this sense, prevention strategies go through extensive market research. How can the appeal of a prevention message most effectively reach the consumers? By conducting research on the target population, the idea is to design campaigns with the greatest likelihood of appeal. An example is the social-marketing campaign carried out at Northern Illinois University. The focus was on informing students that fewer than half of their fellow students engaged in binge drinking, when most students believed more than two out of three students were binge drinkers—the reality is pretty far from "everyone is doing this." The strategy was to convey the message that the majority of students do not engage in binge drinking at parties. Using news media, posters, and student events on campus, the social-marketing campaign went into full swing.

Developmental Guidelines for Assessment in Young Adulthood

The following table presents the developmental guidelines for assessment in young adulthood. These guidelines are meant to be helpful to social workers who need to understand development when making assessments.

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Practice Guidelines:

Developmental Guidelines for assessment in young adulthood

Developmental Milestones	Developmental Issues (not problems)
Emerging adulthood	Increased sexual activity
Vocational and career development	Fertility difficulties
Independent living	Adjustment to marriage
Economic independence	Remaining or becoming single
Cohabitation or marriage	Transition to parenthood
Childbearing and rearing	Divorce and new family arrangements
Formation of adult friendships	
Strengths and landmarks of development	**Developmental observations requiring attention**
Motor skills and physical development peak	Premenstrual syndrome
Development of expertise	Early health problems
Improved mental functioning (formal operational thinking)	Isolation and loneliness
Development of adult intimacy	Abnormal behavior indicative of mental illness
Development of mentorships	Sexually transmitted diseases
Establishment of religious practices	Sexual harassment and rape
	Intimate partner violence
	Alcohol, tobacco, and drug use

Study Table Social Dimension in Emerging and Young Adulthood

Groups and Families

- Marriage and beginning a family are significant life changes in the stage of young adulthood.
- The phases in relationships that lead to marriage are (1) opportunity, physical attraction, and valued behaviors; (2) positive self-disclosure, rapport, sexuality, value concerns, and salient homogeneity and similarity; (3) role compatibility and empathy; and (4) relationship and commitment escalators.
- The factors that influence the outcome of marriage are having parents who divorced, getting married young, having a longer courtship, being lower or working class.
- The origins of sexual orientation are quite diverse.
- Some lesbians, gay men, and bisexuals easily ignore society's prejudices toward their sexuality and others internalize them in a form of self-loathing.
- Several million gay men and lesbians are parents, and new technologies and adoption have advanced these new family structures.
- The transition to parenthood involves significant stress.

Communities and Support Systems

- Volunteering is a way to establish a sense of community.
- Economic realities shape the choices volunteers can make.
- Balancing work life affects opportunities for broader community participation.

Multicultural, Gender, and Spiritual Considerations

- Blended religious families often present children with the dilemma of choosing their mother's or father's religion.
- Different groups have the cultural mandate for women to marry or to have children.

Social Strengths, Hazards, and Risks

- Having social capital is an important strength or protective factor.
- Sexually transmitted diseases are a tremendous risk among young adults.
- Substance-abuse and mental illness rates increase in the emergent and young adult stages of development.
- Vulnerability to experience pressure to consume alcohol increase in young adulthood.

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Applying the Framework

Schizophrenia

Maria is a 24-year-old single woman who looks older than her stated age. She presented with symptoms of schizophrenia—prominent thought disorder, delusions, inappropriate affect or silly affect, and disorganized speech. The police brought Maria to the emergency room after neighbors complained of a young woman, whom they feared might be dangerous, walking down the street, laughing, and talking to herself. Several days later, her brother called the police and reported Maria as a missing person. The police informed her brother that a young woman fitting his sister's description had been taken to the hospital and admitted to the psychiatric ward a few days earlier.

Maria's family history revealed that she came from a problematic family. She was the second of three children and was often the victim of criticism and abuse from her father. Her father was abusive when he came home drunk. Maria's mother died when she was 13 years old, and Maria never recovered. While she was living, Maria's mother had tried to protect the children from their father. Maria and her mother had been particularly close. When Maria's mother died, the children were placed in the custody of the state because of their father's inability to take care of them. The children were separated on several occasions during their tenure in foster homes, and separation took its toll on Maria.

Even when Maria was a young child, she experienced problems adjusting to minor changes and withdrew from her normal activities. Her school records reported problems Maria had in trying to adjust to school routines and how traumatic it was for Maria to leave home and go to school. She had to compete with different children of different age groups while living in foster homes. She was beaten by some of these children and by some of the foster parents. Even before the foster homes, Maria had a history of "bizarre behavior" and was highly withdrawn. Her mother was hospitalized twice before she died, according to Maria's older sister. She told the attending physician, "My mother had emotional problems and was sent away."

Developmental Considerations

Maria had some minor physical abnormalities such as malformed ears and some webbing between her toes. She was born in late winter, which is recognized as a correlate for the development of schizophrenia. She also had some obstetric complications suggestive of the presence of some hypoxia. Maria's problems started when she was very young—physical and psychological abuse, placement in foster homes, and lack of a sense of security. The first signs of her disorder were not detected until adulthood. However, she had a number of developmental issues often noted in the histories of people who develop schizophrenia. She played primarily by herself and had very poor interactions with others. These traits were preceded by some perinatal complications such as engaged in significant fantasy and played primarily by herself. Her early childhood and adolescence indicate that she had issues involving trust versus mistrust, separation-individuation, possible bonding difficulties, and identity difficulties during adolescence. The loss of her mother had a profound effect on Maria because her mother was Maria's only support system. Maria's symptoms of schizophrenia were undetected before the presentation of active psychotic symptoms. Her history of poor functioning in school and at work and her inability to adjust to life events contributed to Maria's disorder. Her disorder had an early and insidious onset. Given the characteristics of the onset, Maria was untreated until she moved into the active phase of schizophrenia.

Biophysical Considerations

Maria's episode with schizophrenia may suggest that she had a predisposition for schizophrenia (genetic), which is supported by the finding that her mother had been hospitalized for emotional problems. Because structural changes in the brain are likely in neurotransmitter systems (namely dopamine), further confirmation for biophysical hypotheses can be found if brain imagery techniques show evidence of cortical atrophy.

Psychological Considerations

Maria manifested some deficits in the cognitive, affective, and behavioral domains. During the active phase of her disorder, she presented with disorganized speech, distorted perceptions (delusions and hallucinations), and distorted thought processes in the cognitive area. Her affective state is best characterized as inappropriate or silly. She laughed inappropriately throughout the admission process.

Continued

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Schizophrenia (continued)

Communication

The communication process within Maria's family is unclear. The family demonstrates some signs of limited communication abilities. Her bizarre behavior further aggravates her communication competence. She smiles inappropriately and does not demonstrate that she can share what she is experiencing.

Social Cognition and Emotional Regulation

It is difficult at this time to assess Maria's attitudes and emotions; she is currently in the active phase of her illness, and the medication has not reduced her symptoms. Usually, her presenting symptoms suggest a poor prognosis with a chronic course. Maria has isolated herself and rarely interacts with others. She does not appear to hold suspicious or bizarre delusions.

Family

Maria is 24 years old. Before her mother died, Maria lived with her parents and two siblings. Maria's father was particularly abusive to her. The family believes that he singled her out because she looks like his paternal grandmother. Maria and her siblings lived in foster homes for about five years. Her sister, Ester, is 18 months her senior, and her brother, Mario, with whom she presently lives, is the youngest member of the family. She has no contact with her extended family.

Social Support

The most consistent support Maria ever had was her mother, who died when Maria was 13 years of age. Her mother's death undoubtedly contributed to many of Maria's problems in later life.

Impressions

Problem list:

1. She developed schizophrenia, and the symptoms are currently in the active phase.
2. She had a prolonged history of social and psychological problems.
3. She was a victim of physical and psychological abuse.
4. The course of her disorder suggests a poor prognosis.
5. Her responses to neuroleptic medications have been marginal at best.
6. Her past medical record was essentially unremarkable.

Four Ps formulation for Integration of the Data

Practice Exercise:

Fill in each of the four Ps for the case that is applying the biopsychosocial framework for this chapter.

Use the results of the 4 Ps' formulation to:

1. Identify relevant problems, diagnoses, or other relevant judgments about the case described in the Applying the Framework section of the chapter.
2. Describe an appropriate biopsychosocial intervention based on the findings in your four Ps' formulation of the case.
3. Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial integrative data that you identified in your formulation of the four Ps.
4. Describe how you would evaluate your invention based on the data captured in your four Ps' assessment.

Write a summary and formulation for the case described above.

1. Use the data from the 4 Ps' framework to identify relevant interventions for this case.
2. Use data from your 4 Ps to identify the appropriate strategies for engaging with this client system.

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	Biological	Psychological	Social
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

Reviewing Your Competencies

You should be able to:

1. Describe the key developmental themes present in emerging and young adulthood, including theories of adulthood and the concept of "emerging adulthood."
2. Understand the key aspects of biophysical growth and development (brain development).
3. Describe the key themes in the psychological dimension for young adulthood (formal operational thought, communication, intimacy and independence, serious mental illness and depression).
4. Describe the key themes in the social dimension for young childhood (marriage, homophobia, parenthood, fertility, work, racism, gender, intimate partner violence, substance use).

Key Terms

acquaintance rape
alienation
basal metabolism rate
controlled reaction
date rape
disorganization phase
emerging adulthood
workplace sexual harassment
existential isolation
expressive communication
grit
health equity
homophobia
infertility
instrumental communication
internalized homophobia
loneliness
menstrual cycle
premenstrual dysphoric disorder
premenstrual syndrome (PMS)
quid pro quo harassment
rape trauma syndrome
rapport talk
reorganization phase
report talk
schizophrenia
sexual harassment
sexually transmitted diseases (STDs)
social determinants of health

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Chapter 9

Middle Adulthood

Learning Objectives

1. Describe the key developmental themes present in middle adulthood.
2. Understand the key aspects of biophysical growth and development.
3. Describe the key themes in the psychological dimension for middle adulthood (intellectual functioning, literacy, nonspeaking adults, development of caring behaviors, drug addiction).
4. Describe the key themes in the social dimension for middle adulthood (marriage at midlife, adult children, caregiving, grandparenthood, career trajectory, ethnic identity, launching children, homelessness).

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Developmental Themes	Key Concepts
	■ Stage: generativity versus stagnation. Life expectancy. Midlife as a crossroads. Stage theories.
Biophysical Dimension	
Biophysical Growth and Development	■ Adaptation to physical changes; changes in physical appearance. Personality type and disease. Menopause. Ethnicity and menopause. Sexuality in middle adulthood.
Biophysical Strengths, Hazards, and Risks	■ Physical fitness. Breast and prostate cancers. Family-systems approach to couples and illness. Psychological interventions for the seriously ill. Women and health care. Overweight and exercise. Brain injury.
Psychological Dimension	
Cognitive Development and Information Processing	■ Stability of intellectual functioning.
Communication	■ Reconnection with one's partner or spouse. Communication on a deeper level. Forgiveness. Concerns about illiteracy. Communication with nonspeaking adults. The hard-of-hearing adult. Title V.
Attitudes, Emotions, and Regulation	■ Well-being and anxiety. Midlife as a crisis. ■ Development of caring and socially responsible behaviors. Crystallized intelligence; fluid intelligence.
Psychological Strengths, Hazards, and Risks	■ Developing optimism and happiness. Alcohol and drug addiction. Need for professional help. False memory syndrome.
Social Dimension	
Groups and Families	■ Blended families. Marriage at midlife. Marital satisfaction among African Americans. Extramarital affairs. Changing relationships with adult children. Addressing the needs of aging parents. Families of adults with intellectual disabilities. Caregiving. Grandparenthood. Grandparents raising their grandchildren.
Communities and Support Systems	■ Decline of civic engagement. Career development and job satisfaction. Spirituality in work. Career changes at midlife.
Multicultural, Gender, and Spiritual Considerations	■ Ethnic identity in adulthood. Problems with generalizing adult development theories to women. Gender differences at midlife. Role strain and role conflict for women. African American women at midlife. The men's movement. Men in therapy. Gender, work, and the family.
Social Strengths, Hazards, and Risks	■ Variety in social roles. Launching children. Occupational advantages in midlife. Joblessness. Homelessness.

Developmental Themes*

Less than 100 years ago, only half of all Americans who reached age 20 lived to see the age of 65. And because their ancestors had little chance of living past 40, the concept of "middle age" as we now know it is new. In America today, most people survive well into their 70s or 80s. But midlife remains a mystery. We have abundant myths about psychological landmarks of midlife, such as the "empty nest syndrome," the "midlife crisis," and the menopausal "change of life" (Infurna et al., 2021; Colarusso, 2012; Cavanaugh & Blanchard-Fields, 2019). Middle adulthood is often

*Catherine Sammons made significant contributions to the revision of this chapter.

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characterized as a time of questioning and "a time of change to an internal focus that provides wisdom for the later years" (Dziegielewski, Heymann, Green, & Gichia, 2002, p. 65). Many adults truly feel that they are at a crossroads at midlife, as aptly described by Margaret Atwood (1991) in her novel *Cat's Eye*:

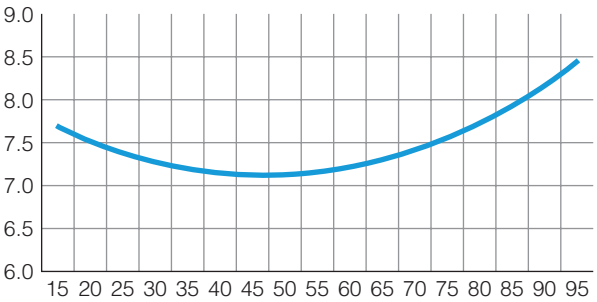
> This is the middle of my life. I think of it as a place, like the middle of a river, the middle of a bridge, halfway across, halfway over. I'm supposed to have accumulated things by now: possessions, responsibilities, achievements, experience, and wisdom. (p. 13)

Midlife is a highly variable developmental phase. For some, it involves "launching" children and focusing on career advancement; yet others are just beginning a family and postponing work achievement career development. Chronological age seems to become a less reliable indicator of what men and women are like at this phase in their lives.

Because we are living so much longer, the midpoint is a moving target. It is often considered to begin at age 35 and continue until age 60—a span of 25 years. However, midlife is different for men and women because of their differences in life expectancy. Therefore, more accurately, midlife begins at age 35 for men and age 39 for women (Baruch & Brooks-Gunn, 1984; Cavanaugh, 2018). For some, middle age has been pushed forward all the way to the 50s because we are living so much longer. We have reconceptualized the life course in adulthood, beginning with provisional adulthood (18–30 years), followed by first adulthood (30–44 years), and ending in second adulthood (45–85 years; Sheehy, 2006). Imagine: young people today are likely to turn 45 years old and begin their second adulthood; they will face the question of how they want to live in this new phase of adulthood. Many adults will choose to make critical changes built on this notion of a "second half" in their lifetime.

Adults at midlife are most typically characterized by a new perspective on their world and who they are in it, including a new definition of self, new expectations about what they want to accomplish, and new satisfactions in living (Infurna et al., 2021; Rauch, 2014). Erikson (1974) referred to this period as one of generativity versus stagnation. **Generativity** represents reaching out to others in ways that guide future generations. Because there is so much diversity in midlife, many experts refuse to identify a timetable for adult development. But popular cultural beliefs about "midlife crisis"—captured and perpetuated by Gail Sheehy's *Passages* books—continue to prevail. Recent research on the "midlife crisis" or more accurately life satisfaction does show midlife can be a time of decreased satisfaction (see Exhibit 9.1). While the myth of a midlife crisis has been debunked newer research is bringing back an old notion but in a different way. Infurna (2022) states that midlife has become a time of crisis. In a study of middle-aged adults who were followed for two years, researchers found that midlife is often experienced as a stressful squeeze where middle-aged adults are struggling with their own time, time with their own aging parents, time with their own children, and life with their grandchildren.

Exhibit 9.1 The Life Satisfaction U Curve.



Source: Adapted from D. G. Blanchflower and A. J. Oswald. (2008). Is well-being U-shaped over the life cycle? *Social Science & Medicine, 66,* 1733–1749.

A comprehensive study examining 35 years of data across 80 nations reveals a consistent pattern of less satisfaction that occurs at midlife. The results show a low point in life satisfaction at an average of 44 years old, 40 for women and 50 for men (Galambos et al., 2020 Blanchflower & Oswald, 2008).

What led to the enormous success of *Passages*? We tend to seek predictability in facing our own life path, and Americans related to the commonsense appeal of Sheehy's life phases. However, as midlife was studied further, generalizations about adult development have grown murkier instead of clearer. Today, most experts underscore many of the problems identified in previous stage theories, and the idea of a midlife crisis is better conceptualized as a drop in life satisfaction or happiness in midlife.

Although stage theories have been commonly used to examine the life course (and midlife in particular), they are becoming increasingly less relevant. Many of

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Study Table Developmental Themes and Biophysical Dimension of Middle Adulthood

Developmental Themes

- Midlife begins at age 35 for men and age 39 for women because of their differences in life expectancy.
- Although midlife is a time of reflection, there is not much empirical support for the popular notion of a midlife crisis.
- Midlife stage: generativity versus stagnation.

the stages are simply not connected with the age ranges originally intended. For example, much of the identity crisis Erikson referred to for adolescence is not resolved until the 20s (Backes & Bonnie, 2019; Arnett, 2012). Furthermore, societal changes have disrupted some of the formerly lock-step timing and sequence of marriage and childbearing (historically, but no longer, associated with the 20s). Women's longer careers and later age for childbearing challenge generalizations about women's life patterns.

Midlife: A Pivotal Period of Human Development

In order to acknowledge the crucial role that midlife plays in each person's life course as well as the success and development of other people in the family, workplace, community, and society at large, midlife has recently been regarded as a vital stage in the life course (Infurna et al., 2020). Middle-aged folks frequently play a significant role in uniting, fostering, and guiding family members and colleagues. By balancing the benefits and costs of aging, connecting earlier and later life stages, and spanning generations, the central position in the life course is captured. Early life events have an impact on the nature of development in midlife. Adversity, parenting methods, and SES in early life are all related, according to empirical studies.

In turn, midlife health and wellbeing frequently have a significant impact on how later life develops (Infurna et al., 2020). For instance, midlife hypertension, but not old age, predicted cognitive deficits in old age (Launer et al., 1995). The biopsychosocial experiences of midlife can be described, explained, and modified using this perspective on midlife as a framework. Midlife is a time when racial/ethnic, socioeconomic, and sexual orientation health inequities are frequently present and amplified, highlighting the significance of midlife biopsychosocial experiences (Adler & Rehkopf, 2008).

Biophysical Dimension

Biophysical Growth and Development

In middle adulthood, individuals often look back to their younger self and for the first time see and feel significant negative physical changes or losses. Most individuals are less fit, with a fuller body shape. And anyone who has been to a 20- or 30-year high school reunion will remark that those additional years have created many bald or gray heads and lined faces. A quick glance around the room always finds plenty of people squinting through reading glasses as they peer at the awards notes for having the most children, having the youngest child, and being the most traveled. Reunion discussion also includes sharing details of life-threatening health events, most likely cancer or heart disease. In the women's restroom, menopause and sexuality changes are likely topics in casual chatting between old friends. The theme is clear: Midlife involves major revision of physical self-image (Colarusso, 2012).

Physical Changes at Midlife

For midlife women, menopause is an expected and normative physical change, whereas sexuality and fitness changes are extremely common although not inevitable. A smaller but significant subgroup of midlife adults are coping with chronic serious conditions such as heart disease, diabetes, and/or high blood pressure, which typically emerge or are diagnosed in midlife and can be life-threatening. Cancer is a big concern as well.

Functional impairment, which refers to trouble with fundamental everyday tasks like washing, dressing, and transferring, is a problem that many of us believe mostly affects older persons, and particularly the very elderly. However, over the past 10 years, the proportion of middle-aged people (ages 45–64) with functional impairment has increased from 13% to 16%. We can better

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comprehend this issue's causes and its effects on the health and **well-being** of this expanding population by approaching it from a life-course viewpoint. Why is this taking place? A rising amount of research indicates that it's a symptom of a bigger pattern of middle-age health status deterioration. In the National Health and Interview Study, a study of over 150,000 people aged 45 to 65 revealed that functional status deteriorated throughout this time.

Physical health issues do arise with age for most people, but more people than ever before stay healthy through their 60s and early 70s by maintaining healthy diet and physical exercise practices. One of the exciting recent findings (Shane, 2017) highlighted in research is that regular exercise promotes mental health as well as physical well-being, helping to maintain mental sharpness and prevent Alzheimer's disease.

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In general, women who have gone through menopause view it more positively than do men and younger women. Some women report increases in energy, self-confidence, and assertiveness.

Menopause

"Among American women of different ethnic groups, sex without thinking about pregnancy was frequently cited as one of the benefits of menopause," says Nanette Santoro, MD, professor and director of Reproductive Endocrinology at Albert Einstein College of Medicine in New York. Some women even find that, because they no longer have to worry about the unanticipated outcome of sex, they can actually enjoy it more once they reach menopause.

—Quoted in *10 Reasons to Look Forward to Menopause*
By Carol Weeg, 2008

Menopause is medically defined as not experiencing a menstrual cycle for one year (NIH, 2021). But as a psychosocial experience, it varies widely, depending on cultural beliefs and individual expectations. In societies in which the woman's social role is primarily reproductive, the cessation of childbearing is a loss of status. In cultures in which the wisdom and experience of older women are valued, menopause is seen as a positive life event (Adler et al., 2000; Thacker, 2009). American women express diverse views, ranging from interpreting menopause as a sign of impending old age, while others, such as the one quoted above, are glad to be rid of menstruation.

Menopause ovaries cease estrogen and progesterone production. It is a gradual process spanning from 5 to 20 years. During **perimenopause**, the time when hormone levels begin to fall until menstrual cycles stop, a woman may notice irregular menstrual cycles; decreased monthly flow and increased spotting; and symptoms of premenstrual tension, such as breast tenderness and fluid retention. The average age of menopause is 51 years old, spanning 45–55 years of age for the majority of women (NIH, 2021; Barbach, 2000; Thacker, 2009). Women who never gave birth or who smoke tend to have menopause earlier (Zhu et al., 2018; Avis, Crawford, & Johannes, 2002). This is critical because women who undergo early menopause, between the ages of 40 and 45 years, are at greater risk for overall mortality, heart disease, osteoporosis, and other chronic diseases than are women who reach menopause later (Scarabin, 2020; Shuster, Rhodes, Gostout, Grossardt, & Rocca, 2010).

While there is no medically identified "male menopause," the male hormone, testosterone, declines gradually with age but the change is minimal, especially for men who continue sexual activity, which stimulates the cells that release testosterone.

Falling estrogen levels affect women in different ways. The most universal change is the **hot flash**, experienced as a wave of heat rising from the chest to the neck, face, and arms, lasting a few seconds to a minute or more, often followed by a cold shiver (Mayo Clinic, 2022; Bromberger et al., 2001). Hot flashes affect about 85% of women in industrial nations (Bansal & Aggarwal, 2019),

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Exhibit 9.2 The Changes of Menopause.

When	Symptom	Comments
Before menopause	Irregular periods	Cycle may shorten or lengthen. Flow may increase or decrease.
During menopause	Periods stop	
	Hot flashes	Skin temperature rises, and then falls. Accompanied by sweating and sometimes heart palpitations, nausea, and anxiety. Occur anywhere from once a month to several times an hour. May begin 12–18 months before menopause and continue for some years thereafter.
	Insomnia	Sometimes caused by nightly bouts of hot flashes. Dream-rich REM sleep may also decrease, disturbing sleep.
	Psychological effects	Irritability, short-term memory loss, and problems with concentration are common. These symptoms may simply result from sleep deprivation.
After menopause	Changes in nervous system	The perception of touch can become more or less sensitive.
	Dry skin and hair	The skin can become thin, dry, and itchy. Hair may thin out. Facial hair may increase.
	Incontinence	Tissue shrinkage in the bladder and weakening pelvic muscles may lead to problems with bladder control.
	Vaginal dryness	The mucous membranes and walls of the vagina become thinner, which may lead to pain on intercourse and susceptibility to infections.
	Bone loss	Increases dramatically.
	Cardiovascular changes	Blood vessels become less flexible. Cholesterol and triglyceride levels rise.

Source: Adapted by authors from "The Changes of Menopause" by Lisa Davis, *Hippocrates*, May/June 1989.

occurring primarily at night, and referred to as "night sweats." Recurrent night sweats can interfere with sleep—a common complaint among women. Another effect of estrogen loss is thinning and drying of the vaginal membranes, which can be treated with a range of locally applied estrogen products, or hormone replacement therapy. This problem occurs with less severity, though, if a woman stays sexually active. Loss of estrogen also affects the urinary tract and can result in an increase in the frequency of urination, as well as occasional incontinence triggered by a cough, sneeze, or laugh (WebMD, 2021). Other physical changes include dry, itching skin, dry hair, and a heightened sense of touch (see Exhibit 9.2).

But the major physical effects of estrogen loss are cardiovascular changes, which put postmenopausal women at greater risk of heart disease, and increased bone loss, which increases **osteoporosis** risk (thinning and weakening of the bones). As a result of this bone loss, postmenopausal women are at increased risk of bone fractures, especially of the hip and vertebrae (in the spine). Women most at risk of osteoporosis are white, slender smokers with low calcium intake, who don't exercise regularly. Although increased calcium intake can help prevent osteoporosis, lower estrogen limits efficiency of calcium metabolism. Bone-density testing is sometimes recommended for women entering menopause depending on their risk factors for osteoporosis (U.S. Preventive Services Taskforce, 2018).

Psychological effects of menopause are unclear. Some women report increased energy, often referred to as "postmenopausal zest." Some attribute this increase in energy, confidence, and assertiveness not to biological events but to "the crisis and resolution of midlife women's psyche" (Apter, 1997, p. 201). In other words, menopausal women may focus on unmet goals or unfulfilled potential and experience an interest in "reclaiming" their lives (Marston, 2002). Also, they retain more iron without a monthly loss of blood, and no longer have premenstrual syndrome. Jones (1999) has recommended that workers refer to menopausal "changes" not "symptoms" of a disease in need of medical treatment.

Some research has found that women who expect menopause to be a negative experience do indeed find it to be a negative experience (Thacker, 2009). Others believe that depression may occur as a result of the psychosocial losses characterizing this life phase: loss of children who leave home and loss of more youthful

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appearance. However, overall, for most women menopause is characterized by unique—but probably no more severe or challenging—physical and psychological changes that unfold over several years, rather than a discrete single event.

Regardless of the physical changes during menopause, it represents an important marker of aging (National Institute on Aging, 2021; Marston, 2002). While seeking medical facts and self-care advice, women also want to explore the personal and social meaning associated with menopause. For most women, menopause is a symbol of changing health, physical appearance, and sexuality, and of aging in general. No longer is menopause considered a time-limited physiological condition, but rather it represents a significant life-stage biopsychosocial developmental change.

Ethnicity and Menopause

Researchers from the Study of Women's Health Across the Nation (SWAN) have noted the preponderance of Caucasian subjects in that, at present, the base for understanding menopause research is Caucasian women. SWAN researchers have identified variability in menopause symptoms across ethnic groups and found that women in different ethnic groups vary in the kinds and degree of menopausal symptoms they report. SWAN looked at two kinds of physical symptom clusters: estrogen-related symptoms (including hot flashes, night sweats, vaginal dryness, and urine leakage) and somatic symptoms (including insomnia, headaches, a racing heart, and joint stiffness and soreness) in the joints, neck, or shoulders. Exhibit 9.3 presents some generalizations of the findings within and across various ethnic and lifestyle groups.

Exhibit 9.3 Menopause Symptoms of Ethnic and Lifestyle Groups.

Ethnic or Lifestyle Group	Symptoms
African American	Report more estrogen-related symptoms and fewer somatic symptoms than all other ethnic groups.
Hispanic	Report more urinary leakage and racing-heart symptoms than all other ethnic groups.
Asian American	Report fewer symptoms than all others.
Smokers	Within all ethnic groups, report more of both estrogen-related and somatic symptoms.
Education level	Less-educated women have more estrogen-related symptoms and more racing-heart symptoms than others.
Physical activity	Women who report getting less physical activity have more of all types of symptoms.

Source: Adapted by authors from DeAngelis. (1997). Copyright © 1997 American Psychological Association.

Sexuality in Middle Adulthood

The majority of older adults remain interested in sexuality and engage in sexual behaviors. However, many professionals have limited knowledge concerning elder sexuality (Williams, Linton, & Rueda, 2017; Hillman, 2014). The midlife years often can lead to problems for marital couples who do not understand some of the changes they are going through. Belsky (2007), in her book, *Over the Hill and Between the Sheets: Sex, Love, and Lust in Middle Age,* discusses the different physical changes that men and women go through during the middle years. A man's aging crisis can be related to the pressure he feels to "make it," and a woman's aging crisis can be related to concerns and anxiety she feels about her physical appearance. These changes have direct implications for their sexual relationship (Belsky, 2007; Hillman, 2014; Williams et al., 2017). Such changes affect the **sexual response cycle**, which includes three phases: desire, excitement, and orgasm. First, desire, being sexually motivated, can be affected by aging. For example, the side effects of diseases (such as diabetes or hyperthyroidism), of psychological

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Understanding the physical challenges that affect sexuality in midlife can help men and women adapt and adjust.

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difficulties (such as depression), or of medical concerns (such as hypertension) that require drug treatment all can negatively affect desire. In general, over time the sex drive declines, particularly for men. The male sex drive is also affected by a drop in testosterone, the male hormone.

Parenting in Middle Adulthood

Many older women are becoming moms for the first time. Births to mothers 35 years and older have increased more than ninefold since the 1970s (CDC, 2012). In fact, in 1990, 8% of first-time moms were over the age of 35 compared to 18% in 2019 (Martin et al., 2019). Women are deciding to postpone motherhood for a variety of reasons: establishing a career, seeking higher education, travel, delayed marriage, and so on. While many women do not feel ready for motherhood until they are in their late 30s, bearing a child at an older age carries a higher risk of complications.

Since women are born with all of their eggs (about 400), by the time a 40-year-old woman decides to get pregnant, her eggs are 40 years old. Her eggs, unlike 20- or 30-year-old eggs, will have a greater chance of dividing abnormally, increasing the risk for genetic disease and infertility. Miscarriage and stillbirths are a common concern for older mothers, as well. To reduce these risks, many women use fertility techniques and genetic testing to increase the chances of a healthy pregnancy and birth (Martin et al., 2019).

A common fertility technique is **in vitro fertilization** (IVF). This process involves hormonally controlling the woman's ovulatory process, removing her ova (eggs) from her ovaries, and allowing sperm to fertilize them in a fluid medium. After fertilization, the egg is transferred to the woman's uterus to carry to term. Approximately 2.0% of births in the United States involved this procedure or other assisted reproductive technologies (WebMD, 2021). IVF is effective for older women who have difficulty getting pregnant and recent data show 50% of IVF procedures in women under 35 resulted in a live birth, with 3.9% resulting in a live birth if the mother is over 42 (WebMD, 2021). Similarly, IVF is helpful for women who had children at a younger age and wish to conceive again but are having difficulty. Successful conception using IVF procedures has improved over the last decade.

Despite the higher rates of conception using IVF, the path to a healthy delivery may be a long one. Miscarriage rates increase dramatically with age. According to the American College of Obstetricians and Gynecologists, women of 35–45 years old will miscarry 20–35% of the time, with women over 45 years old estimated to miscarry up to 50% of the time. Preconception counseling can reduce this rate, providing advice about prepregnancy and prenatal nutrition and care (Chandranipapongse & Koren, 2013; Healthadel, 2007). Additionally, improvements in IVF effectiveness and genetic testing substantially improve a woman's chances of having a healthy birth. The birth rate for older women (aged 40–44) has doubled since 1981, demonstrating a growing confidence that older women can enter motherhood later in life, especially with the help of assistive reproductive technology.

Biophysical Strengths, Hazards, and Risks

Middle adulthood is a time of many biophysical hazards in the area of chronic diseases (such as type two diabetes, heart disease, and hypertension) as well as less common but significant cancers of the breast, prostate, colon, and lung. It is also, however, a time of strengths and opportunity for physical renewal and fitness.

Becoming Healthy and Physically Fit in Midlife

As adults mature and begin to think about their future as possibly shorter than their past, becoming physically healthy often takes on greater importance. Middle-aged adults may be developing a new definition of who they are, both as a physical self and by setting new expectations about what they want to accomplish. Indeed, many midlife adults become passionate about yoga, spinning classes, or vigorous walks—and such interests can take on increasing importance as one grows older.

A regular exercise program can increase one's self-efficacy—an individual's sense of effectiveness as a physical person. This in turn promotes more physical activity (CDC, 2022; McAuley & Blissmer, 2000). In a review of studies (Penedo & Dahn, 2005), engaging in regular exercise such as walking, dancing, or swimming was more strongly associated with self-rated health and positive outlook in older than younger adults. A regular exercise outlet for middle-aged adults enhances their perception of being active for their age and creates a special sense of accomplishment. Also, exercise is likely to reduce the feelings of vulnerability to illness

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that increase with age, providing further psychological benefits (CDC, 2022; Berk, 2013). The end result is often an increase in the person's "physical self-esteem": a positive sense of one's body conditioning and body attractiveness. Developing these characteristics is important given today's sedentary lifestyles and frequent use of electronic devices, usually in a forward-slouching posture. As a society we need to develop new opportunities for creating exercise environments with fewer barriers and increased incentives for getting outdoors—to walk, bike, hike, or climb. For instance, researchers have documented that people can be cued to get more exercise simply by posting "Take the stairs" signs by escalators (Hongu et al., 2019).

Common Chronic Diseases of Midlife

Type 2 diabetes, heart disease, and high blood pressure are endemic in the United States, and the implications are serious. Obesity is implicated in all three conditions, and a major national awareness campaign by former First Lady Michele Obama has emphasized obesity prevention. Women are more likely to have their blood pressure and blood laboratory tests medically reviewed because they tend to see doctors (or nurse practitioners) for their gynecological issues. However, men are much less likely to seek preventive care from a primary doctor (Cimons, 2020; Heidelbaugh & Tortorello, 2012).

Type 2 diabetes, heart disease, and high blood pressure benefit from psychosocial interventions, as well as medical ones in several ways. They often require behavior changes such as dietary restrictions or exercise regimens involving the formation of new daily habits. Also, depression has been implicated not only with heart disease (Gold et al., 2020; Davidson, 2012; Saran, Puri, & Agarwal, 2012) but also as a barrier to self-care in the health domain. Social workers can play a significant role in partnering with medical patients in various settings (inpatient and outpatient) to reduce mood barriers to healthcare treatment adherence.

Type 2 Diabetes

Type 2 diabetes has been rising in prevalence in recent decades among middle adults. Type 2 diabetes is the most common form of diabetes, occurring in 90–95% of the diabetic population. This disease is correlated with obesity and a sedentary lifestyle; however, healthy individuals with a genetic history can also develop type 2 diabetes. Type 2 diabetes is a metabolic condition where the body is unable to properly use the insulin made by the pancreas to process carbs for energy. This creates an increase in the amount of sugar in the blood, leading to hyperglycemia (high blood sugar). Chronic hyperglycemia can lead to numerous health complications, including diabetic retinopathy, diabetic neuropathy, kidney failure, heart disease, and if left undertreated/untreated, death.

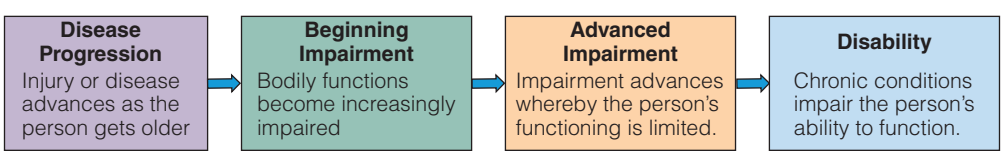
Heart Disease

Heart disease is the leading cause of death for men, women, and most racial groups in the United States (CDC, 2022; Kochanek et al., 2011). In 2020, one person every 34 seconds died from heart disease and one out of every five deaths in the United States were due to heart disease (CDC, 2022). Hispanic and Native Americans or Alaska Natives had the lowest prevalence of heart disease related death (15.8% and 14.2%), compared to white on-Hispanic and Black non-Hispanic people (21.3% and 20.7%) (CDC, 2022). The risk factors for heart disease include high blood pressure, high blood cholesterol, and smoking. Additionally, heart disease is heavily correlated with diabetes, obesity, unhealthy diet, physical inactivity, and excessive alcohol use. There is also research that demonstrates elevated stress or depression levels throughout life that can contribute to heart disease.

Chronic Disease and Disability

As people age, they may face chronic diseases that limit their everyday functioning. If serious enough, this can lead to disability when chronic conditions impact people's ability to engage in activities of daily living. The path to disability is presented in the following exhibit.

Exhibit 9.4: Pathway to Disability.



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In middle adulthood, people often begin the experience of losing some of the functioning they enjoyed throughout their life. As people's functional limitations set in, the awareness of aging begins and psychological adjustments are needed. BIPOC populations often experience disparities in disabilities for a variety of reasons including discrimination, access to health care, and socioeconomic status.

Cancers

In midlife, concerns about cancer are common. Cancer is second only to heart disease as the most common cause of death in men and in women. In fact, more than 12 million people have a diagnosis of cancer at any given time in the United States and one out of two men and one out of three women will be diagnosed with cancer at some point in their life (American Cancer Society, 2022).

In the end, cancer will have taken the lives of one of every five American men, and one of over six American women (American Cancer Society, 2022). Although many people still believe cancer is incurable, increasingly the public is recognizing that many people survive cancer. Public awareness campaigns have reduced some of the stigma associated with cancer. Overall, about 69% of cancer survivors are free of the disease for five or more years (NIH, 2022). The incidence of cancer has fallen during the past several years, but much of this decline is attributed to the increasing numbers of people who have quit smoking.

How does cancer occur? Cancer occurs when a cell is disrupted and begins uncontrolled growth and spread of abnormal cells that crowd out normal tissues and organs. It is believed that damage to gene *p53*, which keeps cells with defective DNA from multiplying, is involved in 60% of cancers. New cancer therapy is targeting the *p53* gene and shows promise in reducing tumor growth (Hu et al., 2021;).

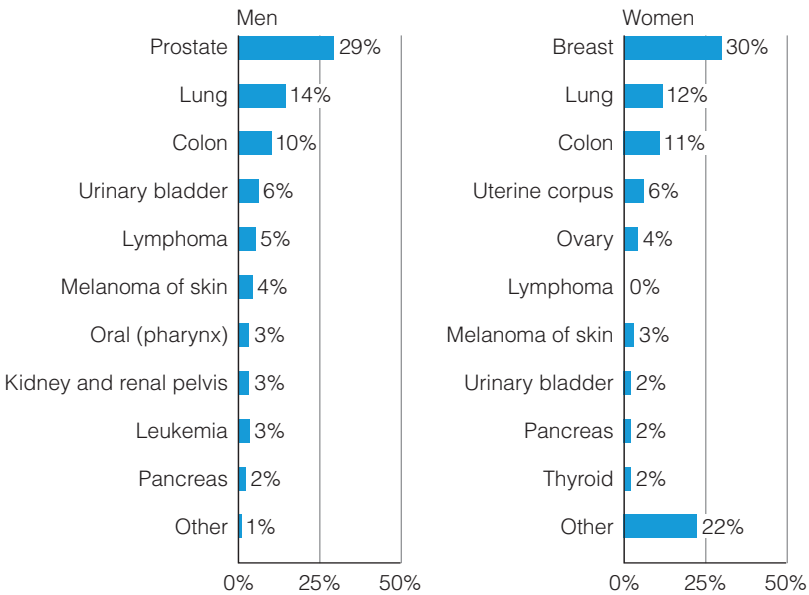
Exhibit 9.5 shows the percentage of total cancer incidence among men and women in the United States.

Breast Cancer

One of the biggest health fears of middle-aged women is breast cancer. Several factors increase an individual woman's risk for breast cancer: One is age. Although the overall chance of developing breast cancer is one in eight (American Cancer Society, 2022), this risk applies to a 95-year-old woman. Also consider that the chance of never developing breast cancer is 87.6%, or about seven in eight (American Cancer Society, 2022). Other risk factors include having a family history of breast cancer, onset of menstrual periods before age 12 or menopause after age 50, being childless or having a first child after age 30, being overweight, having a sedentary lifestyle, being of Caucasian decent, and drinking alcohol (; American Cancer Society, 2022).

Early detection of breast cancer can reduce the need for extensive surgical intervention. In many instances, however, the treatment for breast cancer involves the

Exhibit 9.5 Percentage of Cancer by Men and Women.



Source: Adapted from Greenlee (2000), p. 16.

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surgical removal of part or all of the breast. Because of cultural associations between this body part and sexuality, a woman may perceive breast cancer as a threat to her femininity and sexuality. The psychosocial/psychosexual adjustments to the disease may be more difficult for a woman than the actual physical recovery from the surgery (Love, 2010). Breast cancer survivors have lobbied for insurance to cover breast reconstruction, and it is now common practice following a mastectomy. Many public figures have disclosed their breast cancer struggles, and recently raised awareness of the role of prophylactic mastectomy in women carrying the BRCA gene predisposing them to breast cancer. Actress Angelina Jolie is one such example. Important advances have occurred as women treated for breast cancer are living longer.

Women with breast cancer need support for their emotional as well as their physical well-being, often benefiting from peer support groups. But some research suggests that the most important source of support is the family, in particular the woman's partner (see Love & Lindsey, 2010). The woman needs to be able to maintain good communication with her partner and to feel that her partner is empathic and will not withdraw from her because of disfiguring treatments. To mediate the psychological stress of breast cancer, social workers can help partners improve communication and support each other.

The implications of a diagnosis of breast cancer for women who lack a partner or other significant support are described in the following Focus section.

Prostate Cancer

Approximately one in eight men will be diagnosed with prostate cancer and 1 in 41 will die from the cancer (American Cancer Society, 2022). In spite of its prevalence, most of the men are only vaguely aware of the disease, its treatment, and its consequences. Unlike women, who often talk freely among themselves about intimate health problems, most men shy away from discussion of their physical disorders, let alone problems involving a gland that produces seminal fluid and affects urinary flow.

While prostate screening was common in the past, current best practice is recommending that routine screening not be done (American Cancer Society, 2022; Mulhem et al., 2015). This is because research has found the screening does not lead to a reduction in deaths from prostate cancer. If prostate cancer treatment is implemented, erectile dysfunction is common and psychosocial treatment for sexual recovery should be recommended (American Cancer Society, 2022; Walker, Wassersug, & Robinson, 2015).

Practice Guidelines:

Sexual Recovery Counseling after Cancer Treatment

To better prepare clients for sexual recovery, the following guidelines are recommended (Walker et al., 2015). See Exhibit 9.6.

- Foster realistic expectations. Recovery from prostate cancer treatment can be complicated. Realistic information about recovery should be provided to help couples best prepare.
- Intervene early. In order to facilitate the best transition to recovery, it is best to start erectile dysfunction treatment (this may include drug treatment, injections, or vacuum erection devices) and sexual recovery as soon as possible after treatment so that it is perceived as a normal part of the client's recovery.
- Conduct prehabilitation. In order to normalize the process, it can be helpful to start preemptive administration of ED treatments and sexual recovery counseling. This helps clients anticipate and plan how to cope best with erectile dysfunction.
- Include partners. It is best practice to include not just the client but the couple in the treatment process. The couple can be empowered to take joint ownership of the treatment. This can address common issues of performance anxiety, fear, and embarrassment. It can also assist in a positive and realistic approach.
- Use a comprehensive approach to sexuality. Exhibit 9.6 suggests how a more comprehensive approach might be conceptualized.

A Family-Systems Look at Couples and Illness

When one spouse is sick, is it a family affair? Indeed it is, according to researchers Howard Liddle and Gail Dakov. Liddle and Dakov studied patterns of coping in couples in typo, if one spouse had cancer. Contrary to popular belief, they found that openly talking about the illness is TYPO-always the best coping mechanism. Instead, Liddle and Dakov conclude that what is important is not how much the couple communicates about illness-related concerns but how much "their desire to share is similar." This means that adjustment of couples who do not wish to discuss the illness is just

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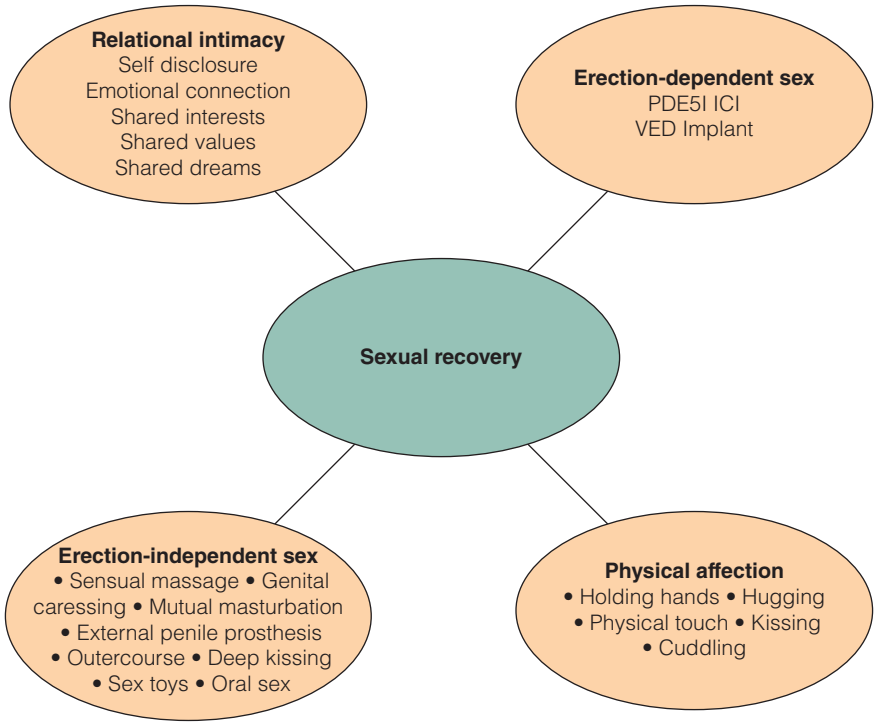
Exhibit 9.6 Sexual Recovery Model of Treatment.



as good as adjustment of those who wish to discuss concerns openly. Adjustment problems occur, however, when partners experience different levels of desire to talk about the illness. When one family member becomes ill, the entire family system is impacted. Medical family therapy can be a way for families to work through their issues as they struggle to adapt to a family member's illness (McDaniel, Doherty, & Hepworth, 2014).

A family's adjustment to illness is not based solely on communication styles but is also related to other factors. Relationship history, for example, plays a role in how couples adjust to illness. In many troubled couples, partners showed hostility toward each other after diagnosis. In happier couples, diagnosis reportedly brought spouses closer together.

Social Work Interventions for the Seriously Ill

Social workers would be quick to tell us that although medical care for cancer patients has improved, psychosocial support remains front and center in the total treatment regimen.

Can stress management or psychosocial interventions slow down the progression of AIDS or cancer? A recent rigorous review found that psychosocial interventions such as cognitive behavior therapy (CBT) stress management activities could be beneficial towards increasing patients' treatment outcomes and survival (Schneiderman et al., 2019). However, studies have found that psychosocial

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A difficult task that patients struggle with Is coming to terms with a serious Illness.

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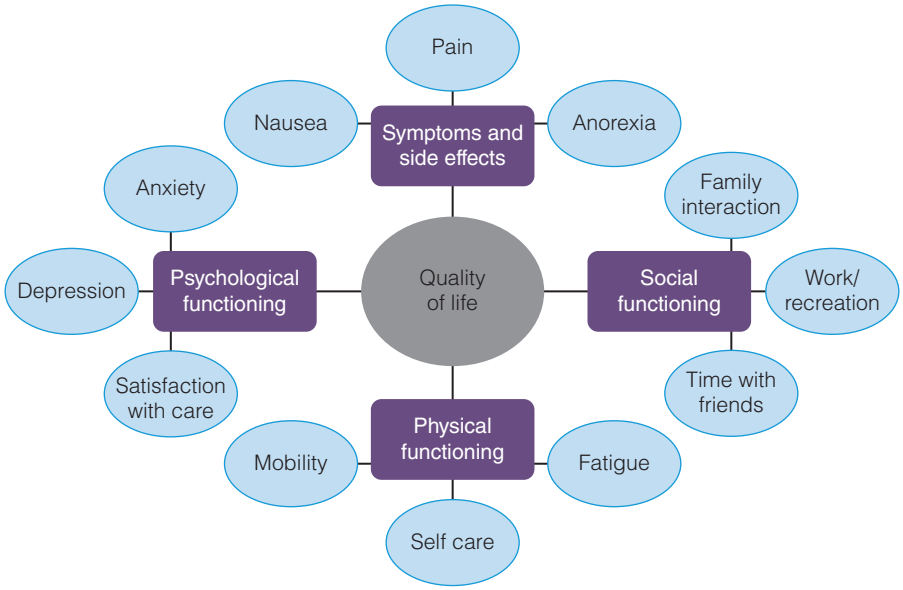
Exhibit 9.7 Psychosocial Considerations for Treatment of the Seriously Ill.



therapies can improve the patient's quality of life, instilling a more positive mood, creating better interactions with family members, and increasing energy levels.

Social workers can play a critical role in providing various supportive therapies for the seriously ill, and even homebound clients may want to participate in group therapy. Yvette Colon, a social worker, provides a telephone and online support group (Murray, 1999). She has described how people's increasing comfort with technology is expanding the available means of delivering client support. Today, telemedicine and virtual therapeutic services are becoming more and more mainstream, especially since the onset of the COVID-19 pandemic. Telephone and online groups provide a forum for clients to address coping ability, emotional overload, fatigue, loss, and death. The American Cancer Society provides online support groups at cancer.org, providing a forum for patients (and their families) to address coping ability, emotional overload, fatigue, loss, and death.

For reasons not yet well understood, low-income minority women have lower rates of follow-up care than do higher-income white women (Office of Women's Health, 2022; Denny et al., 2005), perhaps explaining the significant late-stage diagnosis and cancer fatalities among the low-income minority population. Group support and therapy that take into account the cultural, psychosocial, and systematic barriers encountered by these women as they obtain additional health care could greatly affect their chances for survival. Exhibit 9.7 shows the psychosocial considerations for working with individuals who are seriously ill.

Study Table Biophysical Dimension of Middle Adulthood

Biophysical Growth and Development

- At this stage, individuals see and feel significant changes in themselves physically. Most individuals in middle adulthood are less fit and have a fuller body shape.
- Revision of the physical self-image takes place in midlife, and many people at this age confess fears of disease and decline.
- The leading causes of death during middle age are cancer and heart disease.
- Menopause is a gradual process that occurs when a woman (average age 51) has not experienced a menstrual cycle for one year, and the ovaries stop functioning and no longer produce the hormones estrogen and progesterone. These hormonal changes may lead to hot flashes, night sweats, incontinence, and vaginal dryness, as well as health concerns such as risk of heart disease and osteoporosis.
- Reactions to menopause can be positive or negative. No significant changes in anger, anxiety, depression,

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self-consciousness, or worry about the body have been found to occur with menopause.

- Women who experience menopause are at greater risk for overall mortality.
- The major physical effects of estrogen loss are cardiovascular changes, which put postmenopausal women at greater risk of heart disease, and increased bone loss, which increases osteoporosis risk (thinning and weakening of the bones).
- The physical changes of middle adulthood also lead to changes in the sexual response cycle.

Biophysical Strengths, Hazards, and Risks

- As adults mature, becoming physically healthy often takes on greater importance. Developing a regular exercise program can increase one's self-efficacy.
- The number of Americans who are overweight has steadily increased over the last 30–40 years. This epidemic is linked to overeating, lack of exercise, and biology.
- Cancer is the second most common cause of death (after heart disease) in men and women. 40% of people with cancer are cured; that is, free of the disease for five or more years.
- Many women experience breast cancer (1 in 9), and men face prostate cancer (1 in 5) as they get older.
- Coping with cancer is difficult, and research suggests that couples openly talking is not always the best coping mechanism.
- Physical injuries, such as brain injuries, can take a toll on victims' families as they try to let go of their old image of the person and integrate the "new" person into the family system.
- Psychosocial interventions have not been found to increase patients' survival rates, but they can improve the patients' quality of life.

Psychological Dimension

Cognitive Development and Information Processing

Adult Development

Past researchers have attempted to study adult cognitive development based on the seminal ideas of Piaget. However, recent researchers interested in adult development have discovered that using Piaget's child-oriented theory is not the best approach to adult development. In fact, Piaget's work has contributed to the accepted social stereotype that childhood is the primary period for intellectual development (Schaie & Willis, 2010; Willis & Schaie, 2005). Childhood and adolescence have been seen as the time periods for acquiring the knowledge needed to operate successfully in adulthood. For a long time, it was believed that cognitive development or intelligence peaked in late adolescence and early adulthood. Of course, this belief appeared logical because there is an obvious shift of biological aging in middle adulthood, signaled most obviously by one's graying hair. A critical question related to the attempt to understand how cognitive development changes over the life course is this: Do individuals' cognitive abilities decline after young adulthood, as some stereotypes suggest?

A series of studies by Schaie has dramatically changed our view of cognitive development in middle adulthood. Schaie conducted longitudinal studies that discovered, for example, verbal ability actually peaks in late middle age (Scjaoe & Willis, 2010). Exhibit 9.8 shows fluid and crystallized cognitive ability changes across the life span.

The overall conclusion from this data is that intellectual functioning is stable in middle age. Decline in intellectual ability usually begins after age 60 (Brooks, 2022). Other interesting findings suggest that age-related declines occur earlier for some abilities—for example, numerical computations and spatial reasoning. The gender differences show that men perform at a somewhat higher level than women on spatial ability, but women perform at a somewhat higher level on reasoning ability.

These findings probably will be comforting to the many men and women at midlife who are required to perform at a very high level of intellectual competence. Adults in middle age assume major family, professional, and social responsibilities that demand sharp minds and the ability to acquire new skills and information. Schaie has contended that although we examine children's cognitive functioning by studying how information is acquired, to understand adult intellect, we need to examine how information is used. During adulthood, individuals are not exclusively concerned with acquiring skills but are concentrating more on achieving goals. This means that a majority of their cognitive abilities are focused on applying knowledge to real-world problems, which requires a new set of cognitive abilities—social and abstract cognitive skills. Schaie argued

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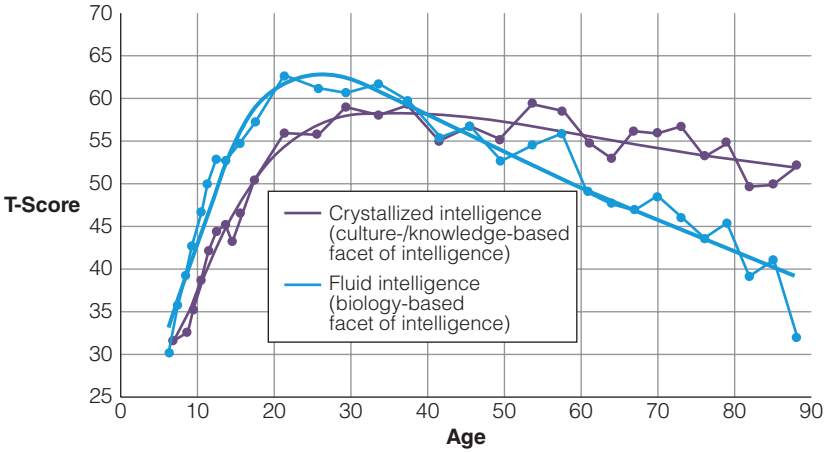
Exhibit 9.8 Fluid and Crystallized Intelligences Across Late Adulthood.



that cognitive and social functioning merge dramatically in midlife, when tasks have what Schaie calls "role-related achievement potential." Adults perform better at these tasks because the tasks are strongly related to the roles adults are assuming. This merging of social and cognitive functioning is also related to adults at midlife who are assuming more responsibility for others. Many adults become increasingly involved in civic and community organizations. Schaie's theory suggests that young adults move from "What should I know?" to the middle-adulthood focus of "How should I use what I know?" to later adulthood, when the emphasis is "Why should I know?" (Schaie, 1977, p. 135).

Crystallized intelligence, an important aspect of middle adulthood cognition, refers to skills that depend on accumulated experience and knowledge, the exercise of good judgment, and social competence. Practical problem solving—sizing up real-world situations and analyzing how to achieve goals—is one aspect of adult crystallized intelligence. This form of intelligence *increases* with age. In contrast, **fluid intelligence** involves more basic information-processing skills, such as the speed of analyzing information and detecting relationships among stimuli and the ability to use working memory. Research has shown that although crystallized intelligence increases through midlife, fluid intelligence begins to decline in the 20s. However, the longer such cognitive skills are used, the longer they will be maintained (Kievit et al., 2016).

Communication

By midlife, the process of communication is clearly established. Communication at this stage is dominated by family and by friends. In terms of the family, this may be the period in life when one can truly reconnect with one's partner or spouse. After many years of raising children, midlife adults often are ready to establish more meaningful relationships with their spouse, adult children, and friends. Before middle adulthood, many adults are simply too busy managing family life to establish a strong network of friends. Also, at midlife, adults begin the process of "life review"; they may reflect on communications that they would like to mend or at least make better. Midlife adults seek more meaning in their lives, and as a consequence, they are interested in communication on a deeper level. The friendships developed at this time are based on values such as honesty, sincerity, closeness, and mutual support.

The Forgiveness Process

In fact, midlife adults increasingly explore the process of **forgiveness** as they reflect on relationships that may not have progressed the way they had hoped. Research studies are beginning to support the social and psychological benefits of forgiveness (Toussaint et al., 2016; Enright & Rothschild, 2015). Individuals seek help with questions such as: How can I make things right after causing or receiving a serious interpersonal hurt such as a betrayal?

By midlife, we have accumulated a history of harms from people with whom we have had close relationships. We have all heard of individuals who are not communicating with a sister, brother, child, parent, or close friend because of some unforgivable act. And yet, forgiveness offers hope for righting or resolving some of the anguish of many wrongdoings. Many people are not at peace with themselves for not having asked the forgiveness of a loved one. Others remain angry at themselves for not being able to forgive a friend or a relative for some harmful action.

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The Illiterate Adult

Many of us take for granted our ability to communicate through writing, reading, and speaking. However, as many as 20% of adults in the United States are *functionally* **illiterate**—they cannot read and write well enough to participate in society. The National Assessment of Adult Literacy (2008) estimates that 26.5 million adults have only simple and concrete literacy skills, and an additional 16 million are considered functionally illiterate. As modern society becomes more complex, concerns about illiteracy become increasingly critical (see Exhibit 9.9).

What does it mean to be functionally literate? Definitions of **functional literacy** vary widely. The U.S. Bureau of the Census defines functional literacy as a sixth-grade reading level. The most common definition of functional literacy is the ability to perform everyday reading, writing, and arithmetic tasks. We do know that illiteracy affects mainly people who have low income, are uneducated, undereducated, and belonging to an ethnic or racial minority group. Illiterate adults may have completed elementary school, and many even received a high school diploma. However, in schools they did not learn some essential skills, such as writing letters, filling out applications, reading instructions on a package, reading the newspaper, and writing a check.

Functionally illiterate adults are often embarrassed that they do not understand essential communication. They are often concerned that people will "discover" that they are illiterate, and therefore they hide their inability to read and write. The stigma of illiteracy increases with age and may particularly be hidden by social work consumers in the midlife age group. Social workers should always consider the possibility of illiteracy when they encounter clients who sign consent forms without appearing to read them, when clients don't complete written between-session homework sheets, or when they seem to have not read educational materials, such as a 12-step brochure.

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There Is significant stigma associated with adult illiteracy.

Non-English-Speaking Adults

In many respects, adults living in the United States who do not speak English may face difficulties similar to those encountered by adults who are illiterate. Often, immigrants who do not speak English face restricted or discrimination in employment opportunities. They may be highly educated and competent in their native language but unable to communicate in fluent, grammatically correct standard English, and thus find themselves in low-paying jobs and lives of poverty. The immigrant may not have important functional skills such as reading street signs, advertisements, newspaper want ads, and so forth. Sometimes immigrant language patterns have a great impact on the receiving country's local ecosystem. Immigration demographics have led to whole neighborhoods within large urban centers that operate primarily in a non-English language. Examples abound on both U.S. coasts and the Southwest for communities speaking, for example, Spanish, Chinese, or Vietnamese. "Koreatown" in Los Angeles is home to the largest community of Korean speakers outside of Korea. Implications of monolingual, non-English-speaking status in the United States are variable and multidimensional, related to the education, income, and social context of the individual. In other words, a non-English-speaking person may experience individual isolation depending upon the social context.

Being shut off from one's surrounding world can lead to anger, frustration, and depression. Often, non-English-speaking people must become dependent on others to translate and communicate for them. This can lead to relationship problems and a difficult lifestyle wherein one cannot communicate with other people. Imagine what it would be like to have to keep your fears, successes, and observations all to yourself—it would make for a lonely existence.

The Hard-of-Hearing Adult

Imagine being 45 years old and noticing that you are having trouble understanding your friend when you are speaking on the telephone. At first you ask the speaker to repeat his statement, but as time goes on, and friends and coworkers wonder why you are always so absentminded, you find it easier not to initiate conversation. This is the confusing picture

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Exhibit 9.9 Adult Literacy.

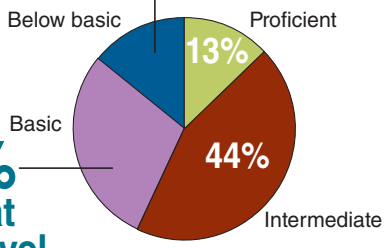
Reading level of U.S. adults

More than 30 million

adults in the United States cannot read, write, or do basic math above a third grade level(1)

More than **20 percent** of adults read at or below a fifth-grade level - far below the level needed to earn a living wage.(2)

14% can't read



29% read at basic level

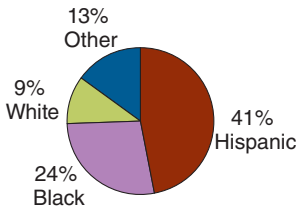
Types of Literacy

prose
Reading news stories, brochures, instructional materials

document
Job applications, payroll forms, maps, drug/food labels

quantitative
Balancing a checkbook, completing an order form

A look at the least literate(3)



Nearly **43%** of adults with lowest literacy levels live in poverty(1)

About 50 percent of the 2 million immigrants that come to the United States each year lack high school education and proficient English language skills(1)

Consequences of literacy

Adults with low-level reading skills frequently suffer from health problems as they lack the ability to read medical directions, health-related literature or prescription labels.

Parents with minimal to no reading skills often cannot provide the kind of support that their children need to do well in school

Consequently, children of disadvantaged parents begin their school life behind their peers.

More than 3 out of 4
of those on welfare are illiterate.

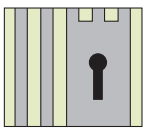
It is estimated that as many as **15%** of American students may be dyslexic.(4)

85% of unwed mothers are illiterate

1 in 3
of high school graduates will NEVER read a book after high school(2)

68% of those arrested are illiterate(5)

7 out of 10 adults
have not been in a book store in the past 5 years(2)

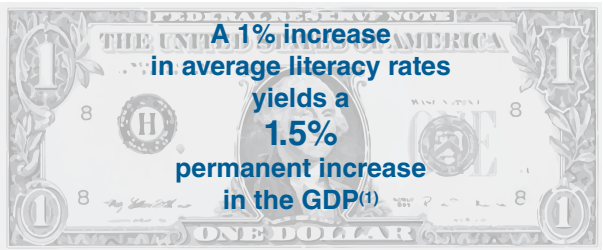


3 in 5 of America's prison inmates are illiterate(5)

Cost of literacy

An excess of **$230 billion** a year in health care costs is linked to low adult literacy(1)

Low literacy costs the U.S. at least **$225 billion** each year in non-productivity in the workforce, crime, and loss of tax revenue due to unemployment. (1)



Improved education results in potential savings in public assistance costs– welfare, food stamps, and public housing of **$7.9–$10.8 billion**(1)

That's approximately an additional **$2.31 billion** increase to the GDP of the United States(1)

Sources:
(1) ProLiteracy.org
(2) National Institute of Literacy, U.S. Department of Education
(3) Washington Literacy Council
(4) U.S. Department of Health and Human Services
(5) U.S. Department of Justice

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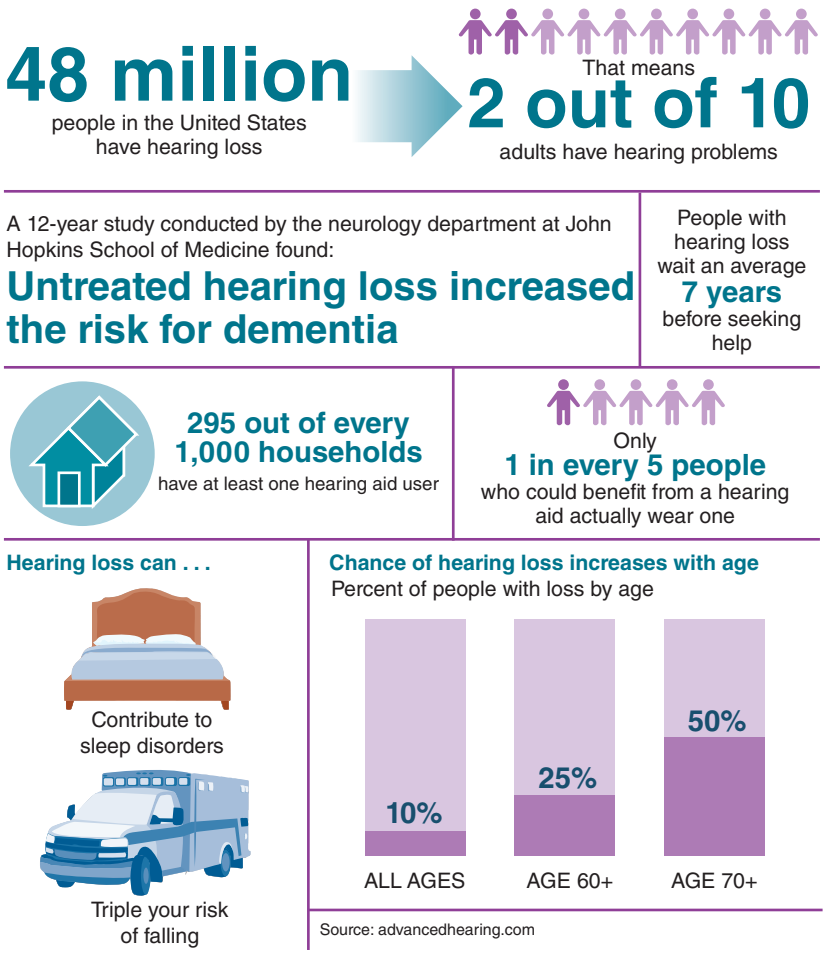
Exhibit 9.10 Hearing Loss Facts.



of slowly progressive hearing loss, a fact of life for many midlife Americans. Exhibit 9.10 presents hearing loss facts.

The estimates of the number of people who are deaf is about 15% (37.5 million) of the American population over the age of 18 (NIH, 2021). The incidence of disabling hearing loss is 2% for adults aged 45–54, 8.5% for adults aged 54–64, 25% for people aged 65–74 and 50% for those over 75 (NIH, 2021). In contrast to the high prevalence of hearing impairment, only 1% of the population is profoundly deaf, and of those, only 22% lost their hearing before age 19. People who were born deaf, then, actually constitute a small percentage of the hearing-impaired population.

Sadly, despite greater social acceptance and mainstreaming of people with disabilities, the stigma of hearing loss has endured over the years. In our culture, hearing loss and hearing aids are commonly associated with aging, being inadequate, or being incompetent (Lash & Helme, 2020). Therefore, people often deny their hearing loss or avoid doing something about it

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Hearing loss Is more common than most people realize. To address this Issue, many adults wear hearing aids.

Practitioners can alert families to basic techniques that improve the lives of people with hearing problems, such as talking directly at them so they can see the speaker's face and read their expressions and lips. Speaking clearly

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and at an unrushed pace also helps the hearing-impaired person to understand conversation. Fortunately, the cost of hearing aids has been dramatically reduced and they are now readily available.

Implications For Practice:

Clients with Hearing Loss

Hearing impairment is one of the most common of all chronic disabilities, and it affects people's lives in profound ways (Eberts & Hannan, 2022). People with hearing loss are subject not only to the particular difficulties that their disability creates but also to any related or resulting social or psychological problems that might require social work intervention. It is important, then, that all social workers understand the differences among deaf and hearing-impaired people and have the tools for assessing the meaning of hearing loss for a particular client (Spencer & Marschark, 2010).

Hard-of-hearing people have little in common with profoundly deaf people, many of whom were born unable to hear, live in a deaf society, use sign language, and flourish in a rich culture of their own. On the contrary, hard-of-hearing people—if they do not address their issues with professional audiologic care—are at risk of increased interpersonal conflict with, or withdrawal from, friends and family with whom they are having increasing difficulty understanding in conversation. They confront psychological issues different from those dealt with by deaf people; with education and encouragement, they can access an array of advanced hearing aid technology, much of which can be worn over the ear or connected to eyeglasses while barely visible to others.

Whereas people whose hearing loss is untreated can become isolated, people whose primary language is ASL tend to come together. Such groups have existed for many generations and have established a culture of their own. Many people tend to marry within the culture and affiliate with formal and informal organizations that are part of it. In addition to language, the culture includes particular behaviors, norms, and beliefs.

Another significant difference between culturally deaf people and those who have experienced progressive loss of hearing are their feelings about deafness itself. People in the deaf community and culture tend to perceive deafness not as a disability but as an alternative lifestyle and culture. In contrast, those who become deaf in later life miss their earlier access to spoken communication, and they miss sound. For them, deafness is both a disability and a loss; it is something to be mourned. Cochlear implant technology has offered the possibility of hearing to deaf people of all ages.

Practice Guidelines:

Clients with Hearing Loss

- ***Being alert and aware***: Be mindful of the hearing and speech needs of new clients who call or walk into your service setting; notice hand signing in the waiting room; hearing aids tucked behind a person's ear or attached to eyeglass arms; a cochlear implant battery pack in a shirt pocket; and a noticeable speech difference. Extend this awareness to the client's family members as well.
- ***Assessing***: Ask about sensory deficits at intake or psychosocial assessment for all new clients. Especially for middle-aged adults, don't assume vision and hearing is 100%. Clarify through direct interviewing whether the hearing deficit is congenital (present at birth) or acquired (at what age?), and how severe (often rated in terms of a percentage). Inquire about signing (which method?); use of adapted telephone equipment; use of interpreters (professional and/or family members); hearing aids; cochlear implant; and other aids, devices, or techniques.
- ***Accommodating***: Ask your client how to position yourselves in the interview space to maximize lipreading and hearing. Usually, this means good lighting toward the social worker's face and proximity of the client. Speak slowly and clearly but not loudly. Offer to write key words, names, or specific information. Know your agency's policies on accessing signing interpreters (live or through a telemedicine setup) and use them. Some clients with good speech and knowledge of English still prefer to involve a professional interpreter for important interactions, and they are legally entitled to that accommodation. Professional interpreters for the deaf are able to use both signed English and ASL and to select the language suited to the individual and the situation.
- ***Advocating***: Appropriate referrals for external services may take longer to assemble since the social worker will need to call ahead to establish how the other agency will receive this client and accommodate their special needs. The social worker might first access a local deaf advocacy group that has compiled and organized referral information for community resources that are—or are not—attuned to this client population.

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Legal Implications: Title V

The U.S. Rehabilitation Act of 1973 addressed the needs of disabled people at different ages. **Title V** was designed to ensure that programs receiving federal funds could be used by disabled individuals. The four major sections of Title V prohibit discrimination and require accessibility in employment; education; and health, welfare, and social services. The Adults with Disabilities Act requires that hospitals and clinics meet the communication needs of their patients, families, and visitors who might be deaf or hearing-impaired

To increase access to services, U.S. federal laws dictate the use of interpreters in mental health settings. Despite this, a survey of all mental health centers in one state found that 29% of the 28 respondents flatly stated that they were not accessible to deaf people. Additionally, 39% stated that they did not provide interpreters, even though 72% of the agencies indicated that they had served deaf individuals; of these 72%, only 25% had used certified interpreters (McEntee, 1995). More recently, healthcare agencies use technology-driven solutions to bridge this communication barrier. For example, an internet line with videoconferencing equipment comprises video remote interpreting (VRI) services to ASL-speaking deaf patients. Communication access real-time translation (CART) is another professional communication service that can be delivered on-site or remotely, providing real-time transcription of spoken words.

To be effective advocates, social workers need to be aware of key legislation on the macro level, as well as how the specific agency implements that legislation. Implementation often involves formal policies, daily practices, and technology. It is not uncommon for the social worker in a health or mental health setting to become the in-house expert on patient access issues related to communication disabilities.

Attitudes, Emotions, and Regulation

Well-Being and Anxiety

Well-being is an essential construct related to attitudes and emotions of midlife adults (Brooks, 2020). Well-being is most often defined as a person's emotional and psychological capacity for coping with demands across time, circumstance, and setting. For example, feelings about deteriorating health, worries about the future, and stress are some concerns that may emerge in midlife (Infurna, Gerstoorf, & Lachman, 2020; Hunter et al., 2002). The physical changes of midlife discussed so far are no doubt challenging: menopause, fitness, chronic illness and cancer, hearing loss, etc. When combined with the more social/interpersonal stressors of aging parents, grandchildren, major career changes such as retraining, layoff, or retirement, midlife would seem to be fertile ground for anxiety, and some research supports this view (Infurna, Gerstoorf, & Lachman, 2020; Almeida & Horn, 2004; Blanchflower & Oswald, 2008). While some fear is normal—about the aging process itself and the reality of death moving closer into view—persistent, overwhelming anxiety is not developmentally normal. *Fear* is the physical, cognitive, and emotional state of hyperarousal we commonly know as "fight-flight-freeze," and it is an adaptive response to imminent physical threats such as an oncoming car or a snake in our path. It becomes maladaptive, however, and morphs into what we call **anxiety**, when it persists long past the original threatening event (such as a trauma), when it pervades daily life and impairs role functioning, or when it's triggered by multiple daily situations because it's excessive or even unrealistic. Exhibit 9.11 shows what it can feel like to be flooded with thoughts during a panic attack. Anxiety can be thought of as fear run amok: too much, too often, and too impairing.

While the changes of early adulthood require decisions about which life path to take as the road forks, the middle-aged adult is aware that this may be the last fork, the last turn, in a shorter road. Existential despair that comes and goes; some worry and tension about specific physical and social challenges: this is usually normal anxiety, but ongoing dread, terror, sleep disruption, and physical symptoms may indicate an anxiety disorder such as GAD (generalized anxiety disorder) that warrants professional help. One of the rare studies addressing vulnerability to anxiety during midlife, and its connection to childhood and early adulthood diagnosed mental illness, is Clark et al.'s 2007 analysis of a prospective 45-year longitudinal study of more than 9,000 general population adults (Clark, Rodgers, Caldwell, Power, & Stansfeld, 2007). Psychological ill health at ages 7, 11, and 16 were associated with a 1.5- to 2-fold increase in risk for midlife anxiety and affective disorder. And risk for midlife disorder increased significantly with the cumulative number of adulthood episodes of psychological ill health. These findings underscore the importance of psychosocial history gathering in the social work assessment process to better understand the risks for anxiety disorders in a middle-aged client.

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Exhibit 9.11 Feelings Associated with Anxiety.

Assessment Tools: Screening for Anxiety

The GAD-7 is a brief clinical measure for the assessment of generalized anxiety disorder. This tool may serve as a screening instrument to identify probable cases of GAD, and the scale scores provide a measure of severity. The measure appears below, and is also available online.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half a day**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

GAD-7 Score and Anxiety Severity

GAD-7	**Anxiety Severity**
0–4	Minimal
5–9	Mild
10–14	Moderate
15–21	Severe

Source: Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine, 166*, 1092–1097.

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Loneliness

Sometimes everyone experiences loneliness. It's an unpleasant sensation that might make us feel lonely and long for companionship and closeness. A rising corpus of research has revealed that loneliness is detrimental to our mental health and our physical health. Perhaps not surprisingly, loneliness is linked to a higher risk of stress, sleep issues, and mood disorders like despair and anxiety.

Loneliness is a major mental health concern, and it impacts both men and women in a significant manner. Recently, attention has been focused on the issue of men and loneliness. Research found that one in five men have no close friends, twice as many as women and this lack of friendship appears to be growing (Taylor, 2022). A recent study found that when men talk about loneliness, they often reveal being socially unimportant, not having a purpose, experiencing a sense of emptiness, feeling of little value to others, and feeing cut off from society (Age UK, 2022). It is also important to acknowledge that men are less likely to tell someone when they are feeling lonely. Engaging men in social groups may be one prescription.

Social Responsibility and Midlife

Although the preceding theories seem to suggest that at midlife there is a strong internal focus on oneself in which change may be experienced as a crisis, Rossi (2004) has argued that midlife represents an increased opportunity to branch out and become involved in socially responsible activities.

The majority of early theorists on adult development discuss this emphasis on social responsibility. Early on, Havighurst (1952) suggested that at midlife the major task was one of civic and social responsibility. Erikson's task of ego integrity emphasizes actions directed toward social causes. It is "an emotional integration which permits participation by followership as well as acceptance of the responsibility of leadership: both must be learned and practiced in religion and in politics, in the economic order and in technology" (Erikson, 1959, p. 97). Positive psychology emphasizes the value that results when a person does something good for the world (Lopez, et al., 2018 Lopez & Pedrotti, 2014).

Social responsibility is often based on two aspects of development. The first is the person's sense of obligation. Midlife adults can move beyond their narrow self-interest and begin to consider the general interest of others. "The obligation is based on a keen awareness of one's group memberships—ultimately, the human race—and of human interdependence in society" (Maas, 1989, p. 260). The second aspect of social responsibility is the person's ability to act on his or her sense of obligation. By midlife, most adults have obtained a level of competence that allows them to be effective in undertaking their obligations. Over time, they develop the capacity to become socially responsible and fulfill their sense of obligation to society.

Psychological Strengths, Hazards, and Risks

As many adult development theories point out, midlife can be a challenging period, requiring many new adjustments. The new roles one must adapt to, the intense reflection about one's accomplishments, and the search for new meaning can lead either to psychological strengths or psychological hazards.

Developing Optimism and Happiness

Our ability to cope with the demands of life changes depends in part on our perspective. Developing optimism and happiness is a viable strategy that fits with the midlife search for more meaning and quality in life.

In the same manner that social work began its emphasis on the "strengths model," psychology has an emphasis on "positive psychology." Many psychologists are recognizing the limits of the deficit or disease model of mental health. Much of the positive psychology movement is related to Seligman's (2003, 2012) work on authentic happiness and flourishing. Seligman discussed three fundamental aspects we need to change to create this emotional state:

1. Being happier about our past. This occurs by resolving the false belief that negative past experiences determine your present and future, as well as by increasing your gratitude about the good things that did occur in your past and forgiving past wrongs.
2. Being happier about our present. This is done by knowing the difference between pleasures and gratifications. Pleasures are sensory delights, whereas gratifications are things we like to do but not necessarily because of the sensory feelings that emerge. Gratifications are tied directly to strengths and virtues.

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Society Is Increasingly focused on optimism and happiness.

3. Being happier about our future. This occurs when we change our explanatory style and learn to become more optimistic and hopeful. Much of one's authentic happiness emerges from focusing on identifying and developing one's "signature strengths." Midlife is an excellent time to reflect and *act* in a way to bring these new positive psychology discoveries into daily living. In midlife, psychological hazards can take a toll; alcohol and drug addiction are some of the most serious of these hazards.

Practice Guidelines:

Increasing Happiness

In order to increase happiness, researchers have found that the following actions can enhance how we experience happiness.

- Strengthening our relationships. Being connected to others can facilitate greater happiness.
- Helping others. Volunteering and giving to other people can make us feel better about ourselves.
- Having new experiences. Challenging oneself to try new things can increase how we perceive our world.
- Being grateful. Practicing grateful behaviors can build our happiness. Writing letters of thanks, righting past wrongs, and telling others what we appreciate about them are all ways we can be more grateful.
- Experiencing the present more consciously. Being mindful of everyday events and experiences, sharing the experience with others more mindfully, and being present in the moment by lingering or taking a deep breath.

Alcohol and Drug Addiction

Alcoholism is the consumption of alcoholic beverages to the extent that either personal safety or social role functioning is impaired. Alcoholism is widely considered a disease, meaning that it follows a prescribed course of physical, psychological, and social symptoms. As discussed in the "Young Adulthood" chapter, alcohol misuse is common problem in a person's 20s, only a subset of those individuals goes on to become alcohol dependent or chronically abusing. By midlife, alcoholism as a progressive problem can manifest with irreversible organ damage and ultimately death. When an alcoholic person abstains from drinking, he or she is said to be "recovering."

According to the National Survey on Drug Use and Health, an estimated 5.3% of the U.S. population, or 14.5 million people aged 12 and over, have Alcohol Use Disorder (National Institute on Alcohol Abuse and Alcoholism, 2022). This number is much higher than the 13.8 million reported nearly 20 years ago. Alcoholism touches all age groups and all sociocultural and economic groups. In prior years, men consumed the majority of alcohol and had the highest rates of alcohol use disorder when compared to women. However, in recent years, women have begun consuming more alcohol and the gender gap is closing. As of 2019, women consumed alcohol at nearly a 1:1 ratio with men, compared to a 1:3 ratio last decade (Pattani, 2021). In a recent analysis of alcohol rate between men and women, White (2020) notes that alcohol use increased for women but not men. He further notes that females are more susceptible than males to alcohol-induced liver inflammation, cardiovascular disease, memory blackouts, hangovers, and certain cancers. Alcoholism is one of the most serious social problems facing Americans. Weiten and Dunn (2014) have noted that alcohol misuse is blamed in 64% of murders, 41% of assaults, 30% of suicides, 60% of child abuse incidents, 45% of drownings, and 55% of arrests. Alcohol contributes to nearly 100,000 deaths annually (National Institute on Alcohol Abuse and Alcoholism, 2022), making it the third-leading cause of preventable mortality in the United States, after tobacco and diet activity patterns. Facts about alcohol poisoning are presented in Exhibit 9.12. It is estimated that as many as one family in three is affected in some way by a drinking problem.

Identification and assessment of alcoholism are complex. Not all alcoholics drink every day, and many

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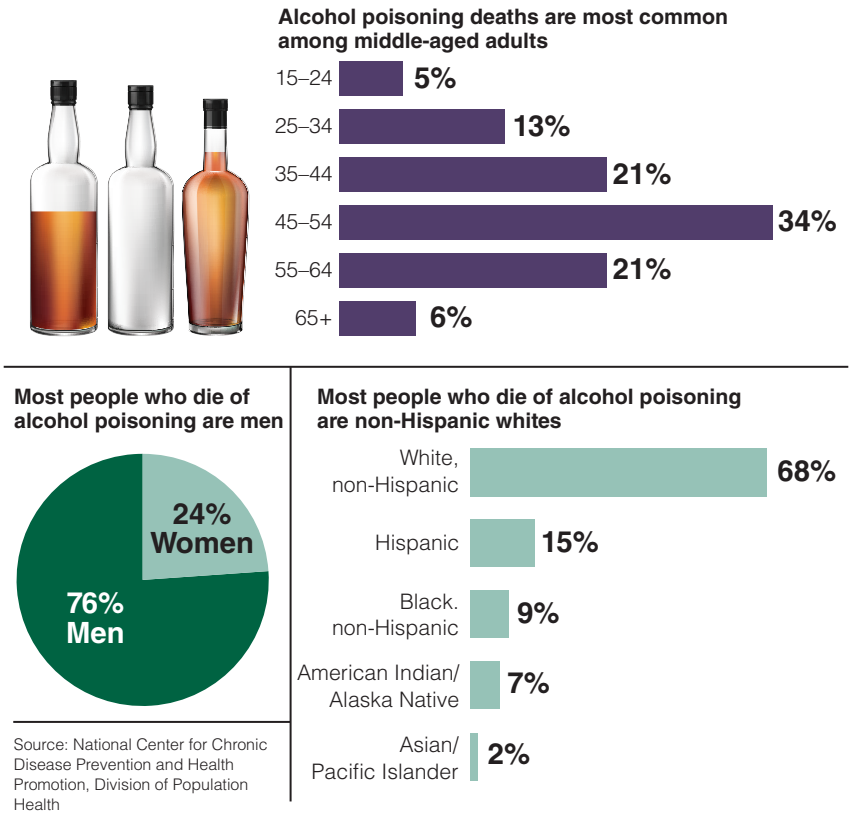
Exhibit 9.12 Alcohol Poisoning in Middle Adulthood.



people who do have one or two drinks every day would not be considered alcoholics. Some people will react to a personal crisis and abuse alcohol as a means of coping for a period of time but not become alcoholics. Indeed, many young adults will abuse alcohol for a short time period but eventually develop a healthy pattern of social drinking. Distinguishing heavy drinking from the early stages of alcoholism sometimes can be difficult.

Assessment usually begins with a person's consumption levels and personal or family history of alcohol-related problems. Common assessment questions include (National Institute on Alcohol Abuse and Alcoholism, 2015): How long have you been drinking this amount? How many times per week (or month) do you have four or more drinks on one occasion? What is the most you have consumed on one occasion during the past year? And a family-history question: Have you or has anyone in your immediate family ever had a drinking problem?

Assessment Tools: Alcohol Use Assessment Using the CAGE and AUDIT for Alcohol Screening

The CAGE for alcohol screening:

When individuals are currently experiencing alcohol-related problems and need to be assessed for alcohol abuse or dependence (now termed *alcohol use Disorder* in DSM-5), the CAGE or the AUDIT is often used as an assessment instrument (National Institute on Alcohol Abuse and Alcoholism, 2015). Indications of dependence are three or four positive responses to the CAGE's four questions:

C—Have you ever thought you should *cut down* on your drinking?

A—Have you ever felt *annoyed* by others' criticism of your drinking?

G—Have you ever felt *guilty* about your drinking?

E—Do you ever have an *eye opener* in the morning?

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The AUDIT for alcohol addiction (alcoholism):

The AUDIT (Alcohol Use Disorders Identification Test) was developed by the World Health Organization. The test correctly classifies 95% of people into either alcoholics or nonalcoholics. The test is structured in the following manner (WHO, 2001).

To correctly answer some of these questions, you need to know the definition of a drink. For this test, one drink is:

One can of beer (12 oz or approx. 330 ml of 5% alcohol),

One glass of wine (5 oz or approx. 140 ml of 12% alcohol), or

One shot of liquor (1.5 oz or approx. 40 ml of 40% alcohol).

1. How often do you have a drink containing alcohol?

Never (score 0)
Monthly or less (score 1)
2–4 times a month (score 2)
2–3 times a week (score 3)
4 or more times a week (score 4)

2. How many alcoholic drinks do you have on a typical day when you are drinking?

1 or 2 (0)
3 or 4 (1)
5 or 6 (2)
7–9 (3)
10 or more (4)

3. How often do you have six or more drinks on one occasion?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

4. How often during the past year have you found that you drank more or for a longer time than you intended?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

5. How often during the past year have you failed to do what was normally expected of you because of your drinking?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

6. How often during the past year have you had a drink in the morning to get yourself going after a heavy drinking session?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

7. How often during the past year have you felt guilty or remorseful after drinking?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

8. How often during the past year have you been unable to remember what happened the night before because of your drinking?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

9. Have you or anyone else been injured as a result of your drinking?

No (0)
Yes, but not in the past year (2)
Yes, during the past year (4)

10. Has a relative, friend, doctor, or healthcare worker been concerned about your drinking, or suggested that you cut down?

No (0)
Yes, but not in the past year (2)
Yes, during the past year (4)

Your score:

If you scored 8–10 or more, it indicates that your drinking may be hazardous.

Some common signs suggest someone is moving into the early stages of alcoholism. For example, many people increasingly use alcohol to cope with their personal problems. Others experience memory lapses or "blackouts" while drinking, cravings for alcohol, and

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an increased tolerance for alcohol. In the middle stages of alcoholism, there is an increase in memory problems from blackouts, and the person becomes increasingly physically dependent on alcohol. This dependence is first suggested when the person experiences early-morning tremors and agitation that require a drink for relief. In the later and final stages, there are regular drinking bouts. Also during this stage, alcoholics experience *delirium tremens*, a withdrawal syndrome whose symptoms include agitation, tremor, hallucination, and sometimes seizures.

Researchers still do not understand the causes of alcoholism; however, it is likely to include a combination of biological, psychological, and social factors. Recent attention has been directed to the incidence of alcoholism in families. Studies based on twins support a genetic contribution to alcoholism (Zillich, 2022) Tsuang, Bar, Harley, & Lyons, 2001). It is estimated that up to 50% of alcoholism risk is determined by genetics (Deak, Miller, & Gizer, 2019; National Council on Alcoholism and Drug Dependence, 2021). As a result, researchers have begun to search for an inherited physical predisposition to alcohol addiction. Some research has suggested that alcoholism is related to a particular gene on chromosome 11. This gene is related to the production of receptor sites, on brain cells, of the neurotransmitter dopamine.

Many researchers have attempted to find a particular personality that would lead to the development of alcoholism, but results have not been encouraging. However, alcoholism does appear to be related to various types of emotional problems. For example, many alcoholics drink to help them cope with feelings of depression or anxiety. Other individuals drink as a means to release their inhibited feelings. Alcoholics may experience role conflicts in their work and family life.

Although in the United States many substance-abuse problems are related to alcohol, serious consequences are also associated with drug dependence. Drug dependence, or drug addiction, is defined by three characteristics. First, it is related to the length of time a person has been using the drug. Just how long a time is required to develop dependence is difficult to say and is related to the particular type of drug and the particular user's characteristics. Second, individuals who are dependent find it difficult to stop using the drug. Continuing to use it requires a lot of effort, even including stealing to get needed money. Third, when dependent drug users do refrain from using, they experience physical pain or psychological stress, referred to as the withdrawal syndrome.

Drug dependence is associated with a large number of different drugs, including nicotine found in tobacco products, Valium used as a sedative, angel dust (a street drug derived from horse tranquilizer), and hallucinogenic drugs (such as LSD and ecstasy), to name only a few. There are six primary classifications of drugs: narcotics, such as heroin, fentanyl, and morphine; sedatives, such as Seconal and Valium, which include barbiturates and nonbarbiturates; stimulants, such as amphetamines and cocaine; hallucinogens, such as LSD and mescaline; cannabis, such as marijuana and hashish; and alcohol, including wine and scotch. Do alcohol and drugs affect women differently than men? The next section looks at the special case of women and drugs.

Addiction and AA's 12-Step Program

The 12-step approach to addiction is so popular that it is now referred to as a social movement (Herman, 1988). In the 12-step approach—the core of Alcoholics Anonymous (AA)—people follow 12 carefully devised steps on the road to recovery (Alcoholics Anonymous, 2002). What exactly is the 12-step program, and how does it work?

The 12-step program is straightforward in its approach to alcoholism (AA, 2000). It sets out a structured road to recovery. Essentially, members are expected to "work the

Focus on **The Lived Experience**

Women and Alcohol Use

Just downing my 2nd glass of wine & thinking about how the pandemic turned a lot of moms into wine or White Claw lushes. (Me) Then I thought about how women were not allowed to work in the 50's, and all the alcohol depictions of moms during that time makes total sense to me now.

—Tweet from Jess Sassenach (2021)

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steps." In the process, individuals must admit wrongdoing, admit their powerlessness, pray and meditate, and meet with sponsors outside the group meetings. AA is famous for its helpful slogans, such as "Live one day at a time" and "Let go and let God."

The program is delivered through a series of weekly (or more frequent) meetings. Members are encouraged to create and adhere to an individualized schedule of meeting attendance. Most meetings begin with an opening statement; then a speaker addresses the group, telling their own personal story. Next, the members are invited to share, and last there is a closing statement. Members may speak about whatever they want, and the group listens without interruption or subsequent comment.

Members are also encouraged to get involved with a sponsor. The sponsor is a kind of "buddy" who helps the member by providing advice and counsel about the program philosophy and structure. There is a strong emphasis on providing members with support. Sponsors and other members make themselves available 24 hours a day to help the person during times of crisis.

Although AA is recognized as often effective, it has come under increasing criticism, first for its lack of empirical research backing up its "success" rate claims. Other critics are less concerned with the underlying science than they are the cultural characteristics of the 12-step movement; for example, its religious terminology. For example, one of the 12 steps states, "[We have] made a decision to turn our will and our lives over to the care of God, *as we understood Him*" [italics added]. Some individuals raised in non-monotheistic religious traditions may be put off by this fundamental belief in AA. Other individuals also dislike the personal responsibility emphasis and putting the alcoholic's addiction completely on the alcoholic's shoulders. But many social workers help their clients understand that while AA promotes a disease concept of alcoholism, the responsibility for recovery rests solely with the individual.

The major countermovement to 12 steps is the harm reduction model of treatment, which challenges some fundamental tenets of AA. The harm reduction approach is widely implemented in urban low-income health clinics and community mental health centers. The AA approach tends toward an either/or concept of motivation whose traditional wisdom holds that the addicted person must hit "rock bottom" in order to reach maximum motivation for change. But the harm reduction proponents see motivation as a more fluid construct, a state that varies by the hour and the day and which can be gradually enhanced in response to skillful therapeutic interventions utilizing the Stages of Change Model proposed by DiClemente and Scott (1997; DiClemente, 2003; DiClemente, Bellino, & Neavins, 1999).

What other contextual factors might relate to people becoming addicted? Increasing research is providing some support for a genetic predisposition toward alcoholism. Also, we know that earlier exposure

Focus on **The Lived Experience**

Goodbye, Johnnie Walker

In the past year, I started drinking in the shower each morning. I was drunk by nine, drunk at noon, drunk at three, drunk at seven, and drunk at 10 o'clock. I had pretty much stopped eating, although I still made dinner for my wife, our dogs, and myself and pretended to enjoy a fine meal in a fine little house on a pretty street in a nice little town. Eventually, my body started eating itself to stay alive. Ketosis is the medical term.

Why my drinking got so out of control after so many years of my being, a functioning and productive alcoholic remains a mystery to me. I just know that I had become (and still am) one sick son of a bitch just a step away from the grave because I suffer from the disease of alcoholism. I drank too much. It is as simple and as difficult as that. I find most books that deal with drinking and rehab somewhat smug and self-congratulatory. I am neither confident enough nor sufficiently proud of getting through a day sober to take that attitude. Truth be told, I am confident only that I will have another drink at some point in my life. Maybe today.

Source: Davidson (1998), p. 19.

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in life (younger age at first drink) is associated with alcoholism in later life (SAMHSA, 2006), These explanations are not consistent with the AA philosophy. Because AA members must admit to "powerlessness," it is difficult to promote notions of empowerment with AA members.

Critics offer additional questions for thought: "Can all human pain be collected into one big bundle labeled addiction? Should it be? What about the feelings of pleasure that people derive from food, drugs, alcohol, sex, and a host of other substances and activities?" (Herman, 1988, p. 59). This "movement" of disease-related addictions raises concerns about turning self-destructive behaviors into diseases and normal people (with problems) into victims rather than promoting empowerment of the individual as a socially responsible member of society. Some of the dissatisfaction with the AA model has inspired new but related approaches, such as Rational Recovery, Secular Organization for Sobriety, and Women for Sobriety. It Is noteworthy that recent research has provided some of the missing research on AA's effectiveness (see Greene, 2021). Fingarette (1988, 2004), an outspoken critic of the AA model, has argued that alcoholism is a mythical disease. He noted that "what seems to be compassion done in the name of a 'disease' turns out to subvert the drinker's autonomy and will to change, and to exacerbate a serious social problem" (p. 64).

If there are so many problems with AA's model of addiction, why do so many professionals believe that it is an effective alternative for alcoholics? Regardless of the criticism, AA does attract a large number of individuals and professional social workers typically refer their clients for this adjunctive, peer-based support. Here are three possible reasons why AA works, at least for some people (Ericksen, 2020; AAWS, 2002; Herman, 1988):

1. It provides a needed social context for addressing the problem. In this social context, it is a safe haven where people can be understood and accepted for who they are. Many people are demoralized and lonely, and any program that can address those issues will be helpful to people.
2. It provides a group setting for social support. In most groups, a critical factor to success is feeling that you are not alone—that you are not unique. By expressing feelings and receiving emotional support, people gain confidence that they can take action to solve their problems.
3. It provides a clear structure—a path to follow. There is a self-determined behavioral routine that members follow, which can be critical when your life is turned upside-down. The steps provide a mechanism to focus one's energy.

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Twelve-step programs, which attract many people who are seeking help offer a social context for addressing problems, a group setting for social support, and a clear structure.

Other Theories of Addiction

The brain disease model is currently the leading model to explain addiction in the world. However, there are other models of addiction. The first and most widely known is the Biological/Brain Disease model that indicates a biological predisposition, neurotransmitter imbalance, and general brain disfunction. The Psychodynamic model of addiction states that people with addictions are self-medicating, and addiction is a symptom of an underlying psychological problem. This model states that once the underlying psychological problem is treated, the addiction will resolve. There is also the Moral/Spiritual Model, which is associated with stigma and states that misusing substances is a choice made from weak, sinful character. Fourth, is the Environmental model, which is similar to the Person in Environment Perspective spoken about throughout this book. The Environmental model states that addiction is a combination of the individual's emotional, social, spiritual, and environment detriments. These could include a lack of support system, observational learning, stress, maladaptive coping skills, the influence of

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advertising and laws, or other factors within the above domains. The Biopsychosocial model states that all of the above theories have some elements of truth, but effective treatment requires addressing the whole person and the environment.

However, given the complexities we all face in modern life, individuals often seek professional help because they feel dissatisfied. The following section examines the controversial false memory syndrome (FMS), stimulated by the large number of women who sought help for having been sexually abused as a child.

Practice Guidelines:

When to Seek Professional Help

Under what circumstances would you recommend that a person seek professional help? Social workers hear this question from their families and friends, and it is a real challenge for the most Americans not working in health or social services. In general, individuals should be encouraged to seek professional treatment when they manifest one of these three "Ds":

- serious Danger,
- serious Dysfunction in role performance, or
- serious psychological Distress.

First, urge the person to consider her/his naturally occurring social support network including family, faith community, and friends. They should carefully consider with whom they would feel comfortable sharing their concerns and asking for feedback, seeking someone who knows them well and will be honest but caring. However, when social support is not available or rejected by the individual, and if the alcohol misuse is endangering the person (through drunk driving, smoking in bed while intoxicated, or other high-risk behaviors), it is best to urge and to assist the person toward professional help. AA helplines and websites are widely available and a good starting point, in addition to primary care doctors, who may also refer the person to addiction treatment covered by their health insurance.

The type of help called for—individual therapy, group therapy, or family therapy—varies depending on the nature of the concern. Other considerations of when to get help might include the following (Bruckner-Gordon, Gangi, & Wallman, 1988):

- There are no friends or acquaintances to talk to the person or help with his or her problem.
- The friends or acquaintances indicate that the person's problems are too difficult for them to handle.
- The person feels extremely overwhelmed and helpless.

False Memory Syndrome

One of the fascinating stories in the recent history of psychotherapy was the emergence of the False Memory Syndrome Foundation (FMSF). This foundation was established after thousands of women revealed that they had been sexually abused as children. In 1985, a *Los Angeles Times* poll reported that 22% of those sampled had been sexually abused before the age of 18. Many of these women sought refuge in *The Courage to Heal* (Bass & Davis, 1994), a self-help book that profiles more than 100 interviews with survivors of sexual abuse. Although this revelation shocked the country, a new development became equally shocking—the organization of a group of parents who believed that they had been falsely accused of sexual abuse. By 1992, thousands of accused parents were involved with the FMSF. These parents claimed their innocence and were exasperated in their attempts to meet with their sons' and daughters' therapists to tell their part of the story. They were angry at having been ostracized by their children and sought scientific evidence that might help explain their children's misperceived judgments.

The interest in FMS intensified as several books were published, among them Elizabeth Loftus's *The Myth of Repressed Memory,* Richard Ofshe's *Making Monsters,* and Mark Pendergrast's *Victims of Memory* (Pendergrast was a father accused of sexual abuse). Also contributing to the growing interest in FMS were the court cases won by the parents accused of sexual abuse against the therapists of women who recalled memories of sexual abuse. The validity of the memories were challenged, with the defense that many of the recollections were false creations, born of the patients' suggestibility and their therapists' leading questions. Indeed, the therapists were found to have reinforced the false memories of their clients. This idea that therapy has gone too far is addressed in detail by Sommers and Satel (2006) in their book *One Nation Under Therapy: How the Helping Culture Is Eroding Self-Reliance*.

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Study Table Psychological Dimension of Middle Adulthood

Cognitive Development and Information Processing

- Verbal ability actually peaks in late middle age. Cognitive abilities do not decline after young adulthood.
- Adult intelligence is more related to performing role-related tasks.
- Crystallized intelligence are skills based on experience and knowledge, judgement and social competence, which increase with age. Fluid intelligence is more basic information processing skills (e.g., using working memory) and declines with age.

Communication

- As adults move closer to doing a "life review" or seeking more meaning, they reassess their communication with others.
- The forgiveness process can play a bigger role in middle adulthood as individuals accumulate more experience with relationships. Forgiveness can be conceptualized as a four-stage process: uncovering anger, deciding to forgive, working on forgiveness, and discover and release. The process can lead to mental health benefits.
- As many as 20% of the adults in our society must adjust to being functionally illiterate. Adults who do not speak English may face discrimination in employment, low-paying jobs, and live in poverty.
- Functional literacy is defined as a sixth-grade reading level.
- Hard-of-hearing people are at risk of isolation and withdrawal from society, as well as the frustration of having cultural and personal links to the hearing world dissipate. Interference with communication is the most damaging aspect of hearing loss.
- Title V was designed to address the needs of individuals with disabilities such as deafness and requires that services meet the communication needs of individuals.

Attitudes and Emotions

- A person's well-being is most often defined as his or her emotional and psychological capacity to cope with the demands across time, circumstances, and settings.
- Fear and anxiety are two emotions that become more prominent in midlife. Both men and women express fear of death and of being alone during their later years.
- Midlife adults may experience an anxiety disorder and screening and assessment tools can help identify these problems.
- A major task of midlife can be one of civic and social responsibility that emerges from a sense of obligation to become socially responsible. Ego integrity emphasizes efforts toward social causes.

Psychological Strengths, Hazards, and Risks

- Our ability to cope depends in part on our perspective. Optimism and happiness play a significant role in the midlife search for more meaning and quality in life.
- Guidelines for increasing our happiness include: strengthen relationships, help others, have new experiences, be grateful, and experience the present.
- An estimated 7.2% of the population abuse alcohol, a problem that touches all age, sociocultural, and economic groups, but the majority of alcohol abusers are men (75%).
- Screening instruments such as the CAGE or AUDIT help identify when an individual is having problems with alcoholism.
- It is estimated that up to 50% of alcoholism risk is determined by genetics.
- Drug dependence is defined by length of time using, difficulty stopping use, and withdrawal symptoms.
- Alcoholics Anonymous is a popular approach to alcohol dependency that uses a social context, a group setting, and a 12-step structure in its treatment design.
- Individuals should seek professional help with the experience of the 3 Ds: danger, dysfunction in role performance, and distress.
- False memory syndrome refers to the belief that many therapists provided clients with leading questions to create "false memories" of past childhood problems such as abuse.

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Social Dimension

Groups and Families

Family diversity was discussed in the "Young Adulthood" chapter, the stage when many adults are beginning their families. Divorce also was addressed, but divorce often leads to new relationships and new marriages—with the end result of a blended family or stepfamily. A **stepfamily** is a newly formed unit consisting of a married or cohabiting couple, one or both of whom have children from a previous marriage. Stepfamilies are a norm in our society today due to high rates of both divorce and remarriage, and the resulting blended or stepfamilies, that emerge in parents' middle adulthood. Over 50% of families are remarried or re-coupled (Stepfamily Foundation, 2021). Adapting to a stepfamily may require facing unique emotional and social tasks, because many changes must be confronted. Children, after witnessing conflict, loss, new commitment, and overall transition after a divorce, are at a higher risk for emotional and behavioral problems (Garriga & Pennoni, 2022 Amato, 2000).

Blended Families or Stepfamilies

As we have seen, divorce and subsequent remarriage are increasingly common, and 60% of partners who divorce have children and become single parents. However, most single parents do not remain so for long. Within five years of a divorce, 75% of single-parent families will become stepfamilies (Ganong & Coleman, 2004; Stepfamily Foundation, 2021). Stepfamilies are families whose kinship is determined by remarriage. Many stepfamilies will then add another birth child to the family.

Stepfamilies face significant changes, as they must adapt to a new marital relationship, continue relationships with prior spouses, and help the children adjust to a difficult family transition. Families must begin with acceptance of loss and changes, readjust expectations about what a family is, facilitate role adjustment for all family members, and coordinate a lifestyle that juggles two family households.

How do such changes affect the children in stepfamilies? Research is just beginning to shed light on this question. In general, following remarriage of their parents, many children develop behavior problems as they adjust to new family roles (Stepfamily Foundation, 2021;). Behavior problems are more likely in boys, whereas girls often experience an increase in emotional problems. Adolescents can pose special problems for the stepfamily because they are moving toward independence and may be adversely affected by the increased stress associated with the stepfamily. Younger adolescents (ages 10–14) have the most difficult time adjusting because they are wrestling with identity formation issues and tend to be oppositional. Older adolescents (ages 15 and up) need less parenting and have less investment in family life. Younger children are the most accepting of a new adult, particularly if he or she is a positive influence on the newly formed family.

Of course, some benefits are also associated with a stepfamily. Moving from a single-parent family to a family with a stepfather or a stepmother can add a significant new relationship to the life of the child. In fact, boys seem to do less well in single-parent families than girls do, and when they gain a stepfather, they become less anxious, experience increased self-esteem, and make a better adjustment in general (Ganong & Coleman, 2004). Girls do not seem to benefit as much in gaining a stepfather. Still, over time both boys and girls make an adjustment to being part of a stepfamily.

Practice Guidelines:

Working with Blended Families

- Research (; Heatherington & Stanley-Hagan, 2000) suggests that the stepparent is most likely to gain acceptance from their stepchildren if they refrain from directly controlling their behavior. Discipline is better left to the biological parent. The stepparent should work at establishing a relationship with the child and support the biological parent in their parenting" (Heatherington, 1988, p. 311). After a stronger relationship is established, then the stepparent can engage in more authoritarian parenting.
- Adapting to the new stepfamily can be complex and may be assisted by professional counseling services. Couples need to bolster their marital relationship and work to adapt to the changes. Wald (1989) wrote that it is essential for social workers to "understand that the characteristics inherent in the stepfamily do not reflect pathological dynamics but rather normal and transitional adjustments to a new situation" (p. 560). Even under the best conditions within the new family, it may take two to four years for members of the family to adjust to one another (Ganong & Coleman, 2004).
- Bray (1999) conducted a nine-year longitudinal study to find out how mental health professionals can help

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families cope with the transition into a blended family. Five specific themes emerged from his study: planning for remarriage, marital relationships, parenting in stepfamilies, stepparent child relationships, and noncustodial-parent issues. Exhibit 9.13 presents a summary of these five coping strategies for newly blended families.

Marriage and Intimate Relationships at Midlife

Many couples at midlife are launching their children into adulthood. For the partners who have been parents throughout much of their lives, this signals a significant change—often referred to as the empty nest syndrome. However, this reference confers some outdated notions on this stage of life. Originally, the empty nest syndrome was of particular concern for the mother who had devoted herself full time to raising children. Of course, that picture has changed with the large increase in the number of working mothers. Studies have found that, rather than being "empty," this stage can be fulfilling for both men and women. Rather than seeing marital satisfaction decline, research has found that it begins a steady climb in the post-childbearing years (Cavanaugh & Blanchard-Fields, 2019).

Why would satisfaction increase as children are launched into adulthood? Most likely the stresses associated with children are due to "role overload," whereby parents with children at home neglect their roles as married partners, and that this situation has a negative effect on marital satisfaction. Overload occurs in these families because communication and companionship are sacrificed in order to respond to the caregiving role as parents. Professional helpers should therefore be alert to the marital problems of their clients at midlife that are related to poor communication and lack of companionship (Infurna, Gerstorf & Lachman, 2020; Hunter et al., 2002).

How do love and intimate relationships change at midlife? One common explanation is that the nature of intimacy changes and couples develop more affectionate and companionate love. Whereas in young adulthood much of the focus on intimacy revolves around romantic love, physical attraction, and passion, by midlife many adults are more concerned about maintaining relationships from the perspective of mutual sharing, security, and loyalty. Indeed, by midlife, the marital relationship is central in the lives of

Exhibit 9.13 Stepfamily Issues, Coping Strategies, and Suggestions.

Issues	Coping Strategies	Suggestions
Planning for remarriage	Financial and living arrangements	Couples who hold a "one pot" philosophy about family money and move into a new home together report greater satisfaction.
	Resolve feelings with the previous marriage	Ex-spouses who reframe a remarriage as a "final emotional divorce" prevent further hurt and allow the new couple a fresh start.
	Anticipate parenting changes and decisions	Making decisions as a team will strengthen the new marital bond and defray some future conflicts.
Marriage quality	Give priority to building the marital bond	Couples who create a strong bond first will ultimately benefit the children by creating a stable home environment.
Parenting in stepfamilies	Recognize children's needs	The new stepparent should act as a "buddy" until a solid bond is formed. Negotiating family rules frees the stepparent from acting as disciplinarian.
Stepparent–child relations	Consider children's gender	Both boys and girls prefer verbal affection such as praises and compliments. Girls are uncomfortable with physical closeness. Boys accept a stepfather more quickly than girls do.
Noncustodial parent issues	Maintain positive relationship	The less a parent visits, the more abandoned a child will feel. Speaking against an ex-spouse undermines a child's self-esteem and puts the child in the unjust position of having to defend a parent.

Source: Adapted by authors from Martin (1995a). Interventions that work for stepfamilies. *APA Monitor,* 34–36. Copyright © 1995 American Psychological Association. Reprinted by permission.

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many men and women. As is well advertised by those that promote marriage, married adults are happier, healthier, and better off financially than other adults (Waite & Gallagher, 2000). The trick is to manage their relationship in bad times so they can reap the rewards that can come with a good marriage over "the long haul" of later life.

Is there such a thing as a good marriage that has survived? Judith Wallerstein (1996) in her classic book, *The Good Marriage,* studied married couples who have experienced satisfying, enduring marriages. What she found is that without a strong appreciation for the other person, a sense of companionship and loyalty, sexual attraction, and empathy, couples are less likely to have a successful marriage. More recently, Barbara Fredrickson has written *Love 2.0: Finding Happiness and Health in Moments of Connection* (2013). Fredrickson attempts to change how we view love noting that rather than seeing love as based on intense relationships she defines it as "micro moments" where we are connected to one another with deep feelings of affection, attention, and respect. In this new conceptualization, Fredrickson believes that love can be seen as more renewable and as a resource to draw from.

Of course, many middle adults' lives move in different directions, which creates distance between the partners. Each partner may be pursuing different goals and commitments that make the development of mutual sharing difficult. For example, the wife may be seeking growth through work and other commitments, while her husband may be seeking stronger emotional support and shared activities. Survival of the marriage may depend on the commitment level each spouse has attained over the years and each one's ability to appreciate and understand the other person's needs. In many respects, it is during middle adulthood that the couple may want to review and renew their commitment to the marriage. Although a couple may face important changes, divorce is much less likely to occur at midlife than at an earlier point in life.

There is contradictory research regarding employment, parental, and marital satisfaction among women as parental roles have continued to shift over the past two decades. Income has remained stagnant while inflation has increased, leading to women entering the workforce during child rearing in greater numbers to assist with providing for their families (U.S. Bureau of Labor Statistics, 2022). In fact, in 2019, prior to the COVID-19 pandemic, two-thirds of women were either breadwinners or co-breadwinners for their families (American Progress, 2021).

With this influx of women entering the workforce, household roles as the parent and significant other have not evolved much to accommodate for this shift, and women are still completing most household responsibilities while working an equal number of hours to their male partners outside of the home (Gallup, 2020). Fifty-five percent of men report being satisfied or very satisfied with the amount of household chores they complete compared to 28% of women. Additionally, 59% of women report feeling they complete more than their fair share of household chores (Pew Research Center, 2021). This has led researchers to believe that as women are entering the workforce in greater numbers without equitable help with household duties, their workload has increased substantially and their satisfaction as parents and spouses has decreased (Spector, et al., 2019).

Marital Satisfaction among African Americans

Most of the research on marital satisfaction has been conducted with couples who are white and middle class or affluent. However, African Americans have a higher divorce rate compared with whites at every income level. Research by Broman (1993) sought to examine what factors predict marital quality among African Americans. The results showed that for both husbands and wives, the perception that family income was adequate to meet the family's needs was predictive of marital satisfaction. For AfricanAmerican women, economic adequacy was related to how positively they assessed their husband's role performance. In addition, the provision of emotional support predicted marital satisfaction and harmony for both men and women. For African American men, having a smaller number of children was related to greater marital satisfaction, but African American women's satisfaction depended not on the number of children but on the degree of problems associated with raising the children. Personal development and the opportunity to express individual freedoms were positively related to marital satisfaction for both husbands and wives. Finally, for African American women, job satisfaction was correlated with marital satisfaction. Later research elaborates on these themes and findings (Dillaway & Broman, 2001; Johnson & Loscocco, 2015).

Extramarital Affairs

A discussion of marriage would not be complete without a discussion of extramarital affairs. For many men and women who struggle with changes in midlife, an extramarital affair offers an opportunity to rediscover themselves. Married couples tend to have established routine patterns that become unexciting and boring. At midlife, they are

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often searching for something new and different, and an affair may offer a unique opportunity to rediscover different aspects of themselves. Such affairs may be related to seeking greater fulfillment in personal relationships, or may emerge out of anxiety over physical aging and a need to perceive oneself as still attractive. For men, an affair may be an opportunity to deny their declining sexual performance. In their classic book, *Fortysomething,* Goldstein and Landau (1990) aptly noted, "If either a man or a woman is haunted by the sense of time running out, if either abruptly realizes that they have spent much of their lives doing what others wanted them to do, then either one is a likely candidate to follow wherever a forbidden impulse leads" (p. 189).

Today, there is more opportunity than ever for individuals to get involved in extramarital affairs, especially with the increased number of women working and the widespread accessibility of the Internet. There are now web sites whose goal is to facilitate extramarital affairs. Most experts agree that affairs often occur not because of a bad marriage or unhappiness but out of a desire for variety and excitement. Glass (2003) found in a study of 350 couples who had affairs that 83% of women and 58% of men reported a strong emotional attachment to the marriage partner. She also found that 26% of the men and 3% of the women reported having extramarital sex with no emotional attachment. Furthermore, men who were involved in affairs were as satisfied in their marriages as men who were not involved in affairs, whereas women who had affairs were less happy in their marriages than women not involved in affairs. Santrock (2022) has stated that for the next generation of midlife women, sexual relationships outside of marriage are likely to continue to increase because of factors such as greater acceptance of women as sexual beings, family changes that leave many women without men, men's shorter life expectancy, and the changing role of women in the workforce.

How common are extramarital affairs or instances of nonmonogamy in couple relationships? A review of the 2018 U.S. General Social Survey suggests that extramarital sex occurs in less than 17% of committed relationships (Djamba & Kimuna, 2020), and that they are more common with men (25%) than women (15%). However, when the definition of cheating was expanded to include emotional relationships without intercourse involved, cheating prevalence increased around 20% for each gender (Brody, 2018). For gay men, nonmonogamous relationships were extremely common—about 50% (Thrasher, 2013). Lesbians were only a little more likely to have nonmonogamous relationships when compared with husbands and wives.

Middle-Aged Adults and Their Aging Parents: Caregiving and Loss

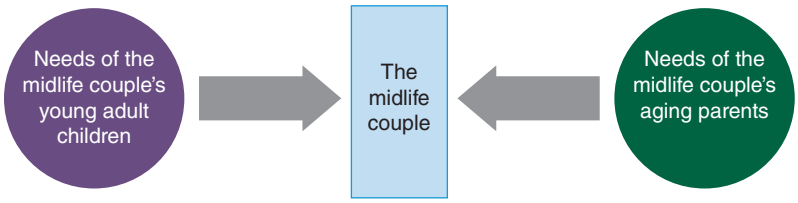
Middle-aged parents often find themselves in the dual-demand situation of raising children and at the same time managing the increasing needs of their aging parents. Thus, middle-aged adults often are referred to as the *sandwich generation,* as shown in Exhibit 9.14.

Even the task of moving, perhaps to a senior apartment or supported living situation, weighs heavily on grown children, primarily daughters, who are also more likely to be the keepers of family symbols, photographs, and heirlooms than are son. The following quote aptly describes the difficulties many middle-aged adults face with their parents.

> It is too late to turn back. I have set in motion events that are tumbling me along like a broken branch in flood-tide. I have run out of choices. I look at my 94-year-old mother. Her thin, hunched body is dwarfed amid a welter of crates, cartons of books, piles of possessions to take to the Salvation Army, and other stacks of worthless items too precious to leave behind. Her expression matches the disheveled room. She doesn't know it yet, but by this time next week, she will be in a nursing home in Colorado, a thousand miles from here, whatever life remains to her drastically changed. The cost of dying, particularly if one does it slowly, is prohibitive in California.
>
> —L. Hartney*

* Quotation from "My Mother's Keeper" by L.L. Hartney, Family Therapy Networker, Sept./Oct. 1989, 38–41. Copyright © 1989 Family Therapy Networker. Reprinted with permission.

Exhibit 9.14 The Midlife Squeeze.



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Caregiving for older adults has Increased and middle aged parents often feel the burden of caring for their own children, as well as their parents.

Thirty-three percent of adults with a parent aged 75 or over say their parent needs assistance, and of those adults who do provide the help, 37% say they do so alone, with an additional 38% noting that they share this burden with another family member (Pew Research Center, 2015). When an elderly parent needs some assistance, family members are usually the ones who provide the needed medical and personal care.

Not only has the number of older people who need caregiving increased but the nature of caregiving also is changing. Because of rapid medical advances, individuals are much less likely to die from acute causes and instead are more likely to die from a chronic illness, such as cancer (Holman, 2020), so the caretaking role is extended over a longer period of time and complicated by ongoing specialized health needs.

Parent care—as it is sometimes called (Maron, 2014)—is best conceptualized as an unexpected career. A **caregiving career** often includes caring for children, caring for elderly parents and relatives, and providing care for a dependent husband. Caregiving is not simply a one-time, limited episode; indeed, caregiving has important implications for women, who provide this care without receiving wages, pension benefits, or other resources (National Partnership for Women and Families, 2021; Lemme, 2008). How the caregiving duties of middle-aged women affect their participation in the labor force is an important consideration for their future. Beck (cited in Lemme, 2008) states that the average woman will spend 17 years caring for children and 18 years caring for aging parents. Although caregiving does offer emotional rewards, it is also a source of stress and often produces negative mental and physical consequences for the caregiver (Centers for Disease Control, 2022; Ingersoll-Dayton, Neal, & Hammer, 2001). Many caregivers are unprepared for this role, especially the daily physical demands associated with feeding, toileting, and lifting their parent (Cleveland Clinic, 2019; Toseland, Haigler, & Monahan 2011). From a psychosocial perspective, caregivers often feel abandoned by their friends and family members and may have feelings of depression, anxiety, self-blame, and general stress (Centers for Disease Control, 2022).

A significant life task for many midlife adults is successful coping with the loss of their parents, and grieving and reevaluating their lives without their parents. For many, it is a difficult adjustment. It is often said that no one is truly an adult until they have lost both of their parents. The change is dramatic for many adults—they can no longer share accomplishments with the people they care for the most, their sense of family is disrupted, and they lose a uniquely intimate relationship that cannot be replaced.

Families of Adults with Neurodevelopmental Disorders

Many social workers work with adults with disabilities in institutional settings. Have you ever thought about people who are being cared for in their parents' home, long after they reach adulthood? Of the estimated 6 million people with developmental disabilities living in the United States, only 15.6% live in institutional settings. Of those living in noninstitutional settings, the majority will live with their families. Consequently, families play a significant role in the service delivery system. Family living often promotes community integration, employment, social relationships, and other benefits that are not easily provided in the social services system.

There are several reasons to become more knowledgeable about families who continue to care for their child past the age of 21. First, researchers have found that, although older caregivers of adults with developmental disabilities experience stress and personal burden, they have greater stability, better morale, and better health than caregivers of elderly people. Support resources have been found to play a significant role in reducing perceived caregiver burden. It has long been known that strong formal or informal social supports

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can buffer the effects of stress. Research has shown that support services can have a positive influence on a family's ability to provide care to a child with developmental disabilities and can postpone the need for out-of-home placement.

There are several implications for social workers who work with families of adults with developmental disabilities. First, social workers employed by public agencies must continue to identify and serve the families with the greatest needs. Second, social workers must learn to listen to how the families define their situations, explore with them the resources available to them, and support them in deciding which resources would be most beneficial. Third, social workers can connect families with parent support groups that provide emotional support and teach parents to use their own strengths and develop coping skills to help them face their particular difficulties. Finally, social workers can serve as advocates for the development of services and support for families of adult children with intellectual disabilities. Social workers can advocate within the social services agency on behalf of the families, connect families with legal advocates or attorneys, provide families with information, and train families to advocate on their own behalf.

Practice Guidelines:

Leading Support Groups for Caregivers

Social workers often lead support groups for caregivers, which contribute to the midlife son or daughter's effective coping and well-being. Toseland and colleagues (2011) identified a number of functions these groups can serve:

- Provide a much-needed respite from caregiving
- Reduce isolation and loneliness
- Provide an opportunity to share feelings and experiences in a supportive atmosphere
- Affirm and validate feelings and thoughts about the caregiving situation
- Instill hope
- Educate caregivers about the effects of chronic disabilities and available community resources
- Encourage a mutual sharing of information about effective coping strategies
- Help caregivers to become motivated to use systematic problem-solving procedures and coping strategies to reduce or eliminate the stress they are experiencing

Grandparenthood

Given the longevity of older adults, most middle-aged parents will live long enough to be involved with grandchildren, and some will live long enough to know their great-grandchildren. The average age of first-time grandparenthood is 50 (AARP, 2019).

Grandparents approach their new roles from different perspectives. Some are interested more in being fun-seekers, having mostly informal and playful interactions, and others are surrogate parents, assuming major childcare responsibilities. This role has increased dramatically post-COVID, where many grandparents stepped in to help with parenting responsibilities. Grandparents can serve as important role models of aging and integrity. They offer the family a sense of continuity.

The role shift to grandparents can require relearning old skills and adapting to new ways of parenting. Grandparents may be called on to help calm a fussy baby, change a diaper, heat a bottle of milk, and teach toilet training to a toddler. Often, the grandparent's approach is different from that of the parent, and the differences between them need to be worked out. Being a grandparent, therefore, involves new roles that affect family relationships (Di Gessa, Bordone & Arpino, 2019). Grandparenting can be very rewarding if it is approached with experience and wisdom.

Being a grandparent may offer a sense of completion to the middle-aged adult. Being a grandparent may reflect a person's influence across the generations, providing an affirmation of his or her values and a sense of general satisfaction (Danielsbacka, Krenkova & Tankanen, 2022; Cherlin & Furstenberg, 1986; Fay & Cline, 2010). Grandparents often are able to share their experience and wisdom in child-rearing, offer emotional support to the parents, and achieve satisfaction in their grandchildren's accomplishments. This new role offers new opportunities and new learning. The tasks of grandparenting can lead to self-reflection on one's own parenting history and call for new competencies.

Grandparents Raising Their Grandchildren

It's like turning back the clock to 20 years ago, yet we're a lot older. We're back to finding a sitter if we have to go out. We're back to having very little, or should I say, no time to ourselves. I am too old for the young mothers, and the people I grew old with do not have grandchildren with them all the time. We have nothing in common anymore. This situation makes me feel like a misfit. I should be going

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to senior citizens' activities instead of parent-teacher meetings. What worries me most is what should happen to him if I should die. (Kelly, 1993, p. 331)

When young parents cannot care for their children because of factors such as substance abuse, mental illness, criminal activity, poverty, homelessness, or AIDS, frequently the grandparents end up raising the children. Though many grandparents willingly accept the responsibility for their children's children, this responsibility often brings added stress, discussed by Sands and Goldberg-Glen (2004):

- Older adults raising their children's children face increased family stress at all levels. Grandparents may worry about their own children, who may be in trouble with addiction or illness. These older adults also may be coping with their own elderly parents who need care. Now they have small children to raise who may have been abused or neglected and may need extra care and support.
- In general, social support mediates stress for parents. But grandparents raising their grandchildren may lose their support network. They often are isolated from their peers, who are no longer raising children.
- The grandparents may worry about living long enough to raise their grandchildren or about becoming ill and being unable to care for their grandchildren.

Because of such stress factors, grandparents may experience problems in relating to their grandchildren. Such stress can lead to a decrease in caregiver–child interactions, which can then affect the children's development (Brunissen et al., 2020; Fay & Cline, 2010).

Organizations such as the American Association of Retired Persons (AARP) have established formal support systems for grandparents raising grandchildren. The AARP publishes a newsletter and offers a grandparent information center. The notion of "kinship care" has gathered a lot of support as it is increasingly recognized (Denby, 2015). Across the country, kinship care centers are starting to take hold as the needs of grandparents caring for children are recognized. Many services are used by grandparents, including support groups, advice on obtaining guardianship, counseling, and parent skills training.

In general, grandparenting can play a critical role in adapting to the aging process. For many grandparents, this new role replaces impending retirement and concern over loss of responsibilities. Being a grandparent contributes to one's personal influence across the generations, and in this sense it may help grandparents become more comfortable with addressing their question of legacy, what they will leave behind when they die. It provides an acceptable opportunity to pass on their cultural heritage and communicate special meanings to grandchildren.

Communities and Support Systems

Robert Putnam's (2001) book *Bowling Alone* struck a chord with many midlife Americans. "Bowling alone" refers to the fact that the number of people who bowled in leagues has sharply dropped, despite the popularity of bowling. Why would this trend occur? Putnam wrote that this symbolized a troubling trend—the erosion of community ties, social networks, informal bonds, and political involvements. In total, this represents a decline in "social capital." Building a successful community involves capitalizing on the social connections between people. Putman found that many aspects of civic engagement were on the decline—national organizations such as the American Legion, the AFL-CIO, and the PTA have seen losses in membership. Fewer people are giving dinner parties, playing card games, and visiting with friends, family, and neighbors. Putnam outlined four critical reasons for these societal changes:

1. Urban sprawl has increased the time spent commuting and decreased neighborhood and town identities.
2. Women's movement into the workforce has created less time for volunteer associations and neighborhood interactions.
3. Use of—some would say addiction to—television has increased and created a "cocooning" effect where we are passive consumers rather than actively engaging with others.
4. Later generations have moved away from social engagement. The Baby Boomers (born 1946–1964) and now Gen Xers (born 1965–1980) display a trend away from social engagement.

However, other social activities may have replaced the social circles that have declined—there are more soccer leagues, self-help groups abound, and the Internet is a source of virtual connection to a growing number of people. What remains clear is that we need civic engagement for a healthy society, and an important task is to learn new ways to reinvigorate communities. In addition to needing civic engagement, middle adults also look to enhanced career development and job satisfaction.

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Career Development and Job Satisfaction

Consider the following comments from Kyle, a 51-year-old man (Bergquist, Greenberg, & Klaum, 1993):

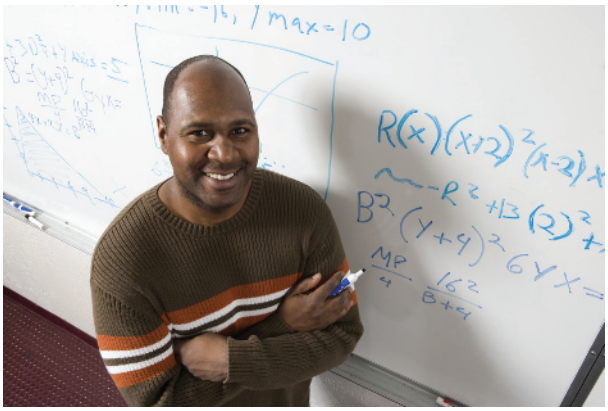
> I have come through the printing industry, from apprentice to journeyman, learning the trade and going through the changes we have experienced in the industry. It's been quite an experience. But my success was moving through the management part of the job, and this has been most rewarding to me. It certainly broadened my scope, and being part of the challenges of the future has been a great lesson. . . . I'm where I am today because of the way I do my job, and I feel I have been recognized for that. This job is a continuing learning process. I don't happen to think that, just because I have this job, I have reached the goal I set for myself in life. I feel that there is a lot more for me to do and still a lot more for me to learn. (pp. 120–121)

Development in work and career is a major context for adult development (Ferrao & Car, 2021). Regardless of the nature of the work, unskilled or professional, it becomes a central focus around which adult life revolves. Indeed, work often provides a growing sense of satisfaction as one gets older (Lemme, 2008). Our jobs may mean more to us, and as a consequence, we are more serious about our work and derive more satisfaction from it—a situation aptly described in the preceding quote.

Unfortunately, husbands and wives often disagree over the amount of time men spend at work. When put in the context of today's working world, which seems to demand "more for less," men feel caught in the middle. They recognize that they need to be more accountable to their spouses and families for *both* financial and time-and-attention contributions, but at the same time, workplace expectations loom large. Families are less willing to be brushed off or placed or marginalized by dads.

Too often, men tend to confuse what they do with who they are. Historically, men have expressed their manhood through their work. Consider this man's dilemma: "If I put myself and my family seriously in the picture, I feel like I'm just not really trying at work, like everyone else is going to get ahead of me and I'm washed up. I know it's illogical, but it's like work is all or nothing—either I go 100% or I'm a has-been" (Waters & Saunders, 1996, p. 47).

Typically, men pursue a narrow career pathway for most of their adult lives. At midlife, they may begin to question their accomplishments at work, but they may also question their contribution to the family. A common male reaction at midlife is to reevaluate one's role in the family in relation to one's commitment to work. Midlife women tend to have more midlife career changes because they have typically already experienced career interruption or reconfiguring for child-rearing or other caregiving (Cavanaugh & Blanchard-Fields, 2019; Hunter et al., 2002). Other women start professional training while raising children and then move into a full-time career. The implication for this pattern is significant in terms of career progress and earning potential for later life. Because retirement income is directly related to work history, women's disrupted earning has negative long-term economic consequences for them in retirement. This fact, coupled with increasing caregiving functions, is likely to contribute to poverty among older women.



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Middle age adults often reflect on their jobs and consider new opportunities.

Many women at midlife pursue schooling as a means of continued growth and change. The pursuit of learning does not just enhance one's education. It reflects something more personal—an opportunity to rediscover strengths and become empowered.

These kinds of changes may create conflict within the family. This may be particularly true when a husband is pulling back from his career and wants to spend more time with his family and his wife wants to spend more time pursuing school or a career. Also, the woman's shift in direction may mean that she will put less emphasis on other more family-oriented roles. The extent to which work and family roles conflict depends in part on how the partners view each other's participation in the world of work (Cavanaugh & Blanchard-Fields, 2019). For example, in a traditional household, a husband may support his wife's new career as long as it is viewed as supplementary to his own career. Successful adaptation will depend on

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Exhibit 9.15 Choosing the next path In Midlife.

how partners resolve the changes in roles and the flexibility with which they approach these changes. Exhibit 9.15 shows the confusing array of choices that often confront men and women.

Jobs and family life has changed significantly for many people post COVID-19. It is estimated that there are 27 million workers who now work from home which is an increase from 5.7% to 17.9% (American Community Survey, 2021). And, while this benefit assists families with managing their household responsibilities there are also concerns as people experience greater isolation. Furthermore, many workers have moved to remote work, and it is unclear how this may impact people's mental health. While remote work offers benefits, it can hasten a sense of loneliness and further broken social connections that many people need.

Risks to Your Money

Midlife is centered on career advancement, employment, and financial security (Infurna et al., 2020). At present, with increasing inflation concerns about making ends meet, financial concerns have risen to a new high. In one study the researchers found that 77% of Americans were anxious about their financial situation. Existing research shows that characteristics associated with the workplace, such as occupational class, workplace risks, and workplace complexity, are predictive of mental and physical health, cognition, and longevity in midlife and old age (Hueluer, Stine-Morrow, 2020). The susceptibility of middle-aged adults to economic failures, employment (in)stability, and dwindling social and healthcare safety nets are the main topics of our discussion of financial vulnerabilities.

For middle-aged adults who are taking on caring obligations for their aging parents, the eroding safety net is particularly noticeable. Feinberg (2018) drew attention to the glaring absence of paid family leave regulations that apply to unpaid help provided by family caregivers to relatives in need of long-term care. These folks have a high risk of declining mental and physical health as well as economic uncertainty. People who work while providing care often work less hours, accept less stressful jobs, retire early, or choose between caregiving and work (Komisar, 2013). In comparison to those with higher incomes who can employ help or pay to put their elderly relative in a care facility, this disproportionately impacts women (who are more likely to offer care) and those from lower **socioeconomic status** (SES) groups.

Multicultural, Gender, and Spiritual Considerations

From a cultural point of view an interesting question is to what extent does **ethnic identity** extends across adult development? In many respects, the notion of ethnic identity is contrary to the idea of assimilation into the larger society. Research among older adults has found that at the point in life when people are becoming increasingly removed from society, ethnic identity is likely to provide a strong source of support. Indeed, research by Luborsky and Rubinstein (1987) found that ethnic identity became more important later in life than it was in early adulthood. Qualitative interviews with older widows uncovered the manner in which ethnic identity became stronger as the individual aged. For example, individuals discussed how, after the death of a spouse, they adopted the role of family historian. As a consequence, they reflected on the importance of family heritage and traditions, which often led to a rediscovery of the significance of their ethnic roots. Also, individuals discussed how reexamining the past had to be integrated with their current selves. This process becomes increasingly important as people age and move toward an overall sense of integrity in their life (Cavanaugh, 2018).

The following Focus section describes a Puerto Rican American woman's experience of being a person of color, who is a professional social worker.

Gender Concerns

What, if any, are the differences between women and men when they reach midlife? Liggett (2010) argued that women experience intense reflection at midlife that is a normal part of their developmental growth, whereas such reflection is reported by only a minority of men. Although women tend to suffer through some doubt and despair,

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Focus on **The Lived Experience**

A Bicultural Life—Living in Two Worlds

It is strange to have lived in the country for almost 40 years and have someone I've just met ask me, "Where do you come from?" as if I had just arrived from the island. At those moments, I feel a sudden split in my being. How do I explain that I come from two worlds, and that most of the time I feel I am on a bridge shuttling back and forth between them? Despite my lush memories of growing up in Puerto Rico—the smell of the ocean, the sound of the breeze, and the taste of cornmeal with coconut milk and ripe plantains—sometimes it seems I have become a gringa in the way I think and live my life. Yet, that question about where I come from always reminds me that others see me as a foreigner, as someone who doesn't belong …

Source: From "On the Bridge" by N. Garcia-Preto (1994), *Family Therapy Networker*. Copyright © 1994 Family Therapy Networker. Reprinted with permission.

a hope of new development sustains them. Apter (1997) explained it this way:

> When women are freed of the supposition that someone else has the answer, when they are no longer shadowed by a need to please a parent, when they are less anxious about standing in opposition to a partner, when the fantasy of the ideal of who they should be is shattered by the mature reflection in the mirror, they grow strong enough to listen to their own answers to the questions they pose. (p. 23)

Therefore, even though midlife can be a difficult time, women become empowered to come up with their own answers. This newfound energy and self-assertion is what Apter refers to as the "secret path that women achieve at midlife." As Marston (2002) describes, women move out of roles and into the self. All with a newfound energy as they confront a critical question: "Why did it take me so long to trust myself?" (Apter, 1997, p. 27).

To answer this question, women may do a lot of "midlife reconstruction." Men, however, appear not to have this need for integration among the various parts of their selves. Their needs are less likely to be in conflict, whereas women must address conflicting needs—for example, pleasing self versus pleasing others, and private time versus development of outside relationships.

From a more theoretical perspective, women at midlife may be dealing with role strain and role conflict. Since women are searching for greater integration, this is likely to reflect attempts to adapt to each role and to the many segments of each social circle subscribed to that role. Indeed, women are often committed to four major roles: wife, homemaker, mother, and employee. In addition, women tend to take very seriously their other roles—such as daughter, daughter-in-law, neighbor, and friend—which can lead to role conflict (Infurna, Gerstorf & Lachman, 2021). (Exhibit 9.16 presents the four major social roles of women in American society.) However, many men and women in midlife relinquish the role of parents, and as the major duties of parenting decline, they are more free to break out of traditional sex roles.

The Men's Movement

Almost everyone is familiar with the women's movement and its influence on American society, but we have only recently been exposed to the men's movement. Although the men's movement is current, it emerged in a different way from the women's movement. In particular, the men's movement seems aimed more toward personal change rather than external change (Grove & Burnaugh, 2002). Perhaps best known in the men's movement is Robert Bly's book *Iron John* (1992), which is about a boy who helps a primitive man escape from the adults who are holding him captive and goes with him to a journey in the woods. Here the boy grows to manhood. This story is about the unavailability and distance many men feel in their relationships with their fathers. Bly addressed the influence of his own abusive and alcoholic father and was concerned about the contemporary separation of boys from their fathers. Bly's book highlighted how our culture contributes to the separation of boys from their fathers, which has led to an absence of appropriate masculine identity and has spawned a movement of men denouncing contemporary culture and rediscovering their lost masculine identity. Much of this work is now referred to as the "mythopoetic men's movement," which is a body of self-help activities and workshops for men.

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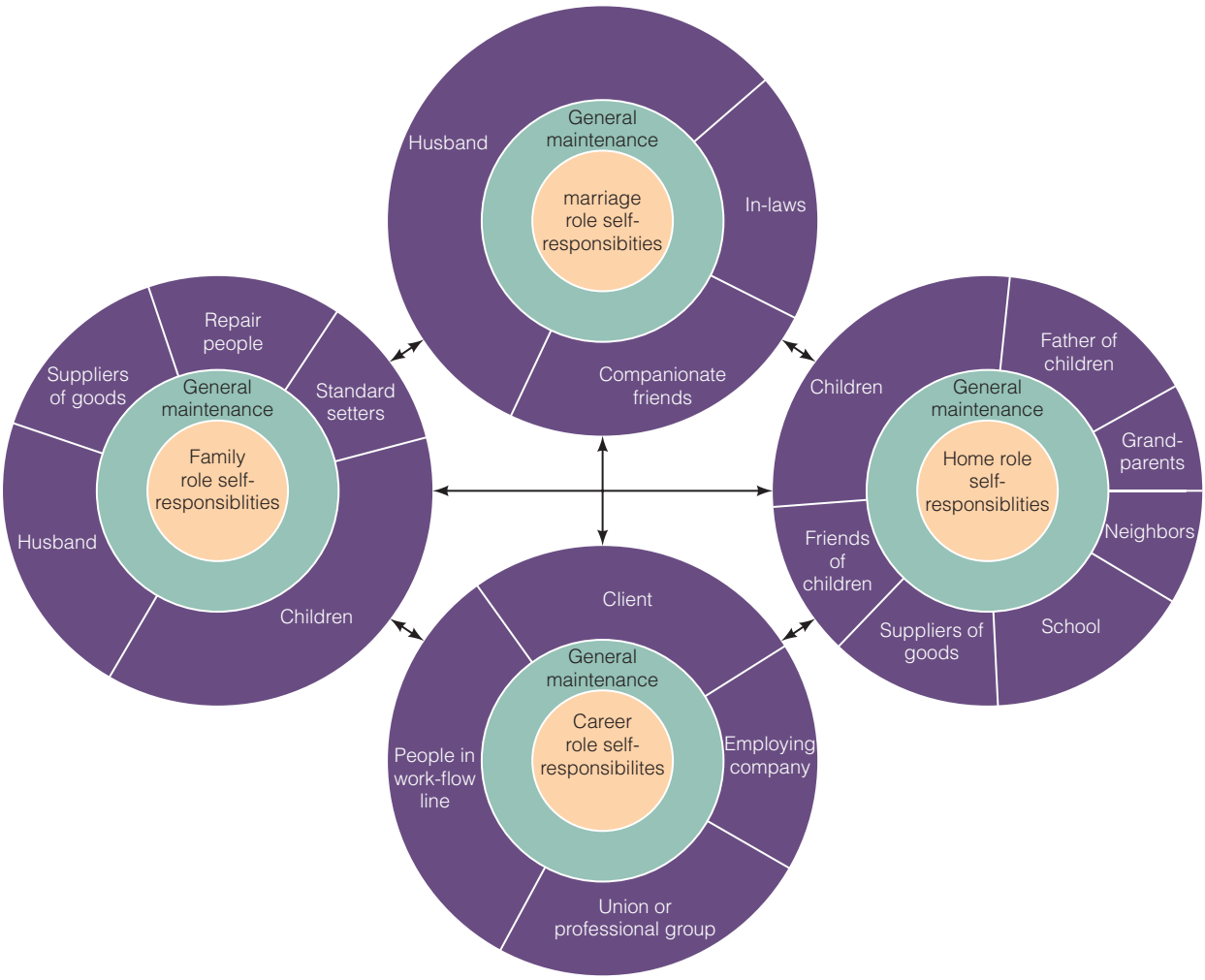
Exhibit 9.16 Four Major Social Roles of Women.



Source: From 'The middle years: Changes and variations in social role commitments' by H.Z. Lopata and D. Barnewolt, in G. Baruch and J. Brooks-Gunn (Eds.), "Women in midlife," p. 85. Copyright © 1984 Plenum Publishing. Reprinted with kind permission from Springer Science and Business Media.

As Graham (1992) noted, "the sensitive-man model was accepted and emulated by few men, and it did not seem that many women found it completely satisfying" (p. 840). To Bly, this image of the sensitive man is what has robbed men of their righteous anger and their ability to act with certainty, splitting them from their identity and their instincts toward manhood (Graham, 1992). Much less analytical is the current emphasis on the profeminist men's movement, which values gender and sexual equality (Okun, 2014). This movement is represented by the National Organization of Men Against Sexism and the global movement MenEngage. Also, important in this movement was the establishment in 2013 of the first Center for the Study of Men and Masculinities funded by the MacArthur Foundation.

The interest in men's issues is also being examined within specific ethnic groups. For example, there is a National Council of African American Men, an organization that fosters understanding of black males. The Million Man March, where African American men bonded together and marched in Washington, DC, was a historic event representing men's issues from a particular ethnic group. One program receiving increasing attention is the Afrocentric socialization model, whereby Black youth are matched with positive Black male role models to help them develop more effective coping responses.

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Men in Therapy

Male and female stereotypes of men can have a significant effect on a man's use of social services. As Sleek (1994) stated, "Men are about as comfortable in therapy as penguins in the desert" (p. 6). Men seek mental health services about half as frequently as women do. When men do enter treatment, they often are uncomfortable with self-disclosure and emotional exploration (Sagar-Ouriaghli et al., 2019; Grove & Burnaugh, 2002). Bogard (1991) described her experience of reaching an impasse with a defensive male client. She confronted her stereotype that "men can't do more" when a colleague confronted her about why she stopped challenging the client.

Mental health practitioners are now realizing the need to make treatment male-friendly. This can be accomplished through several avenues, such as helping the reluctant male client move toward instrumental changes rather than stressing emotional expression. And the process of seeking treatment can be reframed as a sign of strength. Also, many practitioners believe that men's therapy groups work better than individual therapy for many men. Several books, such as *Men in Groups* (Tiger, 2004), *Engaging Men in Couples Therapy* (Shepard & Harway, 2011), and *Men of Honor: Men's Group Study* (Cleveland, 2007) have documented the increasing emphasis on group work with men. The authors discussed tailoring therapy to make it more appealing to men by using more task-oriented approaches. For example, research suggests men may be more open to cognitive-behavioral approaches than to psychodynamic or more emotionally focused strategies. The American Psychological Association in 2019 produced guidelines for practice with men and boys that reviews the needs of men and suggests how treatments might be best modified to address their needs (https://www.apa.org/about/policy/boys-men-practice-guidelines.pdf). The guidelines stress that masculinities are considered based on social, cultural, and contextual norms.

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Men don't often seek therapy and successful engagement may require special skills.

Practice Guidelines:
Counseling Men

The psychotherapy literature abounds with suggestions for helping "traditionally gendered males" (who form a majority in the current cohort of midlife adults) access and utilize mental health services. Social workers should review their own habits and agency practices with these points in mind (Beel, Brownhow, Winterbotham, & du Preez, 2018)):

- Access—men may be less willing than women to take time away from work for appointments, so extended hours in the evening and weekends may attract more men. And take a look at the office décor—does it shout "traditional feminine"? Would traditional males be uncomfortable in the waiting area and interview rooms? Is the front door visible to the street and the public, or more discreetly placed?
- Assess, don't assume—although there is some evidence that alexithymia (socialized to ignore their emotional sides and therefore struggling to express or understand their feelings) is a male norm in American society, a social worker must interview each male client as an individual, since many men do clearly communicate their emotions. And for those who lack these skills, acquiring or expanding a feeling vocabulary is always an appropriate component of the treatment plan.
- Start with and listen carefully to the narrative the male client shares; the initial objective is to convey respect and garner trust, so the man is more likely to return. Let the story unfold.

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- Consider starting with more concrete psychosocial data gathering, holding off on the classic, broad psychotherapy questions such as, "how does that make you feel?" and provide basic education about the process; most men lack accurate information of what transpires in a session and over time across sessions; what can they expect?
- Consider substituting "discussion" and "meeting" for "therapy session," since the vocabulary of therapy may have unique meanings and connotations of failure or shame for American males.
- Try to incorporate activities into sessions; especially with male therapists, a male client may appreciate a side-by-side component to the session, with mutual attention on an activity or task. Don't underestimate the value of sports talk in the session warmup time.

Social Strengths, Hazards, and Risks

Of the many changes experienced in midlife, the variety of social roles that adults can embrace is a significant source of satisfaction and strength. The growing maturity of those around the midlife adult provides new opportunities for friendships and a stronger sense of support. For many midlife adults, friendships deepen as they seek relationships that are increasingly mutual, loyal, and offer true companionship. Studies (Degges-White, 2020) show that being more social—having a group of friends or a confidante—is predictive of midlife satisfaction for women.

Recent research has found that contrary to the "empty nest" syndrome that is characterized as negative, midlife adults capitalize on their increased freedom, reconnect with spouses or friends, and take more time to pursue their own goals and interests (Fingerman, 2002). For women, these positive changes may reflect the larger number of roles they play outside of the home. Parents also experience an improved relationship with their children when they leave home.

An additional strength in midlife is the occupational advantage of being over 40 (Cavanaugh & Blanchard-Fields, 2019). Many high-paying and high-status jobs come only after midlife. Top administrative positions often are left to older, experienced employees. Because midlife often is associated with career success, however, the loss of a job can be a significant social hazard.

Joblessness

Employment is an important aspect of most adults' meaningful participation in life. When adults become jobless, it can have significant physical, psychological, and social consequences. The individual's sense of worth and hope about the future decline. For men, employment has a strong cultural significance—a job is how a man cares for his family. Losing a job can be embarrassing and socially uncomfortable, especially given this country's emphasis on productivity. Joblessness can stimulate feelings of anger, guilt, and shame (Newman & Newman, 2014). African Americans and Hispanic/Latino Americans are more likely to experience unemployment—often chronic unemployment—than are white Americans.

Joblessness affects the entire community. For example, one study (Johnson & Janosik, 1994) found that a 1% increase in unemployment resulted in the following consequences for the community: 5% more suicides, a 3–4% increase in hospitalizations for mental illness, a 4–6% increase in homicides, a 6–7% increase in prison incarcerations, and a 2% increase in the overall death rate. Studies that have compared men who became unemployed with employed men often reveal the psychological effect of unemployment (Berk, 2013). The men felt unwanted and insignificant, lacking a role in society. Many of the men harbored feelings of anger and bitterness. They felt isolated and looked down on by their friends. Particularly revealing was the finding that even after becoming reemployed, they continued to suffer from feelings of low self-esteem. Job loss can impact the major tasks of midlife, such as generativity and the reappraisal of life goals and accomplishments (Berk, 2013).

The effects of joblessness are felt not just by the unemployed individual. If a family is involved, members face problems of increased conflict, loss of morale, violence, feelings of deprivation, and loss of roles. The family's ability to cope with adversity is tested. Children can also be affected because they may no longer have the money to participate in special events or buy new clothes. Children may become depressed at

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Joblessness takes a major toll on the social and emotional well-being of Individuals.

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their situation or angry toward their parents for not being able to provide them with certain necessities. Joblessness often leads to homelessness, a major social problem in America.

Homelessness

Imagine what it would be like without a permanent place to call home. For many people, "home" is a makeshift structure in a desert washout, a county jail cell, a hard plastic chair in a bus station, or even a storm drain. Yet, on a single night in January, 2020, 580,466 people were homeless and slept wherever they could—often in public parks, bus stops, homeless shelters, or just in the street (National Alliance to End Homelessness, 2021; Hendricks & Brogan, 2010; The Urban Institute, 2000). The prevalence of homelessness is often debated, but one estimate states that between 600,000 and 1.5 million people experience homelessness in the United States every year (Population Reference Bureau, 2020).

Who struggles with an unstable residence? They are a diverse group of men and women that includes young people, singles, families, adults, and older adults. They are often disabled or chronically sick individuals without support for housing, older people on fixed incomes who have no family support, veterans who have not readjusted to society, documented and undocumented immigrants, ex-prisoners without support for their return to society, and unemployed people without adequate income (Cavanaugh & Blanchard-Fields, 2019). According to studies conducted in homeless shelters, the majority of the homeless population is white, although African Americans and Hispanic/Latino Americans are overrepresented. And homeless people no longer fit the stereotype of the middle-aged alcoholic male; instead, they are a heterogeneous group. In fact, owing in part to poor wages and a loss in buying power over the last several years, families are the fastest-growing group among the homeless.

What factors contribute to homelessness? The reasons for homelessness are as diverse as the homeless population. In general, homeless people reach that state after a long series of crises, poor decision making, and missed opportunities. Other factors that push people into the streets include drug abuse, deinstitutionalization of the mentally ill, joblessness, flight from violence, reduced welfare benefits, lack of family support, and the gentrification of skid rows.

Mental illness among the homeless is a serious problem in this country (Clark, 2021). Many people with mental illness have become homeless through failures in the mental healthcare system, the disabling effects of mental illness that has gone untreated, the combined influence of substance abuse and mental illness, and the inability of many people with mental illness to set realistic life goals. Also relevant are a loss of adequate income and diminished social supports. Many of the current problems of this segment of the homeless population are related to the effects of deinstitutionalization. When people with mental illness were categorically released from hospitals and care facilities, they were not provided adequate community support programs.

E. F. Torrey (2013) has studied mental illness for years and referred to **deinstitutionalization** as "one of the largest social experiments in American history" and not a successful one. In his recent book, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (2013), he points out many of the problems of deinstitutionalization:

- There are twice as many people living on the streets and in shelters as there are in public psychiatric hospitals.
- There are increasing numbers of people with serious mental illness in the nation's jails and prisons.
- People with serious mental illness are regularly released from hospitals with little or no provision for aftercare or follow-up treatment.
- Violent acts perpetrated by people with untreated mental illness are increasing.
- Housing and living conditions for people with mental illness in the community are grossly inadequate.
- Community mental health centers, originally funded to provide community care to people with mental illness would no longer have to go to state psychiatric hospitals, are almost complete failures.
- Laws designed to protect the rights of people with serious mental illness primarily protect their right to remain ill.
- The majority of the people with mental illness, who were discharged from hospitals, have been officially "lost."

New Trends in Homeless Intervention

The most recent data on homelessness has found a nationwide increase of 2%, reversing a trend of decreased homelessness eight years prior (National Alliance to End Homelessness, 2022). Furthermore, homelessness has more recently become an increasingly visible and divisive social issue in our country. Experts continue to build progress in homelessness using a homeless services paradigm shaped by Dr. Jim O'Connell in the early 1990s that pioneered efforts in

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street-based primary health care at Boston's Healthcare for the Homeless organization. Dr. O'Connell's mobile healthcare approach combined a moral vision—that in modern America, it is not acceptable for individuals to die in the streets—with evidence-based research to identify precisely which health factors contributed to street dwellers' mortality.

Common ground abandoned the "business as usual" model of homeless services, which had focused on shelters and day centers. Traditionally, homeless individuals could—in theory—apply for various transitional and permanent supportive housing services but only after they had gathered all the relevant documents (such as state ID, Social Security card, birth certificate, medical certificate of disability, proof of income from benefits, etc.) and successfully navigated a long waiting period during which they demonstrated to housing intake case managers (at ongoing office appointments) that they were sober and taking their prescribed psychiatric medications. The "street to home" paradigm tackled these issues in reverse order: outreach workers would find the homeless individual wherever he/she slept, establish a trusting relationship, and then guide the individual directly to housing in a customized fast-track process. This paradigm put permanent housing "front-and-center" for all homeless individuals, regardless of their medical, psychiatric, or addiction recovery status or adherence history. After being housed, individuals are supported through an inter-agency services network often provided on-site or close to the residence. These ongoing services address the client's medical, mental health, and addiction issues.

This "housing first" model spread rapidly across the country, to Seattle, San Francisco, and Los Angeles. The model's popularity is often credited to outcome studies which show that cities save money by providing housing first, followed by intensive wraparound services. This occurs because the most vulnerable homeless individuals *when not housed* are higher utilizers of city emergency services, including paramedic, hospital emergency rooms, jails, and psychiatric emergency teams. Los Angeles's Skid Row-based program was evaluated and estimated to have saved the city money over a two-year observation period (Toros & Stevens, 2012).

Developmental Guidelines for Middle Adulthood

Exhibit 9.17 presents the developmental guidelines for middle adulthood. These guidelines are meant to be helpful to social workers who need to understand development when making assessments.

Exhibit 9.17 Developmental Considerations in the Assessment of Middle Adulthood

Developmental Milestones	Development Issues (Not Problems)
Physical aging (gray hair, wrinkles, sight/hearing loss)	Reduced sexual interaction
Grandparent role	More stimulation for erection
Parent–child adult friendships emerge	Empty-nest syndrome—launch children
For women, menopause	Increased weight gain
For men, testosterone declines	Caretaking and kinkeeper roles expanded
Retirement	Adaptation to menopause
Self-reflection or "life review"	
Strengths and Landmarks of Development	**Development Observations Requiring Attention**
Crystallized intelligence	Cancer and cardiovascular disease
Increased role-related achievement	Menopausal symptoms
More purposeful living	General well-being
Generativity increases	Increased fear and anxiety
Job satisfaction	Alcohol and drug use
Enhanced friendships	Role overload
Enhanced marital or partner relationships	Impact of caretaking
Focus on physical fitness	Reduced income
	Long-term effects of homelessness or mental illness

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Study Table Social Dimension in Middle Adulthood

Groups and Families

- Many middle-aged adults join blended or stepfamilies within five years of a divorce, 75% of single-parent families will become stepfamilies.
- Guidelines for working with blended families include discipline is better left to the biological parent, couples should bolster than marital relationship to adapt to new changes in the family, and coping is enhanced by using specific coping strategies.
- The notion of "empty nest syndrome" may be misleading in its negative connotations as martial satisfaction typically increases during this time.
- For African Americans, the divorce rate is higher compared with whites at every income level. For African American women, job satisfaction is related to marital satisfaction.
- At midlife, adults are often searching for something new and different, and an affair may offer them a unique opportunity to rediscover neglected aspects of themselves. Affairs occur in approximately half of marriages for men and women.
- Middle-aged adults become the link between the generations, often serving as kinkeepers. In the family life cycle, the family continues to be a primary source of social support; parents may provide needed babysitting when grandchildren are small, and adult children, particularly women, may provide needed care to parents during times of illness or hospitalization.
- A significant life task for midlife adults is coping with the loss of their parents. They may end up raising children and dealing with aging parents—being in the sandwich generation.
- Caregiving can be a special burden for middle-aged adults.
- Families of adults with neurodevelopmental disorders take on extra burdens of caregiving. Because caregiving can be stressful, resources such as support groups are becoming increasingly available.
- The experience of being a grandparent may offer a sense of completion to the middle-aged adult; however, sometimes grandparents end up raising their grandchildren, which can lead to special difficulties.

Communities and Support Systems

- Civic engagement may be decreasing in America so that less "social capital" is available.
- Development in work and career is a major context for adult development, and this may be different for both men and women.
- Ethnic identity may be more important in later life.

Multicultural, Gender, and Spiritual Considerations

- In middle adulthood, women may become more reflective, and men may seek more integration in their lives. Women often have four major social roles: wife, homemaker, mother, and employee that they are adapting to.
- The men's movement has provided new alternatives in the ways men see their roles and responsibilities; for many men, it has provided a new type of masculine identity.
- Men seek mental health services about half as frequently as women do. When men do enter treatment, they often are uncomfortable with self-disclosure and emotional exploration.
- Therapeutic approaches to men can be improved by following gender-based guidelines: provide easy access, assess men's comfort with emotions, gain respect, start with concrete psychosocial data, use a different language, and be task oriented.

Social Strengths, Hazards, and Risks

- Midlife adults enjoy a variety of social roles. There are new opportunities for friendships and more meaningful relationships with adult children.
- There also can be occupational advantages to midlife.
- Adults can face significant hazards. Joblessness takes a strong social and psychological toll. Homelessness can emerge with decreased opportunities. In particular, homeless adults with mental illness who were deinstitutionalized face difficult adjustments in the community. Poverty and the lack of affordable housing can cause homelessness; mental illness and substance abuse can increase vulnerability to homelessness.
- Deinstitutionalization has led to many problems for individuals who suffer from a mental illness.
- New approaches to homelessness include the "housing first" model.

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Applying the Framework

Alcoholism in Middle Age

Lee Park is a 54-year-old man who has an alcohol addiction. He began treatment at the Harborview Medical Center after his wife and children worked with a substance-abuse counselor who coached them in how to perform an "intervention" on Lee. The "intervention" consisted of a meeting among Lee, his wife, and their two children in which they expressed to him their concern about his drinking and described the negative consequences it had for them. Each family member spoke frankly about his or her fears and anxieties over Lee's drinking behavior. They gave carefully constructed examples of when he had acted inappropriately because of his drinking. They also pressured Lee to seek immediate treatment, and he agreed to go with them to the Harborview Medical Center, which specializes in alcoholism treatment.

Developmental Considerations

Lee began drinking socially as a young adult. He enjoyed entertaining and being in the company of others. His social drinking continued, and slowly, over time, it grew more and more serious. Lee also has experienced bouts of depression. He becomes very withdrawn and loses all motivation for work. He becomes irritable and often does not get enough sleep during the night, and then he feels drowsy during the day.

Lee describes an eventful history that seems to have preceded his move into a serious drinking problem. Throughout his career, Lee had been loyal to one company and performed adequately as an electrical engineer. Slowly his job performance deteriorated, and although Lee still adequately conducted his job, his employer was unhappy with his results. Eventually Lee was "let go" from his job, and at 54 years of age, he did not have an easy time seeking new employment. Lee was unemployed for more than one year. At that time, he desperately searched for a new position; however, it seemed that employers were interested in hiring only younger workers. Lee's frustration at not being able to find work led to an increase in his rate of drinking. Drinking became a way for him to calm his anxieties and move from very unpleasant feelings of worry and concern to more pleasant feelings. Lee was able to start a small business successfully, and it has been going well, although Lee reports feeling extremely nervous about his potential for continued success.

Biophysical Considerations

Lee's alcoholism has developed into a physical dependence. His abstinence from alcohol in the hospital led to alcohol withdrawal, suggesting physical tolerance. He was observed to have coarse tremors of the hands. Family members report the presence of chemically induced alcoholic blackouts. Additional symptoms included insomnia and daytime drowsiness, increased psychomotor activity, and increased blood pressure.

Lee has been drinking for almost 30 years. He began drinking in his 20s, and it has gotten steadily more frequent and more intense. He drinks every day but most heavily on weekends. Lee primarily drinks scotch but also consumes beer. He estimated his drinking to be about "a pint of scotch" a day.

In spite of a long history of drinking, Lee's general health was rated satisfactory by the physician. He has a tendency toward high blood pressure, but the doctor does not consider it to be a medical concern at this time. Lee is 25 pounds overweight, owing primarily to a lack of exercise and excess calories obtained from drinking. All indications suggest Lee does not have any other physical concerns.

Psychological Considerations

Cognitive Development and Information Processing

Lee is a college graduate with a BA degree in engineering. He presents himself as someone who has the capacity for good intellectual functioning. However, this is difficult to assess at times because of his lack of motivation and flat affect. In discussing his current work situation, Lee is able to articulate difficult business decisions he is grappling with. Moreover, he displays reasonable problem-solving abilities in relation to the tasks he is currently working on. For example, he recognizes that one of his difficulties is retaining good employees and keeping them motivated to work. Because he is feeling unmotivated, he is concerned about how his employees may be reacting to his lack of motivation. He has described several ideas for how to address this problem. In general, Lee's judgment about work issues shows careful consideration of consequences and forethought about the implications of his actions.

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When discussing more personal issues, Lee appears to have difficulties with cognitive flexibility. In particular, he displays thinking styles characteristic of a depressed person. For example, when asked about how he could reach out to establish some new relationships with other men, he could think of no alternatives. And when asked about past relationships, he exclaimed, "I should have friends but no one really feels close to me." Such thoughts show minimization and all-or-nothing thinking patterns.

Communication

Lee has serious communication difficulties, particularly in the context of his family. He is reserved and has a timid, unassertive personality style. In family sessions, he often turns to his wife to let her speak for him. His wife describes frustrating attempts to simply "talk to Lee about what is going on with him." He recognizes this and describes difficulties in "expressing my thoughts to my wife and children." Because the children have recently moved out on their own, Lee and his wife are adjusting to having more time by themselves and with each other. Lee's wife wants him to become more involved with social activities and is motivated to push him to confront his drinking problem, so "they can return to a normal life."

Attitudes, Emotions, and Regulation

Although alcohol drinking has been consistent since young adulthood, it became more frequent and more intense after Lee lost his employment. This loss was significant for Lee, because he felt he no longer had a significant role in his family. He reports feeling guilty about not being able to provide for the family. Lee reported a general sense of failure and hopelessness about the future following his employment loss. Although he now has a financially stable business, he reports feeling anxious and nervous about his future. Lee complains often of "low energy" and believes he is depressed much of the time. He states, "I do not have anything to look forward to." Lee is also beginning to wonder what the meaning of his life has been. He describes much of his life to date as "a failure." When asked what he would like to accomplish, he responded, "I don't feel I have anything I can accomplish or look forward to."

Lee's sense of self, or self-concept, is negative. He is focused on his limitations and inadequacies and has a great deal of difficulty when asked to discuss any positive attributes. This is probably related to his depression, as described above.

Lee is beginning to accept the notion that he has a drinking problem. In the past when confronted with concerns about his drinking, he immediately expressed denial of any problems. In the last five years, his wife has been increasingly concerned and confrontational about his drinking. About one year ago, Lee had an alcohol-related accident; fortunately, no one was hurt. At one point, his wife challenged him to quit for three months to prove that he did not have a drinking problem. Lee was unable to meet the challenge. Also, family members, especially after working with a counselor, became better at letting Lee experience the consequences of his drinking behavior rather than covering up for him and assuming caretaking and enabling roles for him. Lee does acknowledge that his drinking is "a problem for other people in my family."

Lee does express much concern over "what he has left in his life." He appears concerned that family members and others perceive him as having made an important contribution. With regard to this issue, he expresses intense dissatisfaction: "I want others to feel I have done right by them, and I should get my act together for the benefit of others." He can express his frustration over wanting to "get more out of life," and it appears he is consistently thoughtful about what he wants to achieve in the future.

Social Considerations

Family

Lee has been married for 30 years and feels his marriage is one of convenience. He gets along with his wife, but she "isn't able to really understand my problems or help me." Although he presents the marriage in a negative light, he is observed to be caring and concerned with discussing his problems with his wife. She has been putting increasing pressure on Lee, which has resulted in an increasing conflict between them. She stated, "I told Lee I was tired of this and I did not want to live under these circumstances."

Lee's relationship with his children also has become increasingly strained. The children and his wife have been more confrontational, which may explain the increase in family conflict. Lee believes the children should "stay out of this" and does not want them to be involved in his treatment. He appears embarrassed to admit that he has a problem and needs help. The children report feeling "cut off" from their father and "do not know how to separate who he is from his drinking problem."

Continued

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Alcoholism in Middle Age (continued)

Lee's parents live far away, and he has not been very involved with them in the past even though he is an only child. However, recently his father had a heart attack and he went to visit them. When he returned, he said he was "shocked" to see how old they were getting and realized that they may need help in the next several years. He reports additional stress and feels that this is not a burden he can take on right now.

Social Support

Lee's greatest social support is from his family. His wife and children are concerned about his behavior and are motivated to help him quit drinking.

And even though he describes his relationships as strained, they are what he appears to care the most about. Lee has a strong sense of social responsibility toward his family, and he wants them to see him as a competent and effective husband and father.

Outside his family, Lee has one business friend with whom he spends a lot of time. He describes this person as his only friend. His wife has encouraged him to attend AA meetings in the past, and within the last six months he did attend AA meetings for about a month. He quit going, complaining that they were too religious and that the people there were "too screwed up to be of any help to me."

Multicultural, Gender, and Spiritual Considerations

Lee comes from a family that has always been accepting and open toward drinking. He can remember drinking with his family of origin when he was only 17 years old. Both of his parents drank alcohol, but he says neither of them had a drinking problem.

Lee also comes from a middle-class family that values success through hard work. It is difficult to determine exactly when Lee's drinking became serious enough to constitute alcoholism. However, his loss of employment was very significant in his life, and he describes his most serious problems as having begun when he lost his job. For Lee, work gave him an acceptable role to play in his family and helped him feel he was making a contribution to society. When he lost that ability, he was not able to cope effectively and turned to alcohol for relief.

Summary and Impressions

Lee is experiencing the following problems:

1. He has an alcohol addiction.
2. He has mild to moderate denial regarding the negative aspects of his alcohol use.
3. He is experiencing clinical depression.
4. He has serious self-doubts concerning his self-worth and experiences worry and anxiety over his future.
5. He needs to reestablish his relationship with his wife and children.
6. He has difficulty expressing himself and being assertive.

Lee is a high-functioning midlife male who has an alcohol addiction and is experiencing depression. It is difficult to assess the relationship between his feeling depressed and his drinking. He may have developed a serious drinking problem in an effort to use alcohol to cope with his depressive feelings. Lee's family is experiencing many concerns related to Lee's drinking and is actively involved in his treatment. They can offer him needed support and reassurance throughout his recovery. Although Lee has entered Harborview Medical Center for his alcoholism, he is still experiencing denial in relation to his alcohol use.

Exacerbating his problems are Lee's concerns regarding his future and his worries about his ability to succeed in life. He is increasingly concerned about his contribution in life. Lee's difficulties in communication and assertiveness make it difficult for him to make his needs known. Lee has some important strengths that will help his prognosis for treatment. He is an intellectually competent man with a successful business. His family is supportive and involved in his treatment. He is making progress on his denial and has agreed to a first step of seeking inpatient treatment.

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Four Ps' Formulation for Integration of the Data

Write a summary and formulation for the case described above.

	Biological	Psychological	Social
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

Reviewing Your Competencies

You should be able to:

1. Discuss the changes in a woman's body after menopause.
2. Identify the three phases of the sexual response cycle.
3. Is there such thing as a midlife crisis?
4. According to Seligman, what three fundamental aspects need to be changed to create authentic happiness? 7a
5. Discuss the three primary reasons why AA may work for some people.
6. Discuss the benefits of a support group for caregivers.
7. Identify and discuss the four major social roles of women in American society.
8. Discuss several problems related to the deinstitutionalization of the mentally ill.
9. Identify several strengths and landmarks of development that present in middle adulthood.

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Key Terms

alcoholism
anxiety
caregiving career
crystallized intelligence
deinstitutionalization
delirium tremens (DTs)
ethnic identity
fluid intelligence
forgiveness
functional literacy
generativity
hot flash
illiterate
in vitro fertilization
menopause
osteoporosis
perimenopause
sexual response cycle
socioeconomic status
stepfamily
Title V
well-being

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Chapter 10

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Late Adulthood and Very Late Adulthood

Learning Objectives

1. Describe the key developmental themes present in late adulthood, including theories of aging.
2. Understand the key aspects of biophysical growth and development of late adulthood (exercise, functioning age, ADL's and IADLs, chronic conditions, medications, gender).
3. Describe the key themes in the psychological dimension for late adulthood (normative vs non-normative cognitive impairments, Alzheimer's disease, depression, alcohol use, isolation).
4. Describe the key themes in the social dimension for late adulthood (widowhood, continuum of care, spirituality, elder abuse).

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Developmental Themes	Key Concepts
	■ Stage: integrity versus despair. Phases of late adulthood. Growth of aging segment of population. Older minorities. Life-course perspective. Functional age. Theories of aging. Defining "successful aging."
Biophysical Dimension	
Biophysical Growth and Development	■ Life span and life expectancy. Age-related changes. Exercise and nutrition. Health care and medications. Changes in sexual relations.
Biophysical Strengths, Hazards, and Risks	■ Chronic health problems. Arthritis. Hypertension. Death and dying. Advance directives for health care. End-of-life care.
Psychological Dimension	
Cognitive Development and Information Processing	■ Road Scholar programs. Cognitive theories of aging. Adjustment to normal changes in memory and learning. Concerns about dementia.
Communication	■ Sensory limitations; disorders; isolation. Dementia and communication.
Attitudes and Regulation Emotions	■ Complexity of emotional experiences. Loss, grief, and mourning. Loneliness.
Reminiscence	■ Maintenance of a stable sense of self. Reminiscence.
Psychological Strengths, Hazards, and Risks	■ Wisdom. Spirituality and religious beliefs. AD and other dementia. Mental illness. Depression. Suicide. Substance use disorders and gambling.
Social Dimension	
Groups and Families	■ Families. Couples. LGBTGQ+ elders. Widowhood. Parent–child relationships. Grandparenthood.
Communities and Support Systems	■ Friendships and social networks. Work, retirement, and volunteering. Living on a fixed income. Continuum of care. Housing options.
Multicultural, Gender, and Spiritual Considerations	■ Elders of color. Extended-family relationships. Social work and cultural competence. Gender issues. Ageism.
Social Strengths, Hazards, and Risks	■ Social support for older adults. Elder abuse and neglect.

Developmental Themes

There are certain pursuits adapted to childhood: do young men miss them? There are others suited to early manhood: does that settled time of life called "middle age" ask for them? There are others, again, suited to that age, but not looked for in old age. There are, finally, some which belong to old age. Therefore, as the pursuits of the earlier ages have their time for disappearing, so also have those of old age. And when that takes place, a satiety of life brings on the ripe time for death.

—Roman Philosopher Cicero, 106–43 B.C., "On Old Age"

The years from age 60 until death are considered late adulthood. Erik Erikson (1959/1980) termed this eighth life stage, "old age," characterized by the developmental task of integrity versus despair. Here, ***integrity*** refers to the ability to integrate or satisfactorily blend one's history and experience with the task of evaluating and accepting one's life. Erikson noted that people tend to become more reflective and introspective as they age. In later life, as people reflect back and find that their life has been meaningful and rewarding, they experience satisfaction and develop integrity. If, however, they are disappointed because of missed opportunities and unresolved conflicts, they may be vulnerable to despair.

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Some theorists have argued that one stage is not enough to encompass all of life from age 60 until death, and many theorists now discuss late adulthood (60–75) and very late adulthood (75 until death). Another way some refer to late life is to differentiate the "third age" (those who are young-old, or from their 60s to early 80s) from the "fourth age"—the oldest old, from about age 85 and beyond. Despite the diversity in the experience of late life, some common tasks for each decade of late life can be identified (see Exhibit 10.1).

Scholars and philosophers have long been interested in aging. Cicero, a Roman philosopher born in 106 B.C., wrote about his "old age" even though he lived to be only 63. It was in the 1950s that the interdisciplinary social science of gerontology—the study of aging and old age—really heated up. And now, in the new millennium, we are faced with a "demographic imperative"—the graying of America and many other nations in the world—that will require an overhaul in our medical and social services in response to this demographic shift. Across the globe, older people (60 years of age or more) outnumber infants and young children (under five years old). It is estimated by the World Health Organization that between 2015 and 2050, the proportion of the world's population in late adulthood will almost double (12% to 22%). As people live longer, with access to better health and personal care, what we think of as "old" keeps getting older. Currently, there are approximately 56 million Americans over the age of 65, or 17% of the population, and it is expected there will be 73.1 million by 2030 (U.S. Bureau of the Census, 2022). The United States has transitioned from an aging society (defined as 7% or more of the population aged 65+) to an "aged society" (14% or more) but by 2028, it is projected to be a "superaged society," with 20% or more of the population aged 65 years and older (The Gerontological Society of America, 2019). But it is the older population that is becoming older. The 85 and up are the fastest-growing segment of the population in the United States and other industrialized nations. In comparison to the year 1900, in 2019 the young-old grew 14 times larger, the middle-old grew 20 times larger, and the old-old grew more than 53 times larger. Today, people who have reached 65 years old can expect to live almost another 20 years (Administration for Community Living, U.S. Department of Health and Human Services, 2021).

By 2040, the older population of white (not Hispanic) people are projected to increase by 29% compared to 115% for people of color (Administration for Community Living, 2021; see Exhibit 10.2). Social work is among the key disciplines responding to the aging imperative. As Baby Boomers reach age 65, there will be a growing demand for social workers to enhance the quality of life for older adults and their families and to assist them with the increasingly complex health, mental health, social service, and community environments.

Exhibit 10.1 General Characteristics of Older Adults by Subperiod.

Subperiod	Characteristics
Young-old (65–74)	The young-old typically remain active in the community and maintain strong ties with families and friends. Some may increase their recreation, adult education, and volunteer activities; many may still be employed full or part time because of financial need or the personal desire to work. Women outliving their spouses begin to emerge. For some, retirement means new freedom, but for others it can bring losses, including loss of status and income, loss of being needed, or loss of meaning in life. Most individuals in this age group maintain a good capacity to cope and use their talents productively.
Middle-old (75–84)	Chronic disease may begin (arthritis, cardiovascular, respiratory, circulatory) and added stresses through widowhood, deaths of friends, relatives, and adult children. Problems with balance that may lead to loss of mobility (e.g., walking, driving); and slowing of response time and judgment of spatial relationships. Many are socially and physically active, in relatively good health, and able to function independently. This group is more diverse than the young-old.
Old-old (85+)	A predominant number of this group is dependent, frail, and experiencing more disabilities and chronic illnesses. Mobility is more likely to be limited. Social isolation tends to become greater for this cohort because they have more physical decrements, many can no longer drive themselves, and many are widowed. The prevalence of dementia, such as AD, increases with age—up to 50% of the 85+ group show evidence of brain disorders or some form of dementia. Women out survive men especially in this age group.

Source: Adapted by authors based on Youdin (2014, p. 6).

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Exhibit 10.2 Projected Rate of Growth of Ethnic Older People (65+) Between 2019 and 2040.

Ethnic Group	Percent Increase
White non-Hispanic	29%
Black non-Hispanic	80%
American Indians, Alaska Native, not Hispanic	67%
Asian, non-Hispanic	102%
Hispanic	161%

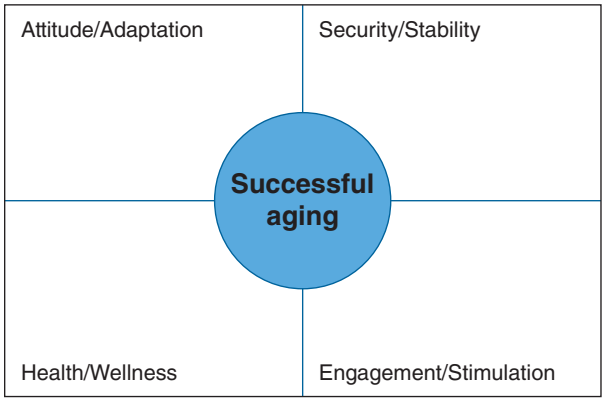
Administration for Community Living, U.S. Department of Health and Human Services (2021)

Implications for Practice:
Functional Age

The following example describes two women who came to the attention of social workers recently, both chronologically in their early 80s but in radically different circumstances. Helen is a white, middle-class, married woman who comes to the local senior center regularly to socialize and play cards. She lives at home with her husband and considers their relationship to be the high point of her life. Their two grown children live in the area and help when needed. Helen still drives, buys groceries, prepares meals, and keeps her own house. Old age has taken a toll on Helen in two ways: she has some painful arthritis that slows her down at times, and many of her closest friends have died. Nevertheless, Helen stays active and optimistic. She says, "When you are a kid, you seem invincible, untouchable even. As you grow up and start to care for others, you realize that life is a precious gift that should not be wasted. I am very blessed that I have been able to live my life fully with someone I dearly love." Although she enjoys chatting with the social worker at the senior center, Helen isn't in need of social work services at the present time.

In contrast, Ann is a recently widowed African American woman whose family reports that she has become more forgetful and anxious. Without anyone else in the home, they worry about her safety and well-being. The family has no extra money and lacks the stability of employment or residence to provide Ann with the help and supervision she needs. She most likely will need to sell her heavily mortgaged home and move to a facility where her Social Security benefit will pay for her care. Ann is constantly worried and sometimes finds it difficult to get out of bed in the mornings because she feels so overwhelmed. Ann needs significant help from social workers to evaluate her needs, refer her for psychiatric assessment and treatment, offer her emotional support, and work with her family on the upcoming move. Clearly, assessment of ***functional age*** gives a more complete picture than chronological age in these two older women.

Exhibit 10.3 Successful Aging.



Source: Based on Administration on Aging (2008).

Despite the difficulties inherent in trying to identify specific common tasks in the stage of life we commonly call "old age," social gerontologists have tried to do so. There are a number of theories of aging that address how people change or do not change with advancing age, how late life differs from earlier adulthood, and characteristics of normal or successful aging—theories that can help us understand aging and inform our social work practice with older adults and their families.

Newer theories of aging revisit classic theories of aging—activity (older people experience well-being when they are active in many roles) and disengagement (mutual withdrawal occurs between the individual and society in late adulthood) in different ways. One branch of inquiry identified factors that contribute to successful aging (see Exhibit 10.3). Three main areas appear to contribute to successful aging: (1) maintaining cognitive

Some occupations allow for role continuity in late life that can contribute to improved health and well-being.

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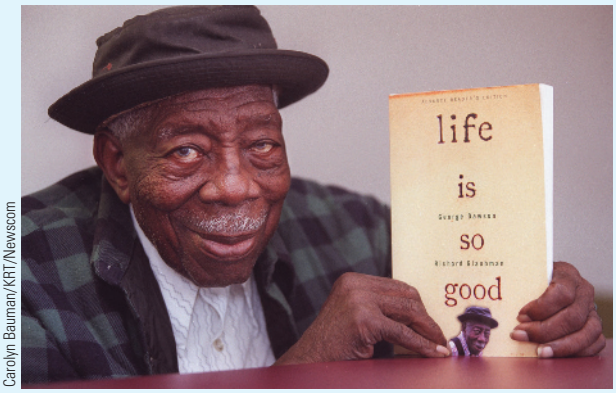
Focus on **The Lived Experience**

Life Is So Good

George Dawson (1898–2001) cowrote his memoir, *Life Is So Good* (Dawson & Glaubman, 2001), at the age of 101. An African American who was the grandson of enslaved people, George had to work on his family's Texas farm and never attended school as a boy. Despite a harsh early life marked by discrimination, his family gave him the skills to survive and even thrive in the world. Blessed with an optimistic spirit and a quick mind, George lived a long and happy life, much of which he recounts in his memoir. One of the most remarkable things about this story is how, long after his retirement as a laborer, George decided to attend literacy classes in Dallas, Texas, at the age of 98. He learned to read and write and then went on to publish his life story, offering an amazing example of successful aging!



Carolyn Bauman/KRT/Newscom

abilities, (2) avoiding disease and maintaining physical functioning, and (3) maintaining active engagement with life. A major message of recent books on successful aging is that many factors are in the individual's personal control, such as the choice to smoke or not, to exercise and maintain a healthy weight, to reach out to others, and to stay actively involved. Others have studied successful aging by asking older adults what they think. Researchers interviewed 72 participants, between the ages of 60 and 99, how they defined successful aging and shared some intriguing results. Four major themes were: attitude/adaptation, security/stability, health/wellness, and engagement/stimulation (Reichstadt, Depp, Palinkas, & Jeste, 2007).

Successful aging is highly related to lifestyle factors. Mora (2022) coined the term "ambiome" to describe the set of physical, psychological, and cultural factors that change the biochemistry, anatomy, and physiology of the brain during the life span of an individual. For example, diet, exercise, an active social life, emotional connections, and ability to cope with stress, can promote healthy aging as well as slow down the progression of many diseases.

Critics of the successful-aging paradigm have pointed out that because of inequalities experienced by female elders and elders of color, who are more highly represented among those living in poverty, the uninsured, and the uneducated, successful aging is not equally attainable by everyone (Chapman, 2005). Another major criticism is the marginalization of disabled, cognitively impaired, or frail seniors as "[un]successful agers" (Chapman, 2005). Others have advocated for inclusion of the inner life, or a spiritual component to round out the successful-aging concept (Edlund, 2014).

Practice Guidelines:

Common Concerns for Older Adults

With all these different theories, is there anything we can say for sure about how people change as they age, or common characteristics of older adults? Most practitioners and researchers (Frazer, Hinrichsen, & Jongsma, 2011; McInnis-Dittrich, 2014) can agree on a number of qualities typical of older adults. Practitioners should consider these factors when working with older adults:

- Concern with leaving a legacy—the meaning of their life in some tangible form, whether it is their offspring and grandchildren, examples of their work, or personal mementos that they wish to pass on to younger friends and family.
- A change in the sense of time: more contented older adults tend to live in the present and experience "now" with a gratitude borne of recognizing the shortened future; other elders may be less flexible and instead cling to earlier times and memories which loom larger than current experience.
- Wanting to fulfill the "wise elder" function, which is closely associated with the notion of legacy, in that

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older people seek to share their wealth of accumulated knowledge, experience, and wisdom with the young.

- Attachment to familiar objects—an increasing emotional investment in familiar household objects, heirlooms, keepsakes, photo albums, letters, and pets, which provide a sense of continuity, assist the memory, and provide both comfort and security. While more active elders often seek to "declutter" their homes or move to smaller ones, some seniors continue or develop new unhealthy attachments to objects with a tendency toward hoarding.
- Creativity, curiosity, and surprise, which suggest that, with continued basic physical health and adequate social and environmental supports, many older people retain a curiosity about life and all living things, and some develop or discover creative abilities.

Can you see how some of these characteristics relate to the theories mentioned above? Do you know some older adults who represent "successful aging" to you? Try the thought-provoking questions in Exhibit 10.4. Before going on to learn about biological, psychological, and social issues in late adulthood, read what Dr. Margaret A. Noel (2000), a geriatric physician, has written about "successful aging":

I regard my patients and older friends as repositories of the secrets of aging well … Battling the visual effect of time and gravity is a rapidly growing industry, but those I want to imitate appreciate youth and beauty as a season and would not exchange the work of time upon their character to have that season back. Long lives portioned with worldly success and failure, joy and grief, giving and receiving, have distilled and refined their spirit. It shines through frailty, through physical and cognitive decline, and continues to be reflected by those who love them, who bear witness to their lives.

Exhibit 10.4 Exploring Attitudes About Age and Aging.

1. When is a person "old"?
2. When will you be "old"?
3. How should you refer to a person who is "old"?
4. What are some changes we will all experience as we become "old"?
5. What is the worst and best part of growing older?
6. How do you define "successful aging"?

Source: Robinson, B. (1994). Teaching Module, Appendix A: Exploring Attitudes about Age and Aging.

Biophysical Dimension

Biophysical Growth and Development

"Most of us are going to be 85, but we're not going to be 100. The annual morality rate for those older than 100 is about 30%" – Eileen Crimmins, Behavioral and Social Sciences Section, The Gerontological Society of America, 2019.

Given successful treatment of illnesses and accidental injuries, the maximum human life span appears to be about 122 years of age (Blagosklonny, 2021). Although ***life span*** represents the upper limit of human age, ***life expectancy*** refers to the number of years the average person who was born in a particular year may live. Because of healthier lifestyles, better nutrition, and technological advances in medicine, life expectancy has historically increased significantly in the last several decades, with the exception of the last two years, in which we experienced a stark decline (nearly a year from 2020 to 2021).

Study Table Developmental Themes of Late Adulthood

Developmental Themes

- Late life is represented by integrity versus despair.
- Two or even three stages constitute late adulthood as life expectancy increases.
- The oldest old and elders of color are the fastest-growing groups.
- Vast differences characterize older adults; one way to assess is by functional age.
- The concept of "successful aging" is currently being debated—maintaining health and independence is one measure of success but may leave out frail and disabled elders.
- Leaving a legacy is an important goal for many in late life.

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Currently, the U.S. life expectancy is the lowest it's been since 1996, particularly for non-Hispanic American Indian Alaskan Native (AIAN) people who lost 6.6 years from 2019 to 2021 (CDC, 2022). The primary reasons for this drop were the pandemic (accounting for 50–75% of deaths), with unintentional injuries following (half of which were due to drug overdoses). For babies born in the year 2021, average life expectancy is 76.1 years (Gregory et al., 2021). Women outlive men by about six years. The life expectancy for Blacks is about two years less than for whites at age 65 but is about equal by age 85.

According to one of the directors of the National Institute on Aging's Biology of Aging program,

> There is no single theory to explain aging . . . It's possible that some age-related changes are genetically programmed while others involve the effects of less predictable activity, such as free radical damage to cells or other insults that seem to occur with age

Despite the lack of a single grand theory of biological aging, no one denies that a predictable pattern of some physical decline, called ***senescence***, naturally occurs in the human organism with age. One of the difficulties with studying physiological aging is that advanced age increases the vulnerability to disease. Thus, it is a challenge to distinguish the effects of aging processes from the effects of disease processes.

Because the rate of physical change due to aging varies from individual to individual and for different organs and tissues within individuals, chronological age cannot be used as an absolute marker for biophysical change. Inevitably, however, physical change does occur in all of the major organ systems of the body. As shown in Exhibit 10.5, virtually no part of us remains unaffected by aging, but the good news is that, along with the increasing longevity, medical, biological, and social scientists have been focusing on ways for older adults to live a healthier, higher-quality life into advanced age.

Historically, we are living longer, but are we living better? One out of four Americans who are 65 years or older and who are not institutionalized are in fair or poor health (CDC, 2022). Discovering ways for older people to maintain higher functioning and avoid disability until shortly before death increases the compression of morbidity—where morbidity means illness and disability. These efforts have resulted in some significant findings about ways to slow and, in some cases, even counteract the physical decline that occurs with age. Exercise is the number-one key to a healthier late life. The research is clear; being physically active contributes substantially to healthy aging. Physical activity can help prevent or control many of the health problems (e.g., high blood pressure [BP], depression, obesity, and diabetes) that can reduce the quality and length of life for older adults. Further, strength training is of particular importance to older adults, as it can provide relief from arthritis pain, improve balance and reduce the risk of falling, strengthen bones, and reduce blood glucose levels. The CDC (2022) recommends that adults 65 years or older exercise for 150 minutes a week of moderately intense activity (or 75 minutes of a vigorous-intensity activity), at least two days of strength-based exercise, and three days of balance-based activities (see Exhibit 10.6 for examples of exercises to support physical activity in older adulthood).

As we age, muscle is gradually replaced with fat, which reduces strength and also reduces the rate of metabolism, because fat burns fewer calories than muscle at rest, thus leading to weight gain. Researchers have found that aerobic exercise combined with strength training can reverse this age-related muscle wasting, called *sarcopenia* (Yoo et al., 2018). On average, muscle strength of an individual in their 80s is measured to be 40% less than in their 20s (Liu & Latham, 2009); diminished muscle strength accounts for physiological changes in older adults including: slower walking speed, higher risk of disability, and higher risk of falling. A literature review, of exercise-related interventions, found the best ways to combat the physical changes with aging, including changes to the immune system and the prevention of disease (Sellami et al., 2018), are through exercise and healthy diet (Escobar et al., 2019 Waters, Baumgartner, Gary, & Vellas, 2010).

Maintaining the body's lean muscle helps avoid frailty and disability, and this study and others like it demonstrate that it is literally never too late to start. Aerobic activity, such as brisk walking, swimming, or other "moving" activities (some of which can even be done by those who use wheelchairs), helps maintain healthy heart and lungs, tones muscles, burns calories, and enhances mood. Both types of exercise also reduce the loss of bone mass that occurs through normal aging, or more severely, through osteoporosis, a condition in which the bones become weak and porous. Two common reasons that older adults avoid physical activity are foot and joint pain due to arthritis or other conditions, and a fear of falling and its possibly serious consequences (Yardley & Smith, 2002). For these reasons, special exercise programs that go at a slow pace, with considerations for the special safety concerns of older adults, are in place in many congregate living facilities.

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Exhibit 10.5 Age-related Changes in Biological Systems.

Skeletal system	Height peaks in a person's late thirties, and by age 75 most people have lost 5 cm in height owing to decline of spinal discs, osteoporosis, and other age-related changes. The chest cavity also becomes deeper and less wide. Bones become less dense due to osteoporosis—a gradual loss of bone mass (more accelerated in women owing to estrogen loss). Joints are more restricted, resulting in a diminished range of motion in the upper arms, lower back, hips, knees, and feet. Arthritis is known to affect approximately 58% of all people aged 70 or older. Foot problems (non-disease-related) may include bunions, heel spurs, hammer toes, and calluses.
Muscle system	Lean body mass decreases with the beginning of middle age, and body fat increases in males (50%) and females (33%); fat redistributes, with more in the midsection. The power and speed of muscular contractions gradually decrease with age; without exercise, there is a gradual decline in muscle strength and endurance.
Brain and nervous system	With age there is a loss of neurons (estimated to be between 5% and 10% until the 70s—may accelerate subsequently), the basic cellular unit of the nervous system; unless the blood supply is blocked, there may be little functional change. If, for example, there is diminished flow of blood to the brain, neurotransmitter changes, accumulations of cholesterol, and so on, these changes may affect reaction time and interfere with perception and cognition.
Sensory system	Gait and balance may be affected by the combined effects of muscular, skeletal, and neurological changes, which may result in an increase in accidents and falls. Reduced tactile sensitivity results from a gradual toughening of the skin; older people develop a higher pain threshold. There is a decline in the sense of smell, owing to gradual degenerative changes in olfactory cells, which is accompanied by a decrease in sense of taste. Age-related changes in vision increase, often as the result of a reduction of the quality or intensity of light reaching the retina. Very old age may be accompanied by degenerative changes in the retina, impairing one's ability to see; the ratio of legal blindness is 1:1,000 in individuals under age 21, but it increases to 14:1,000 in individuals aged 69 and above. Significant hearing impairment occurs with increasing age, as degenerative changes affect the compartments of the ear and the auditory nerve pathway; high-pitched sounds are not heard as well, resulting in jumbled or distorted words and sentences.
Circulatory system	Age-related changes appear to include a slight enlargement of the left ventricle of the heart and thickening of the atrial endocardium and atrial ventricular valves. Changes in the arteries (an increase in collagen and calcification of elastin fibers) make the arterial walls more vulnerable to disorders that cause their hardening and thickening (e.g., the most common form of arteriosclerosis). Factors such as obesity, lack of exercise, anxiety, illness, and hardening of blood vessels may cause an increase in BP, and with increasing age, veins become less elastic, thicker, and more dilated, causing valves in the large leg vein to become less efficient in returning blood to the heart.
Respiratory system	Between the ages of 20 and 80, lung capacity decreases 40%, even in the absence of disease; lungs lose elasticity, the chest decreases in size, and the diaphragm weakens; mouth breathing and snoring result from connective tissue changes that cause the nose to have a retracted septum.
Integumentary system	Aging skin becomes dryer, thinner, irregularly pigmented, and subject to mostly harmless growths and lesions. Without as much connective-tissue support, skin is more easily bruised or injured in old age. Skin has diminished collagen content and less elasticity, resulting in wrinkling and sagging. Fingernails and toenails may thicken; hair thins and loses its pigment; loss of body hair is progressively experienced by men and women in the pubic and armpit area; coarse hair, caused in part by hormonal changes, may grow on the upper lip and lower face of older women and on the ears, nostrils, and eyebrows of older men.

Source: Adapted by authors based on Schaie and Willis (2002); McInnis-Dittrich (2013).

Along with physical activity, adequate nutrition promotes a higher level of wellness in late adulthood. Although the nutritional requirements of older adults are not significantly different from those of middle-aged people, the ideal diet would be lower in fat and higher in protein and complex carbohydrates than those of a similar-sized young adult (Chernoff, 2006). Low-carb diets, including ketogenic diets (less than 50 grams of

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Exhibit 10.6 Physical Activity to Support Healthy Aging.

Aerobic Activity	Moderate intensity 150 minutes or Vigorous-intensity 75 minutes or a mix of both	For example, brisk walking or water aerobics for a half hour five days a week. For example, jogging or running for 75 minutes once a week
Strengthening Activity	Two or more days a week of all major muscle groups	For example, lifting weights or using resistance bands For example, heavy gardening or some forms of yoga
Balance Activity	Three days a week	For example, walking backwards, standing on one leg, or using a wobble board.

*Adapted from the Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion (2022).
** please add visual/graphic to this (Similar to this page. https://www.cdc.gov/physicalactivity/basics/older_adults/index.htm)

carbohydrates a day) that are high in fats and proteins are increasingly being used to reverse metabolic disorders, and sometimes cardiovascular disease (Brandhorst & Longo, 2019). One study found that people who participated in a 12-month-long ketogenic diet-based decreased their total cholesterol, triglycerides, and glucose levels—all known risk factors for cardiovascular disease—with high compliance rates. However, these interventions are somewhat controversial because a higher fat diet is a risk factor for cardiovascular disease. Nutritional issues for older people include a reduced ability to smell and taste, which can lower general appetite and increase fondness for sweet and salty foods. Gastrointestinal changes can occur because of a natural reduction in the stomach's digestive juices. Older adults also experience changes in the body's ability to metabolize nutrients and water, so they can become more susceptible to dehydration in warm weather or after exertion. Low-income elders, those who are functionally impaired, and the oldest old who live alone often face financial limitations, mobility problems, or both, which make it difficult to obtain and prepare a healthy diet.

Regular exercise helps older adults maintain or improve their physical and mental well-being.

Obesity rates and malnutrition rates among older adults are concerning. Just under half of noninstitutionalized men (41.9%) and women (45.9%) aged 65–74 meet the criteria for obesity (rates go down to a third for those 75 and older (CDC 2022). Additionally, almost half of those aged 65 and older are malnourished (Administration for Community Living, 2020). Malnutrition is a nutrition imbalance that affects both those who are under and overweight. Approximately 30% of older people who are admitted to the hospital are malnourished, and those who are malnourished, are more likely to have a longer hospital stay. The Aging Network created through the Older Americans Act provides community-based nutrition programs to sustain the nutritional status of older adults since 1972, and these programs have shown to be successful. Three out of four people who use these programs eat healthier foods and say that their health has improved.

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Health Care and Medications

Almost nine out of 10 older adults regularly take at least one prescription drug (Stefanacci, 2022). The greater number of physiological problems and co-occurring chronic conditions in older adults means they consume a greater number of prescription and over-the-counter medications than do younger adults, estimated at four prescription medications and two over-the-counter medications per person over the age of 65 (Feinberg, 2000). Adults over age 65 consume 30% of all prescription drugs and 40% of all over-the-counter drugs. Although many of these medications are literally "life-savers" to control critical physical functions such as BP, blood sugar, cholesterol, and heart functioning, increased use of medications leads to a greater risk of medication-related side effects and drug interaction problems. "Prescribing cascade" can result when a medication-induced adverse side effect is mistaken for a new and distinct illness, leading the physician to prescribe another medication, and so on (Sternberg et al., 2021). Older people's bodies process medications differently from younger people. Decreased liver and kidney functioning in late life mean that the elimination of medications from the body is not as efficient, and this difference causes older people's reduced tolerance to the usual dosages of many types of medication. This is a particularly serious concern with antianxiety or other sedating medications (Beers, 2015). The Beers criteria for potentially inappropriate medication use in older adults offer tips and advice to address medication concerns of older adults (Beers, 2015). This was updated in 2019 by an interprofessional expert panel using a comprehensive, systematic review and grading of recent evidence on drug-related problems and adverse events in older adults (Fick et al., 2019). The use of computerized decision tools may help to reduce inappropriate prescription and medication use (Monteiro et al., 2019).

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Society is uncomfortable with sexuality in older adults.

Sexuality in Later Life

The capacity for sexual expression continues into late adulthood, although sexual activity may decrease or change because of ill health or lack of access to suitable partners. The first large-scale research on sexual behavior in males (Kinsey, Pomeroy, & Martin, 1948) and females (Kinsey, Pomeroy, Martin, & Gebhard, 1953) suggested that older adults maintain an active interest in sexual relationships in later life and it is a good predictor of global life satisfaction (Skałacka & Gerymski, 2019). Subsequent research has confirmed that older adults are interested in sexual expression but that the frequency of sexual intercourse gradually declines in later life (Smith et al., 2019). Several groundbreaking surveys focusing on sexuality in older adults were conducted over the last decade or so. A large-scale survey by the National Council on Aging (Cutler, 2001) of 1,292 adults aged 60 and older found that 48% (61% of men and 37% of women) reported being sexually active. The proportions were higher for those in their 60s (71% for men and 51% for women) and lower for those in their 70s and 80s. This particular survey tells only part of the story—the researchers specifically asked about sexual practices, such as intercourse, oral sex, or masturbation, to define "sexually active." But information about intimate relationships that do not involve those specific sexual practices, or how many wishes for a sexual partner but do not have one, was not included. However, research conducted over the past two decades supports the view that positive sexual activity is associated with well-being. Smith and colleagues found in a large population-based sample of older English adults that among those who were sexually active, a greater frequency of kissing, petting, and fondling, as well as feeling emotionally close to one's partner during intercourse, was associated with greater enjoyment of life for both men and women.

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Implications for Practice:

Sexuality in Late Adulthood

Social workers are not immune to the biases of our youth-oriented society, which tends to be uncomfortable with the idea of sexuality in late life (Stein, 2016; Walz, 2002). It is easy to detect the negative depictions in popular media, and the limited presence—even in erectile dysfunction ads—of sexually active people in their 70s or older. Here are some topics for the social worker to reflect upon and explore with their supervisors:

- Consider your own exposure to later-adult sexuality, perhaps from your extended family, social network, or neighborhood: Do you know any older couples who may serve—in your mind—as exemplars of lifelong sexual vibrancy?
- Some agencies' psychosocial assessment forms have glaring gaps in the area of gender identity, sexual orientation, and sexuality—be prepared to add your own questions/prompts.
- Keep in mind that these topics should be explored *universally and routinely*, in order to minimize bias; this lessens the chance that your own expectations/stereotypes will guide the inquiry; also, you'll become more comfortable and authentic if the questions are asked in *every* case.
- Sexuality questions can be timed in a very natural narrative flow when gathering initial psychosocial information; for example, starting with household members, marriages, followed by, for singles/widowed/divorced, "Are you dating or romantically involved with anyone right now?" "Many older adults continue to be sexually active. Is this important to you?"
- Another logical entrée into sexuality is the area of medical conditions and physical health; for example, asking a client who takes BP medicine, "Have you experienced any sexual side effects?"; and for a recently occurring disability, "How has this affected your sex life?"
- Sex education for older adults, particularly in residential communities, is important. Rates of sexually transmitted diseases (STD)s in older adults are rising. Older adults are less likely to think of themselves at risk, and may not have had the same education as younger adults about the health benefits of safe protected sex, even without the concern of pregnancy.

Biophysical Strengths, Hazards, and Risks

Mobility

A fundamental component of health and well-being is mobility. It is so strongly related to quality of life that it is usually included in quality-of-life assessments (for example, the 36-item short-form health questionnaire; Syddall et al., 2009). It helps maintain independence, prevents loss of function, and the progression of chronic pain (Gerontological Society of America, 2017). Losing mobility is part of the normative aging process: only 11% of adults aged 45–64 years have difficulty walking three city blocks, and this increases to 32% for adults aged 65+ (Satariano et al., 2012). See Exhibit 10.7 for the impact of declining mobility on health and well-being.

Maintaining mobility is a biophysical strength that promotes healthy aging. Strategies to improve mobility include weight loss (if overweight) and regular physical activity. Community organizations should develop strategies that promote mobility for aging populations through providing more inclusive and accessible opportunities for older adults, such as community exercise programs, neighborhood engagement, or nature-based activities. However, a number of chronic health conditions can impair mobility.

Chronic Health Problems

Physiological aging increases the individual's vulnerability to chronic health conditions. Chronic diseases are defined as conditions that last one year or more and limit activities of daily living or require ongoing medical attention, or both. Many older people have at least one chronic condition, and the older one becomes, the more likely one is to have multiple conditions. About 90% of health expenditures for people aged 65 or older are for chronic conditions (Centers for Disease Control [CDC], 2022). Although chronic diseases increase an older adult's risk of frailty and disability, it is important to remember that the majority of older adults with chronic conditions do not experience significantly impaired functioning. Many older people with chronic conditions manage to live normal lives and cope very well. Furthermore, disability and frailty, two linked concepts, are not "all or nothing" in later life. Many older adults have some degree of impairment in personal ***activities of daily living***—their ADLs—but even more

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Exhibit 10.7 The Health Impact of Declining Mobility.

Physical Health Impact	Psychosocial Impact	Quality-of-Life Impact
■ Weight gain ■ Cardiovascular disease ■ Cancer ■ Falls and associated injuries ■ Diabetes ■ Worsening osteoarthritis ■ Worsening pain	■ Poor cognitive function ■ Depression ■ Anxiety ■ Social isolation	■ Declining activities of daily living and instrumental activities of daily living ■ Loss of employment ■ Institutionalization ■ Hospitalization ■ Mortality

Source: https://www.geron.org/images/gsa/documents/whatshotmobilitydisability.pdf.

may need assistance with ***instrumental activities of daily living*** (IADLs), such as shopping, driving, handling medications, or managing their finances. Maintaining independence to the degree possible and appropriate, despite some degree of impairment from aging and chronic illness, is an important focus of social work practice with older adults and their families (McInnis-Dittrich, 2014).

Heart disease and stroke, cancer, and diabetes are the leading causes of death and disability in the United States (CDC, 2022). Because cancer becomes more common as people age, and current treatments allow older adults to live a number of years with some types of cancer, many cancers are now more like chronic, rather than acute, conditions. Many of these chronic diseases are caused by key risky behaviors. Social workers can help prevent the onset of many chronic diseases and improve the overall quality of life in older adulthood through supporting policies and programs that target these risk and protective behaviors. See Exhibit 10.8 for the top four tips to prevent chronic diseases as recommended by the CDC (2022).

Osteoarthritis, a degenerative joint disease, is the most common type of arthritis and is the largest cause of disability after age 65 in the United States (Theis et al., 2019). Osteoarthritis is the result of repeated trauma or wear and tear on tissue, primarily in large joints such as the shoulder, knee, hip, and ankle. It involves the loss and destruction of cartilage that serves as a buffer between bones where they have contact with each other. Cartilage loss results in severe pain and impaired joint function (Lane & Wallace, 2002). Osteoarthritis is more common in women (particularly after age 50) and in African Americans. Rheumatoid arthritis is an inflammatory joint disease that affects all ages and is more common in females than in males. Arthritis can affect older adults' ability to function independently. Approximately 80% have some degree of physical limitation, 25% have difficulties with ADLs, and 11% require personal care services (CDC, 2017). People with osteoarthritis are less likely to get the recommended amount of weekly physical activity and they are more likely to have mobility impairments. However, a moderate exercise program, use of anti-inflammatory medicines, special shoes or other assistive devices, and sometimes surgery help to maintain the independent functioning of older adults with arthritis.

In the United States, 66.7% of men aged 65–74 (81.5% of 75 and older) and 74.3% of men aged 65–74

Exhibit 10.8 The CDC's (2022) Four Top Tips for Preventing Chronic Diseases.

1. Quit Smoking	It's never too late! People are successful at quitting at any age and doing so reduces your risk for heart disease and lung cancer; 8.3% of noninstitutionalized people aged 65 and older currently smoke.
2. Healthy Eating	Drink lots of water and eat whole fruits, a variety of vegetables, whole-grains, protein, and foods with less saturated fat. Healthy eating patterns reduce the risk for obesity, heart disease, type 2 diabetes, and certain cancers.
3. Exercise	As described earlier in the chapter, a combination of aerobic and muscle-strengthening physical activity improves your health now and in the future. Even if you can't do the recommended amounts, some activity is better than none.
4. Limit Alcohol Use	Cutting back on drinking (two drinks or less a day for men, one drink or less a day for women) reduces your risk for high blood pressure, heart disease, stroke, liver disease, and various cancers.

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(86% of 75 and older) that are noninstitutionalized have hypertension (CDC, 2022). Globally, an estimated one in five of adults with hypertension have it under control (World Health Organization, 2021). Hypertension, or high blood pressure (BP, defined as greater than 140/90 mm Hg), predisposes older people to strokes and heart attacks. The top number, the systolic BP, is more important than the lower number as a risk for cardiovascular disease (Chobanian, Bakris, Black, Cushman, & Green, 2003). Unfortunately, almost half (46%) of adults with hypertension are unaware that they have the condition (WHO, 2017). Risk factors for high BP include a family history, obesity, unhealthy diet (excessive salt, too much saturated and trans fats, and not enough fruits and vegetables), smoking, excessive alcohol use, and lack of exercise. Hypertension in older people is most commonly caused by arteriosclerosis (hardening of the arteries) or atherosclerosis (clogging of the arteries with fatty deposits) and may affect the kidneys and blood vessels. Medications and lifestyle changes, such as following a low-salt, low-carb diet, are used to treat the problem.

The End of Life

Eventually, death is a hazard of living that we can no longer avoid. The average age of death in the United States was 73.7 years in 2020 (CDC, 2021). However, while white and Asian/Pacific Islanders reach almost 75 years old (74.9 years for whites, 74.1 years for Asian/Pacific Islanders), African American and AIAN people have a decade or less of life (66.9 years for African Americans, 62.8 years for AIAN). Heart disease and cancer remain the top two leading causes of death among those aged 65 and older, and COVID-19 became the third-leading cause of death in 2020 (CDC, 2021).

Much of what we have learned about the process people go through when facing imminent death has been based on research or interviews with younger adults with terminal cancer or other prolonged illnesses. Perhaps the best-known investigator of the process of dying is Elisabeth Kübler-Ross. Her classic work (1969) identified five stages in the dying process from the perspective of the patient: (1) denial and isolation, (2) anger, (3) bargaining, (4) depression, and (5) acceptance; however, the five-stage process was never confirmed by research. Kübler-Ross notes that these were not meant to be linear stages, and some people may only experience a few or none of these. It is often used among those that are grieving, though social workers are cautioned that there

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Preparing for death often means addressing emotional pain, grief, and indignity. Grieving the loss of family and friends, as well as the loss of life, is part of the dying process.

are better models that represent the grieving process and expecting that bereaved persons will or should go through stages of grieving can be harmful (Stroebe et al., 2017). These stages may be more appropriately viewed as reactions to death, and it is recognized that people's reactions can vary tremendously and are not easily understood as stages.

In industrialized societies, our institutions tend to embrace the medical model and its goals of curing disease and extending life. In these settings, death tends to be viewed as an unnatural interruption of life, a failure of science and medicine. The array of medical technologies available makes it difficult for medical personnel and families to cease aggressive treatments, even when painful and non-curative and promote positive end-of-life care. Yet up until World War II, death was a part of the human experience and of the life of the community. People died at home in the presence of friends and family. Today, many people live far away from extended family. Many adults have never seen a dying person or experienced a death.

Efforts to provide an alternative to hospital death resulted in the ***hospice*** movement. Hospices offered more holistic, family-centered end-of-life care to terminally ill patients frustrated with aggressive and intensive hospital intervention. In contrast to the cure-and-recovery goals of a hospital, the aim of hospice is ***palliative care*** and support that focuses on comfort, not cure. Hospice eligibility usually requires a six-month estimated life expectancy and the patient's agreement to substitute comfort care (such as intensive pain management and symptom relief for co-existing chronic conditions) for curative interventions such as surgery, chemotherapy, radiation, and so on. Hospice

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care is provided in the patient's home, in a nursing home, or in a special hospice unit in a hospital or community agency. Approximately two-thirds of hospice patients are older persons (Hospice Foundation, 2019).

Home Health Devices May Reduce Medical Costs

Older adults often have complex health needs. Many take multiple medications, participate in a prescribed regimen of physical activity, have specific nutritional needs, and require daily monitoring of their bodily functions (e.g., BP, blood sugar, bowel movements). As cognitive function declines with old age, it can be difficult to remember to meet all of these needs.

With over 76 million Baby Boomers entering and progressing through late adulthood, the U.S. healthcare industry is struggling to meet their needs. Home healthcare devices are a new wave of technology that is helping older adults and alleviating some of the strain on healthcare professionals. These devices generally serve to remind older adults to do something or to make an activity easier to accomplish. Examples of these devices include pill bottles that remind you to take your medicine, a wristwatch that can help locate a lost Alzheimer's patient, smart Band-Aids that check your body temperature and heart rate, sensors in bed sheets that monitor sleep apnea and snoring, and motion detectors that can tell whether you've been up and moving or whether you have fallen (Said, 2005). Other innovations with user-friendly technology include a personal digital assistant, such as Alexa, to help people with medication adherence (Beaney et al., 2020). In this pilot study, patients would receive a notification on their smartphone if they were not in the house to hear Alexa give a medication reminder. Programs such as these could be a promising venture given that older adults are increasingly becoming tech-savvy: 40% of those aged 65 years and older use a smartphone and access the internet "on the go."

These devices help meet older adults' health needs based on their level of functioning. One such device, a remote heart health monitor, allows patients to send information about their weight, BP, and glucose levels to a nurse daily. The nurse is able to monitor the patient, looking for indications of cardiac distress, and contact the patient if needed. This system reduces the number of trips to the clinic, ultimately reducing healthcare costs. Aetna, Inc., says it costs $6,300 for the average heart patient's hospital stay. The device costs $626 and can act as a preventive measure against future heart attacks (Johnson, 2010). Ultimately, Aetna hopes the device will lower healthcare costs while making regular patient care more manageable for healthcare professionals.

Advance Directives for Health Care

Because technological advances in medical care have complicated the dying process in the last several decades, quality of life at the end of life is an issue that will affect many older adults. ***Advance directives*** are legal documents to make one's wishes known about healthcare decisions should one become incapacitated. One common type is a living will. This is a document, used in the event a person has an irreversible terminal illness, stating that the individual does not want to be kept alive by artificial means but instead desires comfort care only. A common directive within these documents is a do-not-resuscitate statement, also known as "no code" in most hospitals and nursing homes, which means the individual—usually with a severely debilitating or terminal illness—does not wish to receive cardiopulmonary resuscitation if breathing stops or the heart stops beating. Although prolongation of life is the most common and perhaps dramatic issue covered in a living will, there are a number of other concerns that arise in caring for very ill elders, including decisions about administration of antibiotics for infections, use of a mechanical ventilator to assist breathing, insertion of a feeding tube or an intravenous line for fluids, and whether or not to perform surgeries. It is not always clear when the time is appropriate to stop active treatment of a disease or symptom and begin palliative care. Because health care has become so complex, a living will cannot anticipate every eventuality, and it is a good idea to designate one close family member or friend to be one's advocate and have decision-making power in the event that serious illness or cognitive impairment renders one incapable of making their own decisions.

A ***durable power of attorney for health care*** is a document that is used to legally designate someone to have the authority to make healthcare decisions should the person become incapacitated. Since the Patient Self-Determination Act of 1990, federal law requires all medical facilities that receive Medicare or Medicaid funding to inform patients about their right to complete these documents upon entry to the facility. Many states now have advance-directive forms that include both a living will section where one can write one's wishes and a section for

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Focus on **The Lived Experience**

Death as a Natural Process

This poem illustrates a traditional culture's view of death as a natural part of the process of life.

A Native American Elder Contemplates Life's End

Today is a very good day to die.
Every living thing is in harmony with me.
Every voice sings a chorus within me.
All beauty has come to rest in my eyes.
All bad thoughts have departed from me.
Today is a very good day to die.
My land is peaceful around me.
My fields have been turned for the last time.
My house is filled with laughter.
My children have come home.
Yes, today is a very good day to die.

Source: From *Many Winters*, by Nancy Wood, p. 31. Copyright © 1974 by Nancy Wood. Illustrations © 1974 by Frank Howell. Used by permission of Bantam Doubleday Dell Books for Young Readers.

designating a person to have durable power of attorney for health care. These forms are recommended because they tend to cover more of the key issues that arise for very ill or dying people (a commonly used form can be found here: http://www.iha4health.org/wp-content/uploads/2015/08/CAHCD_8-17-15.pdf), and Exhibit 10.9 presents more information about advanced healthcare directives.

Exhibit 10.9 Advanced Healthcare Directives

Considerations with an Advanced Healthcare Directive

Health directives help individuals answer a number of difficult decisions:

Making Healthcare Choices

What matters to me in continuing my life is:

- talking to family
- being able to take care of myself
- being free from any pain
- not being hooked up to machines in order to survive
- I want to live no matter what
- frankly, I'm not sure

If I am Dying:

- I want to be at home
- I am OK with being in the hospital
- I am just not certain what I want

Life Support Treatment

- I want to try all life support treatments. I want to stay on life support machines no matter what
- I want to try life support treatments but if treatments do not work, I do not want to stay on life support machines
- I want my doctor to make this decision
- I am not sure

Implications for Practice:
End-of-Life Care

Social workers in all types of healthcare facilities have important roles to play in assisting and advocating for the dying and their families within different care settings. In *Knocking on Heaven's Door: The Path to a Better Way of Death*, author Katy Butler (2013) tells the intense first-person story of her family's experience with the American technology-drive healthcare system and how it exacerbated her father's and the family's suffering. She explores the ethical issues surrounding close ties between medical device companies and cardiologists, and the Medicare reimbursement policies that inadvertently incentivized high-tech interventions that can contradict individual patient and family values and preferences (Butler, 2010).

Nursing homes also do not tend to address the needs of dying people because they were designed and have policies to maintain and enhance residents' health. It is not uncommon for persons with incurable, advanced illness to be treated as if they are still going to recover, because the decision to stop treatment and commence comfort care is not routinely made. In hospitals, emergency treatments may be administered to dying patients unless there is a specific directive or family member who says not to. Once treatments are started, it is sometimes very difficult for families to decide to stop them. Such an instance is described by a hospital social worker working with the family of a 79-year-old woman with advanced dementia, pneumonia, and severe respiratory distress (Kaufman, 1998).

Mrs. A was brought by ambulance with high-flow oxygen to the hospital emergency room and intubated (put on a mechanical ventilator). I was informed by ICU staff

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that her son was with her when she arrived on the unit. He was "very concerned" and wanted "everything done." …

He told me that the doctors in the emergency room needed to know from him if they should intubate her because without mechanical ventilation she would have died immediately. With tears in his eyes, he reported that he had said "yes, go ahead," because he wanted her to live, was hopeful she would stabilize, and could not possibly be singled out to be responsible for her death at that moment … [Two days later, the son agreed to make his mother DNR (Do Not Resuscitate) in case of cardiac arrest] but she was still receiving mechanical ventilation and intravenous medication and nutrition … Ten days after admission, Mrs. A's son continued to want "aggressive care" … for the recalcitrant pneumonia … I spoke again with her son and with her daughter who had just arrived from another state. They both repeated to me that they would not want their mother to be on life support; however, they did not understand that what they were viewing—a woman intubated to receive mechanical ventilation—was indeed life support. Two days later, 12 days after she was hospitalized in the ICU, Mrs. A's kidneys and other organs began to fail. Her doctor discussed her failing condition with her son and daughter at length … They agreed to let her die. She died shortly after the ventilator was withdrawn, with her children [and] the family doctor at her bedside. (p. 718)

In this case, the social worker was involved after treatment had already begun with Mrs. A and her role was one of helping to educate the family about the situation and to hear out their feelings and concerns about the decisions that needed to be made.

Practice Guidelines:
Working with the Dying Person

The following guidelines (adapted from Kayser-Jones, 2002) outline the basic needs of older people who are near death—and ways for medical personnel and social workers to address those needs:

- A dying person needs adequate pain management and medical management of other distressing symptoms, such as shortness of breath. Pain is a physical phenomenon that can be assessed in those who are mentally alert by a simple numeric rating (e.g., "If 0 is no pain and 10 is excruciating pain, how are you feeling now?") or a visual analog scale, where the person is asked to mark or point to the place along a line where the level of pain is.
- The dying person needs competent, gentle physical care to maintain comfort, cleanliness, and personal dignity.
- The dying person and the family need straightforward information about their situation and any options for care—and help to make decisions. This is an area where social workers can be instrumental in helping ease the communication between medical professionals and the patient and family.
- Suffering, more global than physical pain, may occur during the dying process because of anxiety, fears, or regrets. The dying person and his or her family need reassurance and support to ease the emotional distress and anxiety common in their situation. The mentally alert dying person needs the opportunity to talk about fears, unfinished business from the past, and concerns for the future of loved ones. The social worker can spend time allowing the dying person to voice these concerns and may use the technique of Life Review if the person has the strength for longer conversations. This technique helps the person to look back on the major events of his or her life and evaluate them. Visualization and relaxation techniques are often helpful. Ideally, the person's loved ones can be encouraged both to talk about these issues and to listen.
- The dying person and the family need the opportunity to receive spiritual support and to engage in the comforting rituals particular to their religion or culture.

Psychological Dimension

Cognitive Development and Information Processing

All over the United States, and in about 90 other countries, are classrooms filled with eager, enthusiastic students who spend a week or two at a college campus or state park to learn about topics as diverse as bluegrass music, the current state of the media, or the biography of Thomas Jefferson. The interesting thing about these students is that they are attending Road Scholar programs so most of them are over the age of 55, and many are in their 70s, 80s, and 90s. Road Scholar is a nonprofit organization that promotes late-life learning by sponsoring approximately hometown and travel-based brief learning programs (www.roadscholar.org). The growth and success of the Road Scholar program attests to the fact that many older adults are eager to continue learning.

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Study Table Biophysical Dimension of Late Adulthood

Biophysical Growth and Development

- The maximum life span is about 122 years.
- Biological theories attempt to explain senescence, the decline seen in the body and its components with age.
- Exercise is an effective way for older people to maintain muscle mass, flexibility, and even cognitive abilities.
- Older adults are hospitalized at three times the rate of younger adults, and they stay longer. They also use more medications.
- Differences in metabolism with age increase the risks for side effects and drug interactions.
- Interest in sexual expression continues for a majority of older adults. Popular culture stereotypes sexuality of older adults and has a relatively negative view.
- Social workers may want to broach the topic of sexuality in assessments with older clients to support their interest in remaining sexually active and to provide education about STDs and HIV/AIDS prevention.

Biophysical Strengths, Hazards, and Risks

- Chronic health conditions increase with age, and many older adults have more than one condition, yet the majority continue to function independently.
- Many cancers are now considered chronic conditions for older adults.
- Hypertension and arthritis are common chronic health conditions. Arthritis is the largest cause of disability in older adults. Hypertension, or high BP, is very common and associated with higher risk for stroke and heart attacks. Medications and lifestyle changes are used to treat the problem.
- Elders of color experience significant disparities in terms of health conditions and health care.
- Nearly 80% of deaths in the United States are among people over age 65.
- The hospice model provides comfort care and support to dying people and their families.
- Advance directives for health care include living wills and durable power of attorney for health care. Social workers are often involved in the process of completing advance directives and in end-of-life care decisions for patients and families, and they may collaborate with a healthcare team to provide adequate pain management, gentle personal care, complete information about options available, psychological reassurance and support, and access to spiritual support and guidance.

Whether older people think or learn differently from younger adults is a complex question. Schaie and Willis (2000) have outlined six stages of cognitive development across the adult life span, two of which apply to later life. They proposed that in the young-old, the need to acquire and monitor information lessens, leading to a reorganizational stage in which the individual rearranges and reallocates intellectual abilities to meet changing roles and changing personal needs. For those in late old age, the cognitive stage is called reintegration; this stage corresponds to Erikson's idea of integration versus despair. Accordingly, "the information that elderly people acquire and the knowledge they apply is, to a greater extent than earlier in life, a function of their interests, attitudes, and values. It requires, in fact, the reintegration of all of these" (Schaie & Willis, 2002, p. 349).

Another related cognitive theory of aging is ***selective optimization and compensation***, or SOC (Baltes & Baltes, 1990; Zacher, Chan, Bakker, & Demerouti, 2015), which focuses on ways the older person is able to cope and maintain integrity despite declines in reserve capacities. The need to adapt to declines in functioning encompasses the selection component of the model, in which the older person determines which tasks or activities are most important and decides to drop others from the repertoire. Optimization comes with a concerted effort to make the best use of one's remaining strengths, skills, and energies, and compensation arises when a narrowing of the range of capacities requires that behaviors be altered to fit current levels of functioning. Research on cognitive development in older adults has attempted to test these and other similar theories. For example, in a cross-sectional study that looked at both cognitive and social developmental issues, a sample of older adults was asked to rate whether they had become more interested, become less interested, or retained about the same level of interest in a set of activities and pastimes. Adams (2004) found that investment decreased in activities requiring physical and social effort, such as entertaining in one's home, attending social events with strangers, or shopping and buying things, but that interest in intellectually and emotionally satisfying activities over which the older adult has some control remained high.

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Cognitive Decline and Aging

"Cognitive decline and dementia are a primary reason for nursing home institutionalization…cognitive well-being is a fundamental determinant of positive aging."

—Bob Harootyan, Social Research Policy and Practice Section, The Gerontological Society of America, 2019

Healthy aging is defined by the World Health Organization (2020) as "the process of developing and maintaining the functional ability that enables well-being in older age." Cognitive health is a primary determinant of functional ability (see Beaton et al., 2015 for a review). While there is cognitive decline in aging, such cognitive changes are complicated by the multidimensional nature of cognition. Cognitive abilities such as perceptual speed, memory, and categorization show decline with age, but knowledge remains stable up to age 90 (Singer, Verhaeghen, Ghisletta, Lindenberger, & Baltes, 2003). Studies have noted that a large proportion of adults remained stable in cognitive abilities and a few actually improved their performance on some measures. Although the state of knowledge about intellectual decline is imperfect, it appears likely that decline is not given with advancing age and that there is considerable variation in the loss of mental abilities.

One cognitive skill that most consistently declines with age is information processing speed (Schaie & Willis, 2002; Salthouse, 2000). The time it takes to retrieve knowledge is dependent on sensory inputs from the eyes, ears, and other sensory organs. With age, the eye's ability to focus on nearby objects decreases, the amount of light required increases, and there is impairment in the ability to adapt from light to darkness and back to light. The ability to hear, particularly high frequencies, also decreases (Fozard & Gordon-Salant, 2001). With sensory deficits, age seems to affect the quality of perception and the ability to receive, process, and act on information. This change tends to lead to a slowing of behavioral responses or reaction time in late adulthood (Madden, 2001; Salthouse, 2000).

Another common change in cognitive abilities associated with getting older is memory loss, usually in the form of verbal recall and spatial memory (Foster, Cornwell, Kisley, & Davis, 2007). Wordfinding, retrieval of nouns in particular, appears to accompany normal aging and is characterized by that "tip of the tongue" experience (National Institute on Aging, 2008b). There is an interrelationship between memory and learning; that is, memory is the ability to retain (or encode) and recall (or retrieve) what has been learned. Psychologists have identified a number of types of memory. Long-term memory consists of four subtypes (episodic, semantic, procedural, and prospective) and generally remains intact with age, although episodic memory, the ability to remember things associated with a particular time or place, is subject to heavier processing demands and is the most sensitive to age-related reduction (Nyberg, 2017). Short-term memory consists of two main types: primary memory, referring to the "storage space" available for short-term memories, and working memory, the capacity to hold on to a piece of information while mentally manipulating it. Both the encoding and retrieval abilities associated with short-term working memory are shown to decline with normal aging.

Difficulties or impairments in memory may be caused by problems of perception, attention, or motivation. The state of emotional and physical health can have a significant effect on memory functions, and conditions such as diabetes, high BP, cardiovascular problems, and depression all have been shown to negatively impact memory (Backman, Small, & Wahlin, 2001; Xue, 2020). Some memory impairments may be misdiagnosed when, as is often the case, they are transitory or reversible. In addition, a variety of medications and some vitamin deficiencies may affect memory function or mimic certain brain disorders (Backman et al., 2001; Kaye & Grigsby, 2007).

Methods of retraining have been developed to assist older adults in sharpening their cognitive skills. For instance, older adults' ability to remember new material improves after they are shown how to use organizational strategies (Schaie & Willis, 2002). Interventions based on brain plasticity theory (i.e., its ability to change and be modified), suggest that a twice-weekly, six-week training program can yield significant improvements in memory as measured in objective tests of recognition of word pairs and retention of verbal information from list learning. These programs incorporate education on physical activity, stress reduction, and healthy diet (Mewborn et al., 2017)A recent systematic review of exercise-based interventions found that programs that included a total exercise time of 52 hours (through aerobic, strength, or mind-body exercises, or a combination of these), resulted in improved cognitive performance in global cognition, processing speed/attention, and executive function in older adults (Gomes-Osman et al., 2018). The results of this and other studies suggest that cognitive declines due to normal aging may be reversible.

Although all adults experience cognitive declines, not all adults decline at the same rate (Park et al., 2022).

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Early experiences play a critical role in moderating the steepness of age-related declines. For example, neural findings indicate that "rich life experiences" not only impact the maintenance of cognitive function but also brain reorganization. Investment in human development early in the life span is, once again, an investment in healthy aging.

Communication

Communication in late life may be affected by sensory limitations, such as loss of hearing or failing eyesight, or by cognitive impairments or mood disorders. Disorders such as Parkinson's disease affect speech, causing the person to be very soft-spoken by later in the illness. The oldest old, even those who do not suffer from a particular disorder, tend to speak more slowly, with greater response latency in conversation. Some elders suffer from social isolation, particularly frail older people who live alone. There may be no one whom they see and talk with regularly other than helpers such as the volunteer who delivers Meals on Wheels or the aide who comes to help with personal care. For many older adults who have few family members close by or who have difficulty getting out on their own, the telephone and the Internet provide important links to distant loved ones and to the outside world.

Communication with cognitively impaired elders can be very challenging, yet it is important for family members and professionals to continue communicating with them in positive ways. In the 1960s, validation therapy was developed by a social worker who argued that it is most helpful to try and understand the needs and feelings of a confused elder, so that rather than constantly orienting the person to the present, the validation therapy–trained worker or family member will go along with the person's view of reality and ask questions in order to try to interpret his or her needs and messages. The emphasis of the method is listening empathically to the feelings being expressed by the person with dementia (Feil & Altman, 2004). Even hostile or "acting out" behaviors are seen in this approach as forms of communication that need to be listened to by people interacting with the individual. This method has gradually become accepted in many institutions that serve persons with Alzheimer's disease and other dementias, although it is seldom used in pure form; most long-term care settings continue to post the date and season and introduce some current reality into activities with residents with dementia.

Attitudes, Emotions, and Regulation

Research on emotions in later life has found minor differences between younger and older adults in terms of affective intensity, qualities of emotions experienced, and specific emotions that are more prevalent (Ready, Åkerstedt, & Mroczek (2012). For instance, in the very oldest old, a reduction in positive affect is typically seen, along with a small decrease in the frequency with which older adults experience anger and sadness (Magai, 2001). The complexity of emotional experience may be greater in older adults than younger adults. Charles, Mather, and Carstensen (2003) found that older adults experience more positive and fewer negative images than younger adults. This may be related to an awareness of the limited time remaining. Two theories discussed in this chapter, socioemotional selectivity and selective optimization and compensation, were developed through studies of the emotional life of older adults and reflect several of the findings of these studies. Both of these theories suggest that older adults make choices to achieve an appropriate blend of stimulation and comfort, while avoiding negative effects. Overall, studies on emotion in older adults find that they regulate their emotions more effectively than younger adults and, contrary to a popular stereotype of the grumpy old person, aging does not lead to a negative outlook. Further, social workers can help shift the emotional experiences of older adults by altering their perspective. By attuning people to experience "awe," the positive emotion experienced when in the presence of vast things not immediately understood, they become less self-focused and more socially connected (Sturm et al., 2022). One group of researchers used the concept of "awe" and randomized one group of healthy older adults to take weekly 15-minute outdoor walks for eight weeks while practicing "awe" and compared their emotions to a control walk group. Those who took awe walks experienced greater awe, joy, and prosocial emotions during their walks, and displayed an increasing smile intensity over the study. They concluded that cultivating awe enhances positive emotion that fosters greater social connection and can be a prevention tool for aging-related declines.

Loss, Grief, and Mourning

Experiences of loss, anticipation of loss, and adaptation to loss tend to characterize the emotional fabric of late life. In every aspect of late adulthood, losses occur: death of loved ones; decline in health; loss of youth; loss of customary social roles and perhaps their status and prestige; and, for some, loss

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of aspects of independent functioning. Multiple losses at any one point in time are not uncommon, and the fact that many of these losses were expected will not necessarily make them any easier for the person who is experiencing the losses, yet family and friends may minimize the impact of losses on older adults (Knight, 2004). Exhibit 10.10 shows some of the factors that affect older adults' ability to adapt to loss. The loss of loved ones through death may have a profound effect on older survivors, partly because there is less likelihood that the lost relationships will be replaced. Spousal bereavement, in particular, brings a profound role loss.

Grief is the normative emotional reaction in response to the death of a loved one that may be expressed both physiologically and emotionally (McCoyd, Koller, & Walter, 2021). Physiological expressions of grief often include emptiness in the pit of the stomach, a feeling of shortness of breath, tightness in the throat, muscle weakness and fatigue, sensitivity to noise, and a dry mouth. Emotional expressions of grief may include sadness, anger, self-reproach, anxiety, loneliness, helplessness, numbness, and, at times, relief or emancipation. McCoyd and colleagues use a multidimensional perspective on grief and loss across the life course, including addressing the spiritual aspects of loss, particularly when it is important to the individual that you are working with. They consider grief as something that is embodied biologically (for example, one's biochemical response to stress), psychologically (for example, one's cognitive stage of development, one's attachment style), socially (for example, the loss of connection or place in the social order, social rituals), and spiritually (for example, search for meaning after death regardless of if this comes from a religious belief).

Prolonged grief disorder is the newest disorder to be added to the DSM and is included in the text revision of DSM-5-TR (released by the APA in March 2022). It is diagnosed when the loss occurred at least a year ago and the feeling of intense grief persists, it is disabling, and affects everyday functioning. Some symptoms may include avoiding reminders that the person is dead, intense emotional pain, emotional numbness, and feeling that life is meaningless. It is estimated to affect 7–10% of bereaved adults (Szuhany et al., 2021). Adults at greater risk for diagnosis are those with a history of depression or bipolar disorder, caregivers of the loved one, and when the loss is very sudden or under traumatic circumstances. Sleep

Exhibit 10.10 Factors that May Affect Experience, Behavior, and Adaptation in Loss.

Environmental or Extrinsic Factors
Personal losses or gain: marital partners; other loved and significant figures (friends, children)
Social forces (losses or gain): status changes, prestige changes (in social groups other than family)
Socioeconomic adversities: income drop, inflation
Unwanted retirement: arbitrary retirement policies
Cultural devaluation of older persons: sense of uselessness, therapeutic pessimism, forced isolation, forced segregation
Intrinsic Factors
Nature of personality: character structure (defensive and integrative mechanisms), life history, survival characteristics
Physical diseases: disease of any organ system; perceptual decrements; sexual losses; disease of integrative systems (hormonal, vascular, and central nervous systems); brain damage; arteriosclerosis; senile dementia and so on; physical limitations (such as arthritis)
Age-specific changes (largely obscure and mysterious, but inexorable with the passage of time): losses of speed of processing and response; involuntary processes; others (heredity, survival qualities); changes in body size and appearance
Experience of bodily dissolution and approaching death (subjective passage of time)

Source: From *Aging and Mental Health: Positive Psychosocial and Biomedical Approaches*, Fourth Edition, by R. N. Butler, M. Lewis, and T. Sunderland, 1991, p. 89. Used by permission of The Hastings Center Report.

This woman, from French-speaking Louisiana, is confronting a personal problem: her husband has died. Her responses are influenced by socially prescribed customs and coping styles related to death and burial practices.

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problems are common; approximately 80% of people with prolonged grief disorder experience poor sleep long term. The most effective treatments are cognitive behavioral therapy (CBT), complicated grief treatment (which includes components of CBT; Szuhany et al., 2021), and bereavement support groups.

Practice Guidelines:

Coping with Loss

When people who experience the loss of a loved one do not deal with their pain and loss, working through the grief, problems can arise years down the road. Worden (2008, 2018) outlined four tasks essential to mourning a loss:

- Accept the loss. Initially, people deny the reality of a death, so the first task is to accept that the loved one is gone and will not return. Often people display searching behaviors, seeing the loved one in a crowd or hearing his or her voice. This is referred to as *loss-oriented* coping that focuses on processing the emotions associated with grief.
- Many ask after the death of a loved one, "When does this pain go away?" Many simply do not want to hurt so much, so they busy themselves with activities or go on a trip to cope with their feelings. Such *restoration-oriented* coping focuses on distractions from grief, including new roles and new relationships. Bereaved individuals may need to externalize the pain by talking about the death and the loved one. Group therapy situations can be helpful.
- Adjust to the new environment. External adjustments include dealing with practical realities and loss of social roles; internal adjustments may relate to the person's identity as a child or a partner of the person who is deceased; and spiritual adjustments, coming to some understanding of the meaning of the person's life and the loss, need to be made.
- Find an appropriate way to maintain connection with the deceased, yet move on with life.
- Rather than expecting bereaved people to withdraw their emotions from the lost person, Worden suggested thinking of this final step as "relocating" the deceased in one's life.
- Research has found that ruminating over the negative events surrounding the death is not helpful in the long run.

One emerging trend is cyber mourning, particularly in the wake of the COVID-19 pandemic. Worden (2018) outlines the ways in which cyber mourning can 1) be used to remember the deceased, 2) conduct intervention for the bereaved, and 3) allow for further research on bereavement and the mourning process. Examples of this include online memorials, online treatment for conditions such as PTSD or prolonged grief disorder, internet bereavement support groups, peer-support web pages, psychoeducational resources to normalize feelings associated with grief, and communicating with the deceased, such as creating Facebook pages for the deceased where people can regularly write to their loved one to create meaning and continuing a bond. Cyber mourning can be particularly helpful for disenfranchised grief. For example, in cases when people experience a loss that is not socially sanctioned and could potentially be ostracized, such as the death of someone with whom they were having an affair or the loss of a same-sex lover who could publicly "out" them.

Loneliness

Bereavement in late adulthood may lead to loneliness (Vedder et al., 2022). In fact, loneliness has been identified as a core experience associated with grief, linked to difficulties in adjusting to life without the loved one. In the DSM-5, "intense loneliness as a result of the death" is included as part of the criterion C for prolonged grief disorder. ***Loneliness*** has been defined as an unpleasant subjective state in which the person senses a discrepancy between the desired amount of companionship or emotional support and that which is available. People experiencing loneliness often describe it as feeling empty inside and disconnected from others. A person may be socially lonely—there simply isn't enough companionship available from anyone—or lonely for a specific intimate other. Other common age-related losses and transitions, such as moving to a new residence or a change in health that necessitates a change in routine, also may cause loneliness. Loneliness is often a precursor to poor mental health (Vedder et al., 2022). For older adults in congregate living or long-term care facilities, attendance at organized social activities does not appear to inoculate against loneliness (Adams et al., 2004). However, a flexible coping style is a psychological strength can buffer feelings of loneliness (Vedder et al., 2022). A flexible copying style allows the individual to both process and move

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Many older adults experience loneliness, especially after bereavement.

beyond loss. Additionally, having a positive appraisal is also a psychological protective factor; for example, recognizing personal growth that occurred as a result of loss.

Loneliness and isolation are distinct but related concepts; loneliness is a feeling about your experience, whereas isolation is the size of and amount of engagement with your social network, your availability of transportation, and your ability to access resources and information (The Gerontological Society of America (2019). Isolation is recognized in the United States as a growing health epidemic, impacting more than 8 million adults aged 50 and older.

Some important conclusions about loneliness and its impact on older adults include the following: isolation increases the risk of mortality, feelings of loneliness can negatively impact physical and mental health (including depression and a pessimistic outlook), feelings of loneliness are linked to poor cognitive performance, isolation is related to elder abuse, LGBT seniors are more likely to be socially isolated, and lonely people are more likely to engage in unhealthy behavior. A systematic review of interventions that were conducted during the peak of COVID-19's physical distancing measures found that few interventions improved social isolation (Williams et al., 2021). In general, older adults were more depressed and lonelier during this period (Krendl & Perry, 2021). Interestingly, adults were relatively adaptable in staying close to their social network, primarily through social media, but it did help them feel less lonely. Effective interventions for loneliness include mindfulness approaches, lessons on friendship, robotic pets, and social facilitation software (Williams et al. 2021).

Practice Guidelines:

Reducing Loneliness among Older Adults

Possible social work interventions to prevent or alleviate loneliness in older adults in various settings might include the following:

- Social skills groups and friendship lessons for residents in congregate living facilities; in these groups, members learn how to be more sociable, at the same time getting to know one another better.
- Friendly visitor programs for the homebound in the community.
- Telephone "check-in" support from volunteers.
- Volunteering can reduce social isolation and loneliness in older adults.
- Family therapy with a focus on mobilizing social and emotional support for a lonely older family member.
- Promoting access to transportation and arranging social events involving friends or family who reside outside of a long-term care or congregate living facility to help residents maintain ties to the community.
- One of the most effective programs for combating loneliness is interventions with an educational or training component such as classes on health topics, exercise, or technology, including technology-mediated communication.
- Bereavement support groups in which the recently widowed are given the opportunity to talk about the spouse they have lost as well as share in other meaningful activities with one another.
- Using mindfulness or looking for growth in the face of loss.
- Complicated grief treatment for those suffering from prolonged grief disorder.

Reminiscence

I do not live in the past; it is the past which is alive in me.

—Rene Dubos

Reminiscence is defined as an action or process of recalling the past. Many older adults tend to think of themselves in terms of their former occupation or social role. When introduced, they state what job they retired from. And those who have retired may find they engage in volunteer work or other pastimes that reflect those prior roles. This fits

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with ***continuity theory***, which was discussed earlier in the book. As people age, their basic personality or core sense of self does not change, although their psychosocial needs may change, along with their physical bodies and social roles. Reminiscence is one way older people maintain a sense of self. As aging brings loss of some of the roles and relationships that were important in creating the individual's personal identity, thinking over and talking about important past roles, events, and people helps keep these memories alive and literally helps maintain the identity of the person. When people talk about their past to others, they not only reflect on what they believe and value in the relationships among self-relevant events across time, but they also reconstruct an interpersonal context by obtaining input from others and achieving reciprocity or an exchange of ideas. This process contributes to developing and maintaining or reconstructing personal identity (Yen & Lin, 2018). Reminiscing is part of the process of putting meaning to our lives. But there may be more to sharing memories for older people. Reminiscence can be a socialization tool, as memories are shared with friends and relatives. It can help an older person orient to the present by getting a "good grip" on the past. *Life review* (Watts, 2013) is the term used for a more formal effort to review the stages of an older person's life for therapeutic purposes. Reminiscence helps the older adult retrieve positive memories from the past, with the goal of improving mood, but unlike life review, reminiscence is not geared toward gaining insight or resolving earlier conflicts (McInnis-Dittrich, 2014). Reminiscence therapy may involve sharing in a group setting or in the presence of one observer who listens quietly without comment. It is associated with improved cognitive function, social bonding, and overall well-being among older adults. It has also been beneficial for patients with mild-to-moderate Alzheimer's disease, one study used it alongside photographs, videos, and music from the past (Cuevas et al., 2020). In a systematic review in Taiwan, they found Taiwanese culture-specific reminiscence therapies to improve mental and physical health, including overall quality of life, cognitive functions, and depressive symptoms (Yen & Lin, 2018). Perhaps even more notable, they found there were no studies that found negative impacts on participants. As one reviews the events of one's life, past accomplishments and successes may be more appreciated in hindsight, whereas weaknesses and mistakes don't seem as serious as they did decades ago.

Ground Picture/Shutterstock.com

Older adults can reflect on the earlier years by sharing photographs.

Psychological Strengths, Hazards, and Risks

Psychological well-being in late life brings us back to "successful aging"—older people who have kept their minds and bodies active are more likely to age successfully and avoid some of the hazards of aging, including psychological ones. Numerous studies have shown that psychological well-being in later life is associated with a flexible attitude and the ability to adapt to the changes that aging brings (Greene, 2000). Although adaptability is a positive quality, a sense of personal mastery, or control over the environment, is a strength also shown to be important to the psychological well-being of older people (Jang, Haley, Small, & Mortimer, 2002). Older residents of nursing homes and others who have a disability often experience greatly diminished personal control and mastery, and thus are particularly vulnerable to depression. Offering choices to older adults with functional impairments and helping them to maintain their current level of functioning will help with their sense of mastery and enhance their psychological well-being.

Wisdom

As we know, Erikson's developmental crisis for the final stage of life is integrity versus despair, but the strength he saw resulting from successful resolution of the crisis is wisdom. Much has been written about wisdom but, as Schaie and Willis note, the concept is still an elusive one (2002). How would you define wisdom? Do you think older adults seem wiser than younger people? One review of the literature on ***wisdom*** defined it as "the application of tacit knowledge [practical knowledge, or knowing how to do things] toward the achievement of a common good through a balance among intrapersonal, interpersonal

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and extra-personal interests" (Sternberg & Lubart, 2001, p. 507). That sounds complicated, but essentially it means that a wise person is capable but also sees the needs and viewpoints of others. The association of the concept of wisdom with growing older equates accumulated life experience with becoming wiser. Research on wisdom typically includes prosocial behaviors, such as empathy and compassion, emotional regulation, the ability to self-reflect, decisiveness while accepting uncertainty and diversity of perspectives, social advising, and spirituality (Lee et al., 2020). Wisdom, when defined this way, is associated with enhanced compassion, reduced loneliness, and greater well-being (Jeste et al., 2021). On average, older adults are more resilient to anxiety, depression, and stress-related mental health disorders, such as those that emerged during the initial phase of the COVID-19 pandemic in younger populations, because of the resilience associated with wisdom (Vahia et al., 2020).

Cognitive Impairment, Alzheimer's Disease, and Other Dementias

The risk for cognitive impairment increases with age. Even though the term ***dementia*** is widely used and understood to refer to irreversible cognitive impairment that affects memory, personality, and functioning, the American Psychiatric Association's Diagnostic and Statistical Manual, 5th Edition (DSM-5) now uses the broader category, neurocognitive disorders (NCD). Cognitive decline in one or more domains is the hallmark feature of NCD, but it is not exclusively a memory impairment condition. Complex attention, executive function, language, perceptual motor, and social cognition are brought together with learning and memory in this diagnostic group. Using the older terminology, we know that Alzheimer's disease (AD) is the most common form of dementia, accounting for about 60% of the dementia disorders in older adults (Thies & Bleiler, 2011). There are several other types of dementia with similar symptom presentation but different underlying causes, including vascular dementia, Lewy body dementia, and frontal lobe dementia. Exhibit 10.11 presents an infographic on Alzheimer's disease.

It is estimated that 6.5 million Americans aged 65 and older had AD in 2022, and it is projected that by 2050, 12.7 million people will suffer from this disease (Alzheimer's Association, 2022). That means about one in nine adults aged 65 and older has AD in the United States. Blacks are twice as likely, and Hispanics are 1.5 times as likely, to have AD than whites. In 2020, COVID-19 contributed to a 17% increase in AD and dementia deaths. The disorder starts with loss of short-term memory, eventually progressing to interfere with all of the brain's functions. Behavioral and emotional changes are common in people with AD; lack of motivation, or apathy, is part of the usual presentation in the early stages so that the person with AD becomes dependent on others and lacks interest in life or emotional reactivity (Agronin, 2014). By the middle or moderately severe stages, about 50% of those with the disease experience symptoms such as delusions or hallucinations, agitation, verbal and physical aggression, or uncooperativeness with care.

Dementia is related to education. More years of education is associated with fewer age-related cognitive declines and dementia. However, new research has uncovered that the cognitive differences we see in late adulthood are not a result of having more education in older adulthood but rather the educational opportunities that was afforded in early adulthood (Lövdén et al., 2020). Neuroscience research has uncovered three specific ways in which the brain impacts cognitive aging (Cabeza et al., 2018):

1. Reserve: the accumulation of brain resources during the life span (i.e., how much you have)
2. Maintenance: the preservation of these resources through recovery and repair (i.e., how well you keep it)
3. Compensation: the ability to use resources in response to task demands (i.e., when and how you use it).

For example, good education early in life enhances your reserve by increasing synaptic density, which can reduce age-related declines if those new synapses are preserved through maintenance (use it or lose it). This information is relevant in selecting treatment; we won't see positive gains using cognitive training interventions if the patient has significant deficits in maintenance. Similarly, individuals have to be able to use their resources (compensation) for cognitive training interventions to be effective. Ultimately, the best prevention efforts are ones that target cognitive ability earlier in the life course, particularly in early adulthood, to most effectively reduce the burdens related to cognitive aging (Lövdén et al., 2020). Unfortunately, the demand for direct care workers and professionals specializing in geriatrics is projected to grow, while the availability is declining. Only 4% of social workers have formal certification in geriatric social work (Alzheimer's Association, 2022).

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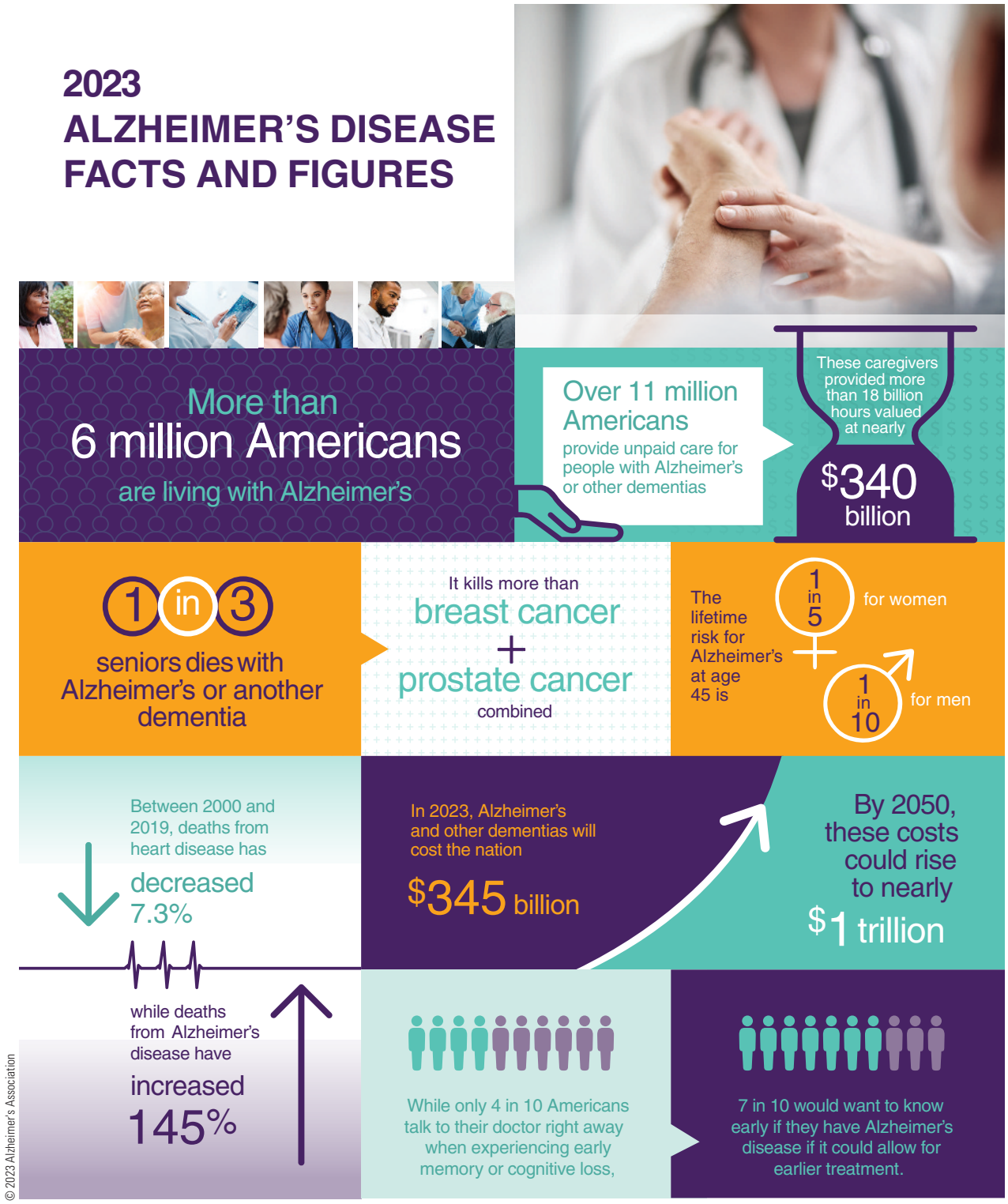
Exhibit 10.11 Alzheimer's Disease Facts.



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Diagnosis of AD or Other Dementias

Cognitive well-being is an overriding concern for older people and their families, and with the graying of the Baby Boomers, longer life spans, and greater visibility of AD and other dementias in the media, a growing phenomenon among middle-aged and older adults is anxiety about experiencing or having AD. The popular term "senior moment," describing a lapse in memory, reflects both a stereotype (i.e., that aging automatically brings poor memory or that only older persons are forgetful) and the high level of societal anxiety about aging. Many older adults are uncertain about the difference between normal forgetfulness and dementia and experience considerable anxiety about this. Fortunately, there are guidelines to help distinguish normal cognitive changes from a possible dementia, such as AD (see Exhibit 10.12).

There is no cure for AD, but there are treatments that can help change the disease progression and also help with symptoms, such as AD behaviors and sleep changes (Alzheimer's Association, 2022). Aducanumab has received accelerated approval as a treatment for AD from the FDA, and is the first FDA-approved therapy to address the underlying biology of AD. Early detection and accurate diagnosis are critical so that people who take Aducanumab can benefit from sustained independence, actively participate in their daily life, and hold onto their memories longer. Unfortunately, the Centers for Medicare and Medicaid Services effectively denies Medicare coverage for this drug. Other options include cognitive interventions, coping tips, and family counseling (Alves et al., 2013; Cotelli et al., 2012).

Alcohol abuse, HIV, traumatic brain injury, and Parkinson's disease can sometimes cause dementia, complicating the diagnosis of AD. The DSM-5 focuses on the specific cognitive clinical details, with medical cause added if known. In addition, because of the apathy present in AD and the cognitive symptoms that accompany late-life depression, early-stage Alzheimer's might "look like" depression, and vice versa. Autopsy to identify the characteristic brain amyloid plaques and neurofibrillary tangles is the only definitive method of diagnosing AD. However, cognitive and neurological tests and a detailed history of the presenting symptoms can identify "probable" AD or another type of dementia in a majority of cases. Structural imaging tests are often used to rule out other conditions (such as tumors, strokes, head trauma). Research in this area is progressing to better diagnose and track the progress of AD with brain imaging techniques. Additionally, improvements have been made with blood tests and are being used in some specialty care centers. With more research, these could revolutionize the diagnostic process for AD and all other dementia (Alzheimer's Association, 2022).

The DSM-5 mild neurocognitive disorder now replaces the previous mild cognitive impairment (MCI). Although there has been some blurring between the diagnosis of MCI and early dementia, MCI is generally diagnosed when the person has cognitive deficits reflected in test scores that are greater than one would expect with normal aging, yet lacks functional impairment and behavioral symptoms that mark AD and related dementias. Research is so far unclear as to whether MCI is a distinct condition or simply a precursor to dementia, partly due to methodological challenges in measuring MCI coupled with the multiple types of dementia, and intervening risk variables such as depression, along with variable subject ages. An estimated 12–18% of people aged 60 and over had MCI and a third of individuals with MCI progress to dementia or AD within five years (Alzheimer's Association, 2022). The uncertain future with MCI can make this a particularly troublesome diagnosis for older adults and their family members.

Exhibit 10.12 Common Myths Associated with Cognitive Impairment.

Is it normal or is it dementia?	
Normal	**Possibly AD or Other Dementia**
1. Temporarily forgetting a colleague's name	Not being able to recall the name later
2. Having a word on the tip of the tongue	Substituting strange words for forgotten words
3. Misplacing objects in moments of distraction	Misplacing things in unusual places and having no memory of putting them there
4. Forgetting for a moment where you're going	Getting lost on your own street
5. Having trouble balancing the checkbook accurately	Forgetting how to add or subtract numbers
6. Not feeling like doing a chore	Not knowing or caring that the chore needs to be done
7. Temporarily forgetting the day of the week	Not knowing what season or year it is, even after thinking about them

Source: Adapted from the Alzheimer's Association (www.alz.org).

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Dementia Caregiving

In a church fellowship hall, a support group for the spouses of people with AD meets with two social workers. Most cradle Styrofoam coffee cups and cookies as they share their stories. Their comments revolve around common themes—"She just doesn't want to do anything." "I have to say it's for *me*, then she'll come with me on a walk." "He watches TV, but he can't read anymore . . . or at least, he'll look at the newspaper, but I don't think he can read." "I think he knows he's got a problem, but we don't talk about it." In every instance, the people attending this group are witnessing the gradual loss of their spouse, because AD is a slow thief—of memory, motivation, reasoning, and, finally, physical functioning; and of the unique qualities of intimate relationships.

In people with moderate or mid-stage AD, behavioral changes such as physical and verbal aggression, delusions, suspiciousness, uncontrollable agitation, and wandering can make living with and caring for the individual very challenging. A recent review of the research on dementia caregiving put it this way: "For some individuals, the caregiving role lasts many years, even decades, and caregivers are increasingly being asked to perform complex tasks similar to those carried out by paid health or social service providers" (Schulz & Martire, 2004). Some common formal services directed at the caregiver consist of support groups such as the one mentioned above, cognitive behavioral group therapy, and individual counseling or psychotherapy. In the past decade, online support groups have become feasible and present opportunities for caregivers to communicate with others in similar situations without leaving their homes or offices. Adult day programs for the person with dementia to relieve the caregiver during day hours, or respite care, usually a service providing overnight In-home care while family members are unable to be at home, are other services that are frequently available. Residential care, such as nursing-home placement, is often seen as a last resort by families. However, placement is often necessary when the person with dementia lives alone, or at the point when problems such as wandering or incontinence become unmanageable for family members in the home setting.

The effects of caring for someone with dementia have been the focus of a great deal of research since the early 1980s. A more recent model of caregiver distress suggests that caregiving tasks is notIys the main cause of distress among caregivers, but rather that grief—due to the many (and ambiguous) losses that occur when a close family member has AD—is a very real and significant contributor to the high levels of depression in caregivers (Adams & McClendon, 2006; Adams et al., 2004; Meuser & Marwit, 2001). A systematic review of caregivers of people with AD found that coping strategies, such as emotion-focused coping and problem-focused coping, can reduce caregiver depression, anxiety, and stress (Monteiro et al., 2018). On the other hand, dysfunctional coping strategies are associated with more caregiver burden.

Mental Illness in Late Life

When an older adult presents for help, a variety of factors (e.g., physical, cognitive, social, and emotional difficulties) may combine in such a way that diagnosis of a mental disorder is confounded. For instance, there is considerable overlap between physical symptoms and emotional

Focus on **The Lived Experience**

Alzheimer's Disease in African Americans

Evidence is accumulating that AD and related dementias affect the African American community disproportionately. Although rates vary among studies, there is a higher incidence of dementia from 14% to 100% among African Americans than whites. Genetic predisposition in Blacks appears to differ from that in whites, and probably is not limited to the APOE-e4 gene. (Risk among first-degree relatives of someone with AD has been found to be 43.7%, while for spouses who share an environment but not genetics, it is 18.4%.) The higher incidence of vascular problems and related disorders, such as hypertension, type 2 diabetes, and high cholesterol among African Americans may be one reason why this group also has higher rates of AD and related dementias. Limited access to good health care and possible distrust of the established healthcare system may contribute to the fact that African Americans tend to be diagnosed later in the dementia process than their white counterparts. There are significant efforts to recruit larger numbers of older African Americans to major AD research centers for diagnosis and participation in research.

Source: Compiled from the Alzheimer's Association, www.alz.org (2022).

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symptoms, between normal bereavement and depression, and between cognitive impairment of early dementia and many other mental disorders. Current cohorts of older adults seek help less frequently for emotional or mental conditions than do younger people, in part because they tend to identify their problems as physical or environmental rather than psychological in origin (Knight, 2004). Even when older adults present with mental health concerns, they generally receive less psychotherapy than younger adults, instead receiving services such as medication or custodial care (Schaie & Willis, 2002), particularly when they are 80 years old and older (Frost et al., 2019). In a qualitative systematic review (Frost et al., 2019), clinicians reported that the stigma related to depression in older adulthood takes time to negotiate, and when they have limited time, they would prioritize their physical health over mental health, particularly for people with fragility.

Among older adults who are seen for mental health services, some have had a long-standing serious mental disorder such as schizophrenia or bipolar disorder. Other older adults have personality disorders, such as narcissistic, dependent, obsessive-compulsive, or borderline. It is not unusual to see an older person with a personality disorder who has been functioning well during middle adulthood but who is not dealing well with age-related transitions and losses (Segal, Coolidge, & Rosowsky, 2000). In these situations, the person may experience a depressive episode or anxiety overlaid upon the preexisting personality disorder and may seek help or may cause his or her family so much distress that they seek help. In addition, many older adults experience a psychological problem for the first time late in life, sometimes in conjunction with bereavement or with a physical illness. Many will seek help from primary care physicians. These late-onset disorders are most commonly some form of depression or anxiety, though a few older adults develop paranoia or other psychotic thinking for the first time in late life.

Depression

A relatively small percentage, estimated at 1–5%, of older people living in the community have major depressive disorders (Blazer, 2003; CDC, 2022) and that rate has stayed relatively stable over time with the exception of the COVID-19 pandemic, which increased rates of depression of older adults, as well as middle and young adults (Krendl & Perry, 2021). However, older adults were less impacted compared to other age groups because they generally have lower stress reactivity, better emotional regulation, and wisdom which helped foster resilience (Vahia et al., 2020). Studies conducted in long-term care settings have found rates of depression, self-harm, and suicide among residents to be much higher (Blazer, 2002; Gleeson et al., 2019), though rates vary quite a bit across studies (11 to 85.5%, see Elias, 2018 for a review). Additionally, depression is one of the most common comorbidities of chronic conditions, such as cancer, heart disease, metabolic, inflammatory, and neurological disorders (Gold et al., 2020). Depressive disorders and subthreshold depressive symptoms in older adults are associated with clinically significant impairments in functioning (Hybels, Blazer, & Pieper, 2001).

Depression is not the same as the unhappiness felt by people confronting everyday life. Symptoms of depression may include feelings of sadness, but in older adults, depression may present as anhedonia, the loss of pleasure in things that used to be pleasurable. **Anhedonia** includes feelings of emptiness, excessive social withdrawal, loss of interest in usual activities, self-neglect, changes in appetite, sleep problems, and expressions of worthlessness, such as concerns about being a burden. Anhedonia has recently emerged as a potential risk factor for suicidal thoughts and behaviors (Auerbach et al., 2022), as well as Alzheimer's disease (Vaquero-Puyuelo, 2021). And finally, older adults may somaticize more than other age groups—meaning they express their psychological distress through concerns with physical symptoms, such as weakness, dizziness, vague pain, or constipation, that don't have an underlying physical cause (Blazer, 2002).

Haigh and colleagues (2018) provide an update on the past 20 years of research on depression in late adulthood by re-examining the five commonly held myths about depression in late adulthood first introduced by Blazer (1997):

- Myth 1: Depression in late adulthood is symptomatically different from depression at earlier stages. False. Although some studies suggest that depression in late adulthood may have more somatic symptoms, generally there is insufficient evidence to support that it presents differently across adulthood.
- Myth 2: Depression is more common in late adulthood. False. In fact, there is some evidence that older adults are more resilient to depression due to increased resilience and wisdom.
- Myth 3: Depression is more chronic in late adulthood. True. Though Blazer found this to be false, more recent research has indicated that older adults

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are more likely to relapse, which is likely due to a medical comorbidity.

- Myth 4: Depression in late adulthood is more difficult to treat. False. Overall, adults respond similarly to psychological interventions regardless of age, however, anti-depressants are less efficacious among older people.
- Myth 5: Depression in late adulthood is more often caused by psychological factors. False. Interestingly, psychological factors may be more protective later in life.

Exhibit 10.13 Assessment tools: The Geriatric Depression Scale.

Choose the best answer for how you have felt over the past week:

Yes/	No	
[ ]	[ ]	1. Are you basically satisfied with your life?
[ ]	[ ]	2. Have you dropped many of your activities and interests?
[ ]	[ ]	3. Do you feel that your life is empty?
[ ]	[ ]	4. Do you often get bored?
[ ]	[ ]	5. Are you in good spirits most of the time?
[ ]	[ ]	6. Are you afraid that something bad is going to happen to you?
[ ]	[ ]	7. Do you feel happy most of the time?
[ ]	[ ]	8. Do you often feel helpless?
[ ]	[ ]	9. Do you prefer to stay at home, rather than going out and doing new things?
[ ]	[ ]	10. Do you feel you have more problems with memory than most?
[ ]	[ ]	11. Do you think it is wonderful to be alive now?
[ ]	[ ]	12. Do you feel pretty worthless the way you are now?
[ ]	[ ]	13. Do you feel full of energy?
[ ]	[ ]	14. Do you feel that your situation is hopeless?
[ ]	[ ]	15. Do you think that most people are better off than you are?

Scoring: (GDS maximum score = 15)

0–4 normal, depending on age, education, complaints

5–8 mild

9–11 moderate

12–15 severe

Available from the public domain. Source: Yesavage, J. A. & Sheikh, J. I. (1986) Geriatric Depression Scale (GDS): Recent Evidence and Development of a Shorter Version. *Clinical Gerontologist 5*, pp. 165–173.

Social workers use a number of short screening tools with older adults, including those that assess ADLs, cognitive impairment, and mood states (Berkman, Maramaldi, Breon, & Howe, 2002; Greene, Cohen, Galambos, & Kropf, 2007). One quick measure for assessing potential depression in older people is the Geriatric Depression Scale (GDS), a 15-item validated scale (a shorter five-item screening also exists) (see Assessment tools: The Geriatric Depression Scale).

Practice Guidelines:
Helping Depressed Older People

Social workers see depressed older people in a number of settings. These guidelines suggest some strategies practitioners can consider when working with depressed older adults:

- Enlisting help from family members and involved friends is a useful strategy to build up a supportive network for the depressed older person.
- Psychosocial treatments are often effective without medication and are preferred by older adults. Research evidence suggests that structured approaches such as problem-solving therapy, interpersonal therapy, reminiscence therapy, and cognitive behavioral therapy are effective in helping elders overcome depression.
- Supportive social work practice with depressed older adults combines (1) establishing a relationship, (2) identifying and mobilizing the individual's strengths, (3) facilitating exploration of negative events that may have precipitated the depression and expression of the accompanying feelings such as grief, and (4) encouraging the client to engage in self-care and feasible activities that were previously enjoyable.

Suicide

Sadly, a disproportionate number of older adults die by suicide each year. Suicide is a significant problem in late adulthood that is difficult to generalize about because the older population itself is so heterogeneous. Seniors aged 75 account for fewer than 10% of all suicides but have the highest suicide rate (19.1 per 100,000; CDC, 2022). Older non-Hispanic white men have the highest rates. Veterans are also at greater risk; people who have previously served in the military account for 13.7% of

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adult suicides. Most serious suicide attempts are made by depressed people, but other diagnosable psychiatric disorders, physical illnesses, disabilities, and substance abuse problems (even if the person is sober) also increase the relative risk for suicide in an older adult. Although suicide attempts are very difficult to predict, a sense of usefulness, feeling of social disconnectedness, and psychological pain associated with chronic physical illness are strongly associated with suicidal behavior (Conejero et al., 2018). Life events, such as the loss of a spouse, among elders who are socially isolated and may be experiencing cognitive difficulties should also raise serious red flags. Clues older adults may provide to family members, service providers, or other informants, include increased isolation, giving away possessions, threats of suicide, wishes to die, saying goodbye, or expressions of worthlessness or hopelessness. Suicides may be prevented by providing adequate mental health and substance-abuse screening services for older adults in community settings they frequent. Healthy IDEAS: Identifying Depression, Empowering Activities for Seniors is an evidence-based depression screening and intervention program first implemented in 2002 and then disseminated to numerous states. It emphasizes behavioral activation and other self-management tools, which can be taught to seniors in health clinics and activity centers (Casado et al., 2008). Finally, it should be noted that as of 2022, physician-assisted suicide is a legal option in ten states for individuals that have a terminal illness as well as less than six months to live. Physicians cannot be prosecuted in those states for prescribing medications to hasten death. Many proponents have removed the term "suicide" and refer to the act of assisting people with their death in order to end their suffering as physician-assisted death (PAD).

Alcohol and Other Drug Use in Late Adulthood

Substance use disorder (SUD) is a growing concern among older adults, with an estimated prevalence of 4% among those aged 65 years and older (Jaqua et al., 2022). The most commonly abused substances are alcohol, prescription drugs such as opiates and benzodiazepines, and over-the-counter medications. Older adults are more likely to experience chronic health issues associated with aging, including chronic pain, as well as experience grief and loss of independence, that attribute to substance misuse, including accidental misuse of prescription drugs. Additionally, the use of cannabis among older adults has increased sharply in the past 15 years and has implications for cognitive functioning, falls and injuries, and interactions with other drugs, though some studies have found it helpful in the treatment of behavioral and psychological symptoms of dementia (Solomon et al., 2021). Alcohol is the most used drug among older adults, with about 65% of people aged 65 and older reporting high-risk drinking, defined as exceeding daily guidelines at least weekly in the past year (Grant et al., 2017). This is particularly significant given that alcohol interacts adversely with a number of prescription medications commonly taken by older people. The National Institute on Alcohol and Alcoholism advises that people who are aged 65 years and older who do not take any medicines to limit their alcohol intake to seven drinks a week. According to the Dietary Guidelines for Americans 2020–2025 (U.S. Department of Agriculture and U.S. Department of Health and Human Services, Dietary, 2020), all adults of legal drinking age should limit drinking to one drink or less per day for women, and two drinks or less per day for men, and that drinking less is better for your health.

Undoubtedly, a large number of older people who do not meet criteria for alcohol use disorder (AUD) nevertheless may be drinking in excess of these recommended amounts. Alcohol use sometimes progresses with age so that a regular moderate drinker may become a heavy drinker in later life. It is estimated that approximately two-thirds of older people with AUD have been drinkers during their entire adult life (Sattar et al., 2003). Late-onset heavy drinking and AUD, defined as beginning at aged 50 years and older, often began in response to a significant loss of role or identity as well as friends' approval of drinking (Emiliussen et al., 2017). Interestingly, retirement and bereavement are not risk factors for late-onset AUD or heavy drinking.

How can we identify older adults with an AUD? In practice, alcohol problems among older adults often go undetected because clinicians may assume presenting symptoms are age-related rather than substance-related (SAMHSA, 2020). Symptoms can look similar to depression, dementia, or other problems associated with aging, and alcohol misuse commonly co-occurs with a number of physical or emotional problems. Older women are particularly likely to be overlooked for alcohol screening. Alcohol screening scales designed specifically for older adults can be very helpful in determining the extent of the problem. One of the best-known screening instruments is the Michigan Alcoholism Screening Test–Geriatric

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Version (MAST-G) (Blow et al., 1992), which has a full-length and a brief 10-item version. Risk factors for substance use disorders among older adults include gender (male), ethnicity (white), marital status (unmarried, divorced, widowed), recent bereavement, avoidant coping style, chronic pain syndromes, poor overall health, polypharmacy, physical disability, medical comorbidities, history of substance abuse, and social isolation (Jaqua et al., 2022).

Older adults often respond well to treatment for AUD. They generally have fewer drinking-related social, legal, and occupational problems to contend with and those with late-onset AUD may be able to cut down or stop drinking when their losses are acknowledged, and they receive needed social and emotional support, usually in an outpatient setting. Social support is a critical piece for achieving and sustaining long-term recovery for AUD (SAMHSA, 2020). Those with a lifelong drinking problem or a co-occurring psychiatric disorder may be less compliant and usually require higher levels of care, perhaps even repeated inpatient treatment stays, before they are able to sustain sobriety in the community. Attending Alcoholics Anonymous (AA) meetings or other recovery meetings is a way to reduce their sense of social isolation, and finding a readymade social group can be very helpful. Many experts believe that older people need elder-specific treatment. For example, some inpatient psychiatric hospital units and AA groups cater primarily to older people. Although such programs can have added benefits for older drinkers, requirements of effective treatment of older people with AUD in any setting will be age sensitivity and an understanding of the unique medical vulnerabilities of older adults. A strengths-based approach, including mutual help groups, can be effective with older adults, as well as pharmacologic interventions for those who continue to struggle with cravings (Joshi et al., 2021).

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Heavy alcohol use is a concern among the elderly and often goes undetected

Another addiction issue for seniors is problem gambling, which has increased more sharply in the elderly than any other age group (Granero et al., 2020). Alcohol use is a strong risk factor for the onset and progression of gambling-related problems in older adults. The DSM-5 classifies gambling disorder under the heading of addictive disorder, and it is the only behavioral addition in this group. It activates neurobiological systems similar to the ones affects in SUDs (Rash et al., 2016). Gambling provides socialization and is a stimulating activity for relieving boredom, escaping from social isolation, and a way for coping with stress or emotional difficulties. As with other addictions, occasional participation can be enjoyable and is distinct from abuse and dependence, when

Exhibit 10.14 Assessment Tools: Short Michigan Alcoholism Screening Test—Geriatric Version.

1. When talking with others, do you ever underestimate how much you actually drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does drinking help?
Scoring: Two or more "yes" responses indicate an alcohol problem.

Source: Blow, Brower, Schulenberg, Demo-Dananberg, Young, and Beresford (1992).

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gamblers spend their rent money, take on high-interest payday loans, hide their gambling, and become mentally preoccupied with it to the detriment of their family and other obligations. The prevalence of a gambling disorder is expected to rise in the coming years, mainly due to the influx and ease of using gambling platforms on the internet, and older adults may be less likely to recognize it as a potential problem.

Study Table Psychological Dimension of Late Adulthood

Cognitive Development and Information Processing

- Many older adults pursue lifelong learning; for example, Road Scholar programs provide older adults with opportunities for learning and travel.
- Stages of cognitive development called reorganization and reintegration characterize some of the cognitive differences found in late adulthood.
- Selective optimization and compensation theory proposes that older adults adapt to declines by purposefully selecting tasks or activities, optimizing their remaining skills and abilities, and compensating for skills that are lost.
- Declines in five primary mental abilities are very gradual up until the late 80s; information-processing speed and memory decrease with age. Perceptual, attention, and physical health issues can affect cognitive abilities in late life. Retraining methods are available to help older people maintain their abilities or even reverse cognitive decline.

Communication

- Communication may be affected by sensory limitations, cognitive impairment, some health conditions, and social isolation.
- Validation therapy, a mode of communication with people with Alzheimer's disease (AD) or other dementia, attempts to get to the underlying feelings and needs being expressed.

Attitudes and Regulation Emotions

- Among the oldest-old, positive emotions, anger, and sadness are little less frequently experienced than in younger persons.
- Loss is a major theme of late life. Grief affects older adults who experience losses, even though they may be "normal" for this stage of life.
- A dual-process model of coping with bereavement proposes that grief operates simultaneously and serially on two levels. Older people who are bereaved, who have moved to a new location, or who have lost some important health and functioning may be vulnerable to loneliness, also a risk factor for depression.
- Older people resist thinking of themselves as old. Identity in late life often rests on former social or occupational roles.
- Reminiscence is a way to maintain a sense of self, and groups to help residents of long-term care retrieve and share positive memories, enhance socialization, and improve morale in these settings.

Psychological Strengths, Hazards, and Risks

- Flexibility and adaptability, along with a strong sense of personal mastery, are important psychological strengths for older people.
- Wisdom is an elusive concept that many believe is associated with growing older, and is associated with increased resilience.
- Spirituality and religious beliefs have positive and significant roles in the lives of many older adults and association with greater health and well-being.
- AD affects approximately 6.5. million people older adults. Diagnosis of probable AD is based on neurological tests and detailed history of presenting symptoms, although it is sometimes difficult to distinguish early AD from depression, or symptoms of another problem such as Parkinson's disease. Early diagnosis is now emphasized because of the available medications to treat symptoms of AD.
- Another diagnosis, mild cognitive impairment (MCI), is becoming more common. People diagnosed with either early AD or MCI need to deal with the anxieties and possible loss of morale inherent in knowing they have a condition that may be progressive and terminal.
- Most AD is late-onset and not predictably inherited. Psychosocial treatments aimed at the person with early dementia seek to improve mood and adjustment; some newer models of psychosocial groups include both the person with dementia and a family member/caregiver to deal with the disease's effects and plan for the future. Behavioral, cognitive,

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and emotional changes of AD are challenging and stressful for families.

- Caregivers of someone with dementia suffer from higher levels of depressive symptoms and health problems than non-caregivers, although there are psychological gains as well. Grief is a new focus in dementia caregiving, as families deal with the ambiguous losses involved.
- Diagnosis of mental disorders in late life is challenging; older adults seek help for emotional or psychological problems less often than for physical problems. Older adults with longstanding mental disorders may have difficulty adjusting to the losses and physical changes of aging.
- Depression, anxiety, and paranoid thinking represent common late-onset disorders. Depression in older people may not include expressions of sadness; anhedonia, lack of interest, social withdrawal, self-neglect, expressions of worthlessness, and unexplained somatic symptoms are all possible indicators of depression. Social workers see many depressed elders in practice. Treatment is often effective with supportive psychotherapy alone, though it is appropriate to refer for a medication evaluation if the depression is severe or if progress is not occurring.
- Suicide is a significant problem among older adults, particularly men over age 85. Most suicides are completed by depressed people, though social isolation, physical illness, substance abuse, and other psychiatric illnesses are all risk factors for suicide attempts. Suicidal elders may give family and professionals behavioral and verbal clues that should be taken seriously.
- The number of older adults with substance-abuse problems is increasing. Metabolic changes with aging mean that the amount of alcohol that can be consumed safely is only about one drink per day or seven drinks per week.
- Two-thirds of older alcoholics are lifelong drinkers, and one-third developed alcohol dependence late in life, usually in response to a loss of role or identity. Detection of older people with AUD is difficult because the symptoms may look like another common problem of old age. Screening tools are available for older persons suspected of an alcohol problem.
- Those with late-onset AUD respond to social and emotional support and information about the dangers of heavy drinking. Lifelong drinkers may require special inpatient units. An age-sensitive, strengths-based approach is useful for older adults with AUD.

Social Dimension

Groups and Families

As was discussed earlier in this text, an ecological approach to human behavior looks at individuals in the context of their physical and social surroundings. The person cannot really be considered separately from their environment—culture, community, neighborhood, family, and residence. Today's young-old, middle-old, and oldest-old adults have been influenced by their families of origin and the home environments of their childhoods; the way they were parented and taught in school; and the families, friendships, and lifestyles they have created over the life span. A life-course approach to human behavior focuses on how, aside from their personal histories, individuals have witnessed and been a part of historic events at unique points in time in their development, influenced by an interaction of history and age. From all of these earlier experiences, older people have developed sets of values, beliefs, and varied ways of interacting with others and with their environments. In turn, the social and physical environment continues to be important to older people's continued growth and development.

Families

The great majority of older adults have some family, and family is the first line of support when older adults need assistance (Hooyman, Kawamoto, & Kiyak, 2014). With longer life spans, the presence of multiple generations in one family is an increasing phenomenon, and intergenerational relationships provide an important source of reciprocal support (Hooyman et al., 2014). Never before in history has there been such a large number of retirement-age "children" who still have one or more living parents. Older people who have them tend to obtain the most emotional support from their spouses, followed by adult children, and then siblings. Sibling relationships frequently become more important in old age, after the parents have died, and possibly after one or both siblings have been widowed.

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Couples

Statistics on marriage for older adults showed that 48% of women over age 65 were married and 30% were widowed, whereas 70% of men were married and 10% were widowed (Administration for Community Living, 2020). The differences in the rates of marriage and widowhood for men and women in late life reflect the fact that women have a somewhat higher life expectancy than men, and cultural norms, particularly in the current cohorts of older adults, have promoted marriages in which the man is older than the woman (Schaie & Willis, 2002). The result is that unattached older women are plentiful, whereas unattached older men are in relatively short supply.

Several studies have focused on the effects on marriages of the youngest child leaving home (i.e., the "empty nest") and retirement from work. In general, both of those important events may cause an increased focus on the marital relationship, but depending on the underlying strength of the bond, the outcome may be either increased strain or increased satisfaction. Overall, much of the literature has concluded that late-life marriages may be characterized by a decrease in disagreements and stability in marital satisfaction (Karney & Bradbury, 2020). Some research finds that disagreements or negative communication between spouses does not necessarily change, but that older couples report higher levels of marital satisfaction despite having similar levels of negative processes. This ability of older couples to "overlook" the negatives and experience high marital satisfaction can be explained by ***socioemotional selectivity theory***, which states that as people age, they attempt to regulate their emotions by choosing to focus on comfortable and reliable social partners. This is important because marital satisfaction, perhaps even more than health, predicts life satisfaction and quality of life for older people who are married, offering the partners "intimacy, interdependence, and a sense of belonging" (Hooyman et al., 2014, p. 343). Indeed, the odds of dying for married people who are very happy or pretty happy are significantly lower compared to those in marriages that are not too happy (Whisman et al., 2018).

As couples grow older, the risk increases that one or both of the partners will become ill with a serious chronic or acute condition. Studies have shown that when one of the marital partners becomes ill, the other partner's morale declines (Schulz & Martire, 2004). In fact, in later life, partners tend to resemble each other in terms of subjective well-being and affective states, such as depression (Townsend, Miller, & Guo, 2001). Social workers in hospitals and other health settings often see couples when one of the partners is ill or newly disabled and in the context of a crisis, or during a transition to a new phase of their lives, which may involve mutual decision making. For married people, the spouse is usually the first and primary caregiver unless the duties involved become too difficult (Hooyman et al., 2014). Many spouses obtain satisfaction in being able to help their partners, yet it can become physically and emotionally draining if the care required is long-lasting and intensive. Nevertheless, older couples have an advantage over singles or widows, as they can often compensate for each other's impairments—one can no longer drive, but the other does; one can't walk well, but the other can help or even push the wheelchair; one can't remember to take important medicines, but the other can keep track—and they offer each other reciprocal help that allows them to continue to function independently as a couple.

The marital relationship may become strained when one or both partners become impaired in some way and the old styles and forms of communication no longer work, leading to isolation or hostility between the partners (McInnis-Dittrich, 2014). As an example, hearing loss in one of the partners is a common impairment in later life and is associated with greater odds of depression (Lawrence et al., 2020). It can be a factor in the well-being of the other partner, affecting the ability to communicate or share pleasant experiences (Walling & Dickson, 2012). Couples trying to navigate life transitions have the added complications of dealing with issues of the partner along with their own. This was illustrated when the Edwardses, a well-groomed couple in their mid-80s, both walking with canes, presented to the admissions office of an assisted-living community. Mrs. Edwards seemed very sociable and talked quite freely, and it didn't take long for her to let the social worker know, in her pleasant soft voice, that her husband, who was not saying much, was very hard of hearing. She stated very definitely that they were there to see the facilities because they wished to obtain an apartment there. Mrs. Edwards needed to use the restroom at one point, and while she was away from her seat, her husband leaned over and spoke, in the loud way of the deaf, confiding that his wife had been diagnosed with AD and her short-term memory was very poor. Mr. Edwards admitted not hearing well, though he took out an amplifying earphone device that he used to better hear the conversation. He told the social worker that he didn't think they'd need the services offered at this

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facility; although his wife wished to move to an assisted-living apartment, he wanted to stay in their home because he loved to garden and work outside. He said, "With my bad hearing and her bad memory, we may need some help, but I'm not ready to give up my yard!" When his wife returned, Mr. Edwards again fell silent and did not express his hesitations about making a move. It would be a challenge for this couple to negotiate the issues surrounding moving from their home. McInnis-Dittrich (2014) recommends communication skills training for older couples who need to adapt to sensory and health changes, so they may successfully decide about lifestyle changes and procurement of services while avoiding the deterioration of their personal relationship.

LGBTQ+ Elders

It is estimated that there are around 3 million LGBTQ+ adults over age 50 in the population, and that is expected to increase to 7 million by 2030 (SAGE, 2021). Older LGBTQ+ are very similar to other older adults, except that to varying degrees they have suffered oppression, discrimination, hostility, and social stigma due to their sexual orientation (Hooyman et al., 2014). Because older LGBTQ+ adults grew up in a time before gay liberation of the late 1960s and early 1970s, many of them feel more comfortable keeping their sexual orientation private and may not be out, even with family members. Thus, there is a danger that the unique needs of LGBTQ+ people, such as the important role of a same-sex partner, may remain invisible to health and social service providers. LGBTQ+ people are diverse, however, there are some national trends (SAGE, 2021): they are twice as likely to be single and living alone, they are four times less likely to have children, they are more likely to face poverty (one-third are living at or below 200% of the federal poverty level), be unhoused, and have worse physical and mental health. Many LGBTQ+ elders delay or avoid medical care because they worry they will face discrimination or mistreatment by health service providers. LGBTQ+ older adults are also less likely to reach out to senior centers, meal programs, or other social services.

Older LGBTQ+ adults tend to have close-knit friendship groups and to rely on these "created families" in times of need, particularly if they are childless and/or unable to rely on support from their own family of origin. One out of five older LGBTQ+ adults have provided care to friends, compared to only 6% of other older adults. Services and Advocacy for GLBT Elders (SAGE), is a nonprofit agency that has served LGBTQ+ elders since 1978. SAGE focuses on helping clients avoid the social isolation that tends to be more common among LGBTQ+ elders, as well as engaging in several lines of national advocacy, including educating policy makers about LGBTQ+ aging issues. Despite the challenges facing LGBTQ+ older adults, they are thriving throughout the country and throughout the world.

> "They were the pioneers who stood up and pushed back at the Stonewall uprising, and the caregivers who stood by friends and loved ones through the height of the AIDS epidemic. They are models of resilience, celebrating their identities while preserving through adversity and helping to bring about incredible change for all LGBT people over just a few short decades."
>
> —SAGE, 2021

Widowhood

Adjustment of older women and men after the death of a spouse or committed partner can vary widely. In our society, nuclear families are often quite independent from the extended family or wider community, and spouses rely on each other to make everyday decisions, share responsibilities and tasks, and provide emotional support. Thus, when one spouse dies, the remaining spouse grieves for the loss of the unique person, a sexual partner, a confidant, but also loses the contributions of that partner to the home, the extended family, and the relationship (Carr et al., 2000). That is, there are two losses: the loss itself, which brings grief and emotional distress, and the loss of the life situation, which brings challenges with managing life without the support of the deceased partner. The higher mortality risk after widowhood is referred to as the ***widowhood effect***. Most studies have focused on sex differences; however, socioeconomic status lays a significant role as well. Dabergott (2022) found that for men, the widowhood effect was more pronounced with a higher SES background, and for women, the widowhood effects were more pronounced with lower SES backgrounds. One potential explanation is that for men, a higher SES was not as important for handling the emotional shock (adjusting to the loss itself), whereas for women, higher SES means greater economic security and potentially a greater ability to pick up new everyday tasks (adjusting to the loss of the life situation).

Researchers have found that adjustment to widowhood is harder, and the widowed partner is more susceptible to

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depression, when the marriage was particularly warm and intimate, and when he or she relied heavily on the partner for instrumental help (Carr et al., 2000). Widowhood, particularly the longer someone has been a widow, is a risk factor for cognitive decline (Singham et al., 2021). Additionally, widowhood is associated with a high prevalence of depression, especially within the first month of widowhood (Kristiansen et al., 2019). Widows and widowers without adequate family and social support tend to have a poorer and slower adjustment. Older men who experience the death of a spouse are thought to have more difficulties, such as depression, in part because their situation is less common, yet one study has found that this difference is due to the fact that men are less depressed than women up until the loss of a spouse, at which time their depression levels become very similar to women's (Lee, DeMaris, Bavin, & Sullivan, 2001). A recent systematic review found no gender differences in the prevalence of depression after widowhood (Kristiansen et al., 2019).

Eighty-five percent of wives outlive their husbands, more than three times the rate of husbands outliving wives (Hooyman et al., 2014). This fact means that the world of older people, particularly among the oldest old, is a world in which women, especially unattached women, vastly outnumber men. Accordingly, it is much more likely for widowed older men to remarry than for widowed older women to do so (Hooyman et al., 2014). For older women in relatively good health and financial situations, widowhood may actually signify a time for growth as they call upon their own resources for the first time, and they may not be eager to remarry. As an example, one study that reported on interviews with older people two years after the death of their spouses found that the widows expressed little interest in finding a new partner and mentioned some advantages to their current freedom. In contrast, the male widowers interviewed did not mention freedom and expressed strong interest in finding new partners (Davidson, 2001).

Blaj Gabriel/Shutterstock.com

After death of a spouse or partner, older adults often face a difficult adjustment.

Parent–Child Relationships

Increased health and longevity have complicated contemporary parent–child relationships. Older adults generally remain in frequent contact with their grown children, whether they live nearby or at a distance, and their relationships are characterized by continuity from earlier life stages. African Americans and older adults with less education have more frequent contact, though they are also less likely to use their children as support as they age (Goldman & Cornwell, 2018). Generally, the support provided by the adult child positively affects the physical and emotional well-being of parents throughout their lives, and especially later in life. As evidence of their importance, when parent-adult child contact was disrupted during the COVID-19 pandemic, it negatively impacted the mental health of older people (Brugiavini et al., 2022). In Brugiavini and colleagues' longitudinal study, the disruption in contact with adult children worsened the depressed mood by 17%.

Researchers have proposed two somewhat divergent theories to describe family ties in later life: solidarity, focusing on the strength of these intergenerational ties throughout the life course, and the expectation of mutual assistance; and ambivalence, focusing on the mixed feelings and conflicts that arise (Fingerman, Pitzer, Lefkowitz, Birditt, & Mroczek, 2008). Practitioners working with older families certainly can attest to the fact that these parent–child relationships in late life appear to be characterized by strong bonds and a sense of responsibility, but that there is considerable ambivalence about giving and receiving help, the time it involves, and shifting roles when the parents become frail or need additional assistance. When aging parents become newly dependent upon adult children, the role reversals can be upsetting to all involved, heightening the ambivalence felt by both parties. Higher levels of ambivalence can contribute to depression in both the adult children and the older parents (Fingerman et al., 2008). Because family connections and support are so important, Greene (2000) has recommended family assessment and family consultation as part of any social work practice with older adults.

In recent years, it has become more common for older adults to relocate to live with or near an adult child. More

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older parents are moving in with their adult children than they did a generation ago (15% according to Pew Research Center of 2018 census data), though they are still more likely to live alone (27%). Such a move to be closer to family can have positive effects. The adult children may get help with caring for the grandchildren, and the older parents gain a sense of security at a time of vulnerability. However, these multigenerational families often struggle with how to set boundaries, and the older parent, who usually has few other social supports in his or her new area, may feel isolated with only the extended family to rely upon.

Caregiving is a very broad term that may describe hands-on assistance with ADLs and IADLs, helping to hire and manage professional caregivers, making decisions about care needs, or overseeing the care someone receives in a nursing home or other institutional setting. Although physical caregiving is obviously burdensome and time-consuming, managing someone's care can also be very stressful for families. Past research consistently showed that daughters were more likely than sons to become the primary caregiver of an older parent (Grigoryeva, 2017), but researchers have begun to examine the role of sons as primary caregivers. When wives, daughters, or daughters-in-law are not available nearby, sons are more likely to become a primary caregiver to the dependent elder. Caregiving can be stressful for any adult child, but researchers have identified factors that add to the resilience of some caregivers (see Exhibit 10.15).

The burdens for low-income families and for single adults caring for an older parent may exceed those of other adult children. Take, for example, the situation of a 57-year-old gay man with chronic mental illness who cares for his 90-year-old mother in the home. Ricardo is stabilized on medication and supportive treatment and has 15 years of sobriety from alcohol. His mother is bedridden and needs constant personal care. According to his social worker, Ricardo and his mother are supported by their disability and Social Security income. Ricardo is a bright, well-read, articulate individual who cultivates a large vegetable garden each year and cares for his mother with tenderness and concern. Ricardo's caregiving role has kept him from pursuing other interests and relationships, but he does not complain. There are times when he speculates about what will happen after the death of his mother and when he reaches old age. There will be no one left in the family to call on. Children caring for aging parents find caregiving to be an emotional rollercoaster, a normatively demanding experience, and an opportunity for personal development (Luichies et al., 2021).

Exhibit 10.15 Contributors to Resilience in Family Caregivers.

Distancing from the care situation, physically and emotionally
Regular physical exercise
Keeping up personal hobbies
Having at least one close confidant for emotional support
Personal religious beliefs
A philosophy of duty toward the parent
Sense of humor

Source: Adapted from Ross, Holliman, and Dixon (2003).

Grandparenthood

For many older adults, the arrival of a first grandchild is an event that rivals the birth of their own first child in level of excitement, pride, and emotionality, as it provides another opportunity to leave a personal legacy in the world. Relationships with grandchildren tend to be mediated by the adult child/parent when the children are young and continue to evolve as the children mature (Hooyman et al., 2014). When the parent is present and functioning, grandparents are free to be more like friends or confidants to their grandchildren rather than disciplinarians; the stereotype of the grandmother spoiling the kids is based on this premise. Despite the reality that becoming a grandparent represents

Grandparents transmit the wisdom of their generation to their grandchildren by teaching them stories, songs, customs, and beliefs. This wisdom is an important strength that social workers cannot overlook.

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a milestone associated with growing older, positive interactions with grandchildren can contribute to a younger age identity for the older adult (Kaufman & Elder, 2003).

Grandparenting appears to have different functions for different families, depending on factors such as the ages of the family members, geographic location, ethnicity, and culture. Researchers have identified five distinct grandparenting styles: (1) influential, (2) supportive, (3) passive, (4) authoritarian, and (5) detached (Mueller, Wilhelm, & Elder, 2002). The most common type, those who were influential, were most intimately involved with their grandchildren, tended to live close by, and provided material support as well as advice and emotional support. Organizations such as the American Association of Retired Persons (http://www.aarp.org) and the Grandparent Foundation (www.grandparenting.org) provide a forum for narratives and advice on the ways grandparents, particularly those who live at a distance, can create and maintain positive connections with grandchildren at every age.

Many grandparents provide hands-on care and supervision for their grandchildren. One study suggests there may be some benefits for some older adults: Among noncustodial grandparents, hours spent caregiving were positively associated with better cognitive functioning at a four-year follow-up among whites, but not among African Americans (Sneed & Schulz, 2019). Right before the pandemic, in February 2020, 52% of grandparents looked after their grandchildren. Consistent with research conducted prior to COVID-19, grandparents who were involved with family activity had a sense of value and attachment that benefited their mental health (Gessa et al., 2022). More than one in ten grandparents have a grandchild living with them, and in about one-third of those situations, a grandparent is the primary caregiver (U.S. Census Bureau, 2019). Along with grandparent foster care placements, formal adoption of grandchildren has also increased since the early 1990s (Hinterlong & Ryan, 2008). Some of the first literature on grandparents providing what is called kinship care looked at African American urban families where the grandparents substituted for parents with substance use disorders (Denby, 2015), but grandparents caring for their grandchildren is a phenomenon that spans urban, suburban, and rural areas and all racial and ethnic groups in the United States. According to the U.S. Census Bureau, in 2019, the highest percentage of grandparents raising grandchildren was in states with higher opioid prescription rates. Financial, social, and interpersonal aspects of providing kinship care can be quite stressful. Many of these grandparents live on fixed incomes, have low-paying jobs or are unemployed, and must rely on public social agencies to provide money and services for their grandchildren.

Grandparents can be important figures in a child's life and can play a significant role in transmitting cultural and family values to children.

Communities and Support Systems

Friendships, Neighbors, and Support Networks

In 2015, "Eradicate Social Isolation" was among the 12 Grand Challenges for Social Work (Lubben et al., 2015). Social isolation from friends, rather than from family, is more strongly associated with depressive symptoms and psychological distress (Taylor et al., 2018). Friends play a very important role in old age, offering emotional support and shared experiences (Cicero, 2013). Sandmaier (1995) has noted that because the bond of friendship is elective; it is

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more fragile than ties with kin and has no formalized rituals. Furthermore, she wrote, "as we move through our lives, the friends we've made and kept over time take on an increasingly vital role as curators of our emotional histories" (p. 34). According to socioemotional selectivity theory, discussed earlier in this chapter, older adults seek social contact with a select few close friends and family members to whom they can relate reliably and comfortably. behavioral or concrete aspects (sharing activities, self-disclosure in conversation, and helping), followed by cognitive aspects (trustworthiness, loyalty, and shared interests), knowing the person a long time, and living nearby, when considering someone a friend.

Although we think of family support and family ties as very important to well-being of older adults, friendships have a special meaning and provide qualitatively different kinds of support. For instance, a study with residents in congregate housing found that more visits from friends, but not from family members or neighbors, were associated with less loneliness among the residents surveyed (Adams et al., 2004). Among a group of men and women ages 55–84, the happiest were those who had the most friends with similar marital status and life situation to their own (Blieszner, 2001). One successful peer-outreach intervention reduced loneliness, depression, and barriers to socializing by matching peers to participants according to shared backgrounds (Kotwal et al., 2021). Participants reported strong feelings of kinship and bonding as well as increased motivation to reach out in other areas of their life. Older adults who live alone or who are without family ties are at high risk for social isolation unless they build a personal support network of friends, neighbors, and formal services that are available when needed. Based on what was learned from the response to the COVID-19 pandemic, Berg-Weger and Morley (2020) recommend that social workers use rapid tools to assess loneliness and social isolation as part of the ongoing assessment of older adults. They developed the ALONE scale (see Exhibit 10.16) for assessing severe loneliness in older adults in clinical settings (Deol et al., 2022).

Offering care and support to others is important to many older adults, and most seek to maintain some reciprocity in their relationships as long as possible (Bruggencate et al., 2018; Hooyman et al., 2014). Thus, older people are not only recipients of care but provide a remarkable amount of support and help to relatives, friends, and neighbors. As noted earlier in the chapter, spouses care for each other, sometimes into late old age; retired "children" must care for their oldest-old parents while also supporting fledgling young-adult children; older siblings help one another and provide emotional support; older parents provide financial help to adult children and grandchildren; neighbors look in on each other; and residents of congregate housing tend to form informal networks to provide assistance when other residents experience a loss or become ill. Even older people who may need assistance with some of their ADLs often offer assistance to others and find that this informal help adds some meaning to their lives. For example, it is not uncommon to see residents in a nursing home, who themselves may have some physical frailty, voluntarily assisting fellow residents who use wheelchairs.

Churches, senior centers, and volunteer programs that recruit older adults are among the many examples of organizations in the community that offers social services and social opportunities to older adults. Many programs specifically targeted to older adults are funded through the Administration on Aging (www.aoa.gov), a federal agency established in the mid-1960s. This agency allocates monies to states and localities to fund local Area Agencies on Aging, which in turn fund senior centers, congregate meal programs, and numerous other programs for older people in the community.

Retirement, Work, and Volunteering

Retirement may be defined as the time when the individual begins receiving pension benefits, reduces or stops paid employment, and identifies themselves as retired

Exhibit 10.16 Assessment: ALONE scale.

Items to Assess Perceptions of Loneliness		Response Options (Yes=1, Sometimes=2, No=3)
A	Are you emotionally **A**ppealing to others	
L	Are you **L**onely?*	
O	Are you **O**utgoing/friendly?	
N	Do you feel you have **N**o friends?*	
E	Are you **E**motionally upset(sad)?*	

*The items with an asterisk (*) are reverse coded and responses are summed across items to yield a total score. Higher scores indicate more loneliness (Deol et al., 2022).

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Focus on **The Lived Experience**

The Church Ladies

The "Church Ladies," a group of seven women friends whose ages span from 70 to the mid-80s attend the same church in Eau Claire, Wisconsin. None of the women are married—they are widows and divorcées—and several are childless. Almost every Sunday, they go for brunch after church at a pancake restaurant, and on Fridays they meet at a local seafood buffet for dinner, or for lunch in the winter because it is difficult to drive after dark. Occasionally they go to a play or a special event as a group. Most of the women have known one another a long time, but their group gradually evolved in just the past few years. With advancing age, there have been health problems; one woman has macular degeneration and has become legally blind. The group makes sure someone will give her a ride when she needs it. As long as they are able, they continue to share good times and look out for one another.

(Duckworth & Langworthy, 2013). Although most people think of retirement as occurring around age 65, a substantial portion of older adults retire early, sometimes attracted by company incentives that give them severance pay and continued health benefits, and often because health conditions begin to interfere with job performance or satisfaction. On the other hand, with the lifting of mandatory retirement laws in the United States through the Age Discrimination in Employment Amendments of 1986, a new phenomenon has become common: women and men who work as long as they want to, well into their 70s and 80s. Data from the U.S. Bureau of Labor and Statistics show that 18% of men and women aged 65 and older participated in the labor force (ACL, 2020). The labor force rate for older women had increased in 2000, peaked in 2019, and then sharply declined in 2020. At the onset of the COVID-19 pandemic, the unemployment rate for people aged 65 and older was higher than the overall unemployment rate; it quadrupled from 3.7% to 15.6% between March and April 2020. Older workers have some disadvantages in today's job market because of a shift toward computer use in the workplace and the increased stress, competition, and cognitive demands of many jobs. Yet the trend for late-life working appears to be continuing among those who are now in their late 50s and 60s (Kromer & Howard, 2013). Older adults continue working after retirement age because they need more money; they want to improve retirement finances; they find fulfillment in an organization's work; and they want to remain productive, useful, or mentally active.

Many older adults also engage in unpaid work after retirement, an important aspect of their civic engagement—the ways that older adults actively participate and contribute to society and their communities. Hospitals, nursing homes, senior centers, social agencies, theaters, museums, and schools across the country rely upon many older volunteers who spend their time helping others. About 40% of adults aged 65–74 and 9% of those aged 75 and older engage in formal volunteer work and tend to work more volunteer hours than younger adults because they have more free time (Hooyman et al., 2014). Volunteering provides older adults with meaningful social roles and can enhance their life satisfaction and well-being (Bruggencate et al., 2018). Across cultures and countries, such as in Chile, Mexico, and Spain, volunteering improved well-being, including life satisfaction and health, but not happiness (Gil-Lacruz et al., 2019). They concluded that people volunteer because they want to feel useful but also because they want to improve situations that they might consider undesirable. They also noted that volunteering may have a stronger impact on male well-being compared to female and that many older adults are unaware of volunteering options available to them. Retirement involves a major shift in one's family roles, daily activity, social interactions, and financial resources. How one anticipates these changes can affect how successfully one retires. Most people who are thinking ahead to their retirement envision the opportunity to spend more time with friends and family, relax, have more fun, travel, and engage in volunteer work. Atchley (2000) has characterized retirement as a process in several phases, beginning with the preretirement phase, during which people imagine their retirement and make plans. Just after retirement, individuals often move into a honeymoon phase, savoring their newfound freedom. Not surprisingly, the honeymoon phase ends and leads to a disenchantment phase, wherein retirement does not seem as pleasant as before. Next in this process, the individual moves to a reorientation phase and becomes more realistic about retirement and learns to make the necessary adaptations. This may involve finding new part-time or full-time work, starting to volunteer, or taking up new hobbies. Finally, the individual establishes a routine whereby retirement has become the normal way of life.

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Living on a Fixed Income

Retirement is made more difficult for individuals who have little income to begin with and must then adjust to a reduction in income. Individuals in other stages of life can look to the future with the hope of increasing their income in various ways (promotion, new job, spouse returns to work, kids leave home). But for many older people, retirement means living on a fixed income, which does not increase from year to year, and adjusting their lifestyles to cope with the reduced availability of financial resources. Adjustments range from eating out less often to substantially reducing food intake; from moving to a smaller home to forgoing necessary home repairs and doing without heat or air-conditioning. Even those who saved money for retirement may find their resources greatly reduced after a prolonged illness.

One in 10 adults aged 65 and older lived in a family with income below the official poverty line (UAdministration for Community Living, 2021). Because of their reduced resources and potential for earnings, if older people fall into poverty, they are more likely to stay in poverty than younger adults Older women are more likely than their male counterparts to be in poverty and to stay in poverty regardless of race, education, and marital status (17% between the ages of 70 and 79, 22% of women aged 80 and older). Social Security is especially crucial for women because less than one-third of older women receive pension income, compared with nearly half of men, and those who have pensions receive less money. Older men who work also earn more than older women who work. Particularly hard hit are women of color and others who have worked at part-time or low-paying jobs that were not covered by Social Security benefits. They may be eligible for other public benefits, such as Supplemental Security Income (SSI), but the typical monetary amounts are very low.

Housing Options

Many older adults prefer to "age in place"—staying in their own homes and neighborhoods indefinitely. In many urban, rural, and older suburban areas, the aging in place of the generation that moved into homes and apartments in the 1960s and 1970s has brought about a phenomenon known as NORCs, or naturally occurring retirement communities (NORC, 2016). These communities tend to have a high density of older adults, some of whom are frail and require in-home services, and it is becoming more common for residents on a street or in an apartment building to join together to share service providers (for a scoping review see Parniak et al., 2022). These communities foster resilience during times of stress, such as during the COVID-19 pandemic, by promoting social networks and providing a context for connectivity (Garcia Diaz et al., 2022). Complications arise when people develop age-related chronic conditions or disabilities and may no longer be able to drive, shop for food, or get around easily. Then the single-family homes that worked so well throughout raising a family and later adulthood become too large to manage, with stairs that can be difficult or impossible, yards requiring too much maintenance, and neighborhoods that are not easily navigated and may not feel safe. It has been observed that older women, in particular, have an attachment to their homes and possessions that derives from their investment in the homemaking role; thus, many widows remain in homes that are larger than required and ill-suited to their practical needs (NORC, 2016).

Influential gerontologist M. Powell Lawton (1975) studied issues of older adults and their physical environment, and developed a model that stresses person–environment congruence and the concept of environmental press. The model proposes that there is an optimal level of stimulation and challenge for each individual provided by the environment. As people age, the balance of stimulation and competence may change, and they may require assistance or a move to a different environment. This model has been important in the field of environmental gerontology, which focuses on modifications to homes and other environments to make them safer and more appropriate for older people with sensory and mobility impairments (Wahl & Weisman, 2003). Social workers use this model as they assess older adults for the "least restrictive environment" in which they can function well—mindful of the fact that functioning can be enhanced or improved through a variety of concrete, supportive, educational, or psychological interventions.

The Continuum of Care

Long-term care can be defined as medical and social interventions for those who have chronic illnesses or impairments. These interventions are geared toward helping a patient live as satisfactorily as possible in an appropriate setting. Long-term care once was synonymous with nursing homes. Nowadays, much long-term care occurs in other settings, starting with regular homes. These home- and community-based services are available through a number of pathways—from private

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home-care agencies that send companions or nursing assistants for an hourly rate, to long-term care services covered by Medicare or Medicaid—that can help older persons remain in their homes. A relatively new profession, the geriatric care manager, usually a trained social worker or a registered nurse, works with older adults and their families to assess their living arrangements and service needs and to arrange for needed care. The geriatric care manager helps the family decide whether remaining in the home is practical or whether a move to another type of housing or long-term care is needed. There are often ethical as well as practical considerations involved in making these recommendations, as the older person's independence and autonomy is balanced with his or her safety, security, and health.

Because of the array of options for older adults who either cannot stay or choose not to stay in their own homes, the distinction blurs between senior housing and long-term care. Among the least restrictive and service-intensive options are several types of congregate housing, most of them age segregated, that offer the residents an independent apartment along with planned social events, recreation, some or all meals, transportation, and selected social and medical services onsite. The NORCs (see above) or Village models of living have been implemented widely across Canada as a community-based solution to support aging adults age-in-place (Parniak et al., 2022). As of 2022, approximately 2% of older adults live in some kind of senior housing where services are available, 4% live in nursing homes, and 65% use in-home care services. The following list outlines the array of senior living and residential care options that are available:

- *Independent living senior apartments* usually consist of just one or two buildings that offer residences for older adults who can function independently in their personal care needs but who wish to be in a sheltered environment where other services are offered.
- *Low-income-housing tax credit* properties provide affordable rental housing for older adults who meet a financial-needs test. Most of these properties have long waiting lists. More than half don't provide any special services, but they may have accessibility features for residents such as grab bars in bathrooms (AARP, 2015).
- Board and care homes or *adult foster homes* are usually small, independently operated homes for older or disabled adults housing three to ten older people in a family-like environment; some specialize in older adults with mental disorders.
- Freestanding *assisted-living facilities* (ALFs) generally offer private apartments designed for older people who need some assistance with personal care but don't require constant supervision or the degree of medical attention they would receive in a nursing home (Hooyman et al., 2014). Usually they provide all meals, help with personal care and medication, and offer a number of social services and activities. Assisted-living homes are overseen and licensed by states, so the offerings differ widely. Monthly costs are usually quite high, but some states provide Medicaid waivers to cover costs for eligible residents.
- *Continuing care retirement communities* offer independent living residences, along with a continuum of care on-site, such as an assisted-living wing or floor, for those who need more help with personal care, and a health facility for those who require skilled nursing care. Financial arrangements to enter continuing care retirement communities vary, but the usual way is for the individual or couple to pay an amount comparable to purchasing a small house in order to "buy in" to the community. From there, they are charged a monthly maintenance and meals fee, but they are guaranteed access to all of the services and medical care facilities at the community. Older adults can afford to enter these communities because they offer peace of mind for the future, as well as many social benefits and services.
- *Nursing homes* provide skilled medical care and rehabilitation services, though many also offer so-called custodial care, assistance with personal care, and supervision. Some nursing homes have specialized units for people with dementia.

Whereas only about 4% of people live in nursing homes in the United States, that number rises to 15% of people over age 85 (Health in Aging, 2020). Although nursing homes traditionally have been based on a hospital-like medical model, a growing culture-change movement in nursing homes began with the passage of the Nursing Home Reform Act of 1987. A nursing home residents' Bill of Rights was established and is now codified in federal and state statutes (see Exhibit 10.17). Many nursing homes now focus on person-centered or resident-centered care, giving residents more control over

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decisions and providing more home-like environments. One influential group, The Eden Alternative, has been at the forefront of humanizing and personalizing nursing homes through the addition of plants, pets, less rigid scheduling, and use of space to enhance quality of life (see www.edenalt.com).

A position paper was published from the American College of Physicians (Crowley et al., 2022) that offers several policy recommendations to improve long-term services and supports so that the care delivered in nursing homes, assisted living facilities, private homes, and other settings are of high quality, accessible, equitable, and affordable. The five policy recommendations address issues of 1) financing; 2) shortages in the workforce; 3) evidence-based interventions to ensure quality; 4) ownership status, including staffing ratios and publicly available financing reports; and 5) funding to develop and implement emergency preparedness plans.

The decision to move to a nursing home can be a difficult one for families and individuals. Older adults usually wish to remain independent, and family members usually try to provide care at home or within less restrictive senior housing for as long as possible. However, when an older adult requires around-the-clock supervision, is incontinent, or is bedridden, placement in a nursing home may become necessary. Most nursing homes employ social workers who assist families and residents with the transition into the facility, offer emotional support, and advocate for their needs during the resident's stay.

Exhibit 10.17 Nursing Home Residents' Bill of Rights.

The right to freedom from abuse, mistreatment, and neglect;
The right to freedom from physical restraints;
The right to privacy;
The right to accommodation of medical, physical, psychological, and social needs;
The right to participate in resident and family groups;
The right to be treated with dignity;
The right to exercise self-determination;
The right to communicate freely;
The right to participate in the review of one's care plan, and to be fully informed in advance about any changes in care or treatment or change of status in the facility; and
The right to voice grievances without discrimination or reprisal.

Source: From AARP.org, "Fact Sheet: The Nursing Home Reform Act of 1987."

Multicultural, Gender, and Spiritual Considerations

Older Adults of Color

The older American population is increasingly diverse racially and ethnically as the overall minority population grows and lives longer. Older adults of color have increased from 7.8 million in 2009 (20% of the older adult population) to 12.9 million in 2019 (24% of older adults) and are projected to increase to 27.7 million in 2040 (34% of older adults) (ACL, 2021).

Older people of color often have histories of social oppression and reduced educational and employment opportunities, and many continue to be disadvantaged today (Beckett & Dungee-Anderson, 2000). For instance, the ***life-course perspective*** reminds us that social conditions during the youth of today's older African Americans were not only very different from what they are today but certainly very different from those of their white majority counterparts. Those born before the 1950s lived in the time before civil rights were won, when racial discrimination was an accepted part of American society. Today, some of them see their children or grandchildren still fighting racism and social oppression (for example, #BlackLivesMatter), and they continue to experience higher rates of violence and poverty in late life (Hooyman et al., 2014). Likewise, AIAN people may have experienced their whole lives on a reservation. Although they may take pride in their traditions and accomplishments, they have lived with restricted opportunities in the greater society. Today, their children and grandchildren disproportionately face poverty and social ills such as a lower life expectancy and high rates of alcohol and drug use. Recent immigrant elders, even those who are well educated and financially comfortable, may have lived under oppressive governments in their homelands. Their opportunities for social integration in the United States may be limited by language and cultural differences (Paolini et al., 2018; George & Farrao, 2015). All of these stresses and hardships have an effect on how these older people view the world and themselves (Beckett & Dungee-Anderson, 2000) and on how they respond to the dominant culture.

In general, the ethnic minority cultures prominent in the United States value extended-family relationships and mutual assistance among family members of different generations. With less emphasis on the stand-alone nuclear family structure, there are usually important roles for older adults within the family. Latino, Native American, and

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Asian American cultures traditionally honor and provide for older people, although modern life may change the ways that families enact or follow these traditions. About 40% of AIAN households are headed by older women who have a strong role in supporting and guiding young families (Hooyman et al., 2014). Many Latino and Asian American extended families also live together so that the grandparents can provide child care while the parents work. Becker and colleagues (2003) conducted interviews with elders from four ethnic groups and uncovered some differences in the way different groups tend to provide support within families. They found that although the Latino elders provided help and childcare to their families, they also expected help and financial support from their grown children and were unhappy when it wasn't available. In this study, the Asian (Cambodian and Filipino) elders were more invested in living with their grown children, which they saw as a sign of their children's devotion to them, and many of the African American elders were in the position of helping out their grown children and grandchildren financially and by providing them with a place to live.

African American elders are more likely than whites to live in multigenerational and extended family households. In the African American community, because of high divorce rates, high death rates among African American men, lack of employment opportunities, and welfare policies that discouraged marriage starting in the 1960s, there are fewer married elders (38%) and 39% live alone (ACL, 2020). Older African Americans are also less likely to have internet access as a means to remain socially connected to others (Pew Research Center, 2019). However, African Americans also have more active informal support networks than whites, often linked with their churches, whose members may assume the role of ***fictive kin*** and can buffer effects of discrimination on mental health (Nguyen, 2018).

This grandmother relies heavily on her niece for various kinds of support.

With these demographic patterns, professional social workers increasingly need cultural competence—information about other cultures, collaboration with Indigenous workers and native speakers, and modeling sensitivity and respect for the values and traditions that are important to clients with backgrounds that may differ from their own and from majority culture. As one writer aptly stated, "Cultural competence is not a tonic or product that can be dispensed at a workshop or noted on a certificate. Cultural competence is a set of skills or perspectives that require lifelong learning and a disciplined effort to try on new and often uncomfortable behaviors" (Yee, 2002, p. 7).

Gender Issues

Like older people of color, older women came of age during a time when girls and young women were disadvantaged in terms of educational and employment opportunities. Older women are more likely to live in poverty than older men, in part because of these cumulative disadvantages, and also because of their predominant roles as wives and homemakers. As has been noted earlier in this chapter, women have a longer life expectancy than men do by about six years. Because of women's longevity, they live alone in greater proportion (nearly half the women who are aged 75 or older live alone) and suffer from more chronic disabilities than men (who may die from other causes before these disabilities set in), which combine to put them at much greater risk for nursing-home placement as they become older.

Ageism is the stereotyping of older people, or prejudice and discrimination against older persons solely because of their age. In our culture, which prizes youthful feminine beauty and physical fitness, older women are particularly vulnerable to ageist attitudes, including some that they believe themselves. Ageism directed toward older adults has a negative impact on their health, well-being, and quality of health care received (Burnes et al., 2019). Interventions that combine education and intergenerational contact have the largest effect on people's attitudes towards older adults, according to a recent systematic review (Burnes et al., 2019). Additionally, interventions have a stronger effect on females that are in adolescence or young adulthood.

Older women deal with the double jeopardy of aging and being female—an intersection of ageism and sexism.

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Older women of color may suffer the triple burden of ageism, sexism, and racism. How gender and race combine to contribute to disadvantaged status is evident in poverty statistics. Older African American and Hispanic women are the most likely to have a low income and the least likely to have income from assets such as savings accounts or stocks and bonds. One in four older African American women (25.2%), one in four older Hispanic women (26.1%), and almost one in four older AIAN women (23.4%) are living in poverty, compared with only one in 10 older white men (9.6%) (Justice in Aging, 2020).

Spirituality and Older Adults

There is a growing awareness of the significance and positive roles of religion and spirituality in the lives of older people. The importance of religious beliefs may increase in later life (Hooyman et al., 2014). Spirituality is considered separate from religious behavior, although the two often may be linked (Ortiz & Langer, 2002). ***Spirituality*** can be defined as faith that there is a greater power than oneself and the possibility of coping through trust in and prayer to that greater power (Hooyman et al., 2014). Spirituality connotes a level of awareness that goes beyond ordinary physical and spatial boundaries. Studies have found an association of religiosity or spiritual beliefs with physical health and even with length of survival (Koenig, 2012). Spiritual beliefs provide older adults with a source of strength, comfort, and hope in difficult times, as well as a sense of community and belonging (Malone & Dadswell, 2018). Additionally, they are associated with indicators of health behaviors and well-being (Litalien et al., 2022), including quality-of-life ratings, the will to live, and the acceptance of the inevitability of death (Hooyman et al., 2014). However, in a cross-cultural systematic review of what successful aging means to older adults across 13 countries, older people mention cognitive health and spirituality least, placing more importance on physical health and independence (Reich et al., 2020).

There has been ongoing interest in expanding the biopsychosocial model of social work assessment with older people to include spirituality. One challenge is that the concept of "spiritual" can range from non-religious and non-theistic (for example, the power of positive thinking) to deeply religious experiences. An awareness of both the religious beliefs and the spiritual needs of our clients is particularly important in residential long-term care, hospitals, end-of-life care, and individual mental health treatment. A brief "spiritual assessment protocol" has been proposed, which can be used by social workers to open discussion of spiritual practices, beliefs, and needs perceived by the older clients, whether or not they participate in organized religious faiths (Ortiz & Langer, 2002). Additionally, Hodge (2015) provides brief and comprehensive methods for including spiritual assessment in social work practice.

Social workers typically include spirituality and religion in their biopsychosocial evaluations in all practice settings, but especially in health care, where life-and-death events routinely occur. Social workers often collaborate with hospital chaplains and consult to nurses and physicians about the role of a patient's religion in healthcare decision making. As in all areas of social work practice, social workers need heightened self-awareness of their own spiritual beliefs, as well as appropriate respect for their clients' divergent beliefs. Approaching this sensitive topic is eased with the use of an interview aid such as the FICA (Borneman, Ferrell, & Puchalski, 2010).

Assessing Spirituality Using the FICA

The FICA tool serves as a guide for conversations in the clinical setting. The acronym FICA can help structure questions in taking a spiritual history by healthcare professionals. As with any other part of the patient interview, the spiritual histories should be patient-centered. Thus, the tool is meant to create an environment of trust by indicating to the patient that the physician or other healthcare professional is open to listening to the patient about his or her spiritual issues if the patient wants to talk about those issues. There are ethical guidelines to which the physician or healthcare provider should adhere when taking a spiritual history. Healthcare professionals are encouraged not to use the FICA tool as a checklist, but rather to rely on it as a guide to aid and open the discussion to spiritual issues. The tool (Puchalski, 1996) uses an acronym, FICA, to suggest questions the interviewer might use. F stands for Faith and belief and an example of a question is "Do you consider yourself spiritual or religious?" The emphasis is on understanding how important religion or spirituality is to the person. The interviewer explores the relationship between how the individual sees stress and coping from a spiritual perspective. The I stands for Importance. An example of a question is "What importance does your spirituality have in our life?" The

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interviewer attempts to examine if spirituality is something that is likely to influence health care decisions. The C stands for Community. An example of a question is "Are you part of a spiritual community?" The interviewer is assessing the quality of social support that might be provided by others in the persons community. Finally, the A stands for Address in Care. An example of a question is "How would you like me, your healthcare provider, to address these issues in your healthcare?" The A can also refer to the degree of spiritual distress the individual might be feeling.

Social Strengths, Hazards, and Risks

Social Support for Older Adults

As we have seen throughout this section, older adults with extended family, with involved grown children, with good friends and neighbors, who are married or partnered with a significant other, who have planned for retirement and have adequate finances, and who are able to continue to get around and enjoy volunteer work and social activities—these are the older adults who have the most social support available to them. Should they require assistance, they are likely to be able to obtain the help and services they need, when they need them, at a cost they can afford. In addition, the personal flexibility to adjust to and accept growing dependence on others, if and when the time comes that independence becomes limited, is an invaluable strength. However, many of these factors are not under the control of the individual. Older adults who live alone, who may not have living children or extended family, those over age 85, and those who live in poverty, in inappropriate or unsafe settings—these are the adults who are particularly vulnerable to social isolation, loneliness, nutritional insufficiency, and unmet healthcare needs, and who may need social work interventions the most.

Photo credit Alex and Kate Photography

June Seamone, age 90, lived the final years of her life in her daughter's home in Canada (pictured below along with her two granddaughters). Nearly four in 10 older adults around the world live with extended family, but those in the United States rarely do (Pew Research Center, 2020).

Elder Abuse and Neglect

With reduced physical strength and independence, older adults are more vulnerable to a social hazard that has increasingly come to the attention of social work and healthcare practitioners—***elder abuse***. This term usually encompasses both abuse and neglect, intentional or unintentional, and includes physical, sexual, emotional, and financial mistreatment or exploitation that causes or creates the risk of harm for the victim (CDC, 2021). Whether in their homes or in residential care, elders suffer abuse and neglect, which include such diverse harmful acts as physical assault, withholding food or water, bullying and threats, abandonment, rape or unwanted sexual touching, or theft of belongings or financial fraud. Self-neglect occurs when an independent older person is incapable of necessary self-care and becomes malnourished, dehydrated, dirty, ill, or living in a cluttered and unsafe environment. Self-neglect most often relates to dementia, depression, or multiple chronic illnesses of an older person who lacks involved family or other social supports nearby (George & Ferraro, 2015). In some cases, legal guardianship procedures and placement of the individual must go through the courts.

It is estimated that one in 10 Americans aged 60 or over have experienced some form of elder abuse (CDC, 2021), and risks increase in institutional settings (Yon et al., 2019). Preliminary studies indicate that rates of elder abuse increased during the COVID-19 pandemic. One study estimated one in five experienced elder abuse; those with financial strain were more at risk and those that had a sense of community and more physical distancing were less at risk (Chang & Levy, 2021). Adult Protective Services (APS) is the organization charged with investigating reports of elder abuse and neglect. Much like Child Protective Services, workers respond to calls

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from both mandated reporters and the public who suspect mistreatment. Usually trained social workers make home or facility visits to assess and respond to the elder's most urgent needs, which may involve medical or psychiatric hospitalization, cross-reporting to law enforcement, or outreach to the elder's extended family.

Abuse and neglect are perpetrated by the adult child, another family member, or the spouse of the victim, most of the time. Females and those over age 80 are disproportionately represented in the victim profiles (National Center on Elder Abuse, 2016). A review of the literature indicates that risk and vulnerability factors for elder abuse are similar and include problems with physical and mental health, substance use, dependency, stress and coping, attitudes, relationships, and previous victimization (Storey, 2020). Caregiver stress and maladaptive coping as a cause of elder abuse refers to situations in which the caregiver becomes overwhelmed by the demands of the dependent older person and may either perpetrate violence in a moment of anger and stress, or may neglect the person's needs, sometimes through a combination of ignorance, denial, and outright inability to meet those needs. Caregiver impairment refers to a caregiver's mental illness, physical health, or substance use disorder, and may involve more serious harms that are perpetrated repeatedly.

Risk factors or signs that might alert social workers of the need for further evaluation of elder abuse or neglect as they work with dependent elders in the community include the following:

- Caregiver stress
- External stressors, such as financial concerns
- Dependency
- Social isolation
- Poor hygiene and nutritional status; obvious lack of care
- Older person appears hypervigilant or nervous
- Caregiver displays hostility and impatience toward the elder

Assessment of Elder Abuse

Increasingly, health professionals are using more systematic methods to screen and assess for elder abuse. The advantage is administering the assessment as part of a routine checkup. See exhibit 10.18 for questions that have been used for screening:

Social workers play important roles in the identification and psychosocial treatment of elder abuse and neglect (Bomba, 2006). Anetzberger (2000) proposed an integrative framework to address elder abuse that consists of protection, empowerment, and advocacy, working with the victim–perpetrator dyad within the family system, and providing emergency support as needed to treat the victim and prevent further abuse. Specific interventions have been developed to empower older victims of domestic abuse, including empathic listening and sensitive questioning to identify the nature of the abuse, minimizing potential danger through appropriate security measures, safety planning, evaluating options (such as a move to another relative's home or pressing charges against the abuser), holding the perpetrator responsible for their actions, and providing hope and support (Hoover & Polson, 2014).

Exhibit 10.18 Assessment Tools: Assessing Elder Abuse.

Question	Yes	No	Did Not Answer
Are you by yourself a lot of the time?			
Has there been a time when someone did not help you when you needed help?			
Has anyone tried to make you sign papers you did not understand?			
Are you afraid of anyone?			
Has anyone touched you in ways you didn't want to be touched?			
Has anyone yelled or threatened you?			
Has anyone hurt you?			

Adapted by the authors from Ansell and Breckman (1988); Hoover and Polson (2014); Yaffe and Tazkarji (2012): These questions are designed to help individuals assess concern or suspicion about elder abuse. A yes on one or more questions suggests concern and the need for more follow-up.

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Study Table Social Dimension in Late Adulthood

Groups And Families

- Older adults are a product of their backgrounds, their culture, parenting, neighborhoods, etc. The physical and social environments continue to affect older people's growth and development.
- Family is the first line of support when older people need help. With longer life spans, there are many multigenerational families. Spouses, adult children, and then siblings provide more support for older adults. There are many forms of family; some are created by upgrading neighbors or friends to a "fictive kin" role.
- More men than women are married in later life. Unattached older women are more available, and unattached older men are scarcer. Late-life marriages are characterized by fewer disagreements and increased satisfaction. Marital satisfaction predicts life satisfaction.
- Illness or disability in one of the partners affects the other partner. Spouses usually serve as primary caregiver as long as possible. Couples compensate for each other's physical and sensory impairments.
- Older LGBTQ+ people may have suffered oppression, discrimination, and hostility because of their sexual orientation. They may not be "out" even to family, and some of their unique needs may be overlooked by service providers.
- Adjustment to widowhood varies widely. A warm, intimate relationship and reliance on the partner for instrumental tasks predict a harder adjustment, as does lack of adequate family and social support. Because older widows outnumber older widowers, remarriage is much more common for men who lose a spouse. Women who are widowed sometimes relish their independence after the period of bereavement.
- Two divergent theories of parent–child ties in later life are solidarity and ambivalence. The majority of older adults are in frequent contact with their grown children, and social workers often include family members in assessment and treatment of older people.
- Daughters are usually elected to be the primary caregivers, but sons also provide a lot of informal care to older parents.
- Becoming a grandparent allows an opportunity to leave a legacy. The relationship is mediated by the adult child but will change as the grandchild grows. Grandparenting styles vary according to many factors, such as geographic location, and stronger links may exist with maternal relatives. Many grandparents care for grandchildren, and many have custody, providing kinship care for children when the parents cannot.

Communities and Support Systems

- Friends play important roles in old age as curators of emotional history. Friends of similar age and marital status tend to provide the most important sources of support and are especially important to elders who live alone or are childless.
- Although some older adults retire early to pursue other interests or because of attractive pension offers, many older adults work beyond normal retirement age. Many retirees work because they need money, but others report they want to remain productive.
- Many older people do volunteer work, and many experience enhanced well-being. Retirement is a major transition and can be seen as a process from honeymoon through disenchantment to reorientation and routine.
- Health and income adequacy are important predictors of successful adjustment. Living on a fixed income can make life difficult for some retirees who may not have adequate savings or other sources of income. Older women, women of color, and those who worked at low-paying or part-time jobs are hardest hit.
- Many older people wish to age in place. Difficulties arise when health conditions or disabilities make living at home impractical or impossible. NORCS have arisen in many established neighborhoods, where older people remain in their homes and start to require in-home services.
- Person–environment congruence refers to the fit of an older person and his or her residence; environmental press means that the level of challenge in the environment has become too intense.
- Geriatric care managers help families determine appropriate services and when a move out of the home may be needed. Senior housing and long-term care often overlap. Age-segregated congregate housing provides many services for residents. Options include independent-living apartments, adult foster-care homes, ALFs, or continuing care retirement communities.

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- Nursing homes house approximately 4% of older adults, but 17% of those over age 85. Newer models of nursing homes provide more homelike environments. Social workers play important roles in nursing-home admissions and adjustment of residents and families after they move in.

Multicultural, Gender, and Spiritual Considerations

- Older adults of color have a history of social oppression and reduced opportunities that affect their perspectives today and contribute to higher rates of poverty in late life.
- Recent immigrants may have poor English-language skills and lack social integration. Ethnic minority cultures tend to value extended family and mutual assistance among members of different generations.
- A higher proportion of African American elders are unmarried; they receive support from extended family and fictive kin from church and neighborhood.
- Older women are disproportionately in poverty, unmarried, and living alone. Their longevity leaves them susceptible to higher rates of chronic illness and institutionalization. Ageism, sexism, and racism all operate to keep poverty rates high for older women of color.
- Our youth-oriented society makes it difficult for older women to feel positive about their physical selves as they age and experience disabilities.

Social Strengths, Hazards, and Risks

- Having the support of family, spouses or partners, friends, or neighbors and having planned for retirement and possessing adequate finances constitute social strengths for older adults. The mobility to participate in paid or volunteer work and to socialize with friends and family are other strengths. Accepting dependency should it arise is another strength that helps older adults adjust well and avoid social isolation.
- Elder abuse includes physical, emotional, financial, or sexual mistreatment, or neglect of needs. Self-neglect occurs when an independent older person is incapable of necessary self-care. An estimated one in four incidents of elder abuse is reported to authorities. Adult Protective Services (APS) investigates reports of elder abuse. Most abusers are family members. Caregiver impairments play a major role in elder abuse.

Developmental Guidelines for Assessment in Late Adulthood

- Exhibit 10.19 presents the developmental guidelines for late adulthood. These guidelines are meant to be helpful to social workers who need to understand development when making assessments.

Epilogue: The Journey of Life

We have now come to the final pages of this book—moving from birth to death. We hope that the framework and information we have provided can help you make some sense of this lifelong progression. And yet, on a deeper level, is it possible for us to make sense of life? After taking this journey, perhaps this is an appropriate time to pause and reflect on the meaning of life. What is the real sense of it all?

Great minds have struggled with this question. Kierkegaard informed us that "life is lived forward, but understood backwards." Socrates was cheerful in his answer to this question—we are here to be happy. And for Socrates, the path to happiness was through knowledge. Other philosophers, such as Epicurus, would simply state that our existence is to cultivate pleasures. Religious philosophers have placed the focus of our existence on faith. Abrahamic traditions have promised that if we have faith, we can be assured of a special place in God's kingdom. Hinduism teaches that physical death is best seen as a transition of the spirit or soul into additional lifetimes through reincarnation. The Buddha is credited with saying, "Each morning we are born again. What we do today matters most." According to Lao-tzu, our existence should focus on knowing the inner harmony of nature's way.

Though we can present the facts and theories of human development in the social environment and philosophize at length, defining the purpose of life is a difficult task—maybe a lifelong task. In the end, perhaps it is up to us

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Exhibit 10.19 Developmental Considerations in Assessment in Late Adulthood.

Routine Observations	Development Issues (Not Problems)
Chronic health conditions	Physical vulnerability due to senescence of bodily systems
Availability of appropriate health care	Continuity of personality traits from earlier adulthood
Functioning in activities of daily living	Cognitive processing speed decreases
Medications used and their side effects	Short-term storage and recall memory decreases
Ability to obtain nutritious meals	Strengthening of religious beliefs (sometimes)
Opportunities for exercise	Preference for reliable, comfortable relationships
Alcohol or other drug use	Selective about appropriate activities and interests
Mental status: memory, judgment	Resisting "old" identity
Emotional expression	Role relinquishment as necessary
Availability of companionship, friendship	Recent bereavement or other losses experienced
Family support or family conflicts	May need to give up driving
Caring for others: spouse, family, grandchildren	May need assistance with daily activities
Neighborhood safety	May need residential placement
Transportation issues	May need supportive end-of-life care
Home safety and appropriateness	
Employment or volunteer opportunities	
Social and community opportunities	
Strengths and Landmarks of Development	**Development Observations Requiring Attention**
Maintaining interests and activities according to capability	Little affect; lack of interest or enjoyment
Interest in remaining as independent as possible	Talks of being worthless or being a burden
Interest in sexual expression and companionship	Persistent loneliness
Desire to leave a legacy—e.g., creative work, possessions, or family	Social isolation
	Paranoid ideation or delusions
Desire to maintain family and friendship connections	Slurred speech or otherwise not alert; can't stay awake
Adapting to new roles	Walking unsteadily but without cane or walker
May be more reflective or introverted	Multiple medications with possible interactions
May take comfort in religious beliefs or spirituality	Possible alcohol misuse
	Repeats same questions, gets lost, obvious memory loss
	Unsafe living situation
	Signs of physical neglect—dirty, unkempt, bedsores

individually to make sense of our lives and to make life something real and meaningful. As we pause, our personal reflections on life may provide our own sense of meaning. These reflections might bring forth images of our origin and our start in life, our growth and struggles throughout life, our hopes and our fears, our achievements, our love, and ultimately our death:

> We whisper a new baby's name to the rising sun, we laugh as the child mistakes a cow for a dog, we call each other "buttface," we learn and grow, we dye our hair purple as we struggle to establish a unique identity, we work and we love and sometimes we cry, we stand at the crossroads and hesitate for just a moment before moving on, we stare as the shoreline recedes and the ship sails away before finally turning to hear the voices calling from the other shore …

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Applying the Framework

Depression in an Older Woman

Esther Rodriguez is a 77-year-old widow who broke her hip three months ago. After a two-week hospital stay for emergency hip-replacement surgery and four weeks in a nursing home for strengthening and mobility training, she is staying in her daughter and son-in-law's home because she was not fully capable of caring for herself independently when her need for skilled services (and thus her Medicare coverage) ended at the nursing home. She was referred to Catholic Social Services by her daughter, who wanted help in making long-range plans for her mother's care.

Mrs. Rodriguez has lived in the same house for nearly 50 years. She raised two sons and a daughter there. Her husband, who died five years ago, worked for the railroad. Mrs. Rodriguez was primarily a homemaker, but she supplemented the family income by selling her homemade tortillas and tamales to neighborhood restaurants. Mrs. Rodriguez's older son died of cancer two years ago, at age 52. Her younger son lives in another state with his second wife and their children. Mrs. Rodriguez's daughter, Ana Clark, 50, and Ana's husband, Joe Clark, are purchasing the modern townhouse that they moved into five years ago. It is located on the opposite side of town from Mrs. Rodriguez. Ana is a self-employed certified public accountant (CPA). She and her husband own their own accounting firm. They have two grown children and three grandchildren. One of their sons, age 24, is living in their home while he seeks employment.

Developmental History

Mr. and Mrs. Rodriguez had made a comfortable adjustment to retirement and had about seven years together before his death five years ago. Mrs. Rodriguez's activities had not changed as much as her husband's, but she spent less time in church activities with the other women and more time gardening and working around the house with her husband. Once a week, however, she had lunch with three of her best high school friends while her husband played bingo with his retired friends at church. On Sundays, her daughter, Ana, and son-in-law, Joe, came for dinner. Her husband's death was very hard for her. It took her nearly two years before she felt she could wake up and not ache from feeling lonely. Following her son's death two years ago, she again had a very hard time. Ana reported that her mother never seemed to be her old self after that.

The current circumstances of Mrs. Rodriguez and her daughter's family have put a strain on the natural stages of family and individual life-cycle development. Mrs. Rodriguez's role with her older son (wise parent, loving mother) has been prematurely interrupted, as has his role with her and his sister (responsible son who can help with maintenance of family home, validation of parental wisdom, and elder's value). Ana is just into the stage of launching children and moving on, but her son's return home and now her mother living with her are requiring a return to more caretaking and home management demands. Ana and her mother have been arguing daily about Mrs. Rodriguez returning to her own home. Ana is worried that her mother will forget to take her blood-pressure medicine, fall down, or even wander away. She doesn't think her mother will bother with eating or, worse still, may forget to turn off the stove, and set fire to her house. This role reversal with her mother (daughter taking more parental responsibility for adult parent, and parent being more dependent) is magnified by the fact that her mother is living in Ana's home, and it is hard for Ana to learn to support her mother without doing too much for her. Their arguing reveals what a considerable strain this is for both mother and daughter. Ana also has admitted that she and her husband have been arguing frequently. They are renegotiating their marital relationship to accommodate both the younger and the older generations living in their family space. Ana is also feeling pressure to put in more hours at work as tax season is approaching, and her husband is expecting her to keep up with her part of their business.

Ana becomes tearful as she confesses to feeling "trapped." She is worried about her mother's current well-being, but she is also fearful that Mrs. Rodriguez may have an incurable problem, such as Alzheimer's disease, and that she will never be able to return to living in her own home. Ana seems to be feeling some resentment over the fact that she has become her mother's chief caretaker even though she works full time, has raised her own children, and has a brother who should be equally responsible for their mother. Ana has had several telephone conversations with her brother to discuss living arrangements for Mrs. Rodriguez. Her brother expresses concern, but he poses distance and his own

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Depression in an Older Woman (continued)

family responsibilities as barriers to his being an integral part of any solution. He has offered some limited financial help and has given his approval to whatever plan his sister and mother work out.

Biophysical Considerations

Mrs. Rodriguez is not frail and is of above-average intelligence. She had been completely independent in her own home before she broke her hip.

She was able to do all her activities of daily living (ADLs) in her familiar environment. She needed partial help with only two instrumental activities of daily living. Following her husband's death, she had asked Ana to help her manage the lump-sum life insurance money from her husband's railroad life policy, and she needed help with transportation for shopping because she had never learned to drive.

Chronic medical problems for Mrs. Rodriguez include arthritis, hearing loss, high blood pressure, digestive difficulties, and osteoporosis. The osteoporosis was a major factor contributing to her broken hip. Whether she fell and the soft bone in her hip broke or whether the hip broke and caused her to fall is not known; either way, the brittleness of her bones puts her at great risk for further broken bones resulting from slight falls and for compression fractures in her spine, which can occur without provocation.

Mrs. Rodriguez is well known to her family doctor, whose office is in her neighborhood. He has treated her for several years, and his late father was her doctor before him. A telephone conversation with the doctor has revealed that Mrs. Rodriguez has managed her chronic medical problems well. She has been compliant in taking her blood-pressure medication and comes in for periodic checkups. Her chronic conditions are stable. However, since being at Ana's home, Mrs. Rodriguez complains of chronic pain "all over." She frequently refuses to take her daily walk, citing pain in her (artificial) hip as the reason. She has frequent headaches and seems tired most of the time. Ana reports that the orthopedic surgeon who replaced her mother's hip states that she is healing well and that, with time and normal activity, the soreness in her hip should decrease. Because Mrs. Rodriguez is now so far away from her doctor's office, she has not seen her regular doctor since she left the hospital. Ana is trying to decide whether to find a doctor near her own home to take over her mother's care or to transport her mother across town to see her regular doctor.

Cognitive Development and Psychological Hazards

Ana reports that her mother "is just not with it." She had always enjoyed watching the news and discussing current events with others, but Ana can no longer engage her in discussion. Mrs. Rodriguez cannot seem to concentrate on the news stories, and she becomes agitated and frustrated when Ana tries to talk with her. "She just doesn't seem to care about anything," Ana says. Ana also reports that her mother has significant short-term memory deficits. She becomes upset with Ana if Ana is late getting home from work, even after Ana calls before leaving the office to tell her that she's stopping for groceries. She often asks what day it is, only to ask the same question 10 minutes later. She tells Ana that she ate the meal Ana left for her, although Ana finds it untouched in the refrigerator. Ana reports that her mother began exhibiting these memory problems a few weeks after she entered the nursing home.

In an effort to sort out whether Mrs. Rodriguez's cognitive difficulties are organic or more psychological and related to a significant depression, the social worker completed a Mini-Mental Status Exam. At first, Mrs. Rodriguez had difficulty comprehending what was being asked of her, but then the social worker decided that perhaps a part of the problem was Mrs. Rodriguez's hearing loss. The social worker began using a voice amplifier attached to earphones that Mrs. Rodriguez was asked to wear, and Mrs. Rodriguez responded much better to the questions and appeared much brighter. She scored 25 out of a possible 30 points. She had the most difficulty with attention/calculation and recall sections. This score is strongly suggestive of a pseudo-dementia caused by depression, rather than an organic, irreversible dementia.

When the social worker asked Mrs. Rodriguez to take the self-administered Geriatric Depression Scale, she scored 12, which suggests that depression may be the root of her cognitive difficulties.

Attitudes and Emotions

The significant losses that Mrs. Rodriguez has experienced in the last few years (losing her husband and eldest son to death, another son to distance, her hearing, and now her mobility) have taxed her abilities to adjust and cope. One coping strategy she has used is to maintain a sense of normality by continuing to perform routine activities of housekeeping, gardening, going to church, and visiting

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neighbors. These are now difficult for her because of her physical limitations and because she resides in a household that is not her own. The loss of her husband, though devastating, was more in the expected process of life, whereas the son's death before her own is more unnatural. This fact makes bereavement more complicated for Mrs. Rodriguez. She often said she would much rather have gotten cancer herself and gone to be with her husband than for her son to have to leave this life so soon.

Ana believes that her son, who is recovering from substance abuse, may be using his grandmother as an excuse to avoid looking for employment. However, Mrs. Rodriguez states that she has developed a "new" and close relationship with this 24-year-old grandson. They have shared a common struggle to recover from different difficulties, and both are concerned about the other succeeding. They may be a newfound resource for each other to cope with loss and the new challenges in their lives.

Support Systems, Contexts, and Multicultural, Gender, and Spiritual Issues

Mrs. Rodriguez's home is in a historic part of town, populated by mostly Latino families. Many of these families have lived in the neighborhood for three or more generations. Mrs. Rodriguez has many friends in the neighborhood, which remains largely intact with a corner grocery, a pharmacy, a school, and an active Catholic church. Mrs. Rodriguez has enjoyed cooking with the churchwomen who provide food for weddings, funerals, and special celebrations. She still takes pride in her tortilla making. She has a number of close neighbors who have known her for years. She has provided them with support (babysitting, cooking, emotional support) many times in the past.

The church remains a central focus for the life of this community as well as for Mrs. Rodriguez. Attending mass on Sundays and religious holidays has always been an important part of her self-identity. She considers the parish priest her advisor on all matters of living and has spoken to him several times about personal matters since her husband died.

Ana's husband is white. Ana has left much of her cultural upbringing behind but continues to attend a Catholic church near her current home. Ana's children have become even more assimilated into the dominant culture. Although Ana and her mother are bilingual, Ana rarely speaks Spanish to her mother because she feels this would be inconsiderate to her husband and son, who speak only English. These cultural differences make Ana's home unfamiliar and, in many ways, uncomfortable for Mrs. Rodriguez. Mrs. Rodriguez's presence in Ana's home has brought up old conflicts for Ana around her Hispanic identity and heritage that Ana thought she had put to rest long ago.

Ecomaps demonstrate the changes in Mrs. Rodriguez's life context from before her husband died (see Exhibit 10.15) to the present time (see Exhibit 10.16). This assessment tool shows the severe constriction of her life space since her husband's death and her surgery. Many nurturing support systems—priest, church, friends, neighbors—and activities are no longer a part of her everyday existence. These accumulated losses will add to her depression and confusion, and her current living situation will only exacerbate the stressful relationship between Mrs. Rodriguez and her daughter, Ana. Restoration of Mrs. Rodriguez to her home and neighborhood, with appropriate formal supports, is the preferred goal of treatment.

Social Hazards

Impoverishment may be a hazard for Mrs. Rodriguez. She owns her home and has several thousand dollars in a savings account, but her income is fixed and just meets her regular expenses. She has Medicare but has not felt she could afford the cost of a supplemental health insurance policy on her fixed income. She has been able to manage comfortably, but added expenses for a prolonged period could quickly deplete her savings and leave her home as her only financial asset.

Summary and Impressions

Problems needing intervention:

1. It is likely that depression has caused Mrs. Rodriguez's cognitive deterioration. Both medical and psychosocial interventions are suggested because there are important issues of loss and grief that Mrs. Rodriguez needs help in resolving, as well as physical signs of depression. With treatment for her depression, Mrs. Rodriguez should suffer less from "generalized pain," be motivated to continue rehabilitating her hip, and be able to make the necessary adjustments to continue her independent living, though with more supports.
2. Hearing impairment may be creating more cognitive deficits and adding to Mrs. Rodriguez's depression. This needs to be further evaluated through an audiologist.

Continued

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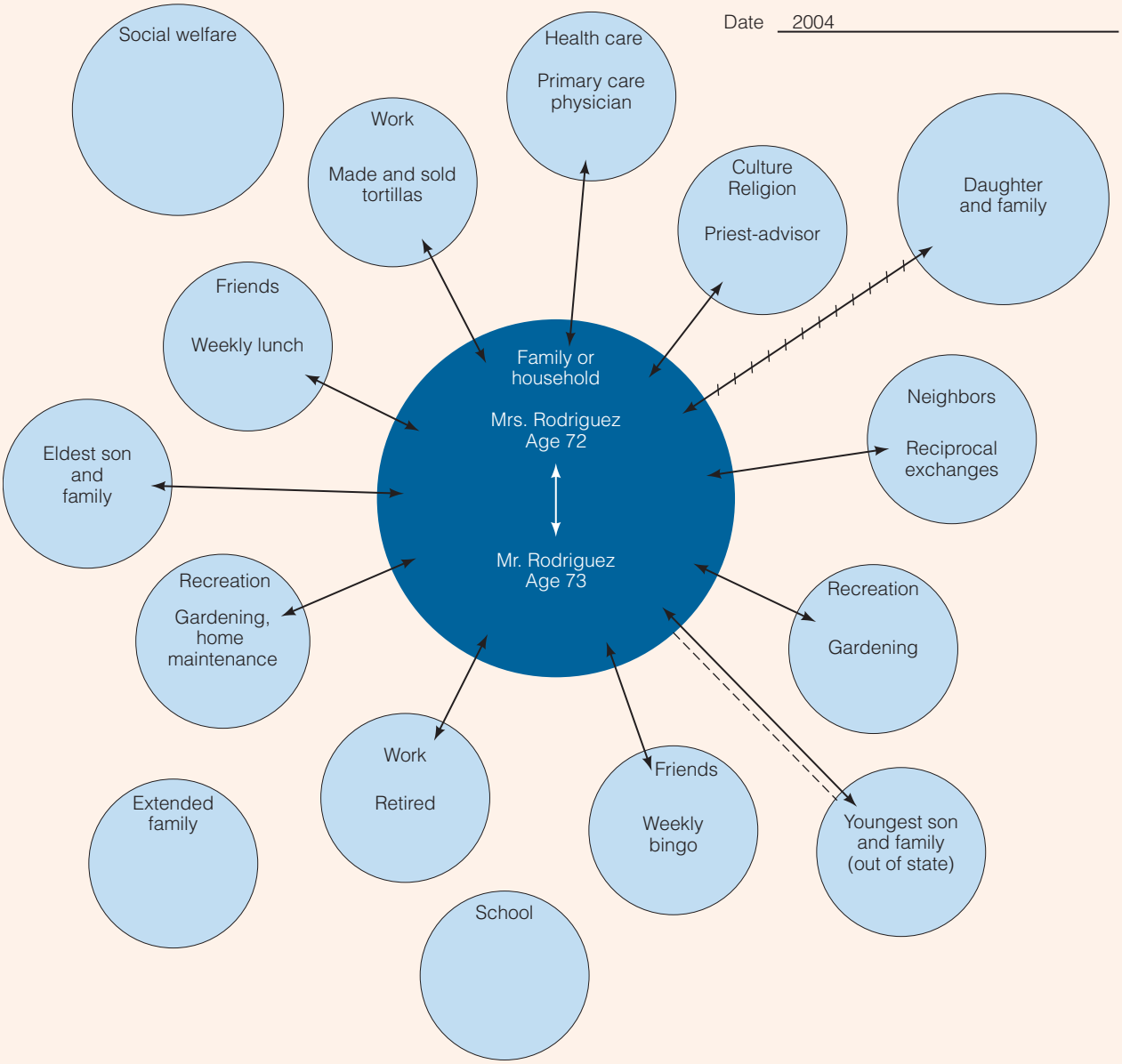
Depression in an Older Woman (continued)

Name Mrs. Rodriguez

Date 2004



Fill in connections where they exist.
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:
———— for strong, – – – – – for tenuous, ⁄ ⁄ ⁄ ⁄ for stressful.
Draw arrows along lines to signify flow of energy, resources, etc. → → →
Identify significant people and fill in empty circles as needed.

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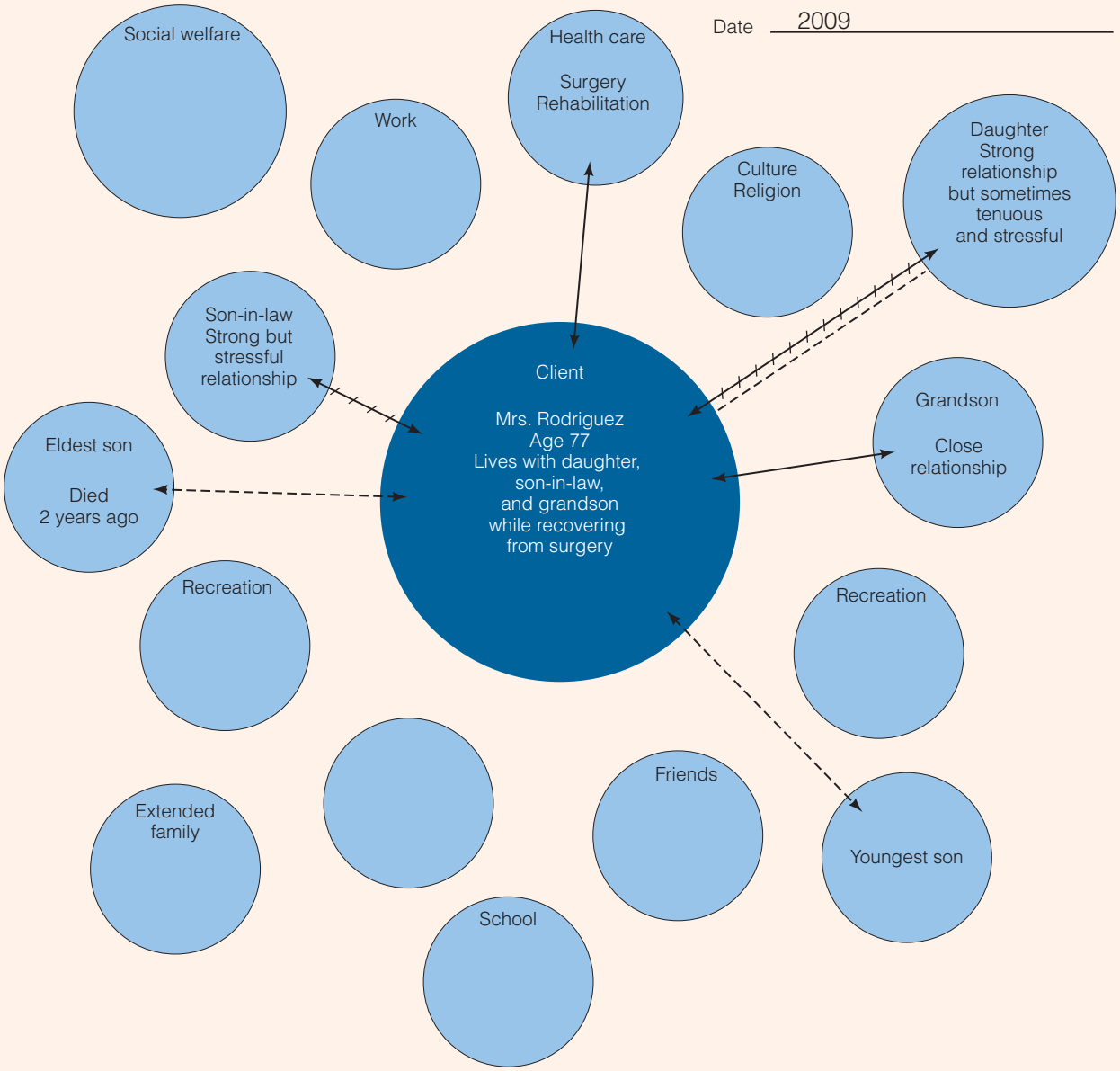
Name Mrs. Rodriguez

Date 2009



Fill in connections where they exist.
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:
———for strong, – – – – –for tenuous, ⁄ ⁄ ⁄ ⁄for stressful.
Draw arrows along lines to signify flow of energy, resources, etc. → → →
Identify significant people and fill in empty circles as needed.

Continued

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Depression in an Older Woman (continued)

3. Confusion as to the source of Mrs. Rodriguez's memory and concentration problems has produced anxiety and catastrophic thinking in Ana and hindered her ability to appropriately plan for her mother's future needs.
4. Mrs. Rodriguez will need help with certain ADLs, such as bathing, dressing, and heavy housework, because her mobility is still limited from the hip surgery.
5. Ana is experiencing increasing stress owing to physical and time demands of caring for her mother and managing all of her other responsibilities.
6. Ana's family is experiencing stress and role strain with the new demands on Ana at a time when the family is facing other demands in the business and the need of the younger son for emotional support to progress to the next stage in his life.
7. Ana and Mrs. Rodriguez are experiencing role strain as Mrs. Rodriguez becomes more dependent.

Strengths identified:

1. There is a strong family bond and commitment to looking for solutions that address everyone's needs.
2. Mrs. Rodriguez has been flexible in adapting to earlier changes in her life and has coping skills that should continue to help her adapt.
3. Mrs. Rodriguez lives in a supportive, close, culturally homogeneous neighborhood where she feels safe and important.
4. Mrs. Rodriguez has built many reciprocal relationships among her neighbors, which makes it more probable that they can help her in ways that can enable her to return to living in her own home.
5. Mrs. Rodriguez has a close relationship with former high school friends with whom she enjoys leisure-time activities.

Four Ps' Formulation for Integration of the Data

Practice Exercise:

Fill in each of the four Ps for the case that is applying the biopsychosocial framework for this chapter.

Use the results of the four Ps' formulation to:

1. Identify relevant problems, diagnoses, or other relevant judgments about the case described in the Applying the Framework section of the chapter.
2. Describe an appropriate biopsychosocial intervention based on the findings in your four Ps' formulation of the case.
3. Identify an appropriate plan for engaging the client in the case described above based on the biopsychosocial integrative data that you identified in your formulation of the four Ps.
4. Describe how you would evaluate your invention based on the data captured in your four Ps' assessment.

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	Biological	Psychological	Social
Predisposing Why me?			
Precipitating Why now?			
Perpetuating Why does it continue?			
Protective What can I rely on?			

Reviewing Your Competencies

You should be able to:

1. Describe the key developmental themes present in late adulthood, Iing theories of aging.
2. Understand the key aspects of biophysical growth and development of late adulthood (exercise, functioning age, ADLs and IADLs, chronic conditions, medications, gender).
3. Describe the key themes in the psychological dimension for late adulthood (normative versus non-normative cognitive impairments, Alzheimer's disease, depression, alcohol use, isolation).
4. Describe the key themes in the social dimension for late adulthood (widowhood, continuum of care, spirituality, elder abuse).

Key Terms

activities of daily living
advance directives
ageism
anhedonia
continuity theory
dementia
durable power of attorney for health care
elder abuse
fictive kin
functional age
grief
hospice
instrumental activities of daily living
integrity
life-course perspective
life expectancy

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life span
loneliness
long-term care
palliative care
prolonged grief disorder
reminiscence
retirement
selective optimization and compensation
senescence
socioemotional selectivity
spirituality
widowhood effect
wisdom

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Glossary

Abstraction The ability to recognize the meaning of symbols.

Accommodation The cognitive process of modifying existing cognitive schema to allow for the admission of new information.

Acquaintance rape Rape by someone the victim knows.

Activity theory A theory of aging that holds that older people who remain active and involved experience greater life satisfaction.

Adaptation The ability to respond to the demands of the environment. Includes the processes of assimilation and accommodation.

Adolescent-limited delinquency Delinquency or a crime pathway that stops after an individual grows out of adolescence.

Advance directives Instructions for doctors and other medical providers that describe the kind of care a person would like to have if unable to make medical decisions due to physical incapacitation.

Affect A person's instant emotional state.

Age Grades are social categories or social groupings based on age that define the expectations, rights, and privileges of individuals at different phases of life, such as infancy, adolescence or old age.

Ageism Prejudice against and stereotypes applied to people on the basis of their age. It assumes age related characteristics attributed to an individual independent of the individual's actual personal qualities and characteristics.

Agency A technical term; includes the idea that goal-oriented people act in intentional ways.

Aggression Acts intended to hurt another.

AGIL scheme Describes the basic functions of the social system as defined by Talcott Parsons.

Alcoholism The consumption of alcoholic beverages to the extent that major aspects of a person's life, such as work, family, and friends, are affected.

Allele One of a pair of genes for a specific trait.

Allostasis The process of maintaining stability through change.

Allostatic load The cumulative cost to the body of allostasis; allostatic overload is a state in which serious pathophysiology can occur.

Alpha-fetoprotein blood screening Blood test used to detect neural-tube defects.

Altruism Helpful behaviors that arise out of concern for the welfare of others, without regard for personal gain.

Amino acids A group of nitrogen-containing organic compounds that serve as the units of structure associated with proteins.

Amniocentesis A prenatal screening procedure in which a needle is inserted through the mother's abdomen into the uterus to collect a sample of amniotic fluid for chromosome testing.

Androcentricity A perspective in which men are considered the norm.

Androgen The hormone secreted from the testes.

Androgyny The combination of masculine and feminine behaviors in the same person.

Angina pectoris A coronary condition involving pain and tightness in the chest.

Anhedonia A mood characterized by a pervasive inability to perceive and experience pleasure in action and events that are normally satisfying or pleasurable.

Anoxia Insufficient oxygen to the fetus during delivery.

Apgar score A newborn assessment scale developed by Virginia Apgar that looks at the newborn's adaptation to

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life in the first minutes after birth. Scores are recorded at 1 minute and 5 minutes after delivery.

Assimilation The cognitive process of consolidating of new information into existing knowledge.

Assisted suicide Helping to provide the means for an individual with a terminal illness to end his or her life.

Associationism One of the oldest constructs in psychology. It involves the formation of mental associations that are registered or stored in the mind.

Asthma A respiratory illness that makes breathing difficult because of narrowing of the bronchial tubes.

Attachment The process by which an infant forms a strong emotional tie to a caregiver.

Attention The ability to focus on a specific stimulus without distraction by irrelevant stimuli.

Attention-deficit/hyperactivity disorder (ADHD) A psychiatric disorder in which a person shows signs of developmentally inappropriate inattention, impulsivity, and hyperactivity.

Attitude A learned evaluative response.

Authoritarian parenting A parenting style based on low levels of warmth and a demanding, restrictive, and punitive approach.

Authoritative parenting A parenting style that encourages warmth and affection. It encourages independence but with limits and controls on the child.

Autism Pervasive developmental disorder in which children suffer psychological, cognitive, and social deficits that impair functioning in almost all areas of life.

Autosomes Chromosomes other than sex chromosomes.

Aversive racism The denial of personal prejudice but overlooking the presence of underlying unconscious negative feelings and beliefs.

Avoidant disorder Fear of strangers and strange or new situations.

Axons Long fibers that carry impulses from the cell body of a neuron to other cells.

Babbling Early communication in which a baby puts vowel and consonant sounds together and repeats them over and over.

Basal metabolism rate The minimum amount of energy that we use in our resting state.

Behavioral genetics A field of psychology that asserts that all human behavioral traits are heritable.

Behavioral intention Our subjective estimate of how likely we are to engage in a specific behavior.

Beliefs In social psychology, information about objects.

Bilingualism Ability to speak two languages.

Biography In the life-course perspective, changes in roles as they are taken up and discarded in the passage from one age group to the next over the course of an individual's lifetime.

Biophysical dimension The biochemical, cell, organ, and physiological systems that represent the material substance of a person.

Blended family A newly formed unit consisting of a husband and wife, one or both of whom have children from a previous marriage.

Brazelton Neonatal Assessment Scale (BNAS) Newborn assessment used to measure the baby's muscle tone and reflexes and how the baby responds to and controls stimulation.

Bronchopulmonary dysplasia A chronic lung disease of infancy characterized by inflammation and scarring in the lungs; involves abnormal development of lung tissue.

Bureaucracy An organization that is ruled by officials.

Canalization The process by which people inherit general pathways that constrain their growth and developmental processes.

Care perspective Reasoning about moral dilemmas, with a focus on the connectedness to others; concern for others is paramount.

Caregiving career The substantial caregiving functions women have, including caring for children, elderly parents, and a dependent husband.

Categorization The ability to place objects into groups on the basis of their similarities.

Central nervous system The brain and spinal cord.

Cephalocaudal Development that progresses from the head to the feet.

Cerebral palsy Brain damage resulting from lack of oxygen during birth or from bleeding in the brain; it can cause paralysis, muscle weakness, and incoordination and also may result in intellectual disablity and speech difficulties.

Cesarean section Delivery of a baby through an incision in the mother's abdomen.

Child abuse Child maltreatment that includes physical abuse, sexual abuse, physical neglect, educational neglect, and psychological abuse.

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Chorionic villus sample (CVS) A prenatal screening procedure in which a catheter is inserted into the uterus through the vagina to obtain a piece of the developing placenta.

Chromosome disorders Abnormalities or defects caused by errors in an entire chromosome or part of a chromosome.

Circular influences The process by which family interactions affect interactions with the infant and affect the infant's interactions with the caregivers, which then affect family interactions.

Classical conditioning The strengthening of an association between a stimulus and a response through the presentation of a second stimulus.

Cliques Small interaction-based groups with close relationships.

Codependency A pattern of behavior in which a person's sense of self-worth is based on external referents.

Cognition Obtaining, organizing, and utilizing sensory and perceptual information from activities such as plans and strategies.

Cohesive group A group in which individual members have strong bonds with one another and to the group itself.

Cohort A group of people of about the same age, born around the same time.

Cohort (period) effects The changes in behavior influenced by being a member of a cohort or being born in a particular period of time.

Colic Uncontrollable, extended crying in a baby who is otherwise healthy and well fed.

Communication patterns How members of a group communicate verbally and nonverbally.

Communitarian agenda Commitment to correcting the current imbalance between rights and responsibilities at the societal or community level.

Concentration A person's ability to sustain inner mental operations without disruption.

Concrete thinking The ability to perform operations such as logical reasoning, which replaces intuitive thought as long as it is applied to concrete examples.

Conduct disorder DSM-IV term which refers to a cluster of behaviors that reflect oppositional, noncompliant, and delinquent actions, such as stealing, robbery, and assault.

Connectedness A person's sensitivity to and respect for others' views.

Conscience In Freudian theory, a component of the superego that causes guilt when its standards are not met; involves internalized mental representations of conduct that are subject to punishment.

Consciousness Awareness of internal and external stimuli.

Conservation The recognition that properties of a substance do not change when its appearance is altered in some manner.

Continuity Associations made because two events occur together in time or space.

Controlled reaction A phase of rape trauma syndrome in which the rape victim assumes a more composed and calm perspective following the trauma.

Coping Active efforts to master, reduce, or tolerate the demands created by stress.

Creolization The process of maintaining original identities but incorporating customs and practices from other groups or cultures into the original identities.

Cretinism A chronic disease due to the absence of, or deficiency in, normal thyroid secretion. Cretinism is characterized by physical deformity and dwarfism.

Crisis A decisive point produced by stress or other types of biopsychosocial demands of life that lead to positive or negative outcomes. For Erikson, a crisis was considered a challenge or turning point at which there are opportunities for individuals to choose between polarities associated with key developmental tasks.

Crisis theory A theory for intervention in the crises of people who are having difficulties coping with various stressors and other demands of life.

Cross-modal transfer The ability to transfer information gained from one sense to another sense. An example would be picking out a picture of something you had only felt with your hands.

Crossover A division process that involves an exchange of chromosome parts.

Crowds Reputation-based groups of similar young people who do not necessarily spend a lot of time together; larger than cliques.

Crystallized intelligence Accumulated information and verbal skills.

Cultural competency The values, principles, beliefs, and behaviors that allow professionals to practice effectively cross-culturally.

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Culture A system of meanings and values shared by a population and transmitted to future generations.

Cumulative continuity An important issue in the life-course tradition that focuses on the way in which behavior at one point in life has consequences that increase the likelihood of continued behavior. For instance, being labeled a troublemaker early in life may prevent a youth from associating with good kids and increase the likelihood of continued delinquency.

Current perspective In the multidimensional integrative approach, assessing how biological, psychological, and social systems influence current states of affairs.

Cynical hostility Tendency toward being resentful, moody, and generally distrusting. Related to an increased tendency toward coronary disease, hypertension, and early mortality.

Cystic fibrosis A serious disease of the exocrine gland that causes secretion of excess, thick body fluids.

Das-Luria model of cognitive functioning A view of cognitive functioning based on two modes of processing information: simultaneous meanings and successive processing.

Date rape Rape by someone the victim is dating.

Deillusionment The process of giving up illusions from earlier periods of life.

Delirium tremens (DTs) A withdrawal syndrome from alcoholism that includes agitation, tremor, hallucination, and, sometimes, seizures.

Dementia Impairment or loss of cognitive abilities, including memory impairment.

Dendrites The branched fibers on the cell body that bring messages to the cell body of the neuron.

Development The refinement or improvement of body components.

Developmental perspective In the multidimensional approach, assessment of how the dimensions interact in leading up to the current state of affairs or developmental outcome.

Developmental waves The idea that children learn in overlapping waves instead of in steps.

Diastolic pressure The measure of the blood's flow during the relaxation of the heart.

Differentiation theory The view that all information needed to interpret sensory input is contained in the sensations themselves.

Difficult child A baby characterized by unpredictable daily habits, negative, intense mood, and slow adaptability.

Discrimination Prejudice or bias applied to a person on the basis of some particular characteristic.

Disengagement theory A theory of aging that holds that people and society withdraw from each other in old age—people because of their diminished capacity and society to make room for younger people.

Dishabituation The process by which an individual attends to a new stimulus after habituating to a previous stimulus.

Disorganization phase A phase of rape trauma syndrome that reflects the woman's immediate expressed or controlled reactions, physical reactions, and emotional reactions to the trauma.

Disoriented states The experience of significant deviations in an individual's levels of awareness of time, place, and person.

Displaced homemakers Women who are forced into the job market because of divorce or widowhood.

Dominant gene A gene that is always expressed for a trait, in paired genes.

Down syndrome A developmental disability that is associated with the presence of three chromosomes, rather than a pair, for chromosome 21.

Durable power of attorney A document that allows a person appointed by you to act as your agent to continue to act on your behalf even after you have become incapacitated.

Easy child A baby characterized by regular, positive responses to new stimuli, high adaptability to change, and mild or moderately intense mood, which is usually positive.

Echolalia Repetition of words, songs, and phrases heard in other people's communications.

Ecomap A tool used in social work to highlight the points of connection between systems influencing a person's life.

Ego According to Freud, the executive branch of one's personality that makes rational decisions.

Ego-ideal In Freudian theory, the mental representation of conduct that is positively valued by the environment.

Ego psychology (self theory) Unlike dynamic psychology, ego psychology focuses on the contributions of the ego or self in determining all aspects of human behavior.

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Egocentrism Inability to distinguish between one's own perspective and another's.

Elder abuse Maltreatment of older people, which can include physical abuse, psychological abuse, material abuse, active neglect, and passive abuse.

Elderspeak Using baby talk in communicating with seniors.

Emerging adulthood A distinct stage of development that is neither adolescence nor young adulthood.

Emotion-focused coping This form of coping focuses on psychological and emotional responses to stress.

Emotional intelligence (EQ) The area of psychology that deals with measuring people's ability to identify their own and others' feelings and to solve problems involving emotional issues.

Empathy The ability to understand the feelings and attitudes of others.

Encopresis Lack of bowel control after age four.

Endocarditis An infection or other factor that damages the heart's valves.

Endocrine glands Glands, namely the pituitary gland and male and female gonads, that secrete into the bloodstream chemicals that help control bodily functioning.

Endorphins Substances in the brain that are related to feeling good.

Enrichment theory The view that the information we receive through our senses is formless and we must augment this information to make sense of it.

Enuresis Lack of bladder control after the age of five, which results in bed-wetting or daytime accidents.

Environmental harassment A hostile work environment that results from unwanted sexual behavior by the person in power.

Environmental paths The various paths followed by people in their social environment—such as work, intimacy and education.

Epigenetic principle The biological blueprint that dictates how an organism grows and reaches maturity.

Estrogen The hormone secreted from the ovaries.

Estrogen replacement therapy (ERT) A synthetic estrogen that is given to women to replace what is lost through menopause.

Etiology The branch of science that deals with understanding causes of behavior.

Euthanasia The act of assisting the death of those with painfully debilitating or terminal illness.

Executive functioning The brain's capacity to absorb and interpret information and make decisions based on it.

Exosystems The larger institutions of society that influence our personal systems.

Explicit memory A memory of an event that occurred in the distant or immediate past.

Expressive communication The expression of emotions and possession of a perspective that is sensitive to how others feel.

Expressive language disorder Includes limited speech and vocabulary shortened sentences, difficulty learning new words, misuse of words, limited or simple grammar, and slowed language acquisition.

Externalizing problems Problems of undercontrol, such as aggressive behavior, fighting, and overactivity.

Extinction The systematic withholding of the reinforcers that had previously maintained a behavior.

Failure to thrive A condition in which a child's weight falls below the 5th percentile for the child's age.

Family A composition of people who decide to live together.

Family structure The manner in which each family organizes itself into interactional patterns.

Fetal alcohol syndrome (FAS) A set of birth defects that occur when a pregnant woman consumes alcohol. It is the leading known cause of intellectual disability. Physical signs include small head, small eyes, thin upper lip, short nose, flattened midfacial area, and poorly developed philtrum (the part of the face between the nose and upper lip).

Fictive kin Individuals who are unrelated by either birth or marriage, who have an emotionally significant relationship with another individual that would take on the characteristics of a family relationship.

Fixed income Income that does not increase from year to year though inflation and other factors may raise the cost of living.

Floating family A family with a formless array of familial relationships that are in a continuous state of flux.

Fluid intelligence Abstract reasoning ability.

Folkways Group ways of solving problems and of doing things.

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Formal operational thought Thought processes characterized by adolescents' abilities to think about their own thought and to recognize both possibility and actuality.

Formal organization Any large social group that is designed to rationally achieve a specific objective.

Formed groups Groups created by an outside influence or intervention and convened for a particular purpose.

Fragile X syndrome A serious form of intellectual disability that is identified in karyotype studies by a constriction at the end of the long arm of the X chromosome.

Frontal lobe The portion of the brain that participates in body movements, thinking, feeling, imagining, and making decisions.

Functional literacy The ability to perform everyday reading, writing, and arithmetic tasks.

Funnel theory Any theory supporting the hypothesis, from early developmental theory, that change tends to contract over time.

Gang "A collectivity consisting primarily of adolescents and young adults who (a) interact frequently with one another; (b) are frequently and deliberately involved in illegal activities; (c) share a common identity that is usually, but not always, expressed through a gang name; and (d) typically express that identity by adopting certain symbols and/or claiming control over certain 'turf'—persons, places, things, and/or economic markets."

Gender The social definitions of male and female.

Gender identity Gender identity is the developmental process by which culturally assigned values and behaviors are considered appropriate for members of that sex.

Gender polarization The organizing of social life around male and female distinctions.

General adaptation syndrome (GAS) A series of bodily reactions to prolonged stress that occur in three stages: alarm, resistance, and exhaustion.

Genotype The actual genes an individual carries for a specific trait.

Gestation Length of time in the womb or fetal age. Full term is 38 to 41 weeks, premature is before 38 weeks, postmature is longer than 41 weeks.

Gestational diabetes High blood sugar (glucose) levels during pregnancy, in a woman who has never had diabetes before.

Glia The supporting cells that make up the bulk of the brain.

Goal-directed behavior A series of actions put together to achieve a desired result.

Gonadotropins Hormones secreted by the pituitary gland that activate the testes and ovaries.

Goodness of fit How well the demands of the environment match the child's behavioral style.

Grammar A set of rules for combining language units into meaningful speech or writing.

Gray matter Areas of the nervous system with a high density of cell bodies and dendrites with few myelinated axons.

Grief The normal, emotional reaction to loss.

Group socialization theory A theory that believes that peer and community influences have the most impact on a child's identity.

Groupthink An emphasis in a cohesive group on consensus at the expense of critical thinking.

Growth A technical term that refers to the addition of new biophysical components, such as new cells or an increase in body size.

Habitat The place where groups of people are normally found.

Habituation The process by which an individual stops responding to a stimulus.

Hemophilia A condition that is due to a defective gene on the X chromosome that causes a deficiency in the blood coagulation factor VIII.

Heterosexuality The assumption that women and men are innately attracted to each other emotionally and sexually and that heterosexuality is normal and universal.

Heterozygous genes Two genes in a specific pair that are different for a specific trait.

Hierarchy Dimension of social space that includes all the elements in a society's system of social stratification.

Holism The philosophy that focuses on the principles of interdependence and on relationships, rather than on reducing elements to their constituent parts.

Holophrastic speech The use of one word to express the meaning of a whole sentence.

Homophobia An irrationally negative attitude toward gay people.

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Homozygous genes Two genes in a specific pair that are the same for a specific trait.

Hormones Chemical substances in the body that regulate various body organs.

Hospice An alternative to hospital care for terminally ill patients. Hospice focuses on comfort and relief of symptoms instead of cure.

Hostile aggression Behaviors derived from the desire to hurt another.

Hot flash A sudden feeling of heat experienced by some women during menopause.

Human capital The form of capital based on an individual's personal as-sets that lead to increased forms of value.

Human immunodeficiency virus (HIV) A virus that destroys the human immune system and leads to the set of opportunistic infections commonly referred to as acquired immune deficiency syndrome, or AIDS.

Human plasticity The changeability of human structures and outcomes.

Human relations school A school of organizational theory that focuses on understanding the influences of informal networks on all forms of organizational activities.

Huntington's chorea A disorder involving a dominant autosomal gene and characterized by progressive chorea (purposeless motions) and the eventual development of dementia (mental deterioration).

Hyperemesis gravidarum Persistent and unrelenting vomiting during pregnancy.

Hyperplasia The type of growth that involves an increase in the number of cells.

Hypertrophic growth The type of growth in which increases are observed in the size of cells.

Hypervigilance An excessive focus on outward factors in the environment.

Hypothalamus The part of the brain that controls the level of hormone secretion from the pituitary gland.

Hypothetical-deductive reasoning The problem-solving process that tests and evaluates hypotheses to find the best solution.

Id According to Freud, the instinctive component of personality that operates from the basis of the pleasure principle.

Ideal type An abstract description derived from real cases that were analyzed to determine their essential features.

Illiterate Unable to read and write well enough to participate in society.

Illness A person's subjective perception of being unwell.

Imaginary audience The belief that others are as preoccupied with an adolescent's behavior as they are.

Immediate memory Information retained for up to 10 seconds.

Implicit memory A memory that a person does not know exists and that is retrieved unconsciously.

Individualized Education Plan (IEP) A cornerstone of the Individuals with Disabilities Education Act (IDEA); ensures that educational opportunities for students with disabilities are individualized.

Individuation A process by which a person develops a stronger sense of autonomy.

Induction Use of explanation and/or rationalizing in an attempt to influence a child's actions.

Inequalities of condition Are conditions that represent differences or disparities in biological, material, and physical capabilities or resources.

Inequities of opportunity These represent disparities in access to needed capacities, resources, respect, and power.

Infant mental health An applied field concerned with the social and emotional well-being of infants within their families.

Infantile amnesia Children's lack of memory for specific events before the age of three.

Infertility Inability to achieve pregnancy after one year of sexual inter-course with no contraception.

Information processing The theory that examines the uptake, selection, coding, and storage of information.

Inhibiting and promoting environments Contexts assessed in terms of the adequacy of resources for developing appropriate competencies. Inhibiting environments are contexts with inadequate resources that create conditions that undermine development; promoting environments have adequate resources to promote appropriate developmental competencies.

Instrumental communication Communication focused on identifying goals and finding solutions.

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Intelligence quotient Mental age divided by chronological age, multiplied by 100.

Intentional means-end behavior The process by which a child takes several random activities and puts them together to achieve a goal.

Intention-cue detection Ability to correctly perceive another person's intention; for example, differentiating prosocial, accidental, or hostile acts.

Internalizing problems Problems of overcontrol, such as anxiety, loneliness, shyness, and/or social withdrawal.

Interrupted career A regular career interrupted by child-rearing and then reestablished when full-time work is resumed.

Intersectionality This is a framework that focuses on the interconnections of social categories and statuses in shaping different experiences of power, discrimination, oppression, and marginalization.

Intrauterine growth restriction (IUGR) Growth slowdown in the prenatal period. Occurs when the fetal weight falls below the 10th percentile for gestational age.

Invisible displacement In testing for object permanence, moving a toy from one hiding place to another without letting the baby view the process of moving the toy.

Justice perspective Reasoning about moral dilemmas with a focus on the rights of the individual to independently make moral decisions.

Klinefelter's syndrome A condition in which a male is born with an extra X chromosome (XXY).

Lability The rapid shift from one emotion to another within a very brief period of time.

Laissez-faire parenting A parenting style representing two types: permissive indifferent parenting and permissive indulgent parenting. Permissive indifferent parents are uninvolved in their child's life; they are neglectful and unresponsive. Permissive indulgent parents are warm, accepting, and responsive but are undemanding.

Learned helplessness Learning to attribute failures to luck or the difficulty of the task.

Lesch-Nyhan syndrome A disorder that involves a gene on the X chromosome and is characterized by intellectual disability spasticity, and self-mutilation.

Libido According to Freud, the sexual energy that drives all human behavior.

Life course A concept and a perspective for looking at developmental issues that takes into account macro contributions to developmental outcomes.

Life-course-persistent delinquency Delinquency that continues after adolescence into adulthood.

Life expectancy The number of years the average person born in a particular year may expect to live.

Life span The upper limit of years humans can live.

Living will A document that allows a terminally ill person to state that he or she does not want to be kept alive by artificial means.

Logical (natural) consequences A disciplinary strategy, used with young children, that connects logically to the behavior that is being disciplined. For example, if the child is late to the dinner table because of watching TV, the logical consequence is removal of TV privileges.

Loneliness A state of feeling as though one has fewer inter-personal relationships than desired or not obtaining the desired level of personal satisfaction from interpersonal relationships.

Long-term memory Retention of information for days to months.

Love withdrawal The response of withdrawing love when a child's behavior is viewed as inappropriate.

Macrosystems The larger subcultural and cultural contexts in which the microsystem, mesosystem, and exosystem are located.

Malignant tumors Tumors that are not self-contained.

Malpresentation Birth presentation other than head down (i.e., feet first, butt first, shoulder first).

Meconium aspiration Inhalation of fetal waste in the amniotic fluid during delivery; may result in later respiratory problems.

Meiosis The process of cell division that creates the sex cells.

Menarche The first menstruation in pubertal females.

Menopause The cessation of menstrual cycles for a continuous period of time; a woman's ovaries stop functioning and no longer produce the hormones estrogen and progesterone.

Menstrual cycle The series of changes in a nonpregnant female involving the preparation of the endometrium to receive a fertilized ovum; if no fertilization occurs, a portion of the endometrium is shed.

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Mental age An intelligence test score that indicates the chronological age at which a child functions cognitively.

Mesosystems The network of personal settings in which we live our lives.

Metacognition Knowledge about knowing. A person's awareness of self as a knower able to use and evaluate strategies.

Metalinguistic awareness The ability to think about language and its properties.

Microsystems Any systems that involve face-to-face or direct contact among the system participants.

Mitosis The cellular process in which a body cell reproduces itself by dividing and producing two new daughter cells.

Mitral valve prolapse A valvular disease of the heart involving the protrusion of one or both cusps of the mitral valve back into the left atrium.

Moderating factors Factors that, when present, weaken the influence of stress.

Monoamines A group of nonacidic neurotransmitters, such as dopamine, norepinephrine, epinephrine, and serotonin.

Mood A prevailing and enduring emotional state.

Moral development The rules of conduct people use in their interactions with others.

Mores Folkways that are considered the right or wrong way of doing things.

Morpheme The smallest unit of meaning in any language system.

Multifactorial disorders Developmental disorders caused by multiple genes.

Multiplex relationship A relationship in which a person has more than one type of exchange with another person.

Munchausen's syndrome by proxy Child abuse in which the caregiver induces symptoms of illness in the child.

Mutation Random events that distort key characteristics in an organism's growth and development.

Myelination The process of coating the nerve cells with myelin, a substance that forms around neurons and acts as insulation, allowing faster and more efficient transmission of nerve impulses.

Myocardial infarction The condition in which insufficient oxygen is directed to the heart's muscle.

Myocarditis An infection or other factor that damages the heart's muscle.

Myth of arrival The myth that someday, after hard work and survived crises, life will be what we always wanted.

Natural (logical) consequences. See logical (natural) consequences.

Natural groups Groups created by naturally occurring events, inter-personal attraction, or the mutual needs of the individuals involved.

Natural helpers Relatives, friends, and neighbors to whom one turns to in time of trouble or need.

Negative reinforcement The following of a response with an end to discomfort or with the removal of a negative state of affairs.

Neighboring An individual's emotional, cognitive, and social attachment to a neighborhood that makes him or her more likely to participate in neighborhood activities.

Neural-tube defects Birth defects of the brain or spinal cord that include the following: spina bifida, in which one or more vertebrae do not close over the spinal cord—if the cord bulges through the opening, the baby has a meningocele; hydrocephalus—excess fluid in the head, resulting in a large head; microcephaly—a much smaller than normal head; anencephaly—absence of all or part of the brain.

Neurons The cells in the nervous system involved in conveying information from one cell to another.

Neurotransmitters Chemicals that are synthesized inside the neuron.

Night terrors A sudden awakening from sleep with intense feelings of panic.

Non-normative events Events or experiences unique to the individual; not the norm, or not predictable.

Normative age-graded influences Predictable experiences that happen universally and are closely tied to age.

Normative history-graded influences Experiences shared by people because they are alive during a particular period.

Norms Expectations and beliefs about appropriate behavior in a group.

Obesity Condition in which body weight is 20% or more above the recommended weight for one's height.

Object permanence The ability to hold an image of an object or person in one's mind.

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Obligatory attention Babies' attention to something they find interesting, without being distracted from it.

Occipital lobe Part of brain located below the parietal lobe and involved in the receiving and sending of visual information.

Open adoption Adoption in which the birth mother and, sometimes, birth father participate in choosing the adoptive family, and often remain in contact with the child after adoption.

Operant conditioning The acquisition of new responses because of their effects on the environment.

Oral rehydration therapy A treatment that prevents dehydration when a child experiences diarrhea.

Organization According to Piaget, a tendency held by all species to systematize their processes into coherent systems.

Osteoporosis The thinning or weakening of bones.

Ovaries Part of the female reproductive system. The ovaries produce the ovum, or egg, and the female hormones estrogen and progesterone.

Overanxious disorder Fears that have no specific focus. Children with this disorder worry that something will go wrong in almost any situation.

Overextension Use of one word to include a larger category. An example is referring to all furry creatures as a dog.

Palliative care Care directed primarily at providing relief to a terminally ill person through symptom management and pain management; also called "comfort care."

Parasympathetic nervous system The branch of the nervous system that counteracts the activities of the sympathetic nervous system and conserves body resources.

Parietal lobe The portion of the brain that is primarily involved in the process of integrating sensory information.

Pattern variables The alternative courses of action in Parson's theory of an action system.

PDP models (parallel-processing or connectionist models of information processes) Models that assume information processing takes place through interactions of large numbers of simple processing elements called units, each sending excitatory and inhibitory signals to other units.

Peer groups Groups of age mates that are durable and composed of interactions based on an established set of social relationships.

Peptides Chains of amino acids.

Perception The interpretation of information detected by the senses.

Perceptual set Objects perceived as having only their most common or recent functional significance.

Pericardium The thin sac that encloses the heart.

Peripheral nervous system All those nerves that lie outside the brain and spinal cord.

Person-in-environment (PIE) system A system for assessing problems in social functioning, developed by Karls and Wandrei.

Personal fable The adolescent's belief that he or she is indestructible and unique—so much so that no one can understand what it is like to be him or her.

Phenotype The trait expressed by genes in the individual.

Phobias Irrational fears.

Phonemes The most basic identifiable sounds in a language system.

Phonological disorder Difficulty articulating speech sounds.

Phonology The component in language studies that examines the system of sound in languages.

Polyhydramnios Excess amniotic fluid, the presence of which may indicate a problem with the fetus, such as anencephaly.

Posttraumatic stress disorder A psychological disorder that involves an individual feeling as though he or she is reexperiencing or reliving a trauma after it occurred.

Power In a group, a person's ability to obtain control through reward, coercion, expertise, personal characteristics, and legitimacy.

Power-assertive discipline A punitive style of discipline that includes physical punishment, threat of punishment, and/or attempts to control the child's behavior.

Pragmatics The study of the rules that specify how language is used across social contexts.

Prejudice A generalized negative attitude that is directed toward another person's membership in a socially defined group.

Prematurity Birth before the 37th week of gestation.

Premenstrual dysphoric disorder A severe form of PMS that includes sadness and crying, anxiousness, food craving, concentration problems, physical problems, and trouble sleeping.

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Premenstrual syndrome (PMS) A set of symptoms some women experience about ten days prior to their menstrual period. The symptoms may include breast tenderness, a bloated feeling, irritability, and negative moods.

Preoperational thought A concept that describes what preschoolers cannot do—they are not capable of operations or mental actions that obey logical rules.

Primary prevention Seeks to stop a problem or situation from occurring in the first place.

Primary-process thinking Thought based on irrational, illogical, and fantasy-oriented notions.

Proactive aggression Aggressive behavior that is used to achieve specific goals.

Problem-focused coping Strategies that seek to deal directly with the source of stress.

Problems of living Involve the normal difficulties of everyday life, such as losing a job, undergoing a divorce, or fearing rejection.

Problem solving The ability to sort out relevant from irrelevant information and to adopt a strategy or plan for completing the task.

Professional half-life The time it takes for 50% of one's professional knowledge to become invalid or obsolete.

Professional obsolescence The use of information, theories, and technology that are less useful in performing tasks than what is currently available in one's field of practice.

Proliferation The stage in brain development when neurons are produced.

Prolonged labor Labor lasting longer than 24 hours for a first-time mother or more than 12 hours for a woman who has previously given birth.

Proteins Any organic compound that has a large combination of amino acids.

Proximodistal Development that progresses from the spine outward to the extremities.

Psychological dimension The systems that contribute to the organization and direction of an individual's mental processes.

Psychological moratorium A gap between childhood security and adult autonomy.

Puberty A period in development that is characterized by maturation of physiological mechanisms, including reproductive capacity and the development of secondary sex characteristics.

Punishment Occurs when a response is followed with pain or an otherwise negative event, or when a response is followed with the removal of a positive reinforcer (response cost).

Purines The category of chemicals that includes adenosine.

Quid pro quo harassment Harassment involving a person in position of power subjecting a person of lower status to unwanted sexual advances.

Quiet sleep The first stages of sleep, characterized by non-rapid eye movement.

Race A large number of people who, for social or geographical reason, have interbred over a long period of time and developed visible physical characteristics and regard themselves and are regarded by others as a biological unit.

Racism Any attitude, action, or institutional structure that subordinates a person because of his or her race.

Rape trauma syndrome A cluster of symptoms experienced by rape victims.

Rapport talk A style of communication that involves discussing similarities and matching experiences.

Reactive aggression An aggressive reaction that is based on anger and includes retaliation.

Readiness Point at which a child's developmental maturity allows them to quickly learn a needed skill or ability.

Recent memory The retention of information learned within the last twenty-four hours.

Recessive gene The gene that is not expressed in a trait unless paired with a similar or homozygous gene.

Reciprocal interaction An interaction in which both parties can influence each other. For example, an infant can influence its mother and the mother can influence the infant.

Reductionism Assumes that the whole is the sum of its parts; attempts to understand problems by focusing on smaller and smaller units.

Refractory period The time between one orgasm and the physical capability to achieve another.

Reification This occurs when people treat social statuses as natural objects rather than as social constructions.

Reinforcement Any event that brings about learning or increases the probability that a particular response will occur.

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Reminiscence The process of remembering the past and reviewing one's life that may arise when one realizes the inevitability of death.

Remote memory Retention of information occurring several weeks or months in the past.

Reorganization phase The adaptation and adjustment phase a rape victim experiences after a rape.

Repetition A factor in association that assumes that ideas are likely to be associated when they occur together often.

Report talk A style of communication that involves discussing knowledge and displaying skill.

Resiliency The ability to recover from or adjust to problems, adversities, and stress in life.

Reversibility The ability to reverse an action by mentally performing the opposite action.

Rh incompatibility The condition in which the mother has Rh-negative blood and the fetus has Rh-positive blood. The mother makes antibodies that attack the fetal blood cells, resulting in anemia in the fetus and possible fetal death or brain damage.

Rickets A deficiency in either diet or sunshine that can induce permanent damage to the body, such as a flat chest, deformed pelvis, or crooked back.

Rite of passage A ritualized recognition of a person's transition from one life stage to another, such as childhood to adolescence.

Role A pattern of expected behavior that a person acts out in a group.

Role-taking ability The mutual ability to see things from another person's perspective. It involves the reduction of egocentric thought.

Schema An internal cognitive structure that facilitates adaptation.

Schizophrenia A psychological disorder marked by disturbances in thought that spill over to affect perceptual, social, and emotional processes.

School phobia (school refusal) Extreme reluctance to go to school, accompanied by various symptoms of anxiety, such as stomachaches and headaches. May be a fear of school or an expression of separation anxiety.

Secondary prevention Aims to intervene as early as possible in a problem situation, before it becomes severe or persistent.

Secondary-process thinking Thought based on realistic and rational approaches to problem solving.

Secular trend The trend toward earlier maturation compared with previous generations.

Selective optimization and compensation The assumption that successful cognitive aging involves maximizing cognitive strengths while developing compensatory skills to shore up weaknesses.

Self-efficacy Belief in one's own capacity to produce a desired result.

Self-esteem Seeing oneself as a worthwhile person; evaluating oneself positively.

Self-help groups Groups of people who share a particular problem and provide mutual support to one another.

Self-selection An assumption in delinquency theory that individuals tend to select experiences that are consistent with internal traits or dispositions established early in life.

Semantics The area in language studies that deals with meaning.

Senescence In biology, the state or process of aging.

Sensation The process in which receptors detect information that is transmitted to the brain.

Sensitive period The period immediately following birth in which the mother and infant bond. Researchers now believe this postbirth bonding is not as important as once thought.

Separation anxiety Distress displayed by an infant in the absence of the primary caregiver; usually begins around 8 to 10 months.

Separation-anxiety disorder Severe anxiety about leaving home or separating from the primary caregivers.

Separation-individuation A developmental process proposed by Margaret Mahler in which the infant grows from having no sense of self as separate from the caregiver to being an autonomous, independent individual.

Sex The biological status of being female or male.

Sex-role stereotypes Categories based on our impressions of what we consider "male" or "female."

Sexual response cycle The three stages that culminate in sexual satisfaction: desire, excitement, and orgasm.

Shaken infant syndrome Infant abuse in which an adult shakes the infant, causing brain damage.

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Short-term memory Memory of an event that can be maintained for about 20 to 30 seconds.

Signs Have a valid relationship with the thing for which they stand.

Similarity A factor in associationism that refers to associations being formed because events or ideas that occur close together have features that are similar.

Single-gene disorders Inherited dysfunctions or defects that result from dominant, recessive, or X chromosome linked genes.

Single representations How preschoolers classify themselves and others: according to age first, gender second, and then by what they can actively do, such as play baseball or climb a tree, and sometimes by what they physically possess.

Slow-to-warm-up child A child who exhibits a sedate, less exuberant orientation to life. These babies are slow to adapt to new situations and many times have negative responses.

Social capital Social connections that form a network of norms, obligations, expectations, and trust that occur among people.

Social cognition The level of awareness one has regarding other peoples' thoughts, feelings, and intentions.

Social cognitive monitoring A person's ability to monitor and make sense of his or her social thoughts; a conscious self-awareness.

Social dimension The systems of social relationships that the person interacts with individually or in a group.

Social environment All the expectations, motives, and incentives that place limits on behavior and that are constructed by other people who live in a person's social world.

Social facts The norms, values institutions, and social structures external to individuals that place constraints on their behavior and choices are known as social facts.

Social forces The factors external to individuals that shape their behavior in different social contexts, which are sometimes referred to in the sociological literature as social facts.

Social functioning All the factors influencing the performance of roles that enable individuals to achieve a reasonable degree of fulfillment and to function as productive and contributing members of society.

Social-learning theory The view that people can learn by observing events that they do not directly experience or perform.

Social marginality The absence of ties to major social institutions.

Social norms The unwritten expectations or rules that guide the behavior of people in groups and other interpersonal contexts are known as social norms.

Social referencing The process by which an infant looks to others for emotional information about how to respond in an unfamiliar situation or to an unfamiliar person or object.

Social role Role based on a set of rules indicating the expectations or duties to be performed by a member occupying a given position in a social group.

Social skills training A treatment program that assumes problem behaviors can be understood in terms of not having the skills needed to cope with situational demands.

Social support systems Continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validations of their expectations about others, which may offset deficiencies in these communications in larger community contexts.

Social stratification The hierarchical arrangement of individuals into ranked ordered groups or classes.

Socioeconomic status The relative position or ranking of an individual or group in a society that is determined by factors such as income, education, occupation, or prestige.

Status The ranking of each member's position in a group relative to the other members.

Stepfamily A family whose kinship is determined by remarriage.

Stereotypes Oversimplified or prejudicial beliefs about a target group held by nonmembers of that group.

Stranger anxiety Distress displayed by an infant at the sight of an unfamiliar face; usually begins around five to six months.

Strengths perspective An approach to assessing people by focusing on strengths and capacities rather than identifying only deficits, disabilities, and/or problems.

Stress The condition that occurs when a challenge or a threat in the environment forces a person to adjust or adapt.

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Subjective norms Beliefs about what important people or significant others think about an object.

Superego According to Freud, the moral guidance that helps balance the drives associated with the id.

Symbols Words, phrases, or written materials that stand for other things or ideas, but do not have a direct relationship with the objects they represent.

Sympathetic nervous system The branch of the nervous system that mobilizes the body for emergencies.

Synaptic cleft The space between any two neurons or between a neuron and another cell.

Syntax The component of language studies that focuses on the rules that govern the way words are combined to form sentences.

System Any set of elements that affect or influence one another.

Systolic pressure A measure of the heart when it is constricting and pumping blood out and through the body.

Task groups Groups that have as their primary purpose to complete the work for which the groups were convened.

Tay-Sachs disease A neurodegenerative disorder that is characterized by progressive intellectual and physical disability.

Telegraphic speech The use of only words that are absolutely necessary to convey a message.

Temperament The characteristic pattern by which an infant responds to and interacts with the environment.

Temporal lobe The portion of the brain involved in emotions and human motivation.

Teratogens Substances that cause birth defects and anomalies.

Tertiary prevention Reduction of the complications or negative consequences of a problem situation by preventing handicaps or impairments that are its known consequences.

Testes Part of the male reproductive system. The testes produce sperm and the male hormone testosterone.

Theory of agency See agency.

Toxemia or eclampsia A serious complication of pregnancy, which can result in maternal death, fetal death, or fetal brain damage. Early stages are referred to as preeclampsia. Symptoms include elevated blood pressure, swelling of hands and face, weight gain, and protein in urine.

Trajectory A specific path or line of development followed by a person to a specific life outcome.

Transgender This gender identity refers to an identity that is expressed in ways that differ from the sex they are assigned at birth.

Transient exuberance During infant brain development, the period of rapid growth of dendrites.

Transitional object Something (a blanket, toy, or teddy bear) the infant uses for comfort in the absence of the primary caregiver.

Transitions Short-term state changes that are marked by life events.

Transracial adoption Adoption in which the child is of a different race than the adoptive parents.

Treatment groups Groups that seek to meet members' socio-emotional needs.

Trial and error The sequential application of possible solutions to problems.

Tumor Mass of purposeless tissue caused by cell growth.

Turner's syndrome Condition in which a female is born with only one X chromosome (X0).

Turning point A change in direction in the life course; alters the probability of a trajectory toward a specific life destination.

Type A personality Competitive, impatient, and sometimes hostile perfectionists.

Type B personality Relaxed, easygoing, and generally amicable individuals.

Ultrasound A prenatal screening procedure in which high-frequency sound waves are passed through the mother's abdomen to form a picture of the developing fetus.

Uninformative messages Messages that do not clarify the exact meaning being communicated.

Uniplex relationship A relationship in which a person has one type of exchange with a person.

Vaginal bleeding A complication of pregnancy that may be associated with spontaneous abortion or with placental complications.

Values Abstract goals, such as beauty, freedom, or health, that do not have specific objects or reference points.

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Verbal control The development of speech through three successive stages: other-external, self-external, and self-internal; the idea that self-verbalizations are related to self-guidance.

Vigilance The capacity of sustaining outward attention over a prolonged period of time.

Wisdom Possession of fundamental pragmatics about life, or good judgment about important but uncertain matters.

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