Understanding Human Behavior and the Social Environment

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INTRODUCTION TO HUMAN BEHAVIOR AND THE SOCIAL ENVIRONMENT

Why do people behave the way they do? Are behavior and personality caused mainly by a person's genetic makeup and given nature? Or are they due to the environment and a person's treatment in that environment?

Human behavior and its dynamics can be remarkably complex. A fascinating example concerns the case of a boy, sometimes referred to as "the wild boy of Aveyron," who grew up alone in the Aveyron forest of southern France at the end of the eighteenth century (Papalia, Olds, & Feldman, 2007). On various occasions, French villagers sighted
the boy, who was naked, filthy, and covered with scars, as he roamed through the wilderness, foraging for roots, nuts, and whatever other food he could find (Yousef, 2001).

In January 1800, the boy, eventually named Victor, was caught burrowing for vegetables in a tanner’s garden in the French village of Saint-Sernin. Although he was only about four and a half feet tall, he appeared to be about 12 or 13 years old (Lane, 1976). He had “delicate white skin, a round face, long eyelashes, a long, slightly pointed nose, an average-sized mouth, a rounded chin, generally agreeable features, and an engaging smile.” Externally he appeared much like any other boy; however, he could make “only weird, meaningless cries,” could not speak, vehemently refused to wear clothing, and rejected any prepared food (Saskatchewan Psychology Portal, n.d.; Shattuck, 1980). Victor also failed to respond to others, neither communicating with them nor paying attention to what they were doing. It became apparent that Victor had been abandoned at an early age and, without human company, had learned to fend for himself in his own way.

Victor was eventually sent to Paris, where he came to the attention of two important Parisian physicians, Philippe Pinel and Jean-Marc Gaspard Itard. A basic question they addressed was the reasons for Victor’s behavior. They focused on the nature–nurture controversy. In other words, was Victor’s behavior the result of nature (i.e., inborn traits), or was it a consequence of nurture (i.e., the influence of his background, experience, and environment)? Pinel, a psychiatrist, determined that Victor was not really wild, but rather mentally deficient and an “incurable idiot” (Human Intelligence, 2004). He believed that nature had caused Victor’s pattern of behavior. But Itard, who was chief physician at the National Institution for Deaf-Mutes in Paris, disagreed. Itard credited Victor for his self-sufficiency and survival, asserting that Victor’s deprivation of human interaction had denied him the opportunity to learn how to fit into society. Itard believed that Victor could learn to interact, communicate, and conform if he were taught to do so. He argued that Victor’s behavior resulted from the nurturance, or lack thereof, he received from his environment.

More specific questions can be raised. Why couldn’t Victor speak? He had a horizontal scar across his throat, apparently caused by a knife, that may have damaged his vocal cords (Yousef, 2001). However, he could utter some sounds, which suggested that his vocal cords were not damaged. Could Victor hear? He would often ignore human speech and even the sound of a gunshot (Human Intelligence, 2004), yet would react to the sound of a walnut being cracked behind him, an unseen dog barking outside, or a door creaking open in the dark (Yousef, 2001). Was Victor autistic (a condition characterized by intense inner-directedness that is discussed further in Chapter 3)? Some believe he presents the first documented case of autism (FeralChildren.com, 2005; Human Intelligence, 2004).

Far ahead of his time, Itard worked with Victor for five years, using behavior modification principles to teach and reinforce desired behavior (Chapter 4 elaborates on behavior modification concepts and techniques). Victor learned to “read and speak a few words, demonstrated affection for his caretakers, and could carry out simple commands” (Human Intelligence, 2004). Consider what great accomplishments these were! However, Itard was greatly disappointed that Victor could not achieve much more and become “normal.” Victor never learned to communicate well; nor did he care much about interpersonal interactions. His focal point continued to be his own desires. Ultimately, he could not survive independently in the civilized world as he had in the wild. Victor spent the remainder of his life being cared for by Madame Guerin, who had been Itard’s housekeeper. He was in his early forties when he died in 1828.
Ethical Question 1.1

Was it ethical for Dr. Itard and the others to remove Victor from the wild against his will?

Victor's story raises many questions about how human behavior and personality develop. Why do we behave the way we do? How much of our behavior is a product of our genetic heritage? To what extent do we think, feel, and interact the way we do because we've been taught to do so by other people—our family, school, the media, our culture, and our government? Understanding Human Behavior will explore various dimensions of human behavior to enhance your understanding of why people have developed as they have and why they behave the way they do.

A Perspective

The goals of this book are to explore the dynamics of human behavior and prepare a foundation of knowledge upon which to build social work practice skills. What do we mean, exactly, by human behavior and the social environment, the title of this book? First, let's break down and define the terminology. Human behavior involves people's actions, conduct, and responses as they go through life. Individuals, of course, demonstrate human behavior. Groups of people ranging from couples to families to communities to nations also exhibit human behavior. People, then, behave within the context of their environment. An environment includes "the surroundings or conditions" in which people or other organisms live and function (Lindberg, 2007, p. 460). For our purposes, the social environment involves the systems of other people, including economic, political, legal, social, spiritual, and cultural, with whom any individual interacts as he or she operates within the encompassing environment.

Why is understanding human behavior and the social environment important for social workers and other helping professionals? Social workers help people solve problems and get access to resources. They must recognize what conditions people are faced with in their social environments and how these conditions affect people's behavior and functioning. The social environment may vary on many levels. It may be urban or rural. It may be wealthy with many resources or impoverished with very few. It may be liberal or conservative. On an international level, it may be democratic, socialist, or communist. Social workers must understand the social environment in order to help people figure out what options are available to them and get the resources they need.

1Ethics are standards that guide behavior. Ethical questions such as this will be raised throughout this book to encourage students to engage in ethical decision making by addressing professional values and using professional ethical standards.
One of the primary steps in the helping process—and the focus of this book—is assessment, the identification and exploration of variables affecting people's behavior, functioning, and well-being. Assessment for social workers entails investigating people's strengths, problems, needs, and issues to begin understanding how to help people and improve their lives.

Human behavior can be fascinating and, sometimes, quite puzzling. For example, I (Karen Kirst-Ashman) once got home from work, walked into the master bedroom, and observed my partner ironing the mattress. Befuddled, I thought, "This is a new one. What in the world is he doing?" Mattress ironing had never been part of my repertoire of logical behavior. As it turned out, my partner, who is an engineer, explained his actions quite rationally. We had recently bought a new mattress, and its covering was so slippery that neither a mattress cover nor sheets would stay in place. This was quite annoying when we were trying to sleep. My partner was using the iron to attach a sheet with Stitch Witchery, a bonding tape that melts and secures materials like hems after heat is applied to it. It's an easy way to get cloth materials to stick together if you don't want to bother with needle and thread. My partner's idea was that we'd put another sheet over the one bonded to the mattress; in effect, the bonded sheet would be a permanent—and nonslippery—mattress cover. As it turned out, his plan worked. The sheets no longer slipped off. This experience reinforced my hypothesis that people always have a reason for doing what they do, as baffling as it might appear at the time.

Social work is unique in that it emphasizes a focus that stretches far beyond that of an individual. Assessment in social work addresses all aspects of a client's situation. Many times, it's not the client's fault that problems exist. Rather, something outside the client may be instigating the problem. The client's whole family may not be functioning well. There may be difficulties beyond the client's control in his or her workplace. Existing social service organizations may not be providing what clients need. Resources may be too difficult to obtain, inadequate, or even nonexistent. Organizational policies or laws affecting the client may be unfair. As part of assessment, social workers focus on families, work groups and environments, social agencies, organizations, neighborhoods, communities, and even local, state, and national government in addition to the individual. Figuring out what to do about any specific problem may directly involve any of these entities.

**Learning Objectives**

This chapter will help prepare students to

**LO 1** Explain the importance of foundation knowledge for social work with an emphasis on assessment

**LO 2** Review the organization of this book that emphasizes lifespan development

**LO 3** Describe important concepts for understanding human behavior (that are stressed throughout the book and include human diversity, cultural competency, oppression, populations-at-risk, empowerment, the strengths perspective, resiliency, human rights, and critical thinking about ethical issues)
LO 1 Explain the Importance of Foundation Knowledge for Social Work with an Emphasis on Assessment**

In order to recognize the significance of foundation knowledge, including that presented in this book, the purpose and process of social work must be understood. Social work may be viewed as having three major thrusts (Baer & Federico, 1978, p. 68). First, social workers can help people solve their problems and cope with their situations. Second, social workers can work with systems, such as social agencies, organizations, communities, and government bureaucracies, so that people can have better access to the resources and services they need. Third, social workers can “link people with systems” (Baer & Federico, 1978, p. 68), so that clients themselves have access to resources and opportunities. Much of social work, then, involves social functioning.

People interact with other people, with organizations (such as social service agencies), and with small groups (such as families and colleagues in the workplace). Social work targets not only how individuals behave, but also how these other systems and people affect each other.

An example is a family of five in which both parents work at low-paying jobs in order to make a marginal living. The father works at a small, non-unionized leather-processing plant. The mother works as a waitress at a short-order diner. Suddenly, the father is laid off. For a short time, the family survives on unemployment compensation. When that runs out, they face a serious financial crisis. Despite a great effort, the father is unable to find another job. In desperation, the family applies for public assistance. Due to some unidentified error in the lengthy application process, the payments are delayed for two months.

Meanwhile, the family is forced to eat poorly and is unable to pay rent and utility bills. The phone is disconnected, the electricity is turned off, and the landlord threatens to evict them. Reacting to the externally imposed stress, the parents begin to fight verbally and physically. The children complain because they are hungry. This intensifies the parents’ sense of defeat and disillusionment. As a result of stress and frustration, the parents hit the children to keep them quiet.

Although this example has not been presented in detail, it illustrates that people are integrally involved with other systems in their environment.

A social worker reviewing this case might assess how the family and other systems in the environment have had an impact on each other. First, the father’s life is seriously affected by his place of employment, the leather factory, when he is laid off. He then seeks unemployment compensation, which affects that system by dipping into its funds. When those benefits
cease, the family then affects the public assistance system by drawing on its funds. The public assistance system, in turn, impacts the family by delaying their payments. The resulting frustration affects all family members, as the parents are unable to cope with their stress. The entire situation can be viewed as a series of dynamic interactions between people and their environment.

**The Profession of Social Work**

The National Association of Social Workers (NASW) is the primary professional organization for social workers in the United States. NASW (1982) defines social work as follows:

*Social work is the professional activity of helping individuals, groups, or communities to enhance or restore their capacity for social functioning and to create societal conditions favorable to their goals.*

*Social Work practice consists of the professional application of social work values, principles, and techniques to one or more of the following ends: helping people obtain tangible services; providing counseling and psychotherapy for individuals, families, and groups; helping communities or groups provide or improve social and health services; and participating in relevant legislative processes.*

The profession of social work is recognized as having the primary responsibility to implement society's mandate to provide safe, constructive, and effective social services. Social work is thus distinct from other professions (such as psychology and psychiatry) because it has the responsibility and mandate to provide social services.

A social worker needs training and expertise in a wide range of areas to effectively handle problems faced by individuals, groups, families, organizations, and the larger community. Although most professions are increasingly becoming more specialized (e.g., most medical doctors now specialize in one or two areas), social work continues to emphasize a generic (broad-based) approach. The practice of social work is analogous to the old general practice of medicine. A general (or family) practitioner has professional education to handle a wide range of common medical problems; a social worker has professional education to handle a wide range of common social and personal problems.

The foundation of social work is described in Highlight 1.1. The knowledge, skills, and values needed for generalist social work practice are described in greater detail later in the chapter.

**The Process of Social Work: The Importance of Assessment**

Accurate assessment is a critically important step in the social work process. Information about the problem or situation needs to be gathered, analyzed, and interpreted. Regardless of the specific type of situation, careful thought is necessary in order to make effective decisions about how to proceed. Assessment also involves basic knowledge and assumptions about human behavior. There are always reasons why people behave the way they do.

For example, a social worker who is trying to help a potentially suicidal adolescent needs certain types of information. The worker needs to know some of the reasons why people consider committing suicide so that he or she knows what questions to ask, how to respond to and treat the person, and what alternatives and supports to pursue.

Additionally, the worker must be able to identify what resources are readily available to suicidal adolescents. How can the crises be addressed immediately, simply to keep them alive? What supportive resources are available to keep them from suicidal thoughts in the future? Where can a social worker refer them to get help? (Chapter 7 explores adolescent suicide in greater depth.)

**Identifying and Evaluating Alternative Courses of Action**

Clients come to social workers with problems and needs. The worker must understand these problems and needs in order to help the client. One primary task for the practitioner is to help the client define the alternatives available to him or her. Often people have tunnel vision: because of stress or habit or lack of experience, they can fail to realize that various alternatives exist. Not only must alternatives be defined, but they also must be evaluated. The positive and negative consequences of each alternative should be clearly stated and weighed. Figure 1.1 illustrates the process of evaluating alternatives.
Generalist Social Work Practice

There used to be an erroneous belief that a social worker was a caseworker (who worked with individuals and families), a group worker (who worked with groups), or a community organizer (who worked on people’s behalf in organizations and communities). Practicing social workers know that such a belief is faulty because every social worker is a change agent working with individuals, groups, families, organizations, and the larger community. Social workers today are generalists. A generalist practitioner is one who uses a wide range of knowledge and skills to help people with an extensive array of problems and issues. These include anything from personal issues that affect an individual to extensive, far-reaching problems that involve entire communities. The amount of time spent at these levels varies from worker to worker, but every worker will, at times, work at each of these levels and therefore needs training in all of them.

The Council on Social Work Education (CSWE, the national accrediting entity for baccalaureate and master’s programs in social work) requires that all bachelor’s (BSW) and master’s (MSW) programs train students in generalist social work practice. MSW programs, in addition, usually require students to select and study in an area of concentration. They generally offer several choices, such as family therapy, administration, corrections, or clinical social work.

The Council on Social Work Education (2015), in *Educational Policy and Accreditation Standards*, defines generalist practice as follows:

> Generalist practice is grounded in the liberal arts and the person-in-environment framework. To promote human and social well-being, generalist practitioners use a range of prevention and intervention methods in their practice with diverse individuals, families, groups, organizations, and communities based on scientific inquiry and best practices. The generalist practitioner identifies with the social work profession and applies ethical principles and critical thinking in practice at the micro, mezzo, and macro levels. Generalist practitioners engage diversity in their practice and advocate for human rights and social and economic justice. They recognize, support, and build on the strengths and resiliency of all human beings. They engage in research-informed practice and are proactive in responding to the impact of context on professional practice.

This text focuses on the generalist-practice approach in social work by describing a variety of assessment strategies. Once you have learned these strategies, you can select the approaches that hold the most promise in facilitating positive changes in your clients.

In working with individuals, families, groups, organizations, and communities, social workers use a problem-solving approach. The process can be described in a variety of ways, but includes these steps:

1. Identify as precisely as possible the problem or problems; in other words, conduct an assessment of the situation.
2. Generate possible alternative solutions, evaluate their potential effectiveness, and establish a plan of action for intervention.
3. Implement the plan and carry out the intervention.
4. Evaluate the intervention’s effectiveness.
5. Terminate the process.

**LO 2 Review the Organization of This Book That Emphasizes Lifespan Development**

Understanding and assessing human behavior includes being knowledgeable about human development. It also involves comprehension of the wide range of issues facing people as they progress through life. For a coherent approach to changes that take place during a person’s lifespan, this text will assume a chronological perspective. The lifespan is divided up into four main phases: infancy and childhood, adolescence, young and middle adulthood, and later adulthood. Three chapters, respectively
focusing on biological, psychological, and social development, address each life phase.

**Biological development** and theories concern the physical aspects of a person's life. For example, biological dimensions for children include when they begin to walk and develop coordination. For adolescents, biological development includes puberty and the physical changes related to it. Biological aspects for older adults concern the physical changes that normally occur as people age.

**Psychological development** and theories emphasize individuals' functioning and cognitive or thought processes. Psychological aspects concern how people think about themselves, others, and the environment around them. For children, this includes the gradual development from more concrete to more abstract thought. Development of a sense of morality is involved. As life progresses, people may make great intellectual contributions involving scientific discovery or artistic expression. They may also experience issues concerning mental health, such as depression or eating disorders.

Finally, **social development** and theories address people's interaction with others around them in the social environment. Children live within the social context of their family. They develop their social lives as they start interacting and playing with other children. As people continue through life, social dimensions include interaction with friends and participation in work groups. They may find significant others as partners and/or start families of their own. Many join organizations for political, social,
Because people are complex, social workers should focus on the dynamic interaction among biological, psychological, and social aspects of development. Various aspects of development act together to affect an individual's overall growth and maturity.

Consider a depressed adolescent. Although his psychological state, or depression, may be the presenting problem, problems related to other systems may also be evident. His psychological depression may cause him to withdraw from others and become isolated. Thus, his social interaction may be drastically affected. He may stop eating and/or exercising, which would have a significant impact on his biological system. (Chapter 6 explores the biological development and Chapter 7 the psychological development of adolescents in much greater detail.)

Another example involves an alcohol-addicted adult. Her drinking affects her biological, psychological, and social development. Biologically, she loses weight and has frequent physical problems such as severe hangover headaches. Her physical health affects her psychological health in that she frequently becomes disgusted with herself. Her psychological condition affects her interactions with those close to her, and they begin to avoid her. Hence, her social interaction and development are affected. Social isolation, in turn, enhances her psychological desire to drink and escape, and her physical condition continues to deteriorate. (Chapter 11 discusses further the dynamics of alcoholism and its effects.)

recreational, or professional reasons. Some become great leaders who initiate and implement major social change.

Considered together, these aspects of development may be referred to as bio-psycho-social development. As Highlight 1.3 explains, these three dimensions integrally affect each other. Sometimes, the dividing lines among them are not clear cut. For instance, where does psychological development end and social development begin? Consider young people who attend school. Children first begin to attend school when they reach a certain biological age. A goal is to learn and develop thinking ability, a psychological dimension. Yet, school also provides a major social context in which children develop communication and interaction skills. People psychologically think about both gaining knowledge and developing their social relationships during this period of biological development.

Because of the importance of human diversity and its effects on human behavior, three chapters on this topic are interspersed throughout the book. These chapters focus on ethnocentrism and racism, gender roles, and sexual orientation. (Note that content on various aspects of human diversity, including aspects of cultural and spiritual development, are also infused throughout the chapters on biological, psychological, and social development.) Figure 1.2 summarizes the chapter layout of this book.

Common Life Events

Throughout each of the life periods—infancy and childhood, adolescence, young and middle adulthood, and later adulthood—people tend to experience common life events related to biological, psychological, and social development that occur at certain times of life. For example, adolescence is a time when people establish an identity. Adolescents strive for independence and search for a place to fit into social peer groups. Sometimes adolescence is even more stressful. It may be marked by running away from home or by delinquency.

Marriage and having children are often characteristic events of early and middle adulthood. Sometimes people face unplanned pregnancy and single parenthood during this time of life. Some people must deal with divorce. Life events in later adulthood include retirement and readjustments to married life when children leave home. Many older adults remain deeply involved in family and community life, as predicted by activity theory. However, disengagement theory predicts that others will become increasingly isolated and detached from society (Santrock, 2012b). Additionally, many older adults must cope with increasingly more serious health problems and illnesses.

These experiences or life events—identity crises, marriage and children, retirement, and detachment—all tend to happen during certain periods of life. Each of these common events will be addressed within the context of the time of life when it generally occurs.
The variety of experiences that may be considered typical is great. However, there are certain life events that social workers are frequently called upon to help people cope with. We will arbitrarily select and focus on some of these experiences because of their relevance to practice.

**Typical Developmental Milestones**

Typical developmental milestones include those significant biological, psychological, emotional, intellectual, and social points of development that typically occur in a person's lifespan. This category focuses on the individual as a distinct entity. It provides a perspective on what can be considered typical. Topics include motor development, personality development, motivation, social development, and learning.

For example, consider a young child's typical motor development. By age three or four, most children begin to jump, hop, run, operate a tricycle, employ a fork effectively, and use a pair of scissors (Berk, 2012a). (Chapter 2 profiles typical developmental milestones for children.)

Or consider the typical developmental occurrences for older adults. Older persons tend to have important changes in their sleeping patterns, such as taking longer to fall asleep and typically sleeping for shorter time periods at night (Ancoli-Israel & Alessi, 2005; Kail & Cavanaugh, 2013). (Chapter 14 further discusses the changes in sleeping patterns commonly experienced by older people.)

In order to distinguish between what is typical and what is atypical, one must have a clear understanding of typical developmental milestones at any age. The term typical is used here to refer to levels of functioning that are considered appropriate for a particular age level. Social work practitioners must be able to distinguish between situations that merit intervention and those that do not. Much time and effort can be wasted on trying to solve problems that are really not problems at all. For instance, it is needless to worry about a baby who is not walking at the age of 12 months. However, it may merit investigation if that baby is still not beginning to walk by the age of 24 months. Likewise, consider the older adult with sleeping problems. It may be senseless to
worry about a tendency to sleep lightly when that is simply a typical sign of age. Social workers may help people adjust their expectations so that they are more reasonable. People can be helped to stop worrying about what is really the typical state of things. On the other hand, sleeping problems at the age of 50 may merit further exploration. At this earlier point in life, such problems may be caused by stress or some physiological problem.

Typical developmental milestones provide a baseline for assessing human behavior. The extent of the problem or abnormality can be assessed only to the extent that it deviates from what is typical.

LO 3 Describe Important Concepts for Understanding Human Behavior

Because of their significance in assessing and understanding human behavior, we will spend some time introducing several major concepts here. They involve themes that will be addressed throughout the book. The first cluster of ideas includes human diversity, cultural competency, oppression, and populations-at-risk, all of which are somewhat related. The second grouping entails empowerment, the strengths perspective, and resiliency, which are also interconnected. The third important dimension discussed here involves critical thinking about ethical issues.

Human Diversity, Cultural Competency, Oppression, and Populations-at-Risk

Social workers must be aware of human differences and the effects they have on human behavior. Human diversity is the vast range of differences among groups, including those related to “age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status” (Council on Social Work Education [CSWE], 2015). Highlight 1.4 elaborates on the importance of one aspect of human diversity—culture.

Anytime a person can be identified as belonging to a group that differs in some respect from the majority of others in society, that person is subject to the effects of that diversity, including discrimination and oppression. Discrimination is the act of treating
people differently because they belong to some group (e.g., racial or religious) rather than on merit. Oppression involves putting unfair and extreme limitations and constraints on members of an identified group. Picture a woman in an all-male business establishment. Think of a 62-year-old person applying for a sales job in a department store where everyone else is under 30. Or consider an African American applying for membership in a country club that has no other members who are people of color. (People of color “is a collective term that refers to the major groups of African, Latino, Asian, and First Nations Peoples [Native Americans] who have been distinguished from the dominant society by color” [Lum, 2011, p. 129].) A population-at-risk, then, is any group of “people who share some identifiable characteristic that places them at greater risk of social and economic deprivation and oppression than the general mainstream of society.” (Kirst-Ashman, 2007, p. 57).

Privilege, Power, and Acclaim
People in any society might be placed on a continuum based on social status and the amount of influence they have over others. People who experience discrimination and oppression might be placed on one end of the continuum. People who have exceptional “privilege, power, and acclaim” might be situated on the other. Power is “the ability to achieve one’s goals despite the opposition of others”; in other words, power involves “the ability to do whatever you want because no one can stop you” (Leon-Guerrero, 2011, p. 48). Power may entail using “force, authority, manipulation, or persuasion” to make others alter their behavior (Eitzen, Zinn, & Smith, 2014, p. 45).

Privilege entails special rights or benefits enjoyed because of elevated social, political, or economic status. Privilege is often related to prestige, “the amount of social respect or standing given to an individual based on occupation. We assign higher prestige to occupations that require specialized education or training [e.g., physicians], . . . or that make more money [e.g., CEOs of major corporations]” (Leon-Guerrero, 2011, p. 48). Acclaim is “enthusiastic approval or praise” (Nichols, 1999, p. 8). People who experience acclaim, such as high-level politicians and famous entertainers, maintain broad influence over what other people think. People who have privilege and acclaim have greater power to influence and control the destinies of others.

Eitzen and his colleagues (2014) make several points regarding power, wealth, and status in the United States:

- “The inequality gap in the United States is the widest of all the industrialized nations. The gap continues to grow especially because of tax benefits for the affluent . . .
- These tax policies, in addition to increasing the unequal distribution of wealth, increase the national debt, reduce government spending for programs to help the less fortunate, and weaken public institutions that benefit all members of society. The widening gap increases the political influence of the wealthy . . .
- The power elite in society (those who control the government and the largest corporations) tend to come from backgrounds of privilege and wealth. Their decisions tend to benefit the wealthy disproportionately. The power elite is not organized and conspiratorial, but the interests of the wealthy are served, nevertheless, by the way in which society is organized. This bias occurs through influence over elected and appointed officials, . . . [social and economic policies that affect the distribution of wealth, and prestige and acclaim that serve as a] control of the masses.” (p. 52)

Group Membership and Values
Membership in any group provides a certain set of environmental circumstances. A Chicano adolescent from a Mexican American inner-city neighborhood has a different social environment from that of an upper-middle-class adolescent of European descent living in the well-to-do suburbs of the same city.

Sensitivity to group differences is critical in understanding any individual’s behavior. This is important from two perspectives. First, the values or orientation of a particular group will affect how an individual behaves. For instance, an individual with a sexual orientation for the same gender may very well choose to participate in social activities with others of the same orientation. The individual might tend to avoid bars and nightclubs where heterosexual singles meet and might join activities or social clubs aimed at helping people with a sexual orientation toward the same gender to meet each other.

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2In this context, an institution is a well-established custom or cultural expectation in a society; examples are public education and public assistance (welfare).
The Societal Perspective on Group Differences

There is a second important perspective concerning sensitivity to group differences. The first perspective focused on how the group member feels and chooses to act. The second perspective directs attention to how other people and groups in the social environment view the (diverse) group in question. The diverse group may be the object of prejudices (predetermined assumptions made without assessing facts) and stereotypes (standardized views about people who belong to some group that do not take into account individual qualities and differences). Each group member tends to lose his or her individual identity and assume the group identity in the eyes of others in the environment. To these outsiders, the characteristics of the group become the characteristics of the individual, whether or not the individual actually has them.

For example, consider a young, single African American mother of three young children who is receiving public aid. She applies for a service job behind the counter of a local delicatessen. The deli is run by a lower-middle-class white family that holds many of the larger society’s traditional values. These values include the outdated ideas that the head of the household must be a man and that women should stay home and take care of the children. The owner of the deli, a man and head of the family, interviews the young woman and makes several assumptions.

The first assumption is that the woman has no business not being married. The second is that she should be staying at home with her children. The third assumption is that the woman, because of her color, is probably lazy and undependable. He uses the excuse that she has no experience in this particular job and refuses to hire her.

This young woman has run up against similar, serious difficulties in her job search. In addition, she may have problems getting adequate day care for her young children. Taken together, all these difficulties may prevent her from finding a job and getting off public aid.

In assessing behavior, then, one must be aware of limitations imposed by the environment. Otherwise, impossible alternatives might be pursued. In the case we presented above, for example, a social worker who does not understand these things might continue to pressure the young woman to go out and get a job. Since she was already trying and failing, however, this additional pressure might make her turn against the social worker and the social service system. She might just give up.

Awareness of how prejudices and stereotypes affect people forms the basis of professional values, one of the foundation blocks of social work. These values include respect for each individual and that individual’s right to self-determination; the importance of confidentiality; commitment to social justice, advocacy, and positive social change; the appreciation of human diversity; and the right to equal treatment and equal opportunity (CSWE, 2015; Reamer, 2013).

Focus on Empowerment, the Strengths Perspective, and Resiliency

The second cluster of vital concepts for understanding human behavior includes empowerment, the strengths perspective, and resiliency. These constitute ongoing themes stressed throughout social work practice.

Empowerment

Empowerment is the “process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situations” (Gutierrez, 2001, p. 210). The empowerment approach is a perspective on practice that provides “ways of thinking about and doing practice” (Lee, 2001, p. 32). Throughout the assessment process and our quest to understand human behavior, it’s critical to emphasize, develop, and nurture strengths and positive attributes in order to empower people. Empowerment aims at enhancing the power and control that individuals, groups, families, and communities have over their destinies.

We have also determined that some groups of people suffer from stereotypes, discrimination, and oppression. It is social work’s task to empower clients in general and members of oppressed groups in particular.

Cowger and Snively (2002) explain further:

Promoting empowerment means believing that people are capable of making their own choices and decisions. It means not only that human beings possess the strengths and potential to resolve their own difficult life situations, but also that they increase their strength and contribute to the well-being of society by doing so. The role of the social worker is to nourish, encourage, assist, enable, support, stimulate, and unleash the strengths within people; to illuminate the strengths available to people in their own environments; and to promote equity and justice at all levels of society. To do
that, the social worker helps clients articulate the nature of their situations, identify what they want, explore alternatives for achieving those desires and then achieve them. (p. 110)

**The Strengths Perspective**

Focusing on strengths can provide a sound basis for empowerment. Sometimes referred to as the strengths perspective, this orientation focuses on client resources, capabilities, knowledge, abilities, motivations, experience, intelligence, and other positive qualities that can be put to use to solve problems and pursue positive changes.

Assessment of human behavior establishes the basis for understanding people's problems and issues, and subsequently helping them improve their lives. Social workers address people's problems every day, but it's the identification of people's strengths that provides clues for how to solve their problems and improve their life situations. Saleebey (2013, pp. 17-20) cites at least four principles involved in the strengths perspective:

1. **Every individual, group, family, and community has strengths.** The case example in the next section concerning the Fernandez family will illustrate this idea.

2. **Trauma and abuse, illness and struggle may be injurious, but they may also be sources of challenge and opportunity.** Have you ever experienced a serious problem or disappointment that turned out to have opened other, perhaps better, opportunities for you? Days after my 16th birthday, I was in a car accident in which my face was crushed. (It happened at about midnight on Friday the 13th, amazingly enough.) My injuries were painful and required four years of plastic surgery. This experience taught me the value and superficiality of exterior beauty, gave me a much more realistic approach to viewing and understanding people, and made me tougher.

   Another trauma occurred when I applied for a second master's degree after receiving my MSW, and was turned down. I was devastated. However, the experience forced me to get out of school and into social work practice, which turned out to be by far the more gratifying and constructive choice.

3. **Assume that you do not know the upper limits of the capacity to grow and change, and take individual, group, and community aspirations seriously.** You don't have a crystal ball telling you what opportunities and choices will confront you in your life. So many students come to me worrying about their choice of major or what will happen after they graduate. It's important to appreciate the strengths you have and to grasp opportunities as they occur. You don't yet know what chances will present themselves to you or where your career will take you.

4. **Every environment is full of resources.** Resources can provide great strengths. One of social workers' major roles is to link clients with the resources they need to empower them to improve their lives.

**Multiple Sources of Strengths: A Case Example**

As mentioned, empowerment through focusing on strengths can occur on the individual, family, group, organizational, and community levels (Saleebey, 2013). For instance, consider the following case situation of a family coming to the attention of a social service agency (Haulotte & Kretzschmar, 2001, pp. 30-31). This provides an example of how a strengths perspective is helpful in assessment:

The Fernandez family consists of Carmen, the 35-year-old wife and mother; Juan, the 36-year-old husband and father; and their two daughters, Oralia, 13, and Mari, 14. The family had immigrated to the United States seven years ago from Mexico. Both Carmen and Juan had finished primary school, which is equivalent to attaining a sixth-grade education. In this country, they had been taking English lessons and were becoming quite fluent. Oralia and Mari both attended the same school and were doing reasonably well. When Juan and Carmen immigrated here, they had high hopes of attaining a better life for themselves and their daughters.

Three months ago, U.S. Citizenship and Immigration Service officers found Juan doing construction work at a site near the Fernandez apartment. After determining that his papers were not in order, the officers then deported Juan to Mexico. Although the family has always experienced financial problems, these problems got much worse when Juan had to leave. Carmen is finding it very difficult making ends meet without her husband being with her. Juan did get a low-paying,
part-time job in a Mexican border town. He is sending his family some money, but not much. He also must support himself and is trying to save money to return to the United States. Carmen works as a checker in a grocery store and just got a second part-time job as a janitor. She thus works from 6:30 a.m. until 11:00 p.m. on most days. Fortunately, bus transportation to and from work is readily available.

The current crisis is that right after Carmen got home last night, a police officer arrived at her door with Oralia. He had found her alone in a nearby park, which violated the local curfew. Apparently, Oralia and Mari had been arguing intensively about something when Oralia stomped off. (Now neither of them can remember what the argument was about.) Carmen told the officer that she was sick to death of listening to the girls’ continuous squabbling. She threw up her hands and said she didn’t know what to do. Carmen had to work long hours to keep the family afloat. She was forced to expect the girls to take care of themselves when she was gone.

The Fernandez family has no relatives in town, although they do have friends in the neighborhood. Juan and Carmen had attended services at a local Pentecostal church, but had not made the final decision to become members. At one point the couple met with the church’s pastor, who suggested that counseling for the girls might help the family. He had referred them to a local social service agency that provides a range of services to immigrants including counseling, legal advice, and help in finding employment. Carmen emphasized, however, that she wanted no one to ask questions about the family’s immigration status.

Carmen finally decides to seek outside help. She is experiencing horrible headaches from all of the stress. She is considering going to see a neighborhood curandera (a traditional unlicensed healer who typically uses herbal remedies and traditional cultural healing practices). Carmen is already taking manzanilla (chamomile, an ingredient found in herbal teas that is thought to calm anxiety in addition to easing stomach aches and intestinal cramping). She also plans to contact the social services agency that provides help to immigrants.

Problems in this case are fairly obvious. They include fighting between Carmen and the girls, financial difficulties, immigration status, Juan’s absence, and Carmen’s headaches. However, focusing on the Fernandezes’ strengths can provide clues about how to deal with the issues.

**Individual strengths** include the facts that both Juan and Carmen have completed middle school and are literate; both had been attending English classes; both have jobs (this is also a family strength as it directly affects the family’s well-being); both Oralia and Mari are doing fairly well in school; and Carmen is motivated to seek family counseling.

**Family strengths** include strong family bonds, mutual concern among family members for each other’s welfare, and the parents’ pride in their daughters and high hopes for their futures.

**Group strengths** include any support and help family members can get from friends and others at work, school, and church, and in the neighborhood. **Organizational strengths** include the fact that the family plans to become involved with the agency serving immigrants, is willing to get counseling, and can use this agency as a resource to help Juan return to the United States. Another organizational strength is that family members can be involved with a church if they choose to do so.

**Community strengths** include having a social services agency, a church, public bus transportation, and access to a curandera to provide alternative health care. (Note the importance of appreciating cultural differences when focusing on natural support networks such as the curandera. A natural support network or helping network is a group of people—including family, friends, neighbors, work colleagues, and fellow members in organizations such as churches and other community groups—who informally provide help and support.) Communities and their significance are covered in greater depth later in this chapter. Can you see any other strengths in the Fernandez example that have been missed?

Consider also that sometimes a strength may overlap two or more categories. For example, spiritual involvement with a church may reflect individual, family, group, organizational, and community strengths. How the strength is labeled is not important. The essential thing is to consider all potential categories of strength when trying to understand human behavior.

**Individual Strengths**

Individual strengths can include educational background, work history, problem-solving and
decision-making skills, personal qualities and characteristics, physical and financial resources, and positive attitudes (Jones & Biesecker, 1980; Kirst-Ashman & Hull, 2012b). This text will explore many aspects of empowerment with individuals. Examples include infertility counseling (Chapter 2); appreciation of ethnic and cultural strengths in families (Chapter 4); culturally competent practice (Chapter 5); sex education for Native Americans (Chapter 6); spiritual development (Chapter 7); women and sexual equality (Chapter 9); persons living with AIDS (Chapter 10); promoting optimal well-being for LGBT people (Chapter 13); and theories of successful aging (Chapter 15).

Understanding yourself enhances your ability to understand others. Other people deal with many of the same feelings, issues, and problems that you do. Recognizing strengths in yourself is just as important as recognizing them in others. How would you answer the questions about your personal strengths posed in Highlight 1.5?

Empowerment Through Groups

An example of using strengths to pursue empowerment for people from a group perspective involves the use of support groups. These are made up of people with similar problems or issues who come together and provide each other with support, information about how to cope with difficulties, and suggestions for resources (Toseland & Rivas, 2012). Such groups emphasize the identification and use of strengths. Examples given by Toseland and Rivas include the following:

- "A group of children meeting at school to discuss the effects of divorce on their lives.
- A group of people diagnosed with cancer, and their families, discussing the effects of the disease and how to cope with it.
- A group of recently discharged psychiatric patients discussing their adjustment to community living."
Assessing Your Strengths

How would you answer the following questions in assessing your own array of strengths?

**Individual Strengths**
- What are your best qualities?
- What are you most proud of about yourself?
- What skills do you have (e.g., educational, work, leadership, communication, social, technological)?

**Family Strengths**
- To what extent do you receive support from your family of origin, current family, or significant other?
- In what ways do you rely on family members for help?
- What are the best characteristics about your family?

**Group Strengths**
- How do your friends, neighbors, colleagues at work, or fellow students help and support you?
- Do you belong to any social, recreational, or counseling groups?
- If so, how does each serve to meet your needs, provide support, or offer opportunities for self-fulfillment, new experiences, or pleasure?

**Organizational Strengths**
- Do you currently belong to any organizations, or have you in the past?
- If so, what benefits and support do or did you receive?
- Do you receive any special advising, support, or financial help from school? If so, in what form?
- If you're working, what are the strengths in your work environment?

**Community Strengths**
- What services and resources are available to you in your community?
- What do you like best about your community?
- What cultural opportunities are available in your community that you appreciate?
- What other strengths do you have that you can draw upon as you interact with others in your environment? Who and/or what helps you pursue your plans and dreams? Who and/or what helps you get through each day and, hopefully, make the most of it?

- A group of single parents sharing the difficulties of raising children alone.” (p. 20)

Chapter 8 elaborates more fully on empowerment through social work with groups.

**Organizational and Community Empowerment**

Kretzmann and McKnight (1993) suggest a strengths perspective for enhancing communities and empowering community residents. They stress using potential community assets, including the following: citizens' “religious, cultural, athletic, [and] recreational” associations; “private businesses; public institutions such as schools, libraries, parks, police and fire stations; [and] nonprofit institutions such as hospitals and social service agencies” to improve a community's functioning and quality of life (pp. 6–8).

McKnight and Block (2010) refer to “the abundant community” that is full of potential and strength (p. 65). They describe communities as unique entities, each having special characteristics and strong points, noting that “[a] competent community takes advantage of its abundance” (p. 65). Its residents strive to identify the community’s positive attributes and use them in creative ways to improve the quality of life.

The following are examples of using the strengths of an abundant community (Kretzmann & McKnight, 1993):
- “About 60 youth leaders are trained to teach a youth empowerment curriculum to 700 younger kids. The curriculum, which develops self-esteem through a variety of nontraditional classes, offers youth alternatives to crime, gangs, and drugs. The project is sponsored jointly by a community college and the neighborhood police precinct.” (p. 37)
- “Seniors organize and convince the Department of Aging to open an alternative nutrition site after two have already been closed down.” (p. 56)
- “A group of homeless women with children are working together to create a housing cooperative in which they will provide care for each other’s
children and also share in community meal preparation several days a week. Their combined effort means that they will be involved in every aspect of planning, purchasing, remodeling, and maintaining their new home.” (p. 89)

- “A group of recently graduated college students created an association that collected information from the people in their neighborhood who were willing to teach others what they knew, either for pay or for free. The group identified thousands of things local people could teach, from how to play a guitar to the works of Aristotle. This ‘library’ of community knowledge became a major new resource for local learning, discussion, and recreation.” (p. 136)

- “A coalition of local churches provides sanctuary for refugees from Central America.” (p. 149)

**Resiliency: Using Strengths to Fight Adversity**

A concept related to the strengths perspective and empowerment is resiliency. Resiliency is the ability of an individual, family, group, community, or organization to recover from adversity and resume functioning even when suffering serious trouble, confusion, or hardship. Whereas the “strengths perspective focuses on capabilities, assets, and positive attributes rather than problems and pathologies,” resiliency emphasizes the use of strengths to cope with adversity and survive, despite difficulties (Greene & Conrad, 2012; Gutheil & Congress, 2000, p. 41).

The following scenarios provide an illustration of the concept of resiliency:

*When a pitched baseball hits a window, the glass usually shatters. When that same ball meets a baseball bat, the bat is rarely damaged. When a hammer strikes a ceramic vase, it too usually shatters. But when that same hammer hits a rubber automobile tire, the tire quickly returns to its original shape. The baseball bat and the automobile tire both demonstrate resiliency.* (Norman, 2000, p. 3)

Resiliency involves two dimensions: risk and protection (Greene & Conrad, 2012; Norman, 2000). In this context, risk involves “stressful life events or adverse environmental conditions that increase the vulnerability [defenselessness or helplessness] of individuals” or other systems (p. 3). Protection, on the other hand, concerns those factors that “buffer, moderate, and protect against those vulnerabilities” (Norman, 2000, p. 3).

On the individual level, an example of a resilient child is one who, despite being shunted from one foster home to another during childhood, still completes high school, enters college, and later begins a healthy family of her own. Regardless of the risks to which she’s been exposed, she uses her strengths to protect and struggle through her adversity. Such strengths might include positive self-esteem and self-worth, good problem-solving ability to address the difficulties confronting her, a positive sense of direction, the ability to empathize with others’ situations, the use of humor, high expectations for personal performance, and the ability to distance herself from the dysfunctional people and negative events around her (Norman, 2000). A key to fostering resiliency is the identification and use of clients’ strengths to overcome problems.

Examples of resiliency on the individual level can also include older adults (Lewis & Harrell, 2012). For example, 79-year-old Steven R. has been lovingly caring for his 80-year-old wife in their home since she was diagnosed with Alzheimer’s disease 2 years ago. 68-year-old Juan T., having vowed to rebuild his business after it burned to the ground, reopened to great fanfare. 73-year-old Eudora B. has been raising her two teenage grandchildren since their mother died. 87-year-old Rose N. continues to write and publish short stories despite her recent stroke which left her wheelchair-bound and nearly totally blind. (Gutheil & Congress, 2000, p. 41)

An example of resiliency at the organizational level is a public university experiencing budget cuts of several million dollars. That university can be resilient to the extent that it responds to the risk of loss, protects its most important functions, makes plans to adapt to the shortfall of resources, and continues providing students with a quality education. Resiliency in this case involves focusing on its strengths to maintain basic functioning.

Resiliency in a community is illustrated by a group of urban neighborhoods that address increasing crime and drug use, problems that put the community at risk of disorganization and destruction. Community strengths include availability of organizations that provide resources, residents’ expectations for appropriate and positive behavior, and opportunities for “neighborhood youths to constructively participate in the community” (Greene & Livingston, 2002, p. 78). A resilient community
might use its concerned citizens to form neighborhood organizations that oversee community conditions and upkeep, work with public services to improve conditions, and advocate for increased resources (Homan, 2011). Neighborhood Watch programs may be formed in which residents volunteer to keep an eye on each other’s premises to prevent and combat crime. Community residents might work with local police and schools to establish drug education and prevention programs for young people. They might also advocate for more police to increase the surveillance and apprehension of drug dealers. A resilient community uses its strengths to address the risks threatening it and to protect its residents.

**Critical Thinking About Ethical Issues**

Another important dimension necessary for understanding human behavior and social work practice involves critical thinking about ethical issues. Values and ethics serve as a major foundation of the social work knowledge base. **Values** are perceptions and opinions held by individuals, professions, and cultures about “what is good and desirable” (Dolgoff, Harrington, & Loewenberg, 2012, p. 25). For example, our culture values education and offers it to everyone. Similarly, you value college or you wouldn’t be here. **Ethics** are principles based on values that guide behavior and determine “what is right and correct” (Dolgoff et al., 2012, p. 25). Values are concerned with ideas, while ethics have to do with the appropriate behavior based on those ideas.

Social workers must be vigilant concerning their adherence to professional values. The National Association of Social Workers (NASW, 2008) has a professional **code of ethics** that specifies the following six basic ethical principles to guide practitioners’ behavior (access the entire Code at http://www.socialworkers.org/pubs/code/code.asp):

1. “Social workers’ primary goal is to help people in need and to address social problems.”
2. “Social workers challenge social injustice.”
3. “Social workers respect the inherent dignity and worth of the person.”
4. “Social workers recognize the centered importance of human relationships.”
5. “Social workers behave in a trustworthy manner.”
6. “Social workers practice within their areas of competence and develop and enhance their professional expertise.”

Although the NASW Code of Ethics is the code followed by social workers in the United States, note that other ethical codes also are available (CSWE, 2008). Consider, for example, the Canadian Association of Social Workers (CASW) code of ethics, available at http://www.casw-acts.ca/sites/default/files/attachements/CASW_Code%20of%20Ethics_0.pdf. Highlight 1.6 addresses the ethical responsibilities of social workers at the international and global levels and discusses an international social work code of ethics.

Throughout a social work career, professionals must face and address **ethical dilemmas**, situations in which ethical principles conflict and all solutions are imperfect. For example, a 16-year-old client tells her social worker that she hates her stepfather and plans to poison him. The social worker is supposed to maintain **confidentiality** (being trustworthy and keeping information in confidence). However, this is a situation where a person’s life may be in danger, which must take precedence over confidentiality. In this case, the worker decides to break confidentiality in order to preserve the stepfather’s life.

Consider another example of an ethical dilemma:

A client told the [social work] field student intern that she was pregnant and was planning to marry the father of the baby. The student also was working with this client’s mother, who had told the student about her own sexual relationship with the same man that her daughter was going to marry. The mother did not want to tell her daughter that she was having a sexual relationship with her daughter’s boyfriend. (Abels, 2001, p. 9)

What should the student intern do? Tell the mother about her mother’s relationship with her boyfriend? Or maintain confidentiality, remaining silent and letting the family work it out for themselves?

The social work student decided to “ask the mother to consider telling the daughter about her relationship, and to ask the boyfriend to do the same. Neither agreed. Because the daughter was 18, the agency could not identify a legal violation of sex with minors” (Abels, 2001, p. 9). The student social worker had tried her best. Maybe things would work out over time. Eventually, “the mother told her boyfriend that she was no longer going to see him” (p. 9).

As this story illustrates, social workers are bound to run into problems with no perfectly satisfactory solution. When this occurs, they must use critical thinking
Social workers should attend to and advocate for the basic rights of all people. National Association of Social Workers (NASW) policy states that social workers must be prepared "to advocate for the rights of vulnerable people and must condemn policies, practices, and attitudes of bigotry, intolerance, and hate that put any person's human rights in grave jeopardy. The violation of human rights on the basis of race, ethnicity, gender, gender identity or expression, sexual orientation, age, disability, immigration status, or religion are examples" (NASW, 2012, p. 206). Human rights involve the premise that all people, regardless of race, culture, or national origin, are entitled to basic rights and treatment. Such essential entitlements include those "basic civil rights recognized in democratic constitutions such as life, liberty, and personal security" (Barker, 2003, p. 203). They also include "people's rights to have paid employment, adequate food, education, shelter, health care, as well as the right to freedom from violence and freedom to pursue their dreams" (NASW, 2012, p. 204). Human rights are based on the concept of social justice, the idea that in a perfect world all citizens would have identical "rights, protection, opportunities, obligations, and social benefits" (Barker, 2003, p. 405).

Human rights and social justice are global issues. NASW (2012) reports the following:

Human rights violations are prevalent throughout the world, including the United States. Civilians are injured, maimed, and killed in times of conflict, far outnumbering military personnel. Refugees and immigrants are fleeing their countries in record numbers. Women everywhere continue to be treated as second-class citizens and subjected to violence in epidemic proportions. The social situation of children and older adults . . . alike is of grave concern the world over and appears to be deteriorating. There has been a resurgence of violence and oppression against ethnic and racial minority groups, and against lesbian, gay, bisexual, and transgender people in many regions of our globe, and poverty is endemic, fueling the fires of unrest and making a sham of the very concept of human rights. (p. 205)

When addressing ethical issues on an international (involving two or more nations) or global (involving the entire world) level, social workers may consult an international social work code of ethics. Two important international organizations that have developed an Ethics in Social Work, Statement of Principles are the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW). IFSW "is a global organisation striving for social justice, human rights and social development through the promotion of social work, best practice models and the facilitation of international cooperation" (IFSW, 2013b). IASSW "promotes the development of social work education throughout the world, develops standards to enhance quality of social work education, encourages international exchange, provides forums for sharing social work research and scholarship, and promotes human rights and social development through policy and advocacy activities" (IASSW, 2013). Both organizations actively engage social workers around the globe.

The Ethics in Social Work, Statement of Principles, concurrently supported by both organizations, consists of the following five parts:

1. Preface
2. Definition of social work
3. International conventions (various organizations' statements of human rights)
4. Principles
5. Professional conduct (IASSW, 2004; IFSW, 2013a)

The "principles" in the Ethics in Social Work, Statement of Principles include "human rights and human dignity" and "social justice." The former indicates that "social work is based on respect for the inherent worth and dignity of all people, and the rights that follow from this. Social Workers should uphold and defend each person's physical, psychological, emotional and spiritual integrity and well-being." The latter suggests that "Social workers have a responsibility to promote social justice; in relation to society generally, and in relation to the people with whom they work"; this involves "challenging negative discrimination," "recognizing diversity," "distributing resources equitably," "challenging unjust policies and practices," and "working in solidarity" (i.e., social workers have the responsibility to confront social injustice).

Information about IFSW is available at http://www.ifsw.org/ and about IASSW at http://www.iassw-aiets.org/.

to determine the best course of action. **Critical thinking** is "the careful examination and evaluation of beliefs and actions" to establish an independent decision about what is true and what is not (Gambrill & Gibbs, 2009, p. 4). Gibbs and Gambrill (1999) explain:

Critical thinkers question what others take for granted. They may ask people to support assumptions that others believe to be self-evident, but which are far from being self-evident. They ask, "What's the evidence for—?" Critical thinking encourages open
dialogue and the consideration of opposing views. It involves taking responsibility for claims made and arguments presented. It requires flexibility and a readiness to admit, even welcome, the discovery of mistakes in your thinking. Critical thinking is independent thinking—thinking for yourself. Critical thinkers question values and positions that may be common in a society, in a group, or in their own family. (p. 13)

Just because someone else says something is true doesn’t mean it is. Just because you read something in a book or a newspaper doesn’t mean it’s accurate. Just because it’s documented as a law doesn’t mean it’s right and just. Critical thinking means not taking things at face value but rather making a determination about their accuracy yourself.

Ethical decision making involves critical thinking. Social workers must assess potential problems and make a decision regarding what is the most ethical thing to do in a given situation. This book’s purpose is not to teach you how to do social work; rather, its purpose is to encourage you to begin to think critically about ethical issues. Ethical questions are incorporated throughout to encourage you to use critical thinking to determine your own answers and opinions.

For example, consider the story of the wild boy of Aveyron that introduced this chapter. The ethical questions posed there were: 1) Was it ethical for Itard and the others to remove Victor from the wild against his will? 2) Did they have the right to take his freedom from him and place him in captivity where he never learned to function independently? 3) Does it matter that he was only 12 or 13 instead of being an adult? What do you critically think about these issues? Questions ripe for critical thinking are endless:

- Should the life-preserving feeding tube be removed from a person who is brain-dead and will never regain consciousness?
- Should existing limited public funding be used to finance the military abroad, save Social Security, or provide scholarships and no-interest loans to finance higher education?
- Should prayer be allowed in public schools?

Highlight 1.7 explores further the application of values and ethics to bio-psycho-social assessments.

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**HIGHLIGHT 1.7**

**Application of Values and Ethics to Bio-Psycho-Social Assessments**

Social workers assess problems and attempt to understand human behavior within the context of social work values and ethics. The National Association of Social Workers (NASW) Code of Ethics (2008) focuses on six areas involving how a worker should behave in a professional role. These include ethical responsibilities (1) to clients, (2) to colleagues, (3) in practice settings, (4) as professionals, (5) to the social work profession, and (6) to the broader society.

Social workers should always keep in mind their clients’ rights and well-being. We have established that to the best of their ability, social workers should strive to abide by professional ethical principles, respect the rights and needs of others, and make decisions about right and wrong consistent with their professional ethics. This sounds simple.

But consider the following scenarios, all occurring within the context of social work assessment.

**Scenario 1:** You are a social worker at a shelter for runaways, assessing an unmarried, pregnant 15-year-old who has been living on the streets. She is in her seventh month of pregnancy. She is addicted to cocaine, which she has been using throughout the pregnancy (prenatal influences will be discussed in Chapter 2). She has been informed of the potential side effects of her cocaine use on the fetus, which are likely to result in an infant who will require more attention than that given to infants born to nonaddicted mothers. She adamantly states that she will keep the baby and figure out what to do about her addiction after it’s born. You have serious concerns for the infant’s well-being. You personally feel that the young woman should place the baby for adoption or at least in foster care until she can solve her own problems. What is the ethical thing to do?

**Scenario 2:** You are a hospital social worker assessing a client with AIDS (AIDS is covered in Chapter 10). He tells you that he has had unprotected intercourse with dozens of women since he received his positive HIV diagnosis. He has shared his diagnosis with none of these women. He boldly states that he is incredibly angry that he has the disease and plans to continue having intercourse with as many women as he can. You believe that it is both unethical and hazardous to his sex partners for him not to tell them about their potential exposure

(continued)
to the disease. Clients are supposed to be able to make choices about their own behavior. You are supposed to keep the interactions between you and your client confidential. But what about the unsuspecting victims of your client's choices? What is the ethical thing to do?

**Scenario 3: You are an Adult Protective Services social worker. Your job is to make assessments and pursue interventions to make certain that vulnerable older adults with limited ability to take care of their basic needs get the help and resources they require. You are assessing an older woman in her own home. Her physical and intellectual health are deteriorating. The woman lives alone in a rundown apartment in a poor section of town. She has no close family. She insists that she wants to remain in her home. Your agency supervisor has told you that older adults deemed unable to take care of themselves must be placed in a nursing home facility. However, you also know that the only nursing home facilities available to poor older people in the area are rundown and understaffed, and offer a minimal quality of life. Ethically, your client has the right to make her own decisions. However, you fear that she may fall and remain helpless, turn the gas stove on and forget to light the flame, or have some other accident. What is the ethical thing to do?**

Each of these situations portrays an ethical dilemma. Dilemmas involve problematic situations for which possible solutions are imperfect and unsatisfactory. Many such dilemmas are encountered in social work practice.

Three basic suggestions can guide your critical thinking process. They are made within the context of assessing human behavior in order to lay the groundwork for determining what intervention to pursue.

1. Put your theoretical and factual knowledge base about human behavior to work. (This text intends to provide you with such a base.)
2. Identify your own values concerning the issues and then distinguish between your values and professional ethics.
3. Weigh the pros and cons of each alternative available to you and your client, and then proceed with the alternative you determine is the most positive.

There are no perfect answers. Following is an example of how these suggestions might be applied to scenario 1.

In scenario 1 (the pregnant, unmarried, 15-year-old cocaine addict), first gather the knowledge you need. You need to know the effects of cocaine on prenatal development (described in Chapter 2), the dynamics of drug addiction (discussed in Chapter 11), and the needs of newborn infants in general (addressed in Chapters 2, 3, and 4). Such information can give you clues regarding what types of information you need to know in order to plan interventions.

The second step is to recognize clearly your own personal values and biases. You should not impose your values on your client. Strive to make decisions that coincide as much as possible with professional ethics.

Finally, as depicted earlier in Figure 1.1, identify the alternatives available to you, weigh the pros and cons of each, and make the decision you consider to be the most ethical. Knowledge of human behavior in the areas cited above can lead you to the questions you need to ask in order to make an effective, ethical decision along with your client. Questions in scenario 1 might include the following:

- What are the client's drug-using behaviors?
- What are the potential effects on the child?
- How motivated is the client to enter a drug treatment program?
- What resources for drug treatment and other supportive services for unmarried teen mothers are available?
- If not available, can needed services be initiated and developed?
- What resources can you turn to in order to maximize the child's well-being?

You can address the dilemmas posed in scenarios 2 and 3 in a similar manner. What theoretical and factual knowledge do you have about human behavior that can be applied to your understanding of the situation? What personal values and biases do you hold concerning the client and the client's situation? What alternatives are available to you and your client? What are the pros and cons of each? Answers to these questions will guide you to the alternative that is the most ethical to pursue.

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**Empowering Conceptual Frameworks for Understanding Human Behavior and the Social Environment: A Person-in-Environment Perspective**

We have established that this book uses the organizing framework of a lifespan approach for studying human development and behavior. We've also emphasized important concepts that will be stressed throughout the book (including human diversity, cultural competency, oppression, populations-at-risk, empowerment, the strengths perspective, resiliency, and critical thinking about ethical issues). Subsequent sections will examine the book's theoretical orientation based on ecosystems theory.

A **theory** is a coherent group of principles, concepts, and ideas organized to explain some observable occurrence or trend. Theories provide conceptual frameworks
for how to view the world. They direct your attention and indicate on what aspects of a situation you should focus when trying to understand why people behave the way they do. (Note that the terms theory, theoretical perspective, and conceptual framework are often used interchangeably.) In this book, ecosystems theory incorporates concepts from both systems theories and the ecological perspective, which focuses on the environment. One definition of ecosystems theory is “systems theory used to describe and analyze people and other living systems and their transactions” (Beckett & Johnson, 1995, p. 1391). Ecosystems theory fits well with the concept known as person-in-environment, a foundation notion in social work practice and our basis for understanding the dynamics of human behavior (Greene, 1999; Sheafor & Horejsi, 2012). As Kirst-Ashman and Hull (2012b) explain,

A person-in-environment focus sees people as constantly interacting with various systems around them. These systems include the family, friends, work, social services, politics, religion, goods and services, and educational systems. The person is portrayed as being dynamically involved with each. Social work practice then is directed at improving the interactions between the person and the various systems. This focus is referred to as improving person-in-environment fit. (p. 12)

Greene (1999, p. 17) describes the importance of the person-in-environment concept as an underlying principle of social work practice:

The person-in-environment perspective has been a central influence on the profession's theoretical base and its approach to practice. This perspective is based on the belief that the profession's basic mission requires a dual focus on the person and the environment and a common structured approach to the helping process (Gordon, 1962). By serving as a blueprint or an organizing guide for social work assessment and intervention at a multiple systems level, the person-[in-] environment focus has allowed for social workers to intervene effectively "no matter what their different theoretical orientations and specializations and regardless of where or with what client group they practice" (Meyer, 1987, p. 409). In short, the person-[in-] environment perspective has established social work's conceptual reference point and has delineated the practitioner's role. (Greene & Watkins, 1998)

Highlight 1.8 discusses social workers' goals as they work with people in the context of their environment.

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**Goals of Social Work Practice**

The National Association of Social Workers (1982) has conceptualized social work practice as having the following four major goals, followed by a fifth goal posed by the Council on Social Work Education (2015).

**Goal 1: “Enhance People’s Problem-Solving, Coping, and Developmental Capacities”**

Social work emphasizes the person-in-environment conceptualization. This conceptualization views every person as interacting with a number of systems. Such systems include (but are not limited to) the political system; the educational system; the family system; the religious system; the employment system; the social service system; and the goods and services system. A depiction of this person-in-environment conceptualization is presented in Figure 1.3.

Using the person-in-environment concept, social work practice at this level focuses on the “person.” With this focus, a social worker serves primarily as an enabler. In this role, the worker may take on the activities of a counselor, teacher, caregiver (providing supportive services to those who cannot fully solve their problems and meet their own needs), and behavior changer (i.e., changing specific parts of a client’s behavior).

(continued)
Goal 2: “Link People with Systems That Provide Them with Resources, Services, and Opportunities”
Using the person-in-environment concept, the focus of social work practice at this level focuses on the relationships between individuals and the systems they interact with. In this situation, a social worker serves primarily as a broker.

Goal 3: “Promote the Effective and Humane Operation of Systems That Provide People with Resources and Services”
Using the person-in-environment concept, the focus of social work practice at this level is on the systems people interact with. One role a worker may fill at this level is an advocate. Additional roles include the following:

Program developer: The worker seeks to promote or design programs or technologies to meet social needs.
Supervisor: The worker seeks to increase the effectiveness and efficiency of the delivery of services through supervising other staff.
Coordinator: The worker seeks to improve a delivery system by increasing communications and coordination between human service resources.
Consultant: The worker seeks to provide guidance to agencies and organizations by suggesting ways to increase the effectiveness and efficiency of services.

(Social work roles that practitioners may assume as they work with larger systems are discussed more thoroughly later in the chapter.)

Goal 4: “Develop and Improve Social Policy”
Similar to goal 3, social work practice at this level focuses on the systems people interact with. The distinction between goal 3 and goal 4 is that the focus of goal 3 is on the available resources for serving people. Goal 4 works on the statutes and broader social policies that underlie such resources. The major roles at this level are planner and policy developer. In these roles, workers develop and seek adoption of new statutes or policies and propose elimination of ineffective or inappropriate ones. In these planning and policy development processes, social workers may take on an advocate role and, in some instances an activist role.

The Council on Social Work Education (CSWE) is the national accrediting body for social work education in the United States. It describes the purpose of social work as follows (CSWE, 2015):

“The purpose of the social work profession is to promote human and community well-being. Guided by a person and environment construct, a global perspective, respect for human diversity, and knowledge based on scientific inquiry, social work’s purpose is actualized through its quest for social and economic justice, the prevention of conditions that limit human rights, the elimination of poverty, and the enhancement of the quality of life for all persons locally and globally.”

This definition of the purpose of social work is consistent with the four goals of social work just mentioned. However, it adds one additional goal of social work, as follows.

Additional Goal 5: “Promote Human and Community Well-Being”
The social work profession is committed to enhancing the well-being of all human beings and to promoting community well-being. It is particularly committed to alleviating poverty, oppression, and other forms of social injustice. Social work has always advocated for developing programs to alleviate poverty, and many practitioners focus on providing services to the poor.

In the following pages, we explain the various concepts involved in ecosystems theory. First, we define significant conceptions in systems theory. We then present a case example involving child abuse that demonstrates the application of these concepts in practice. Next, we discuss important concepts inherent in the ecological perspective that also contribute to ecosystems theory, stressing people’s involvement with multiple systems in the environment.

Note that multitudes of other theories may be applied to various aspects of human development and behavior. Such theories are explained throughout the book in one of two contexts—either a specific developmental phase of life or people’s interaction with the encompassing social environment. Highlight 1.9 provides a summary of these theories and the chapters in which they are addressed.
### A Summary of Some of the Other Theoretical Perspectives Addressed in This Book

The following are some of the conceptual frameworks and theoretical perspectives provided in this book. For ease of location, they are listed in alphabetical order. Some theories related to a specific topic are listed under that topic.

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Understanding Key Concepts in Systems Theories

A number of terms are important to an understanding of systems theories and their relationship to social work practice. These include system, boundaries, subsystem, homeostasis, role, relationship, input, output, feedback, interface, differentiation, entropy, negative entropy, and equifinality.

A system is a set of elements that are orderly and interrelated to make a functional whole. A large nation, a public social services department, and a newly married couple are all examples of systems. We will refer primarily to social systems—that is, those systems that are composed of people and affect people.

Boundaries are the borders or margins that separate one entity from another. For example, your skin provides a boundary between you as an independent, living system and the external environment. Similarly, a boundary encompasses the students enrolled in the class that's using this book. You're either part of the class or you're not.

A boundary may exist between parents and their children. Parents maintain family leadership and provide support and nurturance to their children. (Chapter 4 discusses more thoroughly the application of this and other systems concepts to family systems.)

A boundary may also exist between the protective service workers in a large county social service agency and those who work in financial assistance. These are orderly and interrelated groups set apart by specified boundaries in terms of their designated job responsibilities and the clients they serve, yet each group is part of the larger social services agency.

A subsystem is a secondary or subordinate system that is a component of a larger system. Obvious examples of subsystems are the parental and sibling subsystems within a family. The group of protective service workers in the large social services agency forms one subsystem and the financial assistance workers another. These subsystems are set apart by designated boundaries, yet still are part of the larger, total system.

Homeostasis is the tendency for a system to maintain a relatively stable, constant state of balance. If something disturbs the balance, the system will readjust itself and regain stability. A homeostatic family system is one that is functioning in such a way that it can continue to function and stay together. A homeostatic social services agency is one that works to maintain its ongoing existence. However, neither the family nor the agency is necessarily functioning as well or as effectively as possible. Homeostasis merely means maintaining the status quo.

Sometimes that status quo can be ineffective, inefficient, or seriously problematic.

A role is the culturally established social behavior and conduct expected of a person in any designated interpersonal relationship. Each individual involved in a system assumes a role within that system. For instance, a person in the role of social worker is expected to behave in certain "professional" ways as defined by the profession's code of ethics. Each of us probably fulfills numerous roles because we are involved in multiple systems. The social worker may also assume the roles of spouse and parent within his or her own family system. Additionally, that person may assume the role of executive director within the National Association of Social Workers state chapter, the role of Little League coach, and the role of Sunday school teacher.

A relationship is a reciprocal, dynamic, interpersonal connection characterized by patterns of emotional exchange, communication, and behavioral interaction. For example, a social worker may have a professional relationship with a client. They communicate and interact in order to meet the client's needs. Relationships may exist between systems of any size. A client may have a relationship with an agency; one agency may have a relationship with another agency.

Input involves the energy, information, or communication flow received from other systems. A parent may receive input from a child's grade school principal, noting that the child is doing poorly in physical education. A public agency may receive input from the state in the form of funding.

Output, on the other hand, is the response of a system, after receiving and processing input, that affects other systems in the environment. For instance, output for a social services agency for people who are substance abusers might be 150 hours of individual counseling, 40 hours of group counseling, 30 hours of family counseling, 10 hours of drug education at local schools, and 50 hours of liaison work with other agencies involved with clients. (Chapter 11 discusses substance abuse and its effects on family systems in greater detail.)

Note that the term output is qualitatively different from outcome, a term frequently used in social work education. Output is a more general term for the result of a process. Outcomes are specified variables that are measured for the purpose of evaluation.
For example, outcomes for the social services agency just mentioned might include clients’ decreased use of addictive substances, enhanced communication among family members receiving treatment, and decreased use of drugs and alcohol by students receiving drug education. Output is what is done, which may or may not have value. Outcomes measure positive effects of a system’s process.

An issue that this text will continue to address is the importance of evaluating whether a system’s outputs are worth the inputs. Is an agency, for example, achieving the outcomes it hopes to? Is the agency using its resources efficiently and effectively? Or can those resources be put to a better use by providing some other type of service (output)?

If clients receiving treatment from the substance abuse counseling agency described previously continue to abuse drugs and alcohol at the same rate, to what extent is the treatment effective? Since treatment is expensive, is the agency’s output worth its input? Is the agency achieving its outcomes? If the agency typically sees little progress at the end of treatment for clients, we have to question the agency’s usefulness. Should the agency’s treatment process be changed to achieve better outcomes? Or should the agency be shut down totally so that resources (input) can be better invested in some other agency or treatment system?

Feedback is a special form of input in which a system receives information about its own performance. As a result of negative feedback involving problematic functioning, the system can choose to correct any deviations or mistakes and return to a more homeostatic state. For example, a supervisor may tell a social work supervisee that he or she is filling out an important agency form incorrectly. This allows the worker the opportunity to correct his or her behavior and complete the form appropriately.

Positive feedback is also valuable. This involves a system’s receiving information about what it is doing correctly in order to maintain itself and thrive. Getting a 97 percent score on a history exam provides a sixth grader with the information that she has mastered most of the material. An agency that receives a specific federal grant has gotten the feedback that it has developed a plan worthy of such funding.

An interface is the point at which two systems (individuals, families, groups, organizations, or communities) come into contact with each other or communicate. For example, one interface is the written contract established between a field instructor in an adoptions agency and a student intern placed under his or her supervision. At the beginning of the semester, they discuss plans and goals for the semester. What tasks will the student be given, and what levels of performance are expected? With the help of the student’s field liaison (i.e., the student’s university professor), a written contract is established that clarifies these expectations. Contracts generally involve written, oral, or implied agreements between people concerning their goals, procedures, techniques, time frames, and reciprocal responsibilities during some time period in their relationship.

At his midterm evaluation, the student receives a grade of D. Although he is devastated, he still has half a semester to improve. Focusing on the interface between the field instructor and field intern (in this case, the contract they established at the beginning of the semester) provides direction concerning what to do about the problem of poor performance in his internship. By reviewing the terms specified in the contract, the instructor and student, with the liaison’s help, can elaborate upon problems and expectations. Where did the student go wrong? Which of the student’s expectations did the field instructor fail to fulfill? They can then establish a new contract concerning the student’s performance for the remainder of the semester.

It is still up to the student to “make or break” his field experience. However, the interface (contract) provides a clearly designated means of approaching the problem. Having the field instructor and field liaison vaguely tell the student that he needs “to improve his performance” would probably accomplish little. Rather, identifying and using the interface in the form of the student–instructor contract provides a specific means for attacking the problem. Interfaces are not limited to those between individual systems. Interfaces can characterize interactions among systems of virtually any size. For example, there is an interface between the adoptions agency providing the student placement and the university social work program that places the student intern. This interface involves the specified agreements concerning each of these two larger systems’ respective responsibilities and expectations.

Differentiation is a system’s tendency to move from a simpler to a more complex existence. Relationships, situations, and interactions tend to get more complex over time. For example, in the life
of any particular family, each day adds new experiences. New information is gathered, and new options are explored. The family’s life becomes more complex. And as a social services agency continues over time, it may develop more detailed policies and programs.

**Entropy** is the tendency of a system to progress toward disorganization, depletion, and death. Nothing lasts forever. People age and eventually die. Young families get older, and children leave to start their own families. As time passes, older agencies and systems are eventually replaced by new ones.

**Negative entropy** is the process of a system toward growth and development. In effect, it is the opposite of entropy. Individuals develop physically, intellectually, and emotionally as they grow. Social service agencies grow and develop new programs and clientele.

**Equifinality** refers to the fact that there are many different means to the same end. It is important not to get locked into only one way of thinking. In any situation, there are alternatives. Some may be better than others, but nonetheless there are alternatives. For instance, as a social worker you may get needed resources for a family from a variety of sources. These may include financial assistance, housing allowances, food stamps, grants, or private charities. You may have to choose among the alternatives available from a variety of agencies.

### Application of Systems Concepts to a Case Example of Child Abuse

The following case example concerning the Knoche family involves potential child abuse. The discussion applies various systems concepts (italicized) to the assessment and beginning treatment of the family. Note that child abuse is just one of a wide range of practice situations in which systems concepts can be applied to help understand the dynamics involved. Other issues that you may encounter include unwanted pregnancy, drug and alcohol abuse, potential suicide, severe illness, poverty, intellectual disability (formerly referred to as mental retardation), intimate partner violence, racial discrimination, and grief over illness or death.

**The Presenting Problem**

As she was baking Christmas cookies, Mrs. Green overheard Mr. Knoche in the next apartment screaming at his son, Jimmy. Mrs. Green became very disturbed. Jimmy, who was only 6, was crying. Next, Mrs. Green heard sharp cracks that sounded like a whip or a belt. This was not the first time; however, she hated to interfere in her neighbor’s business. She recalled that last summer she had noticed strange-looking bruises on Jimmy’s arms and legs, as well as on those of his 4-year-old sister, Sherry. She just couldn’t stand it anymore. She finally picked up the phone and reported what she knew to the public social services department. She asked that the Knoch’s not be told who had called to report the situation. She was assured that the report would remain confidential. State law protects persons who report suspected child abuse or neglect by ensuring their anonymity if they wish.

**The Investigation**

Ms. Samantha Chin was the Protective Services worker assigned to the case. She visited the Knoche home the day after Mrs. Green made the report. Both Mr. and Mrs. Knoche were home. Ms. Chin explained to them that she had come to investigate potential child abuse.

She then proceeded to assess the functioning of the family system. Mr. and Mrs. Knoche formed a parental subsystem within that system. Ms. Chin solicited input from that subsystem.

Harry Knoche was 38 years old. He was a tall, slightly overweight, balding man dressed in an old blue shirt and coveralls. He spoke in a gruff voice, but expressed a strong desire to cooperate. He also had a faint odor of beer on his breath.

Marion Knoche was a pale, thin, soft-spoken woman of 32. Mrs. Knoche looked directly at the worker, shook her head in a determined manner, and stated that she was eager to cooperate. However, she often deferred to Mr. Knoche when spoken to or asked a question.

Ms. Chin asked to examine the children. Together, the children formed a sibling subsystem within the larger family system. She found slash-like bruises on their arms and legs. When Mr. Knoche was asked how the children got these bruises, he replied that they continually made noise when he was trying to watch the football game on television or sleep. He stated they had to learn discipline in order to survive in life. He just strapped them a little now and then to teach them a lesson. It was no different from his treatment at the hands of his own father. He also stated that his neighbors could just keep their noses out of the way he wanted to raise his kids. This comment reflected how
the family itself was a subsystem of the larger community system and did not escape Ms. Chin's notice.

Ms. Chin replied that the state's intent was to protect the children from abuse or neglect. The interface between the state and the family was Ms. Chin's contact. She explained that citizens were encouraged to make a report even if abuse or neglect was only suspected. Ms. Chin added that the anonymity of people who made reports was protected by state law.

When asked how she felt about discipline, Mrs. Knoche said she agreed with her husband regarding how he chose to punish the children. Mr. Knoche was the main disciplinarian, and Mrs. Knoche felt all he was doing was teaching the children a lesson or two in order to maintain control and respect.

**The Children**

Jimmy was an exceptionally nonresponsive child of relatively small stature for his age. When he was asked a question, he tended to avoid eye contact and mumbled only one-word answers. When his father asked him to enter or leave the room, he did so immediately and quietly. His mother mentioned that he was having some problems with reading in school.

Sherry, on the other hand, was an extremely eager and aggressive child. When asked to do something, she initially ignored the request and continued her own activities. She refused to comply until her parent raised his or her voice. At that point she would look up and very slowly do what she was told, often requiring several proddings. At other times, Sherry would aggressively pull at her parents' clothing, trying to get their attention. She would also scream at them loudly and ask for things such as food, even though this interrupted their ongoing conversation.

**Parental History and Current Status**

In order to do an accurate assessment, Ms. Chin asked the Knoches various questions about themselves, their histories, and their relationship with each other. Mr. Knoche came from a family of 10. His father drank a lot and frequently used a belt to discipline his children. He remembered being very poor and having to work most of his life. At age 16, he dropped out of high school because he was able to get a job in a steel mill.

Mrs. Knoche came from a broken family; her father had left when she was three. This reflected a state of entropy or disorganization. She had two older brothers who, she felt, often teased and tormented her. She described her mother as being a quiet, disinterested woman who rarely stated her own opinions and liked to keep to herself. The family had always been on welfare. Mrs. Knoche dropped out of high school to marry Mr. Knoche when she was 17. At that time, Mr. Knoche was 23 and had already held six different jobs since he started working at the steel mill seven years before.

The Knoches' marriage had not been an easy one. It was marked by poverty, frequent unemployment, and frequent moves. Mr. Knoche had been laid off 19 months earlier from his last assembly-line job at a local tractor factory. He stated that he was "very disgusted" that the family had to rely on welfare. Despite his frequent job changes, he had always been able to make it on his own without any assistance. Yet this time he had just about given up getting another job. He stated that he didn't like to talk to Mrs. Knoche very much about his problems because it made him feel weak and incompetent. He didn't really have any
buddies he liked to talk to or do things with, either. All he seemed to be doing lately was watching television, sleeping, and drinking beer. He was even starting to watch the daytime reality shows.

Mrs. Knoche was resigned to her fate. She did pretty much what her husband told her to do. She told Ms. Chin that she never did have much confidence in herself. She said that she and Mr. Knoche were never really able to talk much.

The Knoches had been living in their current apartment for six months. However, as usual, they were finding it hard to keep up with the rent and thought they’d have to move soon. The family’s output was surpassing its input. This deficit could affect the family’s homeostasis, or stability, and ability to function effectively. Moving so often made it hard to get involved and make friends in any neighborhood. Mrs. Knoche said she’d always been a lonely person.

The Assessment of Human Behavior
Factors that must be considered in the assessment of a child abuse case include physical and behavioral indicators, and certain aspects of social functioning that tend to characterize abusive families. Before Ms. Chin could plan an appropriate and effective intervention, she needed to understand the dynamics of the behavior involved in this family situation. Additionally, she needed to know what resources or input were available to help the family.

Physical Indicators of Abuse Although definitions vary depending on medical, social, and legal emphases, simply put, physical child abuse is “non-accidental injury inflicted by a caregiver” (Crosson-Tower, 2014, p. 86). Physical indicators of abuse include bruises and welts, burns, lacerations and abrasions, skeletal injuries, head injuries, and internal injuries (Crosson-Tower, 2014; Downs, Moore, & McFadden, 2009).

Often it is difficult to determine whether a child’s injury is the result of abuse or a simple accident. For instance, a black eye may indeed have been caused by being hit by a baseball instead of a parent’s fist. However, certain factors suggest child abuse. These include an inconsistent medical history, injuries that do not seem to coincide with developmental ability (e.g., it is not logical that an 18-month-old girl broke her leg when running and falling when she is not yet old enough to walk well), and odd patterns of injuries (e.g., a series of small circular burns from a cigarette or a series of bruises healed to various degrees).

In Jimmy’s and Sherry’s case, slash-like bruises were apparent on their arms and legs. Upon further investigation, the worker established that these did result from disciplinary beatings by the children’s father. Cases of discipline often involve a discretionary decision on the part of the worker. The issue concerns parental rights to discipline versus children’s rights and well-being. The worker must assess the situation and determine whether abuse is involved.

Behavioral Indicators of Abuse Ms. Chin needed to know not only what types of physical indicators are involved in child abuse but also the behavioral indicators of abused children. These types of behaviors differ from “normal” behavior. She needed to know the parameters of normal behavior in order to distinguish it from the abnormal behavior typically displayed by abused children.

Abused children are sometimes overly compliant and passive (Crosson-Tower, 2013, 2014). If a child acts overly eager to obey and/or is exceptionally quiet and still, this may be a reaction to abuse. Such children may be seeking to avoid further abuse by maintaining a low profile and avoiding notice by the abuser. Jimmy manifested some of these behaviors. He was afraid of being disciplined and so maintained as innocuous a profile as possible. This was a logical approach for him to take in order to avoid being hurt.

Sherry, on the other hand, assumed an aggressive, attention-getting approach, another behavior pattern frequently displayed by abused children (Crosson-Tower, 2013, 2014; Miller-Perrin & Perrin, 2013). She frequently refused to comply with her parents’ instructions until they raised their voices, and often demanded additional prodding. She also tried to get their attention by pulling at them and screaming requests at them. This approach is also typical of certain abused children. Since Sherry was not getting the attention she needed through other means, she was acting aggressively to get it, even though such behavior was inappropriate. Ms. Chin needed to be knowledgeable about the normal attention needs of a 4-year-old in order to understand the dynamics of this behavior.
One other symptom typical of abused children involves lags in development (Crosson-Tower, 2013, 2014; Kolko, 2002; LeVine & Sallee, 1999). They might also regress to an earlier developmental stage, displaying such behaviors as “baby talk, wetting the bed, and sucking fingers or thumb” in order to “cope with their situations” (Crosson-Tower, 2014, p. 97). Jimmy was small for his age and was having difficulty in school. Ms. Chin needed to be aware of the normal parameters of development for a 6-year-old in order to be alert to developmental lags. She also needed to know that such lags were potential indicators of abuse.

Family Social Functioning Not only the children but also the parents must be assessed. A worker must understand the influence of both personal and environmental factors on the behavior of the parents. Only then can these factors be targeted for intervention and the abusive behaviors be changed.

Personal parental factors that are related to abuse include unfulfilled needs for nurturance and dependence, isolation, and lack of nurturing child-rearing practices (Barnett, Miller-Perrin, & Perrin, 2011; Crosson-Tower, 2014). Ms. Chin discovered in her interview that both parents were isolated and alone. They had no one to turn to for emotional support. There was no place where they could appropriately and harmlessly vent their frustrations. Nor had either parent learned appropriate child-rearing practices in their families of origin. Mr. Knoche had learned excessive discipline—to be strict and punitive. Mrs. Knoche had learned compliance and passivity—to be helpless and to believe she could have no effect on others, no matter what she did.

Environmental factors are equally important in the assessment of this case. Specific factors related to abuse often include lack of support systems, marital or cohabiting problems, and life crises (Barnett et al., 2011; Tower, 2014). Life can become more difficult and complicated. Differentiation, in a negative sense, can occur.

Neither parent had been able to develop an adequate support system. Due to frequent moves, they had not been able to develop relationships with neighbors or others in the community systems of which they were part. Nor could they turn to each other for emotional support. They had never learned how to communicate effectively within a marital relationship. Finally, they were plagued by the serious life crises of poverty and unemployment. All of these things contributed to the abusive situation.

Making Connections with Available Resources Ms. Chin considered several treatment directions. Equifinality is reflected in the range of options available. Of course, resource availability in the client’s community system is critically important. If resources had not been available, Ms. Chin might have faced quite a dilemma. Should she work to help get appropriate resources developed? If so, what kind? How should she proceed? This would involve focusing on aspects of the larger social systems in which her clients lived.

However, the Knoches’ community had a number of resource input possibilities. A Parents Anonymous group and various social groups were available to decrease the Knoches’ social isolation. (Parents Anonymous is a self-help organization, similar to Alcoholics Anonymous, for parents who have abused or neglected their children.) Individual and marital counseling were available to improve the Knoches’ personal self-images and to enhance marital communication. A visiting homemaker could encourage Mrs. Knoche to more assertively undertake her homemaking and child-rearing tasks. She could also provide personal support. Parent Effectiveness Training could be used to teach the Knoches parenting skills and alternatives to harsh discipline. Finally, Mr. Knoche could be encouraged to get re-involved in a job search. An employment specialist at the agency could help him define and pursue alternative higher-paying employment possibilities. The intent was to help the Knoches achieve negative entropy.

Ms. Chin discussed these alternatives with the Knoches. In essence, she provided them with input and feedback. Together they determined which were possible and realistic. They then decided which should be pursued first. Mr. Knoche admitted that he could use some help in finding a job, which he stated was his highest priority. He agreed to contact the agency job specialist to help him re-institute his job search. Mrs. Knoche liked the idea of having a visiting homemaker. She felt that this would help her get her work done, and it would also give her someone to talk to. Both agreed to attend a Parents
Anonymous group on a trial basis. They were not interested in pursuing marriage counseling or Parent Effectiveness Training now, but would keep it in mind for the future.

**Ethical Question 1.2**

When child maltreatment is suspected, should children be allowed to remain in their own home? How much risk of child maltreatment is too much risk? What effect does it have on children to be removed from their home?

**Understanding Key Concepts in the Ecological Perspective**

In addition to terms taken from systems theories, concepts from the ecological perspective also contribute to ecosystems theory. In some ways, the ecological perspective might be considered an offshoot or interpretation of systems theories. An ecological approach provides a more specific view of the world within a social work perspective. It tends to place greater emphasis on individuals' and individual family systems' functioning within their environments. It also brings to ecosystems theory many terms such as coping that are very important in understanding human behavior. Systems theories, on the other hand, can assume a broader perspective. They can be used to describe the dynamics in a social service agency or the functioning of an entire government.

Note that some systems and ecological terms, such as interface and the input of energy, overlap. In essence, their meanings are very similar, especially when relating specifically to people functioning within their environments.

Some of the major terms employed in the ecological perspective and defined here include social environment, natural environment, transactions, energy, interface, adaptation, coping, and interdependence.

**Social Environment**

The social environment involves the conditions, circumstances, and human interactions that encompass human beings. Individuals must have effective interactions with this environment in order to survive and thrive. The social environment includes the actual physical setting that the society or culture provides. This involves the type of home a person lives in, the type of work a person does, the amount of money that is available, and the laws and social rules people live by. The social environment also includes the individuals, groups, organizations, and systems with which a person comes into contact, including family, friends, work groups, and governments. Social institutions such as health care, housing, social welfare, and educational systems are yet other aspects of this social environment.

**Natural Environment**

The natural environment is composed of all the non-human living things and non-living things that are naturally on earth. It includes the climate, weather, natural resources, plants, animals, microorganisms, minerals, rocks, and bodies of water on this planet. Humans are strongly impacted by things like hurricanes, tornadoes, thunderstorms, droughts, diseases, animal bites, global warming, mining, industrial damage, mudslides, mountains, deserts, scarcity of fossil fuels, toxic wastes, lead poisoning, toxic chemicals, air pollution, radioactive leaks from power plants, acid rain, chlorinated hydrocarbons, oil spills in large bodies of water, forest fires, blizzards, food preservatives—the list of natural phenomena impacting humans could go on and on. The concept of “environmental justice” first appeared in the 2015 Educational Policy and Accreditation Standards (EPAS) (Council on Social Work Education, 2015). Social workers have an obligation to understand the impact of the natural environment on humans, and to work toward environmental justice. Environmental justice is the fair treatment and meaningful involvement of all people—with respect to the development and enforcement of environmental laws, regulations, and policies. It will be achieved when everyone enjoys (a) the same degree of protection from health and environmental hazards, and (b) equal access to the decision-making process to have a healthy environment to live in.

**Transactions**

People communicate and interact with others in their environments. These interactions are referred to as transactions. Transactions are active and dynamic because something is communicated or exchanged. They may be positive or negative. An example of a
positive transaction is the revelation that the one you dearly love also loves you in return. Another positive transaction is the receipt of a paycheck after two weeks of work. An example of a negative transaction is being laid off from a job that you’ve had for 15 years. Another example of a negative transaction is an irritable neighbor complaining to the police about your dog barking too much.

**Energy**

Energy is the natural power of active involvement between people and their environments. Energy can take the form of input or output. Input is the form of energy coming into a person’s life and adding to that life. For example, an older adult whose health is failing may need input in the form of substantial physical assistance and emotional support in order to continue performing the daily tasks necessary to stay alive. (Chapters 15 and 16 discuss the importance of energy and input from the environment to maintain health and quality of life.) Another example of input is a teacher giving a student feedback on a term paper.

Output, on the other hand, is a form of energy going out of a person’s life or taking something away from it. For instance, parents may expend tremendous amounts of energy in taking care of their young children. So may a person who volunteers time and effort to work on the campaign of a politician he or she supports.

**Interface**

The interface in the ecological perspective is similar to that in systems theory. It is the exact point at which the interaction between an individual and the environment takes place. During an assessment, the interface must be clearly in focus in order to target the appropriate interactions for change. For example, a couple entering marriage counseling initially state that their problem concerns disagreements about how to raise their children. Upon further exploration, however, the real problem is discovered—namely, their inability to communicate feelings to each other. The actual problem, the inability to communicate, is the interface where one individual affects the other. If the interface is inaccurately targeted, much time and useless energy can be wasted before getting at the real problem. (Chapter 12 describes the importance of communication within the context of couples and families.)

The ecological perspective, however, differs from systems theories in its tendency to emphasize interfaces concerning individuals and small groups such as families. It is more difficult to apply the ecological perspective’s conception of interfaces to those involving only larger systems such as communities and organizations.

**Adaptation**

Adaptation refers to the capacity to adjust to surrounding environmental conditions. It implies change. A person must change or adapt to new conditions and circumstances in order to continue functioning effectively. Social workers frequently help people in their process of adaptation to a new marriage partner, a new job, or a new neighborhood. Adaptation usually requires energy in the form of effort. Social workers often help direct people’s energies so that they are most productive.

Not only are people affected by their environments, but environments are also affected by people in their process of adaptation. People change their environments in order to adapt successfully. For instance, a person might find it hard to survive a winter in Montana in the natural environment without shelter. Therefore, those who live in Montana manipulate their environment by clearing land and constructing heated buildings. They change their environment in order to survive in it. Therefore, adaptation is often a two-way process involving both the individual and the environment.

**Coping**

Coping is a form of adaptation that implies a struggle to overcome problems. Although adaptation may involve responses to new conditions that are either positive or negative, coping refers to the way people deal with the negative experiences they encounter. For example, a person might have to cope with the sudden death of a parent, a primary family wage earner losing a job, gangs that are vandalizing the community, or vital public assistance payments that are significantly decreased.

At least five types of coping skills are important for people to develop (Barker, 2003). First, people need to solicit and obtain the types of information they need to function well. For instance, an older adult who becomes sick needs to know how to obtain Medicare benefits (see Chapter 16). Second, people need to have coping skills for thinking about
CONCEPT SUMMARY

**Systems and Ecological Perspective Concepts Prominent in Ecosystems Theory**

**Systems Theory Concepts**
- **System**: A set of elements that are orderly and interrelated to make a functional whole.
- **Boundaries**: The borders or margins that separate one entity from another.
- **Subsystem**: A secondary or subordinate system that is a component of a larger system.
- **Homeostasis**: The tendency for a system to maintain a relatively stable, constant state of balance.
- **Role**: The culturally established social behavior and conduct expected of a person in any designated interpersonal relationship.
- **Relationship**: A reciprocal, dynamic interpersonal connection characterized by patterns of emotional exchange, communication, and behavioral interaction.
- **Input**: The energy, information, or communication flow received from other systems.
- **Output**: The response of a system, after receiving and processing input, that affects other systems in the environment.
- **Feedback**: A special form of input in which a system receives information about its own performance (either negative or positive).
- **Interface**: The point where two systems of any size come into contact with each other or communicate.

**Ecological Perspective Concepts**
- **Social environment**: The conditions, circumstances, and human interactions that encompass human beings.
- **Natural environment**: Composed of all the non-human living things and non-living things that are naturally on earth.
- **Transactions**: The means by which people communicate and interact with others in the environment.
- **Energy**: The natural power of active involvement between people and their environments.
- **Interface**: The exact point at which the interaction between an individual and the environment takes place.
- **Adaptation**: The capacity to adjust to surrounding environmental conditions.
- **Coping**: A form of adaptation that implies a struggle to overcome problems.
- **Interdependence**: The mutual reliance of each person on every other person.

Differentiation: A system's tendency to move from a simpler to a more complex existence.

Entropy: The tendency of a system to progress toward disorganization, depletion, and death.

Negative entropy: The process of a system toward growth and development.

Equifinality: The fact that there are many different means to the same end.

and planning for the future. For example, a person who loses a job needs to develop a plan for finding another one. Third, coping skills involve controlling emotions. For example, a minor disagreement with a significant other should not result in a major battle involving screaming, scratching, and punching. Fourth, people need coping skills to control their needs for immediate gratification. For instance, a family needs to budget its income so that there is food on the table at the end of the week, instead of spending money on a new television set. Finally, coping skills involve identifying alternative ways of approaching a problematic situation and evaluating the pros and cons of each alternative.

Social workers are frequently called upon to help clients develop coping skills. A major theme in the helping process involves working with clients to evaluate alternatives and to choose the one that's best for them. Evaluating alternatives was addressed earlier in this chapter.

**Interdependence**
The final ecological concept is that of **interdependence**, the mutual reliance of each person on every other person. An individual is interdependent or reliant on other individuals and groups of individuals in the social environment.

A person cannot exist without other people. The businessperson needs the farmer to produce food and the customer to purchase goods. The farmer needs the businessperson to provide money to buy seed, tools, and other essentials. The farmer becomes
the customer for the businessperson. People, especially those living in a highly industrialized society, are interdependent; they need each other to survive.

**LO 5 Recognize People's Involvement with Multiple Systems in the Social Environment**

We have established that people are constantly and dynamically involved in interactions with their social environment. Social work assessment tries to answer this question: What is it in any particular situation that causes a problem to continue despite the client's expressed wish to change it? An ecosystems approach provides a perspective for assessing many aspects of a situation. Clients are affected by and in constant dynamic interactions with other systems, including families, groups, organizations, and communities. Figure 1.4 portrays the dynamic interactions of clients with other systems in the social environment.

**Micro, Mezzo, and Macro Systems**

A system is a set of elements that are interrelated to make a functional whole. For our purposes, we will distinguish three basic types of systems throughout this text: micro, mezzo, and macro systems. **Micro system** refers to an individual. In a broad sense, a person is a type of system that entails biological, psychological, and social systems. All of these systems interact. A micro orientation to social work practice involves focusing on an individual's needs, problems, and strengths. It also stresses how that individual might address issues, generate solutions, and make the best, most effective choices possible. Micro practice, then, involves working with an individual and enhancing that person's functioning. Issues concerning micro systems are addressed throughout the text. Examples include dimensions of physical and psychological development and maturity (all chapters on biological and psychological systems throughout the lifespan), women's resilience after violence (Chapter 9), identity development as an LGBT person (Chapter 13), and grief management (Chapter 15).

**Mezzo system** refers to any small group, including family, work groups, and other social groups. Sometimes for assessment purposes it is difficult to clearly differentiate between issues involving a micro system (individual) and a mezzo system (small group) with which the individual is involved. This is because individuals are so integrally involved in interactions with others close to them. In many cases, we will make an arbitrary distinction between an issue concerning a micro system and one concerning a mezzo system. Examples of content about mezzo systems in this text include the importance of play with peers and participation in school for children (Chapter 4), empowerment through social work with groups (Chapter 8), the functions of nonverbal communication (Chapter 11), and family issues for older adults (Chapter 15).

**Macro system** refers to a system larger than a small group. A macro orientation involves focusing on the social, political, and economic conditions and policies that affect people's overall access to resources and quality of life. Macro practice in social work, then, involves striving to improve the social and economic context in which people live. Examples of content in this text about macro systems and how they affect people include the impacts of policies concerning abortion (Chapter 2), legislation regarding people with disabilities (Chapter 3), strategies to promote social and economic justice (Chapter 5), community responses to battered women (Chapter 9), and current services for older adults (Chapter 16).
Interactions Between Micro Systems and Macro Systems

Individual micro systems are also continuously and seriously affected by the macro systems with which they interact within the social environment. Two major types of macro systems impact individual clients: communities and organizations. The two are intertwined.

A community is "a number of people with something in common that connects them in some way and that distinguishes them from others"; the common feature might be a neighborhood where people live, an activity people share such as a job, or other connections such as "ethnic identification" (Homan, 2011, p. 8).

Organizations are structured groups of people who come together to work toward some mutual goal and perform established work activities that are divided among various units. Organizations generally have a clearly defined membership in terms of knowing who is in and who is out.

We have emphasized the importance of clients’ interactions with the many systems engulfing them. It is easy for practitioners, especially those who are new to the field, to focus on micro and mezzo systems. Assuming a "clinical" approach targets trying to change individuals within the context of small groups and families.

We have also emphasized that a unique and vital aspect of social work is assessing the effects of macro systems on individual client systems. Two broad theoretical perspectives that most clearly underlie practice with large systems are organizational theory and community theory.
Organizational theory includes specific attempts to understand how organizations function, what improves or impairs the ability of an organization to accomplish its mission, and what motivates people to work toward organizational goals. Some approaches to organizational theory have focused on management or leadership style; others have dealt with structural issues such as organizational hierarchy, planning, staffing patterns, and budgeting. Groups considered as organizations include virtually every structure with staff, policies, and procedures whose purpose is to continue operation in order to attain certain goals. For example, schools, public social welfare departments, and an agency operating four group homes for adults with intellectual disabilities are all types of organizations.

The second theoretical framework, community theory, has two primary components. First, it involves perspectives on the nature of communities. What constitutes a particular community? How are its boundaries defined? You may think of a community as having specific geographical boundaries, like Muleshoe, Texas, or Mattawamkeag, Maine, or Devil’s Den, Wyoming. However, a community may also be a group of people with shared ideas, interests, and allegiances, like the professional social work community, the military community, or a virtual community.

The second thrust of community theory involves how social workers practice within the community context. How can practitioners improve community services and conditions? What skills must social workers acquire to enhance clients’ quality of life within their community? (Community change theory is more fully described in Chapter 5.)

**LO 6 Recognize Social Worker Roles**

**A Variety of Roles**

In working with individuals, groups, families, organizations, and communities, a social worker is expected to be knowledgeable and skillful in filling a variety of roles. The particular role selected should (ideally) be determined by what will be most effective, given the circumstances. The following material identifies some, but certainly not all, of the roles assumed by social workers.

**Enabler**

In this role, a worker helps individuals or groups to articulate their needs, clarify and identify their problems, explore resolution strategies, select and apply a strategy, and develop their capacities to deal with problems more effectively. This role model is perhaps the most frequently used approach in counseling individuals, groups, and families, and is used in community practice—primarily when the objective is to help people organize to help themselves.

(It should be noted that this definition of the term enabler is very different from the definition used in reference to chemical dependency. There the term refers to a family member or friend who facilitates the substance abuser in persisting in the use and abuse of drugs.)

**Broker**

A broker links individuals and groups who need help (and do not know where to find it) with community services. For example, a wife who is physically abused by her husband might be referred to a shelter for battered women. Nowadays even moderate-sized communities have 200–300 social service agencies and organizations. Even human services professionals are often only partially aware of the total service network in their community.

**Advocate**

The role of advocate has been borrowed from the law profession. It is an active, directive role in which the social worker represents a client or a citizens’ group. When a client or a citizens’ group needs help and existing institutions are uninterested (or openly negative and hostile), the advocate’s role may be appropriate. The advocate provides leadership in collecting information, arguing the validity of the client’s need and request, and challenging the institution’s decision not to provide services. The purpose is not to ridicule or censure a particular institution but rather to modify or change one or more of its service policies. In this role, the advocate is a partisan who is exclusively serving the interests of a client or a citizens’ group.

**Empowerer**

A key goal of social work practice is empowerment, the process of helping individuals, families, groups, organizations, and communities increase their personal, interpersonal, socioeconomic, and political strength and influence. Social workers who engage in empowerment-focused practice seek to develop
the capacity of clients to understand their environment, make choices, take responsibility for those choices, and influence their life situations through organization and advocacy. Empowerment-focused social workers also seek a more equitable distribution of resources and power among different groups in society. This focus on equity and social justice has been a hallmark of the social work profession, as practiced by Jane Addams and other early settlement workers.

**Activist**
An activist seeks basic institutional change; often the objective involves a shift in power and resources to a disadvantaged group. An activist is concerned about social injustice, inequity, and deprivation. Tactics involve conflict, confrontation, and negotiation. Social action is concerned with changing the social environment in order to better meet the recognized needs of individuals. The methods used are assertive and action-oriented (for example, organizing welfare recipients to work toward improvements in services and increases in money payments). Activities of social action include fact-finding, analysis of community needs, research, dissemination and interpretation of information, organizing activities with people, and other efforts to mobilize public understanding and support on behalf of some existing or proposed social program. Social action activity can be geared toward a problem that is local, statewide, or national in scope.

**Mediator**
The mediator role involves intervention in disputes between parties to help them find compromises, reconcile differences, or reach mutually satisfactory agreements. Social workers have used their value orientations and unique skills in many forms of mediation (for example, divorcing spouses, neighbors in conflict, landlords and tenants, labor and management, and contenders for child custody). A mediator remains neutral, not siding with either party in the dispute. Mediators make sure they understand the positions of both parties. They may help to clarify positions, identify miscommunication about differences, and help both parties present their cases clearly.

**Negotiator**
A negotiator brings together people in conflict and seeks to bargain and compromise to find mutually acceptable agreements. Somewhat like mediation, negotiation involves finding a middle ground that all sides can live with. However, unlike a mediator (who maintains a neutral position), a negotiator is usually allied with one side or the other.

**Educator**
The educator gives information to clients and teaches them adaptive skills. To be an effective educator, the worker must first be knowledgeable. Additionally, the worker must be a good communicator so information is conveyed clearly and readily understood by the receiver. An educator can teach parenting skills to young parents, instruct teenagers in job-hunting strategies, and teach anger-control techniques to individuals with aggressive tendencies.

**Initiator**
An initiator calls attention to a problem or to a potential problem. It is important to recognize that sometimes a potential problem requires attention. For example, if a proposal is made to renovate a low-income neighborhood by building middle-income housing units, the initiator will be concerned that low-income residents could become homeless if the proposal is approved (because these current residents may not be able to afford middle-income units). Because calling attention to problems usually does not resolve them, the initiator role must often be followed by other kinds of work.

**Coordinator**
Coordination involves bringing components together in an organized manner. For example, a multi-problem family may need help from several agencies to meet its complicated financial, emotional, legal, health, social, educational, recreational, and interactional needs. Frequently, someone at an agency must assume the role of case manager to coordinate services from different agencies and avoid both duplication of services and conflict among the services.

**Researcher**
At times every worker is a researcher. Research in social work practice can involve reading literature on topics of interest, evaluating the outcomes of one's practice, assessing the merits and shortcomings of programs, and studying community needs.

**Group Facilitator**
A group facilitator serves as a leader for a group discussion in a therapy group, an educational group, a
self-help group, a sensitivity group, a family therapy group, or a group with some other focus.

**Public Speaker**
Social workers occasionally talk to a variety of groups (e.g., high school classes; public service organizations such as Kiwanis; police officers; staff at other agencies) to inform them of available services or to argue the need for new services. In recent years, various new services have been identified (for example, family preservation programs and services for people with AIDS). Social workers who have public speaking skills are better able to explain services to groups of potential clients and funding sources, and are apt to be rewarded (including financially) by their employers for these skills.

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In *Educational Policy and Accreditation Standards (EPAS)*, the Council on Social Work Education (2015) identified knowledge, skills, values, and cognitive and affective processes that accredited baccalaureate and master’s degree programs are mandated to convey to social work students. EPAS is based on a competency approach. The following material is reprinted with permission from EPAS (CSWE, 2015).

The mandated content that Bachelor of Social Work (BSW) and Master of Social Work (MSW) programs are required to provide to students are summarized in the following nine competencies:

**Social Work Competencies**
The nine Social Work Competencies are listed below. Programs may add competencies that are consistent with their mission and goals and respond to their context. Each competency describes the knowledge, values, skills, and cognitive and affective processes that comprise the competency at the generalist level of practice, followed by a set of behaviors that integrate these components. These behaviors represent observable components of the competencies, while the preceding statements represent the underlying content and processes that inform the behaviors.

**Competency 1: Demonstrate Ethical and Professional Behavior**
Social workers understand the value base of the profession and its ethical standards, as well as relevant laws and regulations that may impact practice at the micro, mezzo, and macro levels. Social workers understand frameworks of ethical decision making and how to apply principles of critical thinking to those frameworks in practice, research, and policy arenas. Social workers recognize personal values and the distinction between personal and professional values. They also understand how their personal experiences and affective reactions influence their professional judgment and behavior. Social workers understand the profession’s history, its mission, and the roles and responsibilities of the profession. Social Workers also understand the role of other professions when engaged in interprofessional teams. Social workers recognize the importance of lifelong learning and are committed to continually updating their skills to ensure they are relevant and effective. Social workers also understand emerging forms of technology and the ethical use of technology in social work practice. Social workers

- make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision making, ethical conduct of research, and additional codes of ethics as appropriate to context;
- use reflection and self-regulation to manage personal values and maintain professionalism in practice situations;
- demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication;
- use technology ethically and appropriately to facilitate practice outcomes; and
- use supervision and consultation to guide professional judgment and behavior.

**Competency 2: Engage Diversity and Difference in Practice**
Social workers understand how diversity and difference characterize and shape the human experience and are critical to the formation of identity. The dimensions of (continued)
diversity are understood as the intersectionality of multiple factors including but not limited to age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status. Social workers understand that, as a consequence of difference, a person’s life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim. Social workers also understand the forms and mechanisms of oppression and discrimination and recognize the extent to which a culture’s structures and values, including social, economic, political, and cultural exclusions, may oppress, marginalize, alienate, or create privilege and power. Social workers

- apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels;
- present themselves as learners and engage clients and constituencies as experts of their own experiences; and
- apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies.

Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice

Social workers understand that every person regardless of position in society has fundamental human rights such as freedom, safety, privacy, an adequate standard of living, healthcare, and education. Social workers understand the global interconnections of oppression and human rights violations, and are knowledgeable about theories of human need and social justice and strategies to promote social and economic justice and human rights. Social workers understand strategies designed to eliminate oppressive structural barriers to ensure that social goods, rights, and responsibilities are distributed equitably and that civil, political, environmental, economic, social, and cultural human rights are protected. Social workers

- apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels; and
- engage in practices that advance social, economic, and environmental justice.

Competency 4: Engage in Practice-Informed Research and Research-Informed Practice

Social workers understand quantitative and qualitative research methods and their respective roles in advancing a science of social work and in evaluating their practice. Social workers know the principles of logic, scientific inquiry, and culturally informed and ethical approaches to building knowledge. Social workers understand that evidence that informs practice derives from multidisciplinary sources and multiple ways of knowing. They also understand the processes for translating research findings into effective practice. Social workers

- use practice experience and theory to inform scientific inquiry and research;
- apply critical thinking to engage in analysis of quantitative and qualitative research methods and research findings; and
- use and translate research evidence to inform and improve practice, policy, and service delivery.

Competency 5: Engage in Policy Practice

Social workers understand that human rights and social justice, as well as social welfare and services, are mediated by policy and its implementation at the federal, state, and local levels. Social workers understand the history and current structures of social policies and services, the role of policy in service delivery, and the role of practice in policy development. Social workers understand their role in policy development and implementation within their practice settings at the micro, mezzo, and macro levels, and they actively engage in policy practice to effect change within those settings. Social workers recognize and understand the historical, social, cultural, economic, organizational, environmental, and global influences that affect social policy. They are also knowledgeable about policy formulation, analysis, implementation, and evaluation. Social workers

- identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services;
- assess how social welfare and economic policies impact the delivery of and access to social services;
- apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice.

Competency 6: Engage with Individuals, Families, Groups, Organizations, and Communities

Social workers understand that engagement is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers value the importance of human relationships. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge to facilitate engagement with clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand strategies to engage diverse clients and constituencies to advance practice
effectiveness. Social workers understand how their personal experiences and affective reactions may impact their ability to effectively engage with diverse clients and constituencies. Social workers value principles of relationship-building and interprofessional collaboration to facilitate engagement with clients, constituencies, and other professionals as appropriate. Social workers

- apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies; and
- use empathy, reflection, and interpersonal skills to effectively engage diverse clients and constituencies.

**Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities**

Social workers understand that assessment is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in the assessment of diverse clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand methods of assessment with diverse clients and constituencies to advance practice effectiveness. Social workers recognize the implications of the larger practice context in the assessment process and value the importance of interprofessional collaboration in this process. Social workers understand how their personal experiences and affective reactions may affect their assessment and decision making. Social workers

- collect and organize data, and apply critical thinking to interpret information from clients and constituencies;
- apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies;
- develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies; and
- select appropriate intervention strategies based on the assessment, research knowledge, and values and preferences of clients and constituencies.

**Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities**

Social workers understand that intervention is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers are knowledgeable about evidence-informed interventions to achieve the goals of clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge to effectively intervene with clients and constituencies. Social workers understand methods of identifying, analyzing and implementing evidence-informed interventions to achieve client and constituency goals. Social workers value the importance of interprofessional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, interprofessional, and interorganizational collaboration. Social workers

- critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies;
- apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies;
- use interprofessional collaboration as appropriate to achieve beneficial practice outcomes;
- negotiate, mediate, and advocate with and on behalf of diverse clients and constituencies; and
- facilitate effective transitions and endings that advance mutually agreed-on goals.

**Competency 9: Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities**

Social workers understand that evaluation is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations and communities. Social workers recognize the importance of evaluating processes and outcomes to advance practice, policy, and service delivery effectiveness. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in evaluating outcomes. Social workers understand qualitative and quantitative methods for evaluating outcomes and practice effectiveness. Social workers

- select and use appropriate methods for evaluation of outcomes;
- apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the evaluation of outcomes;
- critically analyze, monitor, and evaluate intervention and program processes and outcomes; and
- apply evaluation findings to improve practice effectiveness at the micro, mezzo, and macro levels.
Chapter Summary

The following summarizes this chapter's content as it relates to the learning objectives presented at the beginning of the chapter. Chapter content will help prepare students to do the following:

**LO 1 Explain the importance of foundation knowledge for social work with an emphasis on assessment.**

This book provides a knowledge base in preparation for social work practice. Social workers need knowledge in order to understand the dynamics of human behavior and conduct client assessments. The social work process then involves helping clients identify and evaluate available alternatives to select the best plan of action.

**LO 2 Review the organization of this book that emphasizes lifespan development.**

This book is organized using a lifespan approach. The lifespan is divided into four phases: infancy and childhood, adolescence, young and middle adulthood, and later adulthood.

Chapters on biological, psychological, and social (bio-psycho-social) aspects of development portray common life events, normal developmental milestones, and relevant issues for each life phase.

**LO 3 Describe important concepts for understanding human behavior (that are stressed throughout the book and include human diversity, cultural competency, oppression, populations-at-risk, empowerment, the strengths perspective, resiliency, human rights, and critical thinking about ethical issues).**

Human diversity is the vast range of human differences among groups, including those related to “age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status” (CSWE, 2015).
Cultural competency is "the mastery of a particular set of knowledge, skills, policies, and programs used by the social worker that address the cultural needs of individuals, families, groups, and communities" (Lum, 2005, p. 4).

Discrimination is the act of treating people differently because they belong to some group rather than on merit. Oppression involves putting unfair and extreme limitations and constraints on members of an identified group. A population-at-risk is any group of people who share some identifiable characteristic that places them at greater risk of social and economic deprivation and oppression than the general mainstream of society.

Empowerment is "the process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situations" (Gutierrez, 2001, p. 210). The strengths perspective is an orientation that focuses on client resources, capabilities, knowledge, abilities, motivations, experience, intelligence, and other positive qualities that can be put to use to solve problems and pursue positive changes. Empowerment based on strengths can occur at the individual, group, organizational, and community levels. Resiliency is the ability of an individual, family, group, community, or organization to recover from adversity and resume functioning even when suffering serious trouble, confusion, or hardship.

Human rights involve the premise that all people, regardless of race, culture, or national origin, are entitled to basic rights and treatment.

Critical thinking can be used to address ethical issues and dilemmas. Critical thinking is "the careful examination and evaluation of beliefs and actions" to establish an independent decision about what is true and what is not (Gambrill & Gibbs, 2009, p. 4). Ethical dilemmas are situations where ethical principles conflict and all solutions are imperfect. Critical-thinking questions about ethical issues are interspersed throughout the book.

**LO 4 Employ a conceptual framework for understanding human behavior and the social environment: ecosystems theory.**

Ecosystems theory is "systems theory used to describe and analyze people and other living systems and their transactions" (Beckett & Johnson, 1995, p. 1391). It offers a framework for viewing human behavior that incorporates concepts from systems theories and the ecological perspective, and provides this book's theoretical orientation. Relevant systems theory concepts include system, boundaries, subsystem, homeostasis, role, relationship, input, output, feedback, interface, differentiation, entropy, negative entropy, and equifinality. Pertinent concepts from the ecological perspective include social environment, transactions, energy, interface, adaptation, coping, and interdependence.

**LO 5 Recognize people's involvement with multiple systems in the social environment.**

People are involved with multiple systems in their environment. A micro system is an individual. A mezzo system is a small group. A macro system is a system larger than a small group. Macro systems that are primary contexts for human behavior include communities and organizations.

**LO 6 Recognize social worker roles.**

Social workers can perform the following roles as they practice in the context of organizations and communities: enabler, mediator, coordinator, manager, educator, evaluator, broker, facilitator, initiator, negotiator, and advocate.

**LO 7 Identify knowledge, skills, and values necessary for generalist social work practice.**

The nine competencies and their respective 31 behaviors necessary for effective generalist social work practice are cited.

**COMPETENCY NOTES**

This section relates chapter content to the Council on Social Work Education's (CSWE) Educational Policy and Accreditation Standards (EPAS) (CSWE, 2015).

One major goal of social work education is to facilitate students' attainment of the EPAS-designated nine core competencies and their 31 related behaviors so that students develop into competent practitioners. Students require knowledge in order to develop skills and become competent. Our intent here is to specify what chapter content and knowledge coincides with the development of specific competencies and behaviors. (This ultimately is intended to assist in the accreditation process.) Therefore, the following listing
first cites the various Educational Policy (EP) core competencies and their related behaviors (which are alphabetized beneath competencies) that are relevant to chapter content. Note that most of the listing follows the order that competencies and behaviors are cited in the EPAS.

We have established (See the Special Notes section at the end of this chapter) that “helping hands” icons such as that illustrated in this paragraph are interspersed throughout the chapter indicating where relevant accompanying content is located. Page numbers noted below indicate where icons are placed in the chapter. Following the icon’s page number is a brief explanation of how the content accompanying the icon relates to the specified competency or practice behavior.

**EP1 Demonstrate Ethical and Professional Behavior (pp. 2, 46)**
Ethical questions are posed.

**EP6a. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies;**

**EP7b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies;**

**EP8b. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies (all of this chapter).**
Material on concepts and theories about human behavior and the social environment are presented throughout this chapter.

**EP1a through EP 9d: All the competencies and behaviors of 2015 EPAS (pp. 57–61).** This section reprints the knowledge, skills, values, and cognitive and affective processes needed for social work practice, as stated in 2015 EPAS.

**WEB RESOURCES**
See this text’s companion website at www.cengagebrain.com for learning tools such as chapter quizzing, videos, and more.
Juanita lovingly watched her 1-year-old Enrico as he lay in his crib playing with his toes. Enrico was her first child, and Juanita was very proud of him. She was bothered, however, that he could not sit up by himself. Living next door was a baby about Enrico's age, whose name was Teresa. Not only could she sit up by herself, but she could crawl, stand alone, and was even starting to walk. Juanita thought it was odd that the two children could be so different and have such different personalities. That must be the reason, she thought. Enrico was just an easygoing child. Perhaps he was also a bit stubborn. Juanita decided that she wouldn't worry about it. In a few weeks, Enrico would probably start to sit up.
Knowledge of typical human development is critical in order to understand and monitor the progress of children as they grow. In this example, Enrico was indeed showing some developmental lags. He was in need of an evaluation to determine his physical and psychological status so that he might receive help.

A Perspective

The attainment of typical developmental milestones has a direct impact on the client. Biological, psychological, and social development systems operate together to affect behavior. This chapter will explore some of the major aspects of infancy and childhood that social workers must understand in order to provide information to clients and make appropriate assessments of client behavior.

Learning Objectives

This chapter will help prepare students to

**LO 1** Describe the dynamics of human reproduction (including conception, the diagnosis of pregnancy, fetal development, prenatal influences and assessment, problem pregnancies, and the birth process)

**LO 2** Explain typical developmental milestones for infants and children

**LO 3** Examine the abortion controversy (in addition to the impacts of social and economic forces)

**LO 4** Explain infertility (including the causes, the psychological reactions to infertility, the treatment of infertility, the assessment process, alternatives available to infertile couples, and social work roles concerning infertility)

**LO 1 Describe the Dynamics of Human Reproduction**

Chuck and Christine had mixed emotions about the pregnancy. It had been an accident. They were both in their mid-30s and already had a vivacious 4-year-old daughter named Hope. Although Hope had been a joy to both of them, she had also placed serious restrictions on their lifestyle. They were looking forward to her beginning school. Christine had begun to work part-time and was planning to go full-time as soon as Hope turned 5.

Now all that had changed. To complicate the matter, Chuck, a university professor, had just received an exciting job offer in Hong Kong—the opportunity of a lifetime. They had always dreamed of spending time overseas.

The unexpected pregnancy provided Chuck and Christine with quite a jolt. Should they terminate the pregnancy and go on with their lives in exotic Hong Kong? Should they have the baby overseas? Questions concerning foreign prenatal care, health conditions, and health facilities flooded their thoughts. Would it be safer to remain in the United States and turn down this golden opportunity? Christine was 35. Her reproductive clock was ticking away. Soon risk factors concerning having a healthy, normal baby would begin to skyrocket. This might be
their last chance to have a second child. Chuck and Christine did some serious soul-searching and fact-searching to arrive at their decision.

Yes, they would have the baby. Once the decision had been made, they were filled with relief and joy. They also decided to take the job in Hong Kong. They would use the knowledge they had about prenatal care, birth, and infancy to maximize the chance of having a healthy, normal baby. They concluded that this baby was a blessing who would improve, not impair, the quality of their lives.

The decision to have children is a serious one. Ideally, a couple should examine all alternatives. Children can be wonderful. Family life can bring pleasurable activities, pride, and fullness to life. On the other hand, children can cause stress. They demand attention, time, and effort and can be expensive to care for. Information about conception, pregnancy, birth, and child rearing can only help people make better, more effective decisions.

Conception

Sperm meets egg; a child is conceived. But in actuality, it is not quite that simple. Many couples who strongly desire to have children have difficulty conceiving. Many others whose last desire is to conceive do so with ease. Some amount of chance is involved.

Conception refers to the act of becoming pregnant. Sperm need to be deposited in the vagina near the time of ovulation. Ovulation involves the ovary's release of a mature egg into the body cavity near the end of one of the fallopian tubes. Fingerlike projections called fimbrae at the end of the fallopian tube draw the egg into the tube. From there, the egg is gently moved along inside the tube by tiny hairlike extensions called cilia. Fertilization actually occurs in the third of the fallopian tube nearest the ovary.

If a sperm has gotten that far, conception may occur. After ejaculation, the discharge of semen by the penis, the sperm travels up into the uterus and through the fallopian tube to meet the egg. Sperm are equipped with a tail that can lash back and forth, propelling them forward. The typical ejaculate, an amount of approximately one teaspoon, usually contains 200 to 400 million sperm; however, only 1 in 1,000 of these will ever make it to the area immediately surrounding the egg (Rathus, Nevid, & Fichner-Rathus, 2014). Unlike females, who are born with a finite number of eggs, males continually produce new sperm. Fertilization is therefore quite competitive. It is also hazardous. The majority of these sperm don't get very far (Hyde & Delamater, 2017; Rathus et al., 2014). Many spill out of the vagina, drawn by gravity. Others are killed by the acidity of the vagina. Still others swim up the wrong fallopian tube, meaning the one without the egg. Only about 2,000 sperm make it up the right tube. By the time a sperm reaches the egg, it has swum a distance 3,000 times its own length; an equivalent swim for a human being would be more than 3 miles (Hyde & Delamater, 2017).

Although sperm are healthiest and most likely to fertilize an egg during the first 24 hours after ejaculation, they may survive up to 72 hours in a woman's reproductive tract; an egg's peak fertility is within the first 8 to 12 hours after ovulation, although it may remain viable for fertilization for up to 24 hours, and some may remain viable for up to five days (Greenberg, Bruess, & Oswalt, 2017; Newman & Newman, 2015). Therefore, sexual intercourse should ideally occur not more than five days before or one day after ovulation for fertilization to take place (Yarber & Sayad, 2016).

In the fallopian tube, the egg apparently secretes a chemical substance that attracts sperm. The actual fertilization process involves sperm reaching the egg, secreting an enzyme, and depositing it on the egg. This enzyme helps dissolve a gelatinous layer surrounding the egg and allows for the penetration of a sperm. After one sperm has penetrated the barrier, the gelatinous layer undergoes a physical change, thus preventing other sperm from entering it.

Fertilization occurs during the exact moment the egg and sperm combine. Eggs that are not fertilized by sperm simply disintegrate. The genetic material in the egg and sperm combine to form a single cell called a zygote.

Eggs contain an X chromosome. Sperm may contain either an X or a Y chromosome. Eggs fertilized by a sperm with an X chromosome will result in a female; those fertilized by sperm with a Y chromosome will result in a male.

The single-celled zygote begins a cell division process in which the cell divides to form two cells, then four, then eight, and so on. Within a week, the new mass of cells, called a blastocyst, attaches itself to the lining of the uterus. If attachment does not occur, the newly formed blastocyst is simply expelled. From the point of attachment until eight weeks of
gestation, the conceptus, or product of conception, is called an embryo. From eight weeks until birth, it is referred to as a fetus. Gestation refers to the period of time from conception to birth.

Diagnosis of Pregnancy

Pregnancy can be diagnosed by using laboratory tests, by observing the mother’s physical symptoms, or by performing a physical examination. Early symptoms of pregnancy can include increased basal body temperature that lasts for up to 3 weeks, breast tenderness, feelings of fatigue, and nausea (Hyde & DeLamater, 2017). Many women first become aware of the pregnancy when they miss a menstrual period. However, women also can miss periods as a result of stress, illness, or worry about possible pregnancy. Some pregnant women will even continue to menstruate for a month or even more. Therefore, lab tests are often needed to confirm a pregnancy. Such lab tests are 98 to 99 percent accurate and can be performed at a Planned Parenthood agency, a medical clinic, or a physician’s office (Hyde & DeLamater, 2017; Rathus et al., 2014).

Most pregnancy tests work by detecting human chorionic gonadotropin (HCG) in a woman’s urine or blood. HCG is a hormone secreted by the placenta (the tissue structure that nurtures a developing embryo). Laboratory tests can detect HCG as early as eight days after conception (Greenberg et al., 2014).

The use of home pregnancy tests (HPTs) has become quite common. Like some laboratory tests, they measure HCG levels in urine. They are very convenient, relatively inexpensive and can be used as early as the first day a menstrual period was supposed to start. However, they are more likely to be accurate if administered after more time has passed.

Most HPTs function in a similar fashion. The user holds a stick in the urine stream or collects urine in a cup and dips the stick into it. Most tests have a results window indicating whether a woman is pregnant or not. Most tests also stress retaking the test a few days or a week later to confirm its accuracy.

Because HCG increases as the pregnancy progresses, HPTs become more accurate as time goes on. Many home pregnancy tests claim to be 99 percent accurate on the day you miss your period. Although research suggests that most home pregnancy tests don’t consistently spot pregnancy this early, home pregnancy tests are considered reliable when used according to package instructions one week after a missed period” (Mayo Clinic, 2013c).

Although HPTs can be highly accurate, there is room for error. If instructions are not followed perfectly, results can be faulty. For instance, exposure to sunlight, accidental vibrations, using an unclean container to collect urine, or examining results too early or too late all can end in an erroneous diagnosis. False negatives (i.e., showing that a woman is not pregnant when she really is) are more common than false positives (i.e., showing that a woman is pregnant when she really is not). Regardless, it is suggested that a woman confirm the results either by waiting a week and administering another HPT or by having a laboratory diagnosis performed. Early knowledge of pregnancy is important either to begin early health care or to make a decision about terminating a pregnancy.

Fetal Development During Pregnancy

An average human pregnancy lasts about 266 days after conception (Papalia & Martorell, 2015). However, there is a great amount of variability in the length of pregnancies among mothers. It is most easily conceptualized in terms of trimesters, or three periods of three months each. Each trimester is characterized by certain aspects of fetal development.

The First Trimester

The first trimester is sometimes considered the most critical. Because of the embryo’s rapid differentiation and development of tissue, the embryo is exceptionally vulnerable to the mother’s intake of noxious substances and to aspects of the mother’s health.

By the end of the first month, a primitive heart and digestive system have developed. The basic initiation of a brain and nervous system is also apparent. Small buds that will eventually become arms and legs are appearing. In general, development starts with the brain and continues down through the body. For example, the feet are the last to develop. In the first month, the embryo bears little resemblance to a baby because its organs have just begun to differentiate.

The embryo begins to resemble human form more closely during the second month. Internal organs become more complex. Facial features including eyes, nose, and mouth begin to become identifiable. The 2-month-old embryo is less than an inch long and weighs about one-third of an ounce.
The third month involves the formation of arms, hands, legs, and feet. Fingernails, hair follicles, and eyelids develop. All the basic organs have appeared, although they are still underdeveloped. By the end of the third month, bones begin to replace cartilage. Fetal movement is frequently detected at this time.

During the first trimester, the mother experiences various symptoms. This is primarily due to the tremendous increase in the amount of hormones her body is producing. Symptoms frequently include tiredness, breast enlargement and tenderness, frequent urination, and food cravings. Some women experience nausea, referred to as morning sickness.

It might be noted that these symptoms resemble those often cited by women when first taking birth control pills. In effect, the pill, by introducing natural or artificial hormones that resemble those of pregnancy, tricks the body into thinking it is pregnant, thus preventing ovulation. The pill as a form of contraception is discussed more thoroughly in Chapter 6.

**The Second Trimester**

Fetal development continues during the second trimester. Toes and fingers separate. Skin, fingerprints, hair, and eyes develop. A fairly regular heartbeat emerges. The fetus begins to sleep and wake at regular times. Its thumb may be inserted into its mouth.

For the mother, most of the unappealing symptoms of the first trimester subside. She is more likely to feel the fetus’s vigorous movement. Her abdomen expands significantly. Some women suffer edema, or water retention, which results in swollen hands, face, ankles, or feet.

**The Third Trimester**

The third trimester involves completing the development of the fetus. Fatty tissue forms underneath the skin, filling out the fetus’s human form. Internal organs complete their development and become ready to function. The brain and nervous system become completely developed.

An important concept that becomes relevant during the sixth and seventh months of gestation is viability. This refers to the ability of the fetus to survive on its own if separated from its mother. Although a fetus reaches viability by about the middle of the second trimester, many infants born at 22–25 weeks “do not survive, even with intensive medical care, and many of those who do experience chronic health or neurological problems” (Sigelman & Rider, 2012, p. 100).

The viability issue becomes especially critical in the context of abortion. The question involves the ethics of aborting a fetus that, with external medical help, might be able to survive. This issue underscores the importance of obtaining an abortion early in the pregnancy when that is the chosen course of action.

For the mother, the third trimester may be a time of some discomfort. The uterus expands, and the mother’s abdomen becomes large and heavy. The additional weight frequently stresses muscles and skeleton, often resulting in backaches or muscle cramps. The size of the uterus may exert pressure on other organs, causing discomfort. Some of the added weight can be attributed to the baby itself, amniotic fluid, and the placenta. Other normal weight increases include those of the uterus, blood, and breasts as part of the body’s natural adaptation to pregnancy.

**Pregnancy Apps**

Many women now use technology as a way to get advice about their pregnancy and parenting. Mobile apps, such as “BabyBump Pregnancy,” “My Pregnancy & Baby Today,” “WebMD Pregnancy,” and “Parenting Tips,” help parents by providing information on subjects such as tracking your period, what to expect during your pregnancy, what your baby looks like in the womb (complete with pictures and photos), fetal development information, tips on how to have a healthy pregnancy, questions to ask at doctors’ appointments, contraction timing, and much more. For those who want up-to-date advice or information, an app might be a source of information to look into. It is important to note, however, that these apps should not be used as a substitute for the prenatal care given by a medical professional, especially for women with at-risk pregnancies.

**Prenatal Influences**

Numerous factors can influence the health and development of the fetus. These include the expectant mother’s nutrition, drugs and medication, alcohol consumption, smoking habits, age, stress, and a number of other factors.

**Nutrition**

A pregnant woman is indeed eating for two. In the past, pregnant women were afraid of gaining too much weight. But a woman should usually gain
25 to 35 pounds during her pregnancy (Berk, 2013; Kail & Cavennaugh, 2013; Sigelman & Rider, 2012). She typically requires 300 to 500 additional calories daily to adequately nurture the fetus (Papalia & Martorell, 2015).

The optimal weight gain depends on the woman’s height and her weight prior to pregnancy. For example, a woman who is underweight before pregnancy might require a greater weight gain to maintain a healthy pregnancy.

Being underweight or overweight poses risks to the fetus. Too little weight gain due to malnutrition can result in low infant birth weight, increased risk of mental or motor impairment, and a higher risk of infant mortality (Berk, 2013; Newman & Newman, 2015). Being overweight either before or during pregnancy can increase the risk of miscarriage and other complications during pregnancy and birth (Chu et al., 2008), in addition to birth defects (Stothard, Tenant, Bell, & Rankin, 2009).

Not only does a pregnant woman need to eat more, but the quality of food also needs careful monitoring and attention. It is especially important for pregnant women to get enough protein, iron, calcium, and folic acid (a B vitamin), in addition to other vitamins and minerals (Berk, 2013; Kail & Cavennaugh, 2013). As Hyde and DeLamater (2017) explain,

Protein is important for building new tissues. Folic acid is also important for growth; symptoms of folic acid deficiency are anemia [low red blood cell count] and fatigue. A pregnant woman needs much more iron than usual, because the fetus draws off iron for itself from the blood that circulates to the placenta. Muscle cramps, nerve pains, uterine ligament pains, sleeplessness, and irritability may all be symptoms of a calcium deficiency. (p. 127)

**Drugs and Medication**

Because the effects of many drugs on the fetus are unclear, pregnant women are cautioned to be wary of drug use. Drugs may cross the placenta and enter the bloodstream of the fetus. Any drugs should be taken only after consultation with a physician. The effects of such drugs usually depend on the amount taken and the gestation stage during which they are taken. This is especially true for the first trimester, when the embryo is very vulnerable.

**Teratogens** are substances, including drugs, that cause malformations in the fetus. Certain drugs can cause malformations of certain body parts or organs.

The so-called thalidomide babies of the early 1960s provide a tragic example of the potential effects of drugs. Thalidomide, a type of tranquilizer used to ease morning sickness, was found to produce either flipper-like appendages in place of arms or legs, or no arms or legs at all.

A variety of prescription drugs can produce teratogenic effects. These include antibiotics such as tetracycline and streptomycin, Accutane (an acne drug), and some antidepressants (Rathus et al., 2014; Santrock, 2016). Generally speaking, women should avoid taking drugs or medications during pregnancy and while breastfeeding unless such medication is absolutely necessary.

Even nonprescription, over-the-counter drugs such as Aspirin (acetosalicylic acid) or caffeine should be consumed with caution (Santrock, 2016). Aspirin can cause bleeding problems in the fetus (Steinberg et al., 2011a). Coffee, tea, colas, and chocolate all contain caffeine. The research findings concerning the effects of caffeine on a fetus have been mixed (Maslova, Bhattacharya, Lin, & Michaels, 2010; Minnes, Lang, & Singer, 2011; Rathus, 2014a). However, some research results have revealed a greater risk of low birth weight (Rathus, 2014a; Santrock, 2016). Even vitamins should be consumed with care and only under a physician’s supervision (Rathus et al., 2014; Steinberg et al., 2011a). An expectant mother’s best bet is to be cautious.

**Ethical Question 2.1**

Should a pregnant woman who consumes alcohol or illegal drugs that damage her child be punished as a criminal? Should her child be taken from her? If so, with whom should the child be placed?

**Alcohol**

Alcohol consumption during pregnancy can have grave effects on a fetus. The condition is termed **fetal alcohol syndrome (FAS)**. Babies of women who were heavy drinkers during pregnancy have “unusual facial characteristics [including widely spaced eyes, short nose, and thin upper lip], small head and body size, congenital heart defects, defective joints, and intellectual and behavioral impairment” (Yarber &
Sayad, 2016, p. 370). Effects stretch into childhood and even adulthood. They include difficulties in paying attention, hyperactivity, lower-than-normal intelligence, and significant difficulties in adjustment and social interaction (Shaffer & Kipp, 2010). The severity of defects increases with the amount of alcohol consumed during pregnancy (Shaffer & Kipp, 2010). However, there is evidence that even more moderate alcohol consumption, such as one or two drinks a day, can harm the fetus (Rathus et al., 2014; Shaffer & Kipp, 2010; Steinberg et al., 2011a). Fetal alcohol effects (FAE) is a condition that manifests relatively less severe (yet still significant) problems, presumably resulting from lower levels of alcohol consumption during pregnancy.

Drugs of Abuse
Illegal drugs, such as cocaine (a powerful stimulant) and heroin (an opioid), can cause significant problems during a pregnancy (Newman & Newman, 2015). Both of these substances can cause infertility, problems with the placenta resulting in the fetus not receiving enough food or oxygen, preterm labor, or death of the fetus via miscarriage or stillborn birth. Babies may be premature, or have low birth weight, heart defects, birth defects, or infections such as hepatitis or AIDS (March of Dimes, 2013). A significant problem is when the baby develops Neonatal Abstinence Syndrome (NAS). In NAS, the baby is born addicted to the addictive drugs the mother used during her pregnancy and goes through withdrawal at birth. These babies have a tendency to have lower birth weights, breathing problems, sleep difficulties, seizures, and birth defects, and may require a longer stay in the hospital. Signs and symptoms of NAS include body shakes, seizures, excessive crying, trouble sleeping, fever, inability to gain weight, and overall fussiness. All of these symptoms may need to be treated with medications, fluids, or higher-calorie feedings (March of Dimes, 2015).

Marijuana may also cause problems during a pregnancy (Papalia & Martorell, 2015). Studies link marijuana use with premature birth, low birth weight, increased chance of stillbirth, withdrawal symptoms in the baby, and problems with brain development (March of Dimes, 2016). Ingredients in marijuana can also pass to a child during breastfeeding; therefore, it is recommended that breastfeeding moms refrain from marijuana use (March of Dimes, 2016).

Note, however, that it is difficult to separate out the direct effects of specific drugs because of the numerous other factors involved (e.g., an impoverished environment or use of other potentially harmful substances by the mother).

Smoking
Numerous studies associate smoking with low birth weight, preterm births, breathing difficulties, fetal death, and crib death (Rathus, 2014a; Santrock, 2016; Shaffer & Kipp, 2010; Yarber & Sayad, 2013). Even secondhand smoke is thought to pose a danger to the fetus (Rathus, 2014a). Some research found a relationship between a mother’s smoking during pregnancy and a child having behavioral and emotional problems when the child reaches school age (Papalia & Martorell, 2017; Rathus, 2014a).

Studies have also found that a father’s smoking during pregnancy may affect the health of the child (Hyde & DeLamater, 2017).

Age
The pregnant woman’s age may affect both the woman and the child. Women “between ages 16 and 35 tend to provide a better uterine environment for the developing fetus and to give birth with fewer complications than do women under 16 or over 35” (Newman & Newman, 2015, p. 118). Women aged 35 and older account for more than 16 percent of all births in the United States (U.S. Census Bureau, 2011). For example, although a woman who is aged 16 to 34 has a very low risk of having a baby with Down syndrome, the likelihood increases to about 1 in 30 births once the mother reaches the age of 45 (Yarber & Sayad, 2016). It is thought that a contributing factor to Down syndrome is deterioration of the female’s egg or the male’s sperm as people age (Newman & Newman, 2015). Mothers aged 40 and over “are also at slightly higher risk for maternal death, premature delivery, cesarean sections, and low-birth-weight babies (London, 2004). As women age, chronic illnesses such as high blood pressure

1Down syndrome is a congenital condition resulting from a chromosomal abnormality. It is characterized by intellectual disability and by physical features including think folds at the corners of the eyes, making them appear slanted; short stature; a wide, short skull; broad hands with short fingers; and wide spaces between the first and second toes (Friend, 2008; Mish, 2008). People with the most common type of Down syndrome, trisomy 21, have an extra chromosome.
and diabetes may also present pregnancy- and birth-related complications” (Yarber & Sayad, 2013, p. 375).

Teen mothers account for about 24 births per 1,000 females in the United States in 2014 (LOC, 2016). Their infants have twice the mortality rates of infants born to mothers in their 20s (Santrock, 2016). Their infants are more likely to be underweight and experience a greater risk of health problems and disabilities (Papalia & Martorell, 2015). Problems are often due to an immature reproductive system, inadequate nutrition, poor or no prenatal care, and poverty (Santrock, 2016; Smithbattle, 2007).

**Maternal Stress**

Maternal stress is another factor that can affect fetal development (Kail & Cavenaugh, 2014; Rathus, 2014a). Bjorklund and Blasi (2014) explain:

*Women who experience high levels of stress during pregnancy are more apt to have premature births and low-weight babies (Mulder et al., 2002). It is important to note that stress is not some phantom effect but quite real in its physical effects: it causes decreased nutrients and oxygen to the fetus and weakens the mother’s immune system, making the fetus more vulnerable as well. Stress in the mother can cause hormone imbalances in the placenta. In addition, women with high levels of stress are more apt to engage in behaviors that are harmful to the fetus, such as tobacco and alcohol use. (pp. 108–109)*

**Other Factors**

Other factors have been found to affect prenatal and postnatal development. For example, lower income level and socioeconomic class can pose health risks to any mother and her fetus (Newman & Newman, 2015). Illness during pregnancy may damage the developing fetus. Rubella (German measles) can cause physical or mental disabilities in the fetus if a woman contracts it during the first three months of pregnancy (Yarber & Sayad, 2016). Prevention of rubella is possible by vaccination; however, this should not be done during pregnancy because it can harm the fetus.

Sexually transmitted infections (STIs) may also be transmitted from mother to newborn in the womb, during birth, or afterward. Pregnant women should be tested for “chlamydia, gonorrhea, hepatitis B, HIV, and syphilis” (described in Chapter 6; Yarber & Sayad, 2016, p. 371). Transmission can often be prevented or infants treated successfully. For example, acquired immune deficiency syndrome (AIDS), which is transmitted by the human immunodeficiency virus (HIV), can infect a fetus through the placenta; it can also infect an infant at birth if there is contact with the mother’s blood, or through breast milk. However, administration of certain drugs, such as azidothymidine (AZT), to the mother during pregnancy and to the infant after birth, in addition to performing a cesarean section (surgical removal of the infant from the womb), has radically decreased mother-to-infant HIV transmission rates in the United States (Santrock, 2016).

**Prenatal Assessment**

Tests are available to determine whether a developing fetus has any of a variety of defects. These tests include ultrasound sonography, fetal MRI, amniocentesis, chorionic villus sampling, and maternal blood tests.

“The development of brain imaging techniques has led to increasing use of fetal MRI to diagnose fetal malformations” (Schmid et al., 2011). “MRI (magnetic resonance imaging) uses a powerful magnet and radio images to generate detailed images of the body’s organs and structures” (Santrock, 2016, p. 61). Ultrasound sonography is generally the first and much more common option for fetal screening because it is cost effective and safe. However, when a clearer image or more information is required to provide an accurate diagnosis and effective treatment planning, an MRI can be used. Frequently, ultrasound sonography will identify a potential abnormality and a subsequent MRI will offer a more comprehensive, clearer picture of what’s involved (Mangione et al., 2011). “Among the fetal malformations that fetal MRI may be able to detect better than ultrasound sonography are certain central nervous system, chest, gastrointestinal, genital/urinary, and placental abnormalities” (Nemec et al., 2011; Triulzi, Managaro, & Volpe, 2011; Amini, Wikstrom, Ahlstrom, & Axelsson, 2011; Santrock, 2016, p. 61).

**Amniocentesis** involves the insertion of a needle through the abdominal wall and into the uterus to obtain amniotic fluid for determination of fetal gender or chromosomal abnormalities. The amniotic fluid contains fetal cells that can be analyzed for a
variety of birth defects including Down syndrome, muscular dystrophy, and spina bifida. The gender of the fetus can also be determined. Amniocentesis is recommended if a woman has had a baby with a birth defect, may be a genetic carrier of such a defect, or is over age 35. A disadvantage of amniocentesis is that the test is usually performed about the 16th or 17th week of pregnancy (Charlesworth, 2014). Results are available in about 2 weeks after that (Santrock, 2016). If a serious problem is discovered, people don’t have much time to decide whether to terminate the pregnancy. Another danger is a small risk of miscarriage (Rathus, 2014a; Santrock, 2016).

Chorionic villus sampling (CVS) is another method of diagnosing defects in a developing fetus. It involves the insertion of a thin plastic tube through the vagina or a needle through the abdomen into the uterus. A sample of the chorionic villi (tiny fingerlike projections on the membrane that surrounds the fetus) is taken for analysis of potential genetic irregularities (National Institutes of Health [NIH], 2014). It can be performed between the 10th and 12th weeks of pregnancy, with results received within about two weeks (NIH, 2014). An advantage of CVS is that it can be done earlier in the pregnancy than amniocentesis. Couples may have a different perspective on whether to abort or keep a defective fetus at this early stage of the pregnancy. A disadvantage of CVS, as with amniocentesis, is an increased risk of miscarriage (Charlesworth, 2014; NIH, 2014; Rathus, 2014a).

Maternal blood tests done between the 16th and 18th weeks of gestation can detect a variety of conditions (Santrock, 2016). For instance, the amount of a substance called alpha-fetoprotein (AFP) can be measured. High levels of AFP forewarn about abnormalities of the brain and spinal cord. Testing AFP levels can also detect Down syndrome. Ultrasound sonography or amniocentesis can then be used to verify the presence of such congenital conditions.

In addition to a pregnant woman’s behavior and condition, numerous other variables in the macro environment and in a woman’s personal situation also directly affect the fetal condition. Highlight 2.1 discusses how social workers can help pregnant women access and maximize the use of prenatal care.
Social Workers Can Assist Women in Getting Prenatal Care: Implications for Practice

Prenatal care is considered vital "because it provides social workers and other health professionals with opportunities to identify pregnant women who are at risk of premature or low-weight births, and to deliver the medical, nutritional, educational, or psychosocial interventions that can promote positive pregnancy outcomes" (Perloff and Jeffee, 1999, p. 117). Early prenatal care is especially significant because of the developing fetus's vulnerability. It is important not to assume that all women's knowledge about prenatal care and easy access to such care is equal.

Barriers to obtaining prenatal care may include a number of factors. Women may be struggling with numerous other life issues (e.g., poverty, stress, and demands on their time for other things). Clinics and services may not be readily available and easy for them to reach. Pregnant women may experience difficulties in getting transportation for services or be struggling with other work and child-care demands. They may distrust the health-care system generally. They may have had previous bad experiences with respect to other health-care issues. They may have faced long waiting periods, crowded conditions, and inconvenient hours while trying to get services (Sable & Kelly, 2008).

There are several implications for social work practice. First, workers can help women navigate a complex health-care system, making certain they have ready access to available insurance and Medicaid payments. Second, practitioners can advocate with clinics to improve their internal environments. Providing child care, magazines, comfortable furniture, and refreshments can significantly improve the clinic experience. Third, workers can assist pregnant women "in gaining access to clinic resources (for example, appointments, laboratory tests, and educational seminars) through regular, ongoing contact with clients" (Cook, Selig, Wedge, & Baube, 1999, p. 136). Fourth, practitioners can "develop innovative service delivery models," including screening women during their initial visit to identify those at greatest risk, mailing or calling reminders of clinic appointments, and participating in community outreach (p. 136). Outreach might entail conducting door-to-door case-finding of pregnant women to expedite early initiation of prenatal care. This could involve sharing information about risks posed without care, benefits of care, and the availability of services.

Problem Pregnancies

In addition to factors that can affect virtually any pregnancy, other problems can develop under certain circumstances. These problems include ectopic pregnancies, toxemia, and Rh incompatibility. Spontaneous abortions also happen periodically.

Ectopic Pregnancy

When a fertilized egg begins to develop somewhere other than in the uterus, it is called an ectopic pregnancy or tubal pregnancy. In most cases, the egg becomes implanted in the fallopian tube. Much more rarely, the egg is implanted outside the uterus somewhere in the abdomen.

Ectopic pregnancies most often occur because of a blockage in the fallopian tube. The current rate of ectopic pregnancy has increased dramatically from what it was 30 years ago (Hyde & DeLamater, 2014). This may be attributed partially to increasing rates of STIs that result in scar tissue (Hyde & DeLamater, 2017). Others have hypothesized that this increase in ectopic pregnancies may be due to the increased use of fertility drugs and escalating external stresses in the environment (Kelly, 2008).

Ectopic pregnancies in the fallopian tubes "may spontaneously abort and be released into the abdominal cavity, or the embryo and placenta may continue to expand, stretching the tube until it ruptures" (Hyde & DeLamater, 2017, p. 140). In the latter case, surgical removal is necessary to save the mother's life.

Toxemia

Toxemia (also called preeclampsia) is an abnormal condition involving a form of blood poisoning. Carroll (2013b) explains:

In the last 2 to 3 months of pregnancy, 6% to 7% of women experience toxemia . . . or preeclampsia. Symptoms include rapid weight gain, fluid retention, an increase in blood pressure [hypertension], and protein in the urine. If toxemia is allowed to progress, it can result in eclampsia, which involves convulsions, coma, and in approximately 15% of cases, death . . . Overall, [African American] . . .
women are at higher risk for eclampsia than White or Hispanic women . . . (p. 319; emphasis in original)

**Rh Incompatibility**

People’s red blood cells differ in their surface structures and can be classified in different ways (Santrock, 2016). One way of distinguishing blood type involves categorizing it as either A, B, O, or AB. Another way to differentiate blood cells involves the Rh factor, which is positive if the red blood cells carry the marker or negative if they don’t (Santrock, 2016). If the mother has Rh-negative blood and the father has Rh-positive blood, the fetus may also have Rh-positive blood. This results in **Rh incompatibility** between the mother’s and fetus’s blood, and the mother’s body forms antibodies in defense against the fetus’s incompatible blood. Problem pregnancies and a range of defects in the fetus may result. Problems are less likely to occur in the first pregnancy than in later ones, because antibodies have not yet had the chance to form. The consequence to an affected fetus can be intellectual disability, anemia, or death.

Fortunately, Rh incompatibility can be dealt with successfully. The mother is injected with a serum, RhoGAM, that prevents the development of future Rh-negative sensitivity. This must be administered within 72 hours after the first child’s birth or after a first abortion. In those cases where Rh sensitivity already exists, the newborn infant or even the fetus within the uterus can be given a blood transfusion.

**Spontaneous Abortion**

A **spontaneous abortion** or miscarriage is the termination of a pregnancy due to natural causes before the fetus is capable of surviving on its own. About 20 to 25 percent of all diagnosed pregnancies result in a spontaneous abortion; however, about 50 percent of non-diagnosed pregnancies are terminated by a spontaneous abortion (Hyde & DeLamater, 2017). Thus, a woman may not even be aware of the pregnancy when the miscarriage occurs. Sometimes it is perceived as an extremely heavy menstrual period. The vast majority of miscarriages occur within the first trimester, with only a small minority occurring during the second or third trimester.

Most frequently, spontaneous abortions occur as a result of a defective fetus or some physical problem of the expectant mother. The body for some reason knows that the fetus is defective or that conditions are not right, and expels the fetus. Maternal problems may include a uterus that is “too small, too weak, or abnormally shaped . . . maternal stress, nutritional deficiencies, excessive vitamin A, drug exposure, or pelvic infection” (Carroll, 2013b, p. 318). Some evidence indicates that faulty sperm may also be to blame (Carrell et al., 2003).

**The Birth Process**

The birth process involves three stages: early labor and active labor, the birth of the baby, and delivery of the placenta.
There are three phases of the first stage of labor: early labor, active labor, and the transition phase. Early labor is the longest phase, lasting from 8 to 12 hours (American Pregnancy Association, 2015). Contractions may come every 5–30 minutes, lasting about 30–45 seconds each time (American Pregnancy Association, 2015). As the woman moves through early labor, contractions will increase in frequency and duration. During early labor, the cervix will begin to dilate and contractions start. The woman may experience a bloody mucus discharge (the mucus plug that has been sealing the opening of the uterus is discharged) and lower back pain that will not go away (back labor); and her “water” (amniotic sac) may break (American Pregnancy Association, 2015).

For women who have health complications, such as hypertension or preeclampsia, a baby whose health may be in danger (lack of oxygen), or whose amniotic sac has ruptured but whose labor has not started, labor may be induced. Labor may be induced by starting medications, such as oxytocin and prostaglandin; by artificially rupturing the amniotic sac for those who have not experienced this yet; or by nipple stimulation to increase oxytocin production, which may trigger labor (American Pregnancy Association, 2015). More and more women are choosing to induce labor as a means of “scheduling” their pregnancies; however, doctors encourage women to keep the baby in the uterus as long as medically possible.

In addition, some women experience Braxton Hicks contractions during early labor, referred to as “false labor.” This occurs when the uterus tightens for a period of 30 seconds to 2 minutes. Unlike true labor, Braxton Hicks contractions do not grow longer, stronger, or closer together. It is important for a woman to talk to her doctor about her contractions to verify the type of contractions she is experiencing.

The second phase of early labor, active labor, lasts from 3–5 hours, during which time contractions feel stronger and last longer. It is important that the woman head to the hospital or contact the midwife during this process if she has not done so already.

Local anesthesia or an epidural (spinal anesthesia) may also be given to aid in reducing any pain during the labor process. Typically, women make a plan about having a baby naturally (without medications) or with anesthesia prior to going into labor; however, it is not uncommon for a woman to change her mind about the use or non-use of an anesthesia once labor has begun. During the final phase, the transition, the cervix will dilate to 8–10 cm. This tends to be the hardest phase, but lasts the shortest amount of time (from 30 minutes to 2 hours). Contractions are long, strong, and intense (occurring every 30 seconds to 2 minutes and lasting about 60–90 seconds) (American Pregnancy Association, 2015). In addition, the woman might experience nausea, hot flashes, or chills, and have a strong urge to push. During the second stage of transition, the birth of the baby occurs. The second stage can last from 20 minutes to 2 hours (American Pregnancy Association, 2015). The woman will be encouraged to push between contractions to help the baby move through the birth canal. The cervix is fully dilated, allowing the baby to move through the vagina. The baby’s head will eventually appear, called “crowning,” at which time the woman is told not to push any longer.

After the baby completely emerges, the umbilical cord, which still attaches the baby to its mother, is clamped and severed about three inches from the baby’s body. Because there are no nerve endings in the cord, this does not hurt. The small section of cord remaining on the infant gradually dries up and simply falls off.

At times, an episiotomy (making an incision in the perineum, away from the vagina) might be needed to help deliver the baby. This may occur when the baby’s head is too large for the vaginal opening, the baby is in distress, the perineum has not stretched enough, the baby is in a breech position, or the mother is unable to control her pushing (American Pregnancy Association, 2015). It is important to note that episiotomy rates are on the decline (American Congress of Obstetricians and Gynecologists, 2016). The American Congress of Obstetricians and Gynecologists recommends that physicians avoid performing routine episiotomies, using them only when needed for safety reasons (American Congress of Obstetricians and Gynecologists, 2016).

The last stage of labor, the afterbirth, involves the body contracting in order to remove the placenta from the uterine wall. This can take from 5 to 30 minutes (American Pregnancy Association, 2015).

**Birth Positions**

The majority of babies are born with their heads emerging first. Referred to as a **vertex presentation**, this is considered the normal birth position and
most often requires no assistance with instruments. Figure 2.1 depicts various birth positions.

In 1 in 25 deliveries, babies are born in a breech presentation (Santrock, 2016, p. 101). Here, the buttocks and feet appear first and the head last as the baby is born. This type of birth may merit more careful attention. Often a cesarean section is performed (Santrock, 2016). A cesarean section, or C-section, is a surgical procedure in which the baby is removed by making an incision in the abdomen through the uterus. Cesarean sections account for over 32 percent of all births in the United States (CDC, 2015).

Note that more cesarean sections are carried out in the United States than in any other nation (Santrock, 2013). Cesarean sections are necessary when the baby is in a difficult prenatal position, when the baby's head is too large to maneuver out of the uterus and vagina, when fetal distress is detected, or when the labor has been extremely long and exhausting. Today it is usually safe with only minimal risks to the mother or infant. The mother's recovery, however, will be longer because the incisions must heal.

A common recommendation following a cesarean delivery is that all future deliveries be done via a cesarean delivery. Despite this, many women whose first child was born through a cesarean birth want to explore a VBAC (vaginal birth after cesarean). Physicians are concerned about risks associated with VBAC procedures, but due to recent studies showing risks being low, it has been determined that a trial of labor can be attempted for most women (Papalia & Martorell, 2015).

Finally, about 1 percent of babies are born with a transverse presentation (Dacey, Travers, & Fiore, 2009). Here the baby lies crossways in the uterus. During birth, a hand or arm usually emerges first in the vagina. As such positions also merit special attention, a cesarean section is typically performed (Santrock, 2016).

In the United States, 98.8 percent of all births occur in hospital settings, and a doctor is usually present (Martin et al., 2012). However, it's quite a different scene throughout much of the world, where home births and midwifery (the practice of having a person who is not a physician assist a mother in childbirth) are much more common. Although midwives are present for only 8.1 percent of births in the United States (American College of Nurse-Midwives, 2012), this reflects a significant increase from the less than 1 percent evident in 1975 (Martin et al., 2005).

Families also have the option of hiring a doula. A doula is a hired, trained professional who provides emotional and physical support to a woman and her partner during her entire pregnancy, from pregnancy to the postpartum period. A doula's main role is to provide support during the labor and delivery; however, it is important to note that a doula is not a medical professional. Research has shown that support from a doula might be associated with decreased use of pain medication, decreased length of labor, and a decrease in negative childbirth experiences during the labor process (MFMER, 2016).

**Natural Childbirth**

In natural childbirth, the emphasis is on education for the parents, especially the mother. The intent is to maximize her understanding of the process
and to minimize her fear of the unknown. Natural childbirth also emphasizes relaxation techniques. Mothers are encouraged to tune in to their normal body processes and learn to consciously relax when under stress. They are taught to breathe correctly and to facilitate the birth process by bearing down in an appropriate manner. The Lamaze method is currently popular in the United States, although other methods are also available. Most "emphasize education, relaxation and breathing exercises, and support" in addition to the partner’s role as a labor coach (Santrock, 2016, p. 107).

Many women prefer natural childbirth because it allows them to experience and enjoy the birth to the greatest extent possible. When done correctly, pain is minimized. Anesthetics are usually avoided so that maximum feeling can be attained. It allows the mother to remain conscious throughout the birth process.

**Newborn Assessment**

Birth is a traumatic process that is experienced more easily by some newborns, often referred to as neonates, and with more difficulty by others. Evaluation scales have been developed to assess an infant’s condition at birth. The sooner any problems can be attended to, the greater the chance of having the infant be normal and healthy. Two such scales are the Apgar and the Brazelton.
In 1953, Virginia Apgar developed a scale, commonly known as the Apgar scale, that assesses the following five variables (note the acronym):

1. Appearance: Skin color (ranging from bluish-gray to good color everywhere).
2. Pulse: Heart rate (ranging from no heart rate to at least 100 beats per minute).
3. Grimace: Reflex response (ranging from no response while the airways are being suctioned to active grimacing, pulling away, and coughing).
4. Activity: Muscle tone (ranging from limpness to active motion).
5. Respiration: Breathing (ranging from not breathing to normal breathing and strong crying) (Apgar, 1958; Berk, 2013; Steinberg et al., 2011a).

Each of these five variables is given a score of 0 to 2. Evaluation of these signs usually occurs twice—at one minute and at five minutes after birth. A maximum total score of 10 is possible. Scores of 7 through 10 indicate a normal, healthy infant. Scores of 4 through 6 suggest that some caution be taken and that the infant be carefully observed. Scores of 4 or below warn that problems are apparent. In these cases, the infant needs immediate emergency care.

A second scale used to assess the health of a newborn infant is the Brazelton (1973) Neonatal Behavioral Assessment Scale. Whereas the Apgar scale addresses the gross or basic condition of an infant immediately after birth, the Brazelton assesses more extensively the functioning of the central nervous system and behavioral responses of a newborn. Usually administered 24 to 36 hours after birth, the scale focuses on finer distinctions of behavior. It includes a range of 28 behavioral items and 18 reflex items that evaluate such dimensions as motor system control, activity level, sucking reflex, responsiveness while awake or sleeping, and attentiveness to the external environment (Brazelton Institute, 2005). Extremely low scores can indicate brain damage or a brain condition that, given time, may eventually heal (Santrock, 2013).

**Birth Defects**

Birth defects refer to any kind of disfigurement or abnormality present at birth. Birth defects are much more likely to characterize fetuses that are miscarried. It should be noted that the term “birth defects” carries negative undertones, and that the term does not reflect the many abilities and talents of those affected by these problems. A consensus has not been reached as to a more appropriate term. Miscarriage provides a means for the body to prevent seriously impaired or abnormal births. The specific types of birth defects are probably infinite; however, some tend to occur with greater frequency.

**Down syndrome** is a disorder involving an extra chromosome that results in various degrees of intellectual disability. Accompanying physical characteristics include a broad, short skull; widely spaced eyes with an extra fold of skin over the eyelids; a round, flattened face; a flattened nose; a protruding tongue; shortened limbs; and defective heart, eyes, and ears. We’ve already noted that a woman’s chances of bearing a child with Down syndrome increase significantly with her age.

**Spina bifida** is a condition in which the spinal column has not fused shut and consequently some nerves remain exposed. Surgery immediately after birth closes the spinal column. Muscle weakness or paralysis and difficulties with bladder and bowel control often accompany this condition. Frequently occurring along with spina bifida is hydrocephalus, in which an abnormal amount of spinal fluid accumulates in the skull, possibly resulting in skull enlargement and brain atrophy. Spina bifida has a prevalence rate of 3.49 per 10,000 births (Centers for Disease Control [CDC], 2011).

**Low-Birth-Weight and Preterm Infants**

Low birth weight and preterm status (prematurity) pose grave problems for newborns. Low birth weight is defined as 5 pounds 8 ounces or less; “about 1 in every 12 babies in the United States is born with low birth weight” (March of Dimes, 2014). Primary causes for low birth weight are premature birth and fetal growth restriction (i.e., being small for gestational age due to any of a number of reasons); other maternal factors increasing risk for low birth weight include chronic health conditions (such as those involving high blood pressure, diabetes, or lung and kidney problems), some infections (especially those involving the uterus), troubles with the placenta (resulting in inadequate nutrients provided to the fetus), inadequate weight gain during pregnancy, and the pregnant mother’s behavior and experience (e.g., smoking, drinking, poor nutrition, chronic maternal health problems, and lack of access to adequate resources) (March of Dimes, 2014).

Preterm or premature babies, born before the 37th week of gestation, often experience low birth weight.
An International Perspective on Low-Birth-Weight Infants

Santrock (2013) reflects on the circumstances of low-birthweight infants in various countries around the world:

The incidence of low birth weight varies considerably from country to country. In some countries, such as India and Sudan, where poverty is rampant and the health and nutrition of mothers are poor, the percentage of low birth weight babies reaches as high as 31 percent . . . In the United States, there has been an increase in low birth weight infants in the last two decades. The U.S. low birth weight rate of 8.2 percent in 2007 is considerably higher than that of many other developed countries (Hamilton et al., 2009). For example, only 4 percent of infants born in Sweden, Finland, Norway, and Korea are low birth weight, and only 5 percent of those born in New Zealand, Australia, and France are low birth weight.

The causes of low birth weight also vary (Mortensen et al., 2009). In the developing world low birth weight stems mainly from the mother’s poor health and nutrition (Christian, 2009). For example, diarrhea and malaria, which are common in developing countries, can impair fetal growth if the mother becomes affected while she is pregnant. In developed countries, cigarette smoking during pregnancy is the leading cause of low birth weight (Fertig, 2010). In both developed and developing countries, adolescents who give birth when their bodies are not fully matured are at risk of having low birth weight babies (Malamitsi-Puchner & Boutsikou, 2006).

In the United States, the increase in the number of low birth weight infants is due to such factors as the use of drugs, poor nutrition, multiple births, reproductive technologies, and improved technology and prenatal care, resulting in a higher survival rate of high-risk babies (Chen et al., 2007). Nonetheless, poverty still is a major factor in preterm birth in the United States . . . (p. 121).

A full-term pregnancy is considered to last between 37 and 42 weeks, with most babies being born at about 40 weeks; about 1 in 10 of all babies born in the United States are preterm (CDC, 2015). Premature infants tend to weigh less because they haven’t had the necessary time to develop. Risk factors for premature birth include having born a prior premature baby, being part of a multiple birth scenario, and uterine or cervical abnormalities (CDC, 2013d). Other risk factors resemble those involved in infants having a low birth weight (CDC, 2015).

Both low birth weight and preterm status place infants at higher risk for a range of problems (CDC, 2013d; March of Dimes, 2014). However, note that most low-birth-weight babies eventually function normally (Santrock, 2013; Wilson-Costello et al., 2007; Xiong et al., 2007). The earlier infants are born and the lower their birth weight, the greater their potential for developmental delays and long-term disabilities (CDC, 2015; Santrock, 2016).

Due to modern technology and care, low-birthweight babies are much more likely to survive than they were in the past. Yet, early on, they are also more likely to experience problems involving breathing, bleeding, heart problems, intestinal difficulties, and potential loss of vision (March of Dimes, 2014). There is some indication that by school age, low-birth-weight children are more likely to experience learning and attention difficulties or breathing problems such as asthma (Anderson et al., 2011; Berk, 2013; Santo, Portuguez, & Nunes, 2009; Santrock, 2016). Increasing evidence indicates that low-birth-weight infants have greater difficulties socializing as adults (Berk, 2013; Moster, Lie, & Markestad, 2008). Be aware, however, that it is difficult to distinguish the direct effects of low birth weight from the effects of other variables such as an impoverished or abusive environment. Highlight 2.2 addresses the circumstances of low-birth-weight infants internationally.

Social work roles that are used to help pregnant women bear healthy infants might include that of a broker to help women get the resources they need. These resources include access to good nutrition and prenatal care. If such resources are unavailable,

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3One type of attention difficulty involves attention deficit hyperactivity disorder (ADHD). This is a syndrome of learning and behavioral problems beginning in childhood that is characterized by a persistent pattern of inattention, excessive physical movement, and impulsivity that appears in at least two settings. ADHD is discussed further in Chapter 3.
especially to poor women, social workers might need to advocate on the women's behalf. Funding sources and services might need to be developed.

Treatment for low-birth-weight babies includes immediate medical attention to meet their special needs and provision of educational and counseling support. Group counseling for parents and weekly home visits to teach parents how to care for their children, play with them, and provide stimulation to develop cognitive, verbal, and social skills also appear to be helpful.

Early Functioning of the Neonate
The average full-term newborn weighs about 7½ pounds and is approximately 20 inches long (most weigh from 5½ to 10 pounds, and measure from 18 to 22 inches long). Girls tend to weigh a bit less and to be shorter than boys. Many parents may be surprised at the sight of their newborn, who does not resemble the cute, pudgy, smiling, gurgling baby typically shown in television commercials. Rather, the baby is probably tiny and wrinkled with a disproportionate body and squinting eyes. Newborns need time to adjust to the shock of being born. Meanwhile, they continue to achieve various milestones in development. They gain more and more control over their muscles and are increasingly better able to think and respond.

First, newborn babies generally spend much time sleeping, although the time spent decreases as the baby grows older. Second, babies tend to respond in very generalized ways. They cannot make clear distinctions among various types of stimuli, nor can they control their reactions in a precise manner. Any type of stimulation tends to produce a generalized flurry of movement throughout the entire body.

Several reflexes that characterize newborns should be present in normal neonates. First, there is the sucking reflex. This obviously facilitates babies' ability to take in food. Related to this is a second basic reflex, rooting. Normal babies will automatically move their heads and begin a sucking motion with their mouths whenever touched even lightly on the lips or cheeks beside the lips. The rooting reflex refers to this automatic movement toward a stimulus.

A third important reflex is the Moro reflex, or startle reflex. Whenever infants hear a sudden loud noise, they automatically react by extending their arms and legs, spreading their fingers, and throwing their heads back. The purpose of this reflex is unknown, and it seems to disappear after a few months of life.

Five additional reflexes are the stepping reflex, the grasping reflex, the Babinski reflex, the swimming reflex, and the tonic neck reflex. The stepping reflex involves infants' natural tendency to lift a leg when held in an upright position with feet barely touching a surface. In a way, it resembles the beginning motions involved in walking. The grasping reflex refers to a newborn's tendency to grasp and hold objects such as sticks or fingers when placed in the palms of their hands. The Babinski reflex involves the stretching, fanning movement of the toes whenever the infant is stroked on the bottom of the foot. The swimming reflex involves infants making swimming motions when they're placed face down in water. Finally, the tonic neck reflex is the infant's turning of the head to one side when laid down on its back, the extension of the arm and leg on the side it's facing, and the flexing of the opposite limbs. Sometimes, this is referred to as the "fencer" pose as it resembles just that.

LO 2 Explain Typical Developmental Milestones for Infants and Children
As infants grow and develop, their growth follows certain patterns and principles. At each stage of development, people are physically and mentally capable of performing certain types of tasks. Human development is the continuous process of growth and change, involving physical, mental, emotional, and social characteristics, that occurs over a lifespan. Human development is predictable in that the same basic changes occur sequentially for everyone. However, enough variation exists to produce individuals with unique attributes and experiences.

Four major concepts are involved in understanding the process of human development: (1) growth as a continuous, orderly process, (2) specific characteristics of different age levels, (3) the importance of individual differences, and (4) the effects of both heredity and the social environment.

Growth as a Continuous, Orderly Process
People progress through a continuous, orderly sequence of growth and change as they pass from one
age level to another. This has various implications. For one thing, growth is continuous and progressive. People are continually changing as they get older. For another thing, the process is relatively predictable and follows a distinct order. For example, an infant must learn how to stand up before learning how to run. All people tend to follow the same order in terms of their development. For instance, all babies must learn how to formulate verbal sounds before learning how to speak in complete sentences.

Several subprinciples relate to the idea that development is an orderly process. One is that growth always follows a pattern from simpler and more basic to more involved and complex. Simple tasks must be mastered before more complicated ones can be undertaken.

Another subprinciple is that aspects of development progress from being more general to being more specific. Things become increasingly more differentiated. For example, infants initially begin to distinguish between human faces and other objects such as balloons. This is a general developmental response. Later they begin to recognize not only the human face, but also the specific faces of their parents. Eventually, as they grow older they can recognize the faces of Uncle Horace, Mr. Schmidt the grocer, and then-best friend Joey. Their recognition ability has progressed from being very basic to being very specific.

Two other subprinciples involve cephalocaudal development and proximodistal development. Cephalocaudal development refers to development from the head to the toes. Infants begin to learn how to use the parts of the upper body such as the head and arms before their legs. Proximodistal development refers to the tendency to develop aspects of the body trunk first and then later master manipulation of the body extremities (e.g., first the arms and then the hands).

Individual Differences

The third basic principle of development emphasizes that people have individual differences. Although people tend to develop certain capacities in a specified order, the ages at which particular individuals master certain skills may show a wide variation. Some people may progress through certain stages faster. Others will take more time to master the same physical and mental skills. Variation may occur in the same individual from one stage to the next. The specific developmental tasks and skills that characterize each particular age level may be considered an average of what is usually accomplished during that level. Any average may reflect a wide variation. People may still be "typical" if they fall at one of the extremes that make up the average.

The Nature-Nurture Controversy

A fourth principle involved in understanding human development is that both heredity and the surrounding environment affect development. Individual differences, to some extent, may be influenced by environmental factors. People are endowed with some innate ability and potential. In addition, the impinging environment acts to shape, enhance, or limit that ability.

For example, take a baby who is born with the potential to grow and develop into a typical adult, both physically and intellectually. Nature provides the individual baby with some prospective potential. However, if the baby happens to be living in a developing country during a famine, the environment or nurture may have drastic effects on the baby’s development. Serious lack of nourishment limits the baby’s eventual physical and mental potential.

Given the complicated composition of human beings, the exact relationship between hereditary potential and environmental effects is unclear. It is impossible to quantify how much the environment affects development compared to how much development is affected by heredity. This is often referred to as the nature-nurture controversy. Theorists assume stands at both extremes. Some state that nature’s heredity is the most important. Others hypothesize that the environment imposes the crucial influence.

You might consider that each individual has a potential that is to some extent determined by inheritance. However, this potential is maximized or
minimized by what happens to people in their particular environments.

Former president Ronald Reagan maintained only a C average in college. Yet he was able to attain the most powerful position in the United States. It is difficult to determine how much of his success was due to innate ability and how much to situations and opportunities he encountered in his environment.

Our approach is that a person develops as the result of a multitude of factors including those that are inherited and those that are environmental.

**Relevance to Social Work**

Knowledge of human development and developmental milestones can be directly applied to social work practice. Assessment is a basic fact of intervention throughout the lifespan. In order to assess human needs and human behavior accurately, the social worker must know what is considered normal or appropriate. He or she must decide when intervention is necessary and when it is not. Comparing observed behavior with what is considered normal behavior provides a guideline for these decisions.

This book will address issues in human development throughout the lifespan. A basic understanding of every age level is important for generalist practice. However, an understanding of the normal developmental milestones for young children is especially critical. Early assessment of potential developmental lags or problems allows for maximum alleviation or prevention of future difficulties. For example, early diagnosis of a speech problem will alert parents and teachers to provide special remedial help for a child. The child will then have a better chance to make progress and possibly even catch up with peers.

**Profiles of Typical Development for Children Ages 4 Months to 11 Years**

Children progress through an organized sequence of behavior patterns as they mature. Research has established indicators of normality such as when children typically say their first word, run adeptly, or throw a ball overhand. These milestones reflect only an average indication of typical accomplishments. Children need not follow this profile to the letter. Typical human development provides for much individual variation. Parents do not need to be concerned if their child cannot yet stand alone at 13 months instead of the average 12 months. However, serious lags in development or those that continue to increase in severity should be attended to. This list can act as a screening guide to determine whether a child might need more extensive evaluation.

Each age profile is divided into five assessment categories. They include motor or physical behavior, play activities, adaptive behavior that involves taking care of self, social responses, and language development. All five topics are addressed together at each developmental age level in order to provide a more complete assessment profile.

Occasionally, case vignettes are presented that describe children of various ages. Evaluate to what extent each of these children fits the developmental profile.

**Age 4 Months**

*Motor:* Four-month-old infants typically can balance their heads at a 90-degree angle. They can also lift their heads and chests when placed on their stomachs in a prone position. They begin to discover themselves. They frequently watch their hands, keep their fingers busy, and place objects in their mouths.

*Adaptive:* Infants are able to recognize their bottles. The sight of a bottle often stimulates bodily activity. Sometimes teething begins tins early, although the average age is closer to 6 or 7 months.

*Social:* These infants are able to recognize their mothers and other familiar faces. They imitate smiles and often respond to familiar people by reaching, smiling, laughing, or squirming.

*Language:* The 4-month-old will turn his or her head when a sound is heard. Verbalizations include gurgling, babbling, and cooing.

**Age 8 Months**

*Motor:* Eight-month-old babies are able to sit alone without being supported. They usually are able to assist themselves into a standing position by pulling themselves up on a chair or crib. They can reach for an object and pick it up with all their fingers and a thumb. Crawling efforts have begun. These babies can usually begin creeping on all fours, displaying greater strength in one leg than the other.
Children achieve their developmental milestones step by step.

**Play:** The baby is capable of banging two toys together. Many can also pass an object from one hand to the other. These babies can imitate arm movements such as splashing in a tub, shaking a rattle, or crumpling paper.

**Adaptive:** Babies of this age can feed themselves pieces of toast or crackers. They will be able to munch instead of being limited to sucking.

**Social:** Babies of this age can begin imitating facial expressions and gestures. They can play pat-a-cake and peekaboo, and wave bye-bye.

**Language:** Babbling becomes frequent and complex. Most babies will be able to attempt copying the verbal sounds they hear. Many can say a few words or sounds such as *mama* or *dada*. However, they don’t yet understand the meaning of words.

**Age 1 Year**

**Motor:** By age 1 year, most babies can crawl well, which makes them highly mobile. Although they usually require support to walk, they can stand alone without holding onto anything. They eagerly reach out into their environments and explore things. They can open drawers, undo latches, and pull on electrical cords.

**Play:** One-year-olds like to examine toys and objects both visually and by touching them. They typically like to handle objects by feeling them, poking them, and turning them around in their hands. Objects are frequently dropped and picked up again one time after another. Babies of this age like to put objects in and take them out of containers. Favorite toys include large balls, bottles, bright dangling toys, clothespins, and large blocks.

**Adaptive:** Because of their mobility, 1-year-olds need careful supervision. Because of their interest in exploration, falling down stairs, sticking forks in electric sockets, and eating dead insects are constant possibilities. Parents need to scrutinize their homes and make them as safe as possible.

Babies are able to drink from a cup. They can also run their spoon across their plate and place the spoon in their mouths. They can feed themselves with their fingers. They begin to cooperate while being dressed by holding still or by extending an arm or a leg to facilitate putting the clothes on. Regularity of both bowel and bladder control begins.

**Social:** One-year-olds are becoming more aware of the reactions of those around them. They often vary their behavior in response to these reactions. They enjoy having an audience. For example, they tend to repeat behaviors that are laughed at. They also seek attention by squealing or making noises.

**Language:** By 1 year, babies begin to pay careful attention to the sounds they hear. They can
understand simple commands. For instance, on request they often can hand you the appropriate toy. They begin to express choices about the type of food they will accept or about whether it is time to go to bed. They imitate sounds more frequently and can meaningfully use a few other words in addition to *mama* and *dada*.

**Case Vignette A:** To what extent does this child fit the developmental profile?

Wyanet, age 1 year, is able to balance her head at a 90-degree angle. She can also lift her head when placed on her stomach in a prone position. She is not yet able to sit alone. She can recognize her bottle and her mother. Verbalizations include gurgling, babbling, and cooing.

**Age 18 Months**

**Motor:** By 18 months, a baby can walk. Although these children are beginning to run, their movements are still awkward and result in frequent falls. Walking upstairs can be accomplished by a caregiver holding the baby’s hand. These babies can often descend stairs by themselves but only by crawling down backward or by sliding down by sitting first on one step and then another. They are also able to push large objects and pull toys.

**Play:** Babies of this age like to scribble with crayons and build with blocks. However, it is difficult for them to place even three or four blocks on top of each other. These children like to move toys and other objects from one place to another. Dolls or stuffed animals frequently are carried about as regular companions. These toys are also often shown affection such as hugging. By 18 months, babies begin to imitate some of the simple things that adults do such as turning pages of a book.

**Adaptive:** Ability to feed themselves is much improved by age 18 months. These babies can hold their own glasses to drink from, usually using both hands. They are able to use a spoon sufficiently to feed themselves.

By this age, children can cooperate in dressing. They can unfasten zippers by themselves and remove their own socks or hats. Some regularity has also been established in toileting training. These babies often can indicate to their parents when they are wet and sometimes wake up at night in order to be changed.

**Social:** Children function at the solitary level of play. It is normal for them to be aware of other children and even enjoy having them around; however, they don’t play with other children.

**Language:** Children’s vocabularies consist of more than 3 but less than 50 words. These words usually refer to people, objects, or activities with which they are familiar. They frequently chatter using meaningless sounds as if they were really talking like adults. They can understand language to some extent. For instance, children will often be able to respond to directives or questions such as “Give Mommy a kiss,” or “Would you like a cookie?”

**Case Vignette B:** To what extent does this child fit the developmental profile?

Luis, age 18 months, can crawl well but is unable to stand by himself. He likes to scribble with crayons and build with blocks. However, it is difficult for him to place even three or four blocks on top of each other. He can say a few sounds, including *mama* and *dada*, but he cannot yet understand the meaning of words.

**Age 2 Years**

**Motor:** By age 2, children can walk and run quite well. They also can often master balancing briefly on one foot and throwing a ball in an overhead manner. They can use the stairs themselves by taking one step at a time and by placing both feet on each step. They are also capable of turning pages of a book and stringing large beads.

**Play:** Two-year-olds are very interested in exploring their world. They like to play with small objects such as toy animals and can stack up to six or seven blocks. They like to play with and push large objects such as wagons and walkers. They also enjoy exploring the texture and form of materials such as sand, water, and clay. Adults’ daily activities such as cooking, carpentry, or cleaning are frequently imitated. Two-year-olds also enjoy looking at books and can name common pictures.

**Adaptive:** Two-year-olds begin to be capable of listening to and following directions. They can assist in dressing rather than merely cooperating. For example, they may at least try to button their clothes, although they are unlikely to be successful. They attempt washing their hands. A small glass can be held and used with one hand.

They use spoons to feed themselves fairly well. Two-year-olds have usually attained daytime bowel and bladder control with only occasional accidents. Nighttime control is improving but still not complete.
Social: These children play alongside each other, but not with each other in a cooperative fashion. They are becoming more and more aware of the feelings and reactions of adults. They begin to seek adult approval for correct behavior. They also begin to show their emotions in the forms of affection, guilt, or pity. They tend to have mastered the concept of saying no, and use it frequently.

Language: Two-year-olds can usually put two or three words together to express an idea. For instance, they might say, "Daddy gone," or "Want milk." Their vocabulary usually includes more than 50 words. Over the next few months, new vocabulary will steadily increase into hundreds of words. They can identify common facial features such as eyes, ears, and nose. Simple directions and requests are usually understood. Although 2-year-olds cannot yet carry on conversations with other people, they frequently talk to themselves or to their toys. It's common to hear them ask, "What's this?" in their eagerness to learn the names of things. They also like to listen to simple stories, especially those with which they are very familiar.

Case Vignette C: To what extent does this child fit the developmental profile?

Kenji, age 2 years, can walk well but still runs with an awkward gait. He likes to play with and push large objects such as wagons and walkers. He also likes to play alongside other children but is not able to play with them in a cooperative fashion. His vocabulary includes about 25 words, but he is not yet very adept at putting two to three words together to express an idea.

Age 3 Years

Motor: At age 3, children can walk well and also run at a steady gait. They can stop quickly and turn corners without falling. They can go up and down stairs using alternating feet. They can begin to ride a tricycle. Three-year-olds participate in a lot of physically active activities such as swinging, climbing, and sliding.

Play: By age 3, children begin to develop their imagination. They use books creatively such as making them into fences or streets. They like to push toys such as trains or cars in make-believe activities. When given the opportunity and interesting toys and materials, they can initiate their own play activities. They also like to imitate the activities of others, especially those of adults. They can cut with scissors and can make some controlled markings with crayons.

Adaptive: Three-year-olds can actively help in dressing. They can put on simple items of clothing such as pants or a sweater, although their clothes may be on backward or inside out. They begin to try buttoning and unbuttoning their own clothes. They eat well by using a spoon and have little spilling. They also begin to use a fork. They can get their own glass of water from a faucet and pour liquid from a small pitcher. They can wash their hands and face by themselves with minor help. By age 3, children can use the toilet by themselves, although they frequently ask someone to go with them. They need only minor help with wiping. Accidents are rare, usually happening only occasionally at night.

Social: Three-year-olds tend to pay close attention to the adults around them and are eager to please. They attempt to follow directions and are responsive to approval or disapproval. They also can be reasoned with at this age. By age 3, children begin to develop their capacity to relate to and communicate with others. They show an interest in the family and in family activities. Their play is still focused on the parallel level where their interest is concentrated primarily on their own activities. However, they are beginning to notice what other children are doing. Some cooperation is initiated in the form of taking turns or verbally settling arguments.

Language: Three-year-olds can use sentences that are longer and more complex. Plurals, personal pronouns such as I, and prepositions such as above or on are used appropriately. Children are able to express their feelings and ideas fairly well. They are capable of relating a story. They listen fairly well and are very interested in longer, more complicated stories than they were at an earlier age. They also have mastered a substantial amount of information including their last name, their gender, and a few rhymes.

Age 4 Years

Motor: Four-year-olds tend to be very active physically. They enjoy running, skipping, jumping, and performing stunts. They are capable of racing up and down stairs. Their balance is very good, and they can carry a glass of liquid without spilling it.
Play: By age 4, children have become increasingly creative and imaginative. They like to construct things out of clay, sand, or blocks. They enjoy using costumes and other pretend materials. They can play cooperatively with other children. They can draw simple figures, although they are frequently inaccurate and without much detail. Four-year-olds can also cut or trace along a line fairly accurately.

Adaptive: Four-year-olds tend to be very assertive. They usually can dress themselves. They’ve mastered the use of buttons and zippers. They can put on and lace their own shoes, although they cannot yet tie them. They can wash their hands without supervision. By age 4, children demand less attention while eating with their family. They can serve themselves food and eat by themselves using both spoon and fork. They can even assist in setting the table. Four-year-olds can use the bathroom by themselves, although they still alert adults of this and sometimes need assistance in wiping. They usually can sleep through the night without having any accidents.

Social: Four-year-olds are less docile than 3-year-olds. They are less likely to conform, in addition to being less responsive to the pleasure or displeasure of adults. Four-year-olds are in the process of separating from their parents and begin to prefer the company of other children over adults. They are often social and talkative. They are very interested in the world around them and frequently ask “what,” “why,” and “how” questions.

Language: The aggressiveness manifested by 4-year-olds also appears in their language. They frequently brag and boast about themselves. Name calling is common. Their vocabulary has experienced tremendous growth; however, they have a tendency to misuse words and some difficulty with proper grammar. Four-year-olds talk a lot and like to carry on long conversations with others. Their speech is usually very understandable with only a few remnants of earlier, more infantile speech remaining. Their growing imagination also affects their speech. They like to tell stories and frequently mix facts with make-believe.

Case Vignette D: To what extent does this child fit the developmental profile?

Chaniqwa, age 4 years, is very active physically. She enjoys running, skipping, jumping, and performing stunts. She can use the bathroom by herself. She has a substantial vocabulary, although she has a tendency to misuse words and use improper grammar.

Age 5 Years

Motor: Five-year-olds are quieter and less active than 4-year-olds. Their activities tend to be more complicated and more directed toward achieving some goal. For example, they are more adept at climbing and at riding a tricycle. They can also use roller skates, jump rope, skip, and succeed at other such complex activities. Their ability to concentrate is also increased. The pictures they draw, although simple, are finally recognizable. Dominance of the left or right hand becomes well established.

Play: Games and play activities have become both more elaborate and competitive. Games include hide-and-seek, tag, and hopscotch. Team playing begins. Five-year-olds enjoy pretend games of a more elaborate nature. They like to build houses and forts with blocks and to participate in more dramatic play such as playing house or being a space invader. Singing songs, dancing, and playing DVDs are usually very enjoyable.

Adaptive: Five-year-olds can dress and undress themselves quite well. Assistance is necessary only for adjusting more complicated fasteners and tying shoes. These children can feed themselves and attend to their own toilet needs. They can even visit the neighborhood by themselves, needing help only in crossing streets.

Social: By age 5, children have usually learned to cooperate with others in activities and enjoy group activities. They acknowledge the rights of others and are better able to respond to adult supervision. They have become aware of rules and are interested in conforming to them. Five-year-olds also tend to enjoy family activities such as outings and trips.

Language: Language continues to develop and becomes more complex. Vocabulary continues to increase. Sentence structure becomes more complicated and more accurate. Five-year-olds are very interested in what words mean. They like to look at books and have people read to them. They have begun learning how to count and can recognize colors. Attempts at drawing numbers and letters are begun, although fine motor coordination is not yet well enough developed for great accuracy.

Case Vignette E: To what extent does this child fit the developmental profile?
Sheridan, age 5 years, can draw simple although recognizable pictures. Dominance of her left hand has become well established. She can readily dress and undress herself. She enjoys playing in groups of other children and can cooperate with them quite well. She has a vocabulary of about 50 words. She can use pronouns such as I and prepositions such as on and above appropriately. She can put two or three words together and use them appropriately, although she has difficulty formulating longer phrases and sentences.

**Ages 6 to 8 Years**

**Motor:** Children ages 6 to 8 years are physically independent. They can run, jump, and balance well. They continue to participate in a variety of activities to help refine their coordination and motor skills. They often enjoy unusual and challenging activities, such as walking on fences, which help to develop such skills.

**Play:** These children participate in much active play such as kickball. They like activities such as gymnastics and enjoy trying to perform physical stunts. They also begin to develop intense interest in simple games such as marbles or tiddlywinks and collecting items. Playing with dolls is at its height.

Acting out dramatizations becomes very important; these children love to pretend they are animals, horseback riders, or jet pilots.

**Adaptive:** Much more self-sufficient and independent, these children can dress themselves, go to bed alone, and get up by themselves during the night to go to the bathroom. They can begin to be trusted with an allowance. They are able to go to school or to friends' homes alone. In general, they become increasingly more interested in and understanding of various social situations.

**Social:** In view of their increasing social skills, they consider playing skills within their peer group increasingly important. They become more and more adept at social skills. Their lives begin to focus around the school and activities with friends. They are becoming more sensitive to reactions of those around them, especially those of their parents. There is some tendency to react negatively when subjected to pressure or criticism. For instance, they may sulk.

**Language:** The use of language continues to become more refined and sophisticated. Good pronunciation and grammar are developed according to what they've been taught. They are learning how to put their feelings and thoughts into words to express themselves more clearly. They begin to understand more abstract words and forms of language. For
example, they may begin to understand some puns and jokes. They also begin to develop reading, writing, and numerical skills.

Ages 9 to 11 Years

*Motor:* Children continue to refine and develop their coordination and motor skills. They experience a gradual, steady gain in body measurements and proportion. Manual dexterity, posture, strength, and balance improve. This period of late childhood is transitional to the major changes experienced during adolescence.

*Play:* This period frequently becomes the finale of the games and play of childhood. If it has not already occurred, boys and girls separate into their respective same-gender groups.

*Adaptive:* Children become more and more aware of themselves and the world around them. They experience a gradual change from identifying primarily with adults to formulating their own self-identity. They become more independent. This is a period of both physical and mental growth. These children push themselves into experiencing new things and new activities. They learn to focus on detail and accomplish increasingly difficult intellectual and academic tasks.

*Social:* The focus of attention shifts from a family orientation to a peer orientation. They continue developing social competence. Friends become very important.

*Language:* A tremendous increase in vocabulary occurs. These children become adept at the use of words. They can answer questions with more depth of insight. They understand more abstract concepts and use words more precisely. They are also better able to understand and examine verbal and mathematical relationships.

A Concluding Note

We emphasize that individuals vary greatly in their attainment of specific developmental milestones. The developmental milestones provide a general baseline for assessment and subsequent intervention decisions. If a child is assessed as being grossly behind in terms of achieving normal developmental milestones, then immediate intervention may be needed. On the other hand, if a child is only mildly behind his or her normal developmental profile, then no more than close observation may be appropriate. In the event that the child continues to fall further behind, help can be sought and provided.

Significant Issues and Life Events

Two significant issues will be discussed that relate to the decision of whether to have children. They have been selected because they affect a great number of people and because they often pose a serious crisis for the people involved. The issues are abortion and infertility.

**LO 3 Examine the Abortion Controversy: Impacts of Social and Economic Forces**

Many unique circumstances are involved in any unplanned pregnancy. Individuals must evaluate for themselves the potential consequences of each alternative and assess the positive and negative consequences of each.

A basic decision involved in unplanned pregnancy is whether to have the baby. If the decision is made to have the baby, and the mother is unmarried, a subset of alternatives must then be evaluated. One option is to marry the father (or to establish some other ongoing relationship with him). A second alternative is for the mother to keep the baby and live as a single parent. In the past decade, the media have given increasing attention to fathers who seek custody. Joint custody is a viable option. Or the mother’s parents (the child’s grandparents) or other relatives could either keep the baby or assist in its care. Still another option is adoption. Each choice involves both positive and negative consequences.

Abortion is the termination of a pregnancy by removing an embryo or fetus from the uterus before it can survive on its own outside the womb. Social workers may find themselves in the position of helping their clients explore abortion as one possibility open to them. Highlight 2.3 provides a case example of how one young woman struggled with her dilemma.

The concept of abortion inevitably elicits strong feelings and emotions. These feelings can be very positive or negative. People who take stands against abortion often do so on moral and ethical grounds.
Case Example: Single and Pregnant

Roseanne was 21 years old and two months pregnant. She was a junior at a large midwestern state university, majoring in social work. Hank, the father, was a 26-year-old divorce she met in one of her classes. He already had a 4-year-old son named Ronnie.

Roseanne was filled with ambivalent feelings. She had always pictured herself as being a mother someday—but not now. She felt she loved Hank but had many reservations about how he felt in return. She'd been seeing him once or twice a week for the past few months. Hank didn't really take her out much, and she suspected that he was also dating other women. He had even asked her to babysit for Ronnie while he went out with someone else.

That was another thing—Ronnie. She felt Ronnie hated her. He would snarl whenever she came over and make nasty, cutting remarks. Maybe he was jealous that his father was giving Roseanne attention.

The pregnancy was an accident. She simply didn't think anything would happen. She knew better now that it was too late. Hank had never made any commitment to her. In some ways he felt he was a creep, but at least he was honest. The fact was that he just didn't love her.

The problem was, what should she do? A college education was important to her and to her parents. Money had always been a big issue. Her parents helped her as much as they could, but they also had other children in college. Roseanne worked odd, inconvenient hours at a fast-food restaurant for a while. She also worked as a cook several nights a week at a diner.

What if she kept the baby? She was fairly certain Hank didn't want to marry her. Even if he did, she didn't think she'd want to be stuck with him for the rest of her life. How could she possibly manage on her own with a baby? She shared a two-bedroom apartment with three other female students. How could she take care of a baby with no money and no place to go? She felt dropping out of college would ruin her life. The idea of going on welfare instead of working in welfare was terrifying.

What about adoption? That would mean seven more months of pregnancy while she was going to college. She wondered what her friends and family would say about choosing adoption as an option. She thought about how difficult that would be—she would always wonder where her child was and how he or she was doing. She couldn't bear the thought of pursuing this option.

Yet, the idea of an abortion scared her. She had heard so many people say that it was murder.

Roseanne made her decision, but it certainly was not an easy one. She carefully addressed and considered the religious and moral issues involved in terminating a pregnancy. She decided that she would have to face the responsibility and the guilt. In determining that having a baby at this time would be disastrous both for herself and for a new life, she decided to have an abortion.

Fourteen years have passed. Roseanne is now 35. She is no longer in social work, although she finished her degree. She does have a good job as a court reporter. This job suits her well. She's been married to Tom for three years. Although they have their ups and downs, she is happy in her marriage. They love each other very much and enjoy their time together.

Roseanne thinks about her abortion once in a while. Although she is using no method of contraception, she has not yet gotten pregnant. Possibly she never will. Tom is 43. He has been married once before and has an adult child from that marriage. He does not feel it is a necessity for them to have children.

Roseanne is ambivalent. She is addressing the possibility of not having children and is looking at the consequences of that alternative. She puts it well by saying that sometimes she mourns the loss of her unborn child. Yet, in view of her present level of satisfaction and Tom's hesitation about having children, she feels that her life thus far has worked out for the best.

A common theme is that each unborn child has the right to life. On the opposite pole are those who feel strongly in favor of abortion. They feel that women have the right to choice over their own bodies and lives.

The issue concerning unplanned and, in this context, unwanted pregnancy provides an excellent example of how macro-system values affect the options available to clients. In June 1992, the U.S. Supreme Court ruled that states have extensive power to restrict abortions, although they cannot outlaw all abortions. Due to this ruling, restrictions have increased significantly. From 2011 to 2013, 205 new restrictions were enacted in the United States (Center for Reproductive Rights, 2014). If abortions are illegal or unavailable to specific groups in the population, then women's choices about what to do are much more limited.

The abortion issue illustrates how clients function within the contexts of their mezzo and macro environments. For example, perhaps a woman's parents are unwilling to help her with a newborn, or
The abortion issue is one of most controversial in the country. Here, opposite sides confront each other at a demonstration.

the child's father shuns involvement. In both these instances, some of the woman's potential mezzo system options have already been eliminated.

Options are also affected by macro environments. If abortion is illegal, then social agencies are unable to provide them. Another possibility is that states can legally allow abortion only under extremely limited circumstances. For instance, it may be allowed only if the conception is the product of incest or rape, or if the pregnancy and birth seriously endanger the pregnant woman's life.

Even if states allow abortions, the community in which a pregnant woman lives can pose serious restrictions on her options. For instance, a community renowned for having a strong and well-organized antiabortion movement may be supportive of actions (including legal actions) to curtail abortion services. Abortion clinics can be picketed, patients harassed, and clinic staff personally threatened. Such strong community feelings can force clinics to close.

Additionally, the abortion issue provides an excellent opportunity to distinguish between personal and professional values. Each of us probably has an opinion about abortion. Some of us most likely have strong opinions either one way or the other. In practice, our personal opinions really don't matter. However, our professional approach does. As professionals, it is our responsibility to help clients come to their own decisions. Our job is to assist clients in assessing their own feelings and values, in identifying available alternatives, and in evaluating as objectively as possible the consequences of each alternative. It is critical that social workers provide options, not advice.

The National Association of Social Workers (NASW) has established issue and policy statements on family planning and reproductive choice that include its stance on abortion. A policy is a clearly stated or implicit procedure, plan, rule, or stance concerning some issue that serves to guide decision making and behavior. The statements read as follows:

"As social workers, we support the right of individuals to decide for themselves, without duress and according to their own personal beliefs and
convictions, whether they want to become parents, how many children they are willing and able to nurture, the opportunity for them to have children, and with whom they may choose to parent . . . To support self-determination, . . . reproductive health services, including abortion services, must be legally, economically, and geographically accessible to all who need them . . . Denying people with low income access to the full range of contraceptive methods, abortion, and sterilization services, and the educational programs that explain them, perpetuate poverty and the dependence on welfare programs and support the status quo of class stratification . . . NASW supports . . .

- [A] woman’s right to obtain an abortion, performed according to accepted medical standards and in an environment free of harassment or threat for both patients and providers.
- [R]eproductive health services, including abortion services, that are confidential, available at a reasonable cost, and covered in public and private health insurance plans on a par with other kinds of health services (contraceptive equity).
- [I]mproved access to the full range of reproductive health services, including abortion services, for groups currently underserved in the United States, including people with low income and those who rely on Medicaid to pay for their health care . . .” (NASW, 2012, pp. 131, 133)

Seven aspects of abortion are discussed here. First, we describe the current impact of legal and political macro systems. Second, we note the incidence of abortion and provide a profile of women who have abortions. Third, we explore reasons why women seek abortions. Fourth, we explain the abortion process and the types of abortion available. Fifth, we briefly examine some of the psychological effects of abortion. Sixth, we compare and assess the arguments for and against abortion. Seventh, we describe a variety of social work roles with respect to the abortion issue.

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*A Medicaid is a public assistance program, established in 1965 and funded by federal and state governments, that pays for medical and hospital services for eligible people, determined to be in need, who are unable to pay for these services themselves.

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The Impacts of Macro-System Policies on Practice and Access to Services

People’s values affect laws that, in turn, regulate policy regarding how people can make decisions and choose to act. Government and agency policies specify and regulate what services organizations can provide to women within communities. Subsequently, whether services are available or not controls the choices available to most pregnant women.

The abortion debate focuses on two opposing perspectives, antiabortion and pro-choice. Carroll (2013b) describes the antiabortion stance as the belief “that human life begins at conception, and thus an embryo, at any stage of development, is a person. Therefore, . . . aborting a fetus is murder, and . . . the government should make all abortions illegal” (p. 366).

Pro-choice advocates, on the other hand, focus on a woman’s right to choose whether to have an abortion. They believe that a woman has the right to control what happens to her own body, to navigate her own life, and to pursue her own current and future happiness.

For more than four decades, the political controversy over abortion has been raging. In 1973, the U.S. Supreme Court decision known as Roe v. Wade overruled state laws that prohibited or restricted a woman’s right to obtain an abortion during the first three months of pregnancy. States were allowed to impose restrictions in the second trimester only when such restrictions related directly to the mother’s health. Finally, during the third trimester states could restrict abortions or even forbid them, excluding those necessary to preserve a woman’s life and health. Women, in essence, won the right to “privacy,” or in other words, “the right to be left alone” (Hartman, 1991, p. 467). This, of course, is a pro-choice stance.

The courts have gotten increasingly more conservative concerning abortion. In Planned Parenthood v. Casey (1992), the Supreme Court ruled that states had the right to restrict abortions as they saw fit, except that they could not outlaw all abortions. Additionally, the Court has put restrictions of increasing severity into place. In Harris v. McRae (1980), the Court confirmed that both Congress and individual states could legally refuse to pay for abortions. This significantly affected poor women.

In Webster v. Reproductive Health Services (1989), the Supreme Court upheld a restrictive Missouri law.
This law "prohibits performing abortions in public hospitals unless the mother’s life is in danger; forbids the spending of state funds for counseling women about abortion; and requires doctors to add an expensive layer of testing before performing abortions after twenty weeks if they feel it will help them determine whether a fetus would be viable outside the womb" (Wermiel & McQueen, 1989, p. 1).

Since this decision, many states have passed bills imposing restrictions on abortions that will be discussed in more detail later (e.g., requiring waiting periods or parental consent for teens). Kirk and Okazawa-Rey (2013) reflect on the gradual chipping away of abortion rights:

For nearly forty years, well-funded anti-abortion groups have worked strategically to undermine and overturn the right to abortion. They have used public education, mainstream media, protests and direct action—including attacks on clinics and their staffs. They have financed and elected anti-choice political candidates at city, state, and congressional levels. Republican congresspersons have introduced bills after session to whittle away at the legality of abortion and elevate the unborn child, even as a "nonviable fetus," to the status of "personhood" with rights equal to or greater than those of the mother. If the Supreme Court overturns Roe v. Wade, legal jurisdiction will revert to the states, many of which are poised to ban abortion or to re-criminalize it. This issue is central to women's autonomy and will continue to be highly contentious. (p. 217)

The abortion debate continues. New decisions are made daily at the state and federal levels. However, numerous issues remain in the forefront when assessing the impacts on clients' rights and on their ability to function. Several have surfaced in recent years and will probably continue to characterize the abortion debate. We will discuss a number of them here: restricting access through legal barriers, limiting financial support, the mother's condition, the fetus's condition, violence against clinics, stem cell research, and intact dilation and extraction (often referred to by opponents as "partial-birth abortion"). Spotlight 2.1 presents some international perspectives on abortion policy.

**Restricting Access**

There are several ways legislation can restrict access to abortion (Center for Reproductive Rights [CRR], 2014). First, states can enact mandatory delays before an abortion can be performed. For example, a state may require a 24-hour waiting period from the time a woman initiates the abortion process to the time the procedure is completed. The decision to abort can be very painful for many reasons, and a waiting period can result in significant stress. Critics indicate that such rules aim to impose obstacles in getting abortions, thus discouraging women from doing so. This rule makes access to abortion especially difficult for poor women from rural areas who have to travel significant distances for the abortion and have little or no money for lodging.

A second type of restriction requires women to receive designated material that may present a negative view of abortion or counseling prior to undergoing an abortion. Critics of this legislation maintain that it only encourages women to delay an abortion procedure; "intrudes on a woman's autonomy and dignity; interferes with the physician's professional practice; and corrupts the informed consent process" (CRR, 2009).

The following summarizes state waiting periods and mandatory counseling requirements (Guttmacher Institute, 2016a).

- Thirty-five states require that women receive counseling prior to receiving an abortion.
- Twenty-seven of these states also require that a specified period of time, usually 24 hours, elapse between counseling and the actual abortion.
- Thirteen states require two separate visits to the facility, one for counseling and another to begin the waiting period.

A third legal barrier concerns requiring teenagers to either notify one or both parents or receive consent from one or both parents before getting an abortion. Some states also allow minors to seek a court order to exempt them from parental involvement. Thirty-eight states have enacted parental involvement laws (Guttmacher Institute, 2016b). Fear of confronting parents may cause many young women to delay making the decision to have an abortion. Receiving court permission, where allowed, may also result in difficult delays.

Other legal barriers can also be established. In 2013 Texas passed a law that "requires doctors performing abortions to have admitting privileges at a . . . hospital" that must be located within 30 miles of the clinic (Liptak, 2013). Although a number of
SPOTLIGHT ON DIVERSITY 2.1

International Perspective on Abortion Policy

Abortion incidence and policy vary around the world as explained by the following statistics (Guttmacher, 2016c). During 2010–2014, an estimated 56 million abortions occurred each year worldwide. This number is up from the rates of abortions from 1990 to 1994, mainly due to population growth. However, rates vary significantly among countries, especially between developed and developing nations. Women in developing regions have a higher likelihood of having an abortion than in developed regions. In developing regions, the number of abortions annually in 2014 was 50 million, whereas in developed regions the number was 7 million. The highest rates of abortion in 2010–2014 were in the Caribbean and South American, with the lowest rates being in North America and Western and Northern Europe. Induced abortions can be medically safe when done in accordance with recommended guidelines, but globally many are performed in unsafe conditions. Almost all abortion related deaths occur in developing countries.

Women who are poor that live in developing countries have little access to family planning services and few economic resources to pay for safe abortions. As a result, they are more likely to encounter health problems related to unsafe abortion practices. In places where abortion is legal, it tends to be much safer. On the other hand, where abortion is forbidden, it is less safe. That makes sense as legality offers the opportunity for trained, knowledgeable, and skilled personnel to perform abortions.

Huge variations exist around the world in abortion policy (Cohen, 2009):

Throughout Europe, except for Ireland and Poland, abortion is broadly legal, widely available and safe... China was the first large developing country to enact a liberal abortion law—in 1957. The Soviet Union and the central and western Asian republics enacted similar laws in the 1950s. Over the next 50 years, abortion become legal on broad grounds in a wide range of less developed countries, including Cuba (1965), Singapore (1970), India (1971), Zambia (1972), Tunisia (1973), Vietnam (1975), Turkey (1983), Taiwan (1985), Mongolia (1989), South Africa (1996) and Cambodia (1997).

Indeed, the worldwide trend in abortion law has continued to be toward liberalization. And since 1997, another 21 countries or populous jurisdictions have liberalized their laws, including Colombia, Ethiopia, Iran, Mexico City, Nepal, Portugal, and Thailand. During this same period, only three countries—El Salvador, Nicaragua, and Poland—have increased restrictions.

Today, 60% of the world’s 1.55 billion women of reproductive age (15–44) live in countries where abortion is broadly legal.

The remaining 40% live where abortion is highly restricted, virtually all in the developing world. In Africa, 92% of women of reproductive age live under severely restrictive laws; in Latin America, 97% do.

Also consider the following global facts (Cohen, 2009):

- Unsafe abortions take the lives of 70,000 women annually (or 12.5 percent of all deaths related to pregnancy).
- Around the world, seven women die from an unsafe abortion every hour.
- Eight million women experience complications from abortion that can be very serious.
- Almost 3 million women who experience serious complications related to abortion receive no medical attention.

Cohen (2009) makes the following conclusions. The most effective way to address unwanted pregnancy is to provide readily available contraception to prevent pregnancy from occurring to begin with. However, in developing nations where resources are scarce, this is now a difficult, perhaps impossible, goal. Women who are desperate will resort to abortion whether it is legal or not. In places where abortion is not legal, it is likely unsafe and potentially deadly.

abortion rights groups and clinics subsequently sought the attention of the U.S. Supreme Court, the Court refused to address and rule on the law. As a result, the law effectively closed 36 abortion clinics, left 24 counties without such services, and prevented “some 20,000 women a year from access to safe abortions” (Liptak, 2013).

Bill and Karen Bell (National Abortion Federation, 2004) tell the story of their “beautiful, vibrant, 17-year-old daughter Becky [who] died suddenly, after a six-day illness.” The diagnosis was a form of pneumonia “brought about by an illegal abortion.” Bill and Karen couldn’t believe that this had happened to their daughter. Why didn’t she tell them she was pregnant? They could have helped and supported her. They learned the heartbreaking answer by talking to Becky’s friends. Becky’s parents reflected, “Becky had told her girlfriends that she believed we would be terribly hurt and disappointed in her if she told us about her pregnancy. Like a lot of
young people, she was not comfortable sharing intimate details of her developing sexuality with her parents.” A parental consent law was in effect in Becky’s state. Although a request to the court was an option, the presiding judge had never granted a request for an abortion in over a decade. Desperate, Becky opted for an illegal, unsafe “back-alley abortion.”

The U.S. military also restricts access to abortion while at the same time women in the military report difficulty getting the type of birth control they wanted before deploying or having trouble refilling prescriptions while on duty (Miller, 2016). Medical treatment facilities on military bases are restricted from performing abortions for U.S. military personnel unless the life of the mother is endangered or the pregnancy is the result of rape or incest. This can cause difficulties for military women who want to seek an abortion as they may need to return to the United States to receive safe and legal abortions and it also forces them to have to pay out of pocket for the expense.

Limiting Financial Support

One clear trend since 1973 has been the antiabortion factions’ pressure to limit, minimize, and eventually prohibit any public financial support for abortion. This significantly affects poor women. Only 17 states provide Medicaid funding for medically necessary abortions (Guttmacher Institute, 2016d). (Medicaid is a public assistance program, established in 1965 and funded by federal and state governments, that pays for medical and hospital services for eligible people, determined to be in need, who are unable to pay for these services themselves.) The Hyde amendment, introduced to Congress in 1977, abolished federal funding for abortion unless a woman’s life was in danger. Congress has renewed this legislation annually, imposing various restrictions on abortion funding. Since 1993, Medicaid can fund an abortion only in the case of rape, incest, or a life-threatening situation; 32 states and the District of Columbia abide by this standard (Guttmacher Institute, 2016d).

“Even when a woman’s health is jeopardized by her pregnancy to the extent that it will leave her incapacitated, unable to care for her children or hold down a job, she is still not eligible for Medicaid funding in many states” (CRR, 2003, July 8).

Nabha and Blasdoll (2002) provide an example:

31-year-old “Alina” had bipolar disorder [a mental disorder involving extreme moods including manic frenzy, severe depression, or both] and obsessive-compulsive disorder [a mental disorder involving an obsession with organization, neatness, perfectionism, and control], and was taking psycho-tropic medications known to cause fetal anomalies. She also had fibromyalgia, a disease that causes weakness, exhaustion, numbness, and dizziness, in addition to other symptoms. As a result of these circumstances, Alina chose to have an abortion. Although Alina was enrolled in Medicaid during this period, the program in her state refused to cover abortions necessary to protect a woman’s health, so she was unable to receive any public funds.

Another approach for limiting financial support involves the concept of a gag rule—that is, banning federal funding to agencies that allow staff to talk to pregnant women about abortion as an alternative. Depending on the stance of various administrations, gag rules have been supported or rebuffed. For example, at one point Planned Parenthood said it would give up its federal funding rather than fail to discuss all options available to clients, including abortion. (Planned Parenthood is an international organization dedicated to promoting the use of family planning and contraception.) The gag rule also has the potential to prohibit giving federal money to international groups that perform abortions or provide abortion information.

Ten states forbid private insurance plans from covering abortion; 21 states restrict insurance coverage of abortions for public employees (Guttmacher Institute, 2016e).

Condition of the Mother

Some people support the idea that abortion is acceptable under specific conditions. One involves the mother’s health. Should an abortion be performed if carrying the fetus to full term will kill the mother? Whose life is more important—that of the mother or that of the fetus?

Another issue is this: Should a woman impregnated during rape or incest be forced to carry the fetus to term? Is it fair for a woman who has undergone the horror of a sexual assault to be forced to live with the assault’s result, an unwanted child, for the rest of her life?

Fetal Condition

The condition of the fetus illustrates another circumstance in which some people consider abortion
acceptable. If the fetus is severely damaged or defective, should the mother have to carry it to term? If the woman is forced to bear the child, shouldn’t she be provided with resources to care for herself and the child before and after birth? To what extent would a mother forced to bear a severely disabled child also be forced to provide the huge resources necessary for maintaining such a child?

Violence Against Clinics
The abortion controversy has been fraught with violence. Statistics on violence against abortion clinics have been recorded since 1977 (NAF, 2015). In 2014, there were 99 incidents of violence against abortion providers in the United States and Canada; these included arson, attempted bombings, invasions, vandalism, trespassing, anthrax threats, assault and battery, death threats, burglary, and stalking (“the persistent following, threatening, and harassing of an abortion provider, staff member, or patient away from the clinic”) (NAF, 2014). Several recent attacks reflect extreme aggression by people who stand strongly against abortion (LeCaire, 2013).

Since the first attack on an abortion clinic in 1976, antiabortion extremists have continued to attack abortion clinics, physicians who perform abortions, and women seeking abortions or medical care. In 2015, “heavily-edited, misleading” antiabortion videos were released on the internet and were said to be the reason for an attack on abortion facility in Colorado Spring, CO (which was featured in one of the videos) in which three people were killed and nine were injured (NAF, 2015). In the same year, there were arsons at clinics in California, Washington, Louisiana, and Illinois.

Abortion clinics and pro-choice groups stress that they are functioning legally and need protection from harassment and violence. In 1994, a legal decision and legislation served to help safeguard women’s right to access their legal rights. After the public outcry associated with the public harassment, wounding, and death of abortion services providers, and the vandalism and bombing of various clinics, the Supreme Court ruled in Madsen et al. v. Women’s Health Center, Inc. [1994] to allow a buffer zone around clinics to permit patients and employees access and to control noise around the premises. The same year the Freedom of Access to Clinic Entrances (FACE) Act made it a federal crime to block access, harass, or incite violence in the context of abortion services. (Shaw & Lee, 2012, p. 308)

The Freedom of Access to Clinic Entrances (FACE) Act prohibits such activities as trespassing, physical violence such as shoving, “vandalsizing a reproductive health care facility by gluing locks or spraying butyric acid” (an acid used in disinfectants and other pharmaceuticals), threatening violence, stalking employees, and making bomb or arson threats (NAF, 2015; Blasdel & Goss, 2004).

To the extent that violence against clinics and harassment of clinic staff and patients continue, women’s access to legal abortions may be significantly curtailed. For whatever reason, the number of U.S. abortions performed has reached its record low since 1980 (Guttmacher, 2016c).

Stem Cell Research
An ongoing controversial issue related to abortion involves the use of fetal tissue (stem cells) for health research and treatment. As Kail and Cavanaugh explain,

stem cells are unspecialized human or animal cells that can produce mature specialized body cells and at the same time replicate themselves . . . Medical researchers are interested in using stem cells to repair or replace damaged body tissues because stem cells are less likely than other foreign cells to be rejected by the immune system when they are implanted in the body. (Tissue and organ rejection is a major problem following transplant surgery, for example.) Embryonic stem cells have the capacity to develop into every type of tissue found in an adult. Stem cells have been used experimentally to form the blood-making cells of the bone marrow and heart, blood vessel, muscle, and insulin-producing tissue. (Kail & Cavanaugh, 2014, p. 26)

Significant research has focused on the potential for using stem cells to combat spinal cord injuries,
Parkinson’s disease, juvenile diabetes, heart disease, and Alzheimer’s disease; more than 100 million Americans suffer from some form of disease that could potentially benefit from stem cell research (Kalb & Rosenberg, 2004). Kalb and Rosenberg give the example of Maggie, age 4, who suffers from juvenile diabetes and is in need of help. “Ten to 15 times a day, Maggie’s blood sugar must be checked. And the little blond ballerina has to wear a portable insulin pump, which delivers insulin through a tube inserted into her abdomen or lower back. She carries the device to preschool in a fanny pack decorated with yellow and green ladybugs” (Kalb & Rosenberg, 2004, p. 44).

Although research has focused on a few different types of cells with some potential to function as stem cells (the discussion of which is beyond the scope of this book), much attention and research has centered on embryonic stem cells. **Embryonic stem cells** are cells taken from a 3-to-5-day-old embryo that has been developed during an in vitro fertilization process. **In vitro** is Latin for “in glass,” referring to something done in an artificial environment, such as in a laboratory dish or test tube; **in vitro fertilization** (discussed later in this chapter) refers to a procedure that unites the egg and sperm in a laboratory; stem cells “are not derived from eggs fertilized in a woman’s body” (NIH, 2015). When such cells were no longer needed for the in vitro fertilization process, “they were donated for research with the informed consent of the donor” (NIH, 2015). Sometimes, you might hear the term **embryonic stem cell lines**. This refers to embryonic stem cells that “have been cultured under in vitro conditions” for continuous cell division and specialization (as they develop into more specific types of tissue) and are studied “for months to years” (NIH, 2015).

Many people have strong opinions about stem cell research. An issue at the heart of the debate concerns whether the study and use of human embryonic tissue reflects the obliteration of human life. “Religious conservatives argue that using those stem cells means deriving benefit from the destruction of human embryos—fertilized eggs in early stages of development—in their eyes no less a crime than abortion” (Lacayo, 2001, p. 17).

People who support embryonic stem cell research contend that it has incredible positive potential. The National Institutes of Health (2013b) reports on “the promise of stem cells”:

**Studying stem cells will help us understand how they transform into the dazzling array of specialized cells that make us what we are. Some of the most serious medical conditions, such as cancer and birth defects, are due to problems that occur somewhere in this process. A better understanding of normal cell development will allow us to understand and perhaps correct the errors that cause these medical conditions.**

Another potential application of stem cells is making cells and tissues for medical therapies. **Today, donated organs and tissues are often used to replace those that are diseased or destroyed. Unfortunately, the number of people needing a transplant far exceeds the number of organs available for transplantation . . . [S]tem cells offer the possibility of a renewable source of replacement cells and tissues to treat a myriad of diseases, conditions, and disabilities including Parkinson’s disease, amyotrophic lateral sclerosis, spinal cord injury, burns, heart disease, diabetes, and arthritis.**

The debate rages in the national and state political arenas. Depending on the political orientation of those in power at the national and state levels, stem cell research may or may not receive various degrees of support. Research may be encouraged or prohibited. Funding may be provided or withdrawn.

Consider recent shifting national policy (Research America, 2013). Former president George W. Bush limited stem cell research by allowing federal funding for study only involving already established stem cell lines (stem cells already cultured in vitro and ready for use in research). Subsequently, President Barack Obama issued an executive order in 2009 negating the prior mandate, allowing federal funding for potential study of new stem cell lines, and thereby expanding stem cell research. However, since

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1. Parkinson’s disease is a progressive disease of the nervous system, usually occurring later in life, that is characterized by muscular weakness, tremors, and a shuffling gait.
2. Juvenile diabetes is a severe, chronic disease affecting children and young adults, in which the body fails to produce enough insulin, resulting in increased sugar in the bloodstream, extreme thirst, frequent urination, and gradual deterioration (Berube, 2002).
3. Alzheimer’s disease is a degenerative brain disorder that gradually causes deterioration in intelligence, memory, awareness, and ability to control bodily functions.
4. In vitro fertilization, discussed later in the chapter, is a process in which eggs are removed from a woman’s body, fertilized with sperm in a laboratory, and then implanted in the woman’s uterus.
this mandate has not been signed into law, the future of stem cell research remains uncertain. It depends on national leadership and the political climate.

Note that “individual states have the authority to pass laws to permit human embryonic stem cell research using state funds” instead of or in addition to federal funds (NIH, 2010). Numerous states have taken steps to support stem cell research through funding (e.g., grants), such mechanisms as technical assistance, and encouragement of inter-agency and inter-state cooperation (NIH, 2010).

Stem cell research provides an example of how the ever-changing political context affects what can be and is done. As with many other issues influencing the human condition, social workers should keep abreast of such circumstances in their ongoing learning about human behavior. Participating in a career-long learning process is part of their professional responsibility.

Highlight 2.4 addresses another very controversial issue—the late-term abortion procedure known as intact dilation and extraction (referred to by some as “partial-birth abortion”).

**Intact Dilation and Extraction (Late-Term Abortion)**

Intact dilation and extraction (D&E) is “a late-term abortion involving partial delivery of a viable fetus before extraction” (Berube, 2002, p. 1014). It is performed after “20 weeks and before viability” (Crooks & Baur, 2014, p. 323). Although physicians refer to it as intact dilation and extraction, its opponents often refer to it as partial-birth abortion (DiNitto, 2005, p. 462). Opponents view the procedure as “the interference with the birth of a live baby, rather than the termination of a pregnancy” (Greenberg, Bruss, & Conklin, 2011, p. 264). In practice, it has been “reserved for situations when serious health risks to the woman, or severe fetal abnormalities, exist” (Crooks & Baur, 2014, p. 323).

In November 2003, President Bush “signed into law the first ban on a specific abortion procedure,” namely the D&E, making it “a criminal offense for doctors to perform the procedure, even to preserve the woman’s health” (DiNitto, 2005, p. 462). In April 2007, the Supreme Court upheld this law that “includes no health exception” and prohibits the procedure from being used (Guttmacher Institute, 2013a).

The following facts reflect the current state of partial-birth abortion (Guttmacher Institute, 2013a):

- The definition of “partial-birth” abortion varies widely from one state to another.
- All 32 state laws incorporate some kind of exception.

In reality, the majority (61.2%) of abortions are performed at less than 9 weeks’ gestation, and 88.6 percent at or before 12 weeks (U.S. Census Bureau, 2011).

**Ethical Question 2.4**

What is your opinion about intact dilation and extraction? Should it be legally allowed if the pregnant woman faces serious health risks with continued pregnancy? If the woman risks death? If the fetus suffers from serious mental or physical abnormalities?
Commentary

We have just scratched the surface of some of the debates currently raging. Social workers need to understand the issues and the context in which opposing views are raised in order to help clients make difficult decisions. The abortion issue with its potent pro-choice and antiabortion factions in the political arena illustrates the impact that macro systems can have on individual lives. The extent to which national policies limit the availability of abortion relates directly to service accessibility. Organizations in the macro environment must have the sanction of the national and state macro systems in order to provide women with free choice.

The next sections describe the incidence of abortion, reasons for abortion, common abortion procedures, and the pros and cons of abortion. Finally, various social work roles concerning the issue are discussed.

Incidence of Abortion

In 2011, the abortion rate was on the decline, with 1.06 million abortions performed compared to the 1.21 million in 2008 (Guttmacher, 2016c).

“Nearly half of pregnancies among American women are unintended, and four in 10 of these [unintended pregnancies] are terminated by abortion. Twenty-two percent of all pregnancies (excluding miscarriages) end in abortion” (Guttmacher Institute, 2016c). As Table 2.1 indicates, about one-third of all abortions were performed for women ages 20 to 24. Almost three-quarters of all abortions were for women between the ages of 15 and 29, which makes sense in terms of maximum female fertility. The largest number of women having abortions (41%) had not had any children. This was followed by those having had one previous child (26%) and two or more previous children (19%).

“Fifty-one percent of women who have abortions had used a contraceptive method (usually the condom or hormonal method) during the month they became pregnant” (Guttmacher Institute, 2016).

Almost 86 percent of women having abortions are unmarried (Jerman, Jones, & Onda, 2016). Abortions are spread across races. Thirty-nine percent of abortions occur to non-Hispanic white women, 28 percent to non-Hispanic African American women, 25 percent to Hispanic women, and 3 percent to women of other races (Jerman, Jones, & Onda, 2016). Thirty percent of women having an abortion state they are protestant and 24 percent Catholic (Guttmacher Institute, 2016). Women having abortions tend to be poor. Forty-nine percent of women having abortions have incomes below the federal poverty line, and another 26 percent have incomes of 100 to 199 percent of the poverty line (Guttmacher Institute, 2016).

Reasons for Abortion

Unplanned or accidental pregnancy has three basic causes. First, the couple may not use contraception at all. Second, they may use it ineffectively, inconsistently, or incorrectly. Third, no method of contraception is perfect; each has a failure rate. (Chapter 6 discusses contraception in greater detail.)

Women give several reasons for having an abortion. “Three-fourths of women cite concern for or responsibility to other individuals; three-fourths say they cannot afford a child; three-fourths say that having a baby would interfere with work, school or the ability to care for dependents; and half say they do not want to be a single parent or are having problems with their husband or partner” (Guttmacher Institute, 2016). Many abortions are also performed annually in the United States following a rape.

<table>
<thead>
<tr>
<th>TABLE 2.1</th>
<th>FACTS ABOUT WOMEN HAVING ABORTIONS* 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>TOTAL ABORTIONS (%)</td>
</tr>
<tr>
<td>Under 15</td>
<td>.2</td>
</tr>
<tr>
<td>15 to 17 years</td>
<td>3.4</td>
</tr>
<tr>
<td>18 to 19 years</td>
<td>8.2</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>33.6</td>
</tr>
<tr>
<td>25 to 29 years</td>
<td>26.5</td>
</tr>
<tr>
<td>30 to 34 years</td>
<td>15.9</td>
</tr>
<tr>
<td>35 to 39 years</td>
<td>9.1</td>
</tr>
<tr>
<td>40 years and over</td>
<td>3.1</td>
</tr>
<tr>
<td>Number of previous childbirths</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>40.7</td>
</tr>
<tr>
<td>One</td>
<td>26.2</td>
</tr>
<tr>
<td>Two or more</td>
<td>19.1</td>
</tr>
</tbody>
</table>

*These facts were gleaned from Jerman, J., Jones, R. K., and Onda, T. (2016), “Characteristics of U.S. abortion patients in 2014 and Changes since 2008”.
No one desires to have an unwanted pregnancy that ends in abortion. It is a difficult choice to make among a range of alternatives, all of which have negative consequences. One implication is the importance of readily accessible contraception and family planning counseling so that the difficult alternative of abortion is no longer necessary.

Methods of Abortion

Several different procedures are used to perform abortions, depending on how far the pregnancy has progressed. The cost for an abortion during the first trimester is about $1,500 depending on the length of gestation, where you get services, and what type of services they are (Planned Parenthood, 2016). Costs are higher when the abortion occurs later in the pregnancy. The two major kinds of abortion are a medication abortion (sometimes referred to as an “abortion pill”) and abortion procedures performed within a clinic. Methods used early in pregnancy include vacuum aspiration and medication abortion. Procedures used later on include dilation and evacuation, and intact dilation and evacuation (discussed in Highlight 2.4). Illegal abortion will also be mentioned.

Medication Abortion

A medication abortion is an abortion induced by taking certain drugs. The most commonly used drug in the United States, mifepristone (formerly referred to as RU-486), triggers a deterioration of the uterine lining (Planned Parenthood, 2016). It was approved by the U.S. Food and Drug Administration (FDA) for use as an abortion drug in 2000, and has been used in several European countries for over a decade earlier. The process involves taking mifepristone and then taking a dose of misoprostol (a prostaglandin that triggers uterine contractions) up to three days later. As mentioned, mifepristone causes the uterine lining to break down, which makes it unable to support a fetus. The subsequent dose of misoprostol then causes uterine contractions that expel the fetus. A medication abortion can be performed up to 70 days (10 weeks) after the first day of a woman’s last period and costs up to $800; note that some states restrict the period of use to 49 days (Planned Parenthood, 2016).

A majority of women abort within four or five hours of taking misoprostol; overall, the process is 97 percent effective (Planned Parenthood, 2008a). Potential side effects include dizziness, severe cramping, nausea, diarrhea, abdominal pain, and mild fever or chills (most of which can be reduced by taking Tylenol or ibuprofen [e.g., Advil], not aspirin) (Planned Parenthood, 2013). In 2011, about 23 percent of all abortions were medication abortions (Guttmacher Institute, 2016b).

Vacuum Aspiration

Vacuum aspiration (also referred to as vacuum curettage or suction curettage) is a procedure used up to 16 weeks after a missed period (Planned Parenthood, 2016). The cervical entrance is enlarged, and the contents of the uterus are evacuated through a suction tube. Usually done under local anesthesia, the procedure involves first dilating the cervix (i.e., widening the opening into the uterus) by inserting a series of rods with increasing diameters. Then a small tube is inserted into the vagina and subsequently through the cervix into the uterus. The tube is connected to a suction machine that vacuums out the fetal tissue from the uterus. Sometimes, curettage (scraping with a small, spoon-shaped instrument called a curette) is used afterward (Planned Parenthood, 2016). The entire procedure takes about 5 to 10 minutes in addition to preparation time (Planned Parenthood, 2016).

Most abortions are performed in clinics, where staff usually require that a patient remain for a couple hours following an abortion. Primary side effects include some bleeding and cramping, which are considered normal. Vacuum aspiration is considered a very safe procedure and rarely has complications.

Dilation and Evacuation

Second-trimester abortions are more complicated and involve greater risks. An abortion method that can be used during the fourth and fifth months of pregnancy is dilation and evacuation (D&E). This method resembles vacuum aspiration in that fetal material is initially suctioned out of the uterus and then usually scraped out with a curette. However, because a D&E is performed later in pregnancy, a greater amount of fetal material must be removed. General anesthesia instead of local is used. Potential complications include those associated with vacuum aspiration and those resulting from general anesthesia.

Illegal Abortion

Many women turn to unsafe illegal abortions when safe procedures are illegal or inaccessible. We have
established that 40 percent of women of reproductive age live in nations where abortion is highly restricted or prohibited (Cohen, 2009). In desperation, many women turn to unregulated, unqualified abortionists who may use unclean or unsafe instruments. Other women try to abort themselves by using some sharp object or ingesting some harmful substance. We have also established that 70,000 women around the world die annually from dangerous illegal abortions (Cohen, 2009).

The Importance of Context and Timing

Although abortion is considered a very safe medical practice in the United States, the further a woman is into her pregnancy, the greater the risk of death; only one death occurs for every million abortions performed before eight weeks of pregnancy, one death for every 29,000 abortions during weeks 16 to 20 of pregnancy, and one death per 11,000 abortions performed at 21 or more weeks of pregnancy (Guttmacher Institute, 2013e). Problems are also less likely to occur when the woman is healthy, conditions are clean and safe, and follow-up care is readily available. Women are about 11 times more likely to die in childbirth than from an abortion performed during the first 20 weeks of pregnancy (Planned Parenthood, 2016).

Risks from abortion complications are negligible; less than 0.5 percent of women having an abortion require subsequent hospitalization for complications (Guttmacher Institute, 2013e). Risks such as allergic reactions to medication or sedation, infection, blood clots, or heavy bleeding are very rare in first-trimester abortions, but increase in probability as the pregnancy continues (Planned Parenthood, 2016).

Spotlight 2.2 explores the psychological effects of abortion on both women and men.

Arguments for and Against Abortion

Numerous arguments have been advanced for and against permitting abortions. Many of these views are related to how facts are interpreted and presented. Following is a sampling of arguments in favor of abortion rights:

- Permitting women to obtain an abortion corresponds with the principle of self-determination and allows women to have greater freedom of choice concerning their own bodies and lives.

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**SPOTLIGHT ON DIVERSITY 2.2**

**Effects of Abortion on Women and Men**

Research indicates that most women demonstrate positive adjustment a year after an abortion and rarely suffer long-term psychological effects from an abortion (Hyde & Delamater, 2014; Munk-Olsen et al., 2011). Many women "report feeling relieved, satisfied, and relatively happy, and say that if they had the decision to make over again they would do the same thing"; there is little support for the existence of a "postabortion syndrome" characterized by traits similar to those of posttraumatic stress disorder* (Hyde & Delamater, 2014, p. 181).

However, Kelly (2008) cautions:

> Although serious emotional complications following abortion are quite rare, some women and their male partners experience some degree of depression, grieving, regret, or sense of loss. These reactions tend to be even more likely in second or third abortions. Support and counseling from friends, family members, or professionals following an abortion often help to lighten this distress, and it typically fades within several weeks after the procedure. Counseling often helps in cases where the distress does not become alleviated in a reasonable time. (p. 324)

A frequently ignored psychological aspect of abortion is the male's reaction to the process. Many men experience feelings of "residual guilt, sadness, and remorse" (Yarber & Sayad, 2013, p. 355). A man may feel ambivalent about the pregnancy and the abortion similar to that felt by his pregnant partner. Many clinics now provide counseling for male partners of women seeking abortion (Yarber & Sayad, 2013). Both partners should receive the counseling they need to make difficult decisions and to cope with whatever feelings they are experiencing.

*Posttraumatic stress disorder is a condition in which a person continues to reexperience an excessively traumatic event, such as a bloody battle or a sexual assault.
If abortions were prohibited, women would seek illegal abortions as they did in the past. No law has ever stopped abortion, and no law ever will. Performed in a medical clinic or hospital, an abortion is relatively safe; but performed under unsanitary conditions, perhaps by an inexperienced or unskilled abortionist, the operation is extremely dangerous and may even imperil the woman's life.

If abortions were prohibited, some women would attempt to self-induce abortions. Such attempts can be life-threatening. Women have tried such techniques as severe exercise, hot baths, and pelvic and intestinal irritants, and have even attempted to lacerate the uterus with such sharp objects as nail files and knives.

No contraceptive method is perfectly reliable. All have failure rates and disadvantages. Contraceptive information and services are not readily available and accessible to all women, particularly teenagers, the poor, and rural women.

Abortions are necessary in many countries with soaring birth rates. Contraceptives may be inadequate, unavailable, or beyond what people can afford. Abortion appears to be a necessary population control technique to preserve the quality of life. (In some countries, the number of abortions is approaching the number of live births.)

Opponents of abortion argue:

- The right of a fetus to life is basic and should in no way be infringed.
- Abortion is immoral and against certain religious beliefs. For example, former Pope John Paul II condemned abortion as a sign of the “encroaching ‘culture of death’ that threatens human dignity and freedom” (Woodward, 1995, p. 56).
- A woman who chooses to have an abortion is selfish. She prefers her own pleasure over the life of her unborn child.
- In a society where contraceptives are so readily available, there should be no unwanted pregnancies and therefore no need for abortion.
- People supporting abortion are antifamily. People should take responsibility for their behavior, cease nonmarital sexual intercourse, and bear children within a family context.

Professional social workers must be aware of arguments on both sides of the issue. Only then can they assist a client in making the decision that is right for her.

Social Worker Roles and Abortion: Empowering Women

Social workers can assume a variety of roles when helping women with unwanted pregnancies. Among them are enabler, educator, broker, and advocate. First, as enablers, social workers can help women make decisions about what they will do. This involves helping clients identify alternatives and evaluate the pros and cons of each. Chilman (1987) reflects upon how social workers can counsel women concerning abortion:

_The ultimate decision . . . should be made chiefly by the pregnant woman herself, preferably in consultation with the baby’s father and family members. To make the decision that is best for the couple and their child, the pregnant woman—ideally, with the expectant father—needs to view each option in the context of the couple’s present skills, resources, values, goals, emotions, important interpersonal relationships, and future plans. The counselor’s role is to support and shape a realistic selection of the most feasible pregnancy resolution alternative._ (p. 6)

A second role social workers can assume is that of educator. This involves providing the pregnant woman with accurate information about the abortion process, adoption, fetal development, and options available to her. The educator role may also entail providing information about contraception to avoid subsequent unwanted pregnancies.

A third social work role involves being a broker. Regardless of her final decision, a pregnant woman will need to acquaint herself with the appropriate resources. These include abortion clinics, prenatal health counseling, and adoption services. A social worker can inform her of available resources, explain them, and help her obtain them.

Finally, a social worker can function as an advocate for a pregnant woman. A woman might want an abortion, yet live in a state that severely restricts them; if she is poor, her access to an abortion is even further restricted. A worker can advocate on this woman’s behalf to improve her access to abortion or to financial support for abortion services. Another form of advocacy would be to work to change the laws and policies that inhibit women from getting
the services they need. If a woman decides against an abortion, a social worker can advocate for the resources and services the woman needs to support herself and her pregnancy.

**Abortion-Related Ethical Dilemmas in Practice**

Picture yourself as a professional social worker in practice. What happens when your own personal values seriously conflict with those expressed by your client? A basic professional value clearly specified in the NASW Code of Ethics is the right of clients to make their own decisions.

By definition, an ethical dilemma involves conflicting principles. When two or more ethical principles oppose each other, it is impossible to make a “correct” decision that satisfies both or all principles involved. There is no perfect solution. For example, if a 15-year-old client tells you that she plans to murder her mother, you are caught in an ethical dilemma. It is impossible to maintain confidentiality with your client (a basic social work professional value) and yet do all you can to protect his mother from harm.

A wide range of situations involving abortion can force workers to address ethical dilemmas. Social workers should first consider what principles in the NASW Code of Ethics might help to guide their practice and make decisions. We have emphasized that professional values should take clear precedence over personal values about issues.

Doloff, Harrington, and Loewenberg (2012) have formulated a hierarchy of ethical principles, the Ethical Principles Screen (EPS), to provide a guide for making difficult decisions. They suggest which principle should have priority over the other when two ethical principles conflict. The hierarchy can be helpful in working through difficult situations. If the Code of Ethics does not directly apply or a significant amount of ambiguity exists, the worker may turn to the EPS described next.

The EPS hierarchy involves the following seven principles (pp. 80–82):

- **Principle 1:** Protection of life is of utmost importance. This might include provision of adequate food, shelter, clothing, or health care. It might concern acting in response to a person's suicide threat or threat of physically harming another. This principle applies not only to clients but also to others whose survival is imperiled.

- **Principle 2:** After protection of life, social workers should strive to nurture equality and address inequality. On the one hand, groups should be treated equally and have equal access to resources. On the other hand, groups who are oppressed or hold lesser status should be treated specially so that their rights are not violated. For example, consider a child abuse situation. Because the child does not hold an equal position with that of an abusive parent, “the principles of confidentiality and autonomy with respect to the abusing adult are of a lower rank order than the obligation to protect the child, . . . even when it is not a question of life and death” (p. 81).

- **Principle 3:** Social workers should make practice decisions that “foster a person’s self-determination, autonomy, independence, and freedom” (p. 81). People should be allowed to make their own choices about their lives. However, this should not be at the expense of their own or someone else’s life as Principle 1 prescribes. Maintaining autonomy should not be pursued if equality supported by Principle 2 would be sacrificed.

- **Principle 4:** Social workers should pursue an option that results in the least harm to those involved in the decision and its results.

- **Principle 5:** Social workers should make practice decisions that promote a better quality of life for all people. People’s overall well-being is important. This involves not only the well-being of an individual or family, but also that of entire communities.

- **Principle 6:** Social workers should respect people’s privacy and maintain confidentiality. However, this principle is superseded when people’s quality of life is endangered.

- **Principle 7:** Practice decisions should allow workers to be honest and disclose all available information. Workers should be able to provide any information that they deem necessary in any particular situation. However, the “truth” should not be told for its own sake when it violates a client’s confidentiality, which is championed by Principle 6.

The following scenario poses an ethical dilemma concerning abortion that a worker might face in practice. Next, we give an example of how Doloff and colleagues’ hierarchy of ethical principles might be applied in this case. Highlight 2.5 provides several
More Abortion-Related Ethical Dilemmas in Practice

Apply the hierarchy of ethical principles to each of the following case examples.

**Scenario A**
A 45-year-old woman becomes pregnant. She already has seven children and numerous grandchildren. Her personal physician refused to prescribe birth control pills for her because of her age and other health reasons. Nor did he discuss other forms of contraception with her or offer her the alternative of sterilization. Physically, it would be hazardous for her to have more children. She comes to you, distraught and crying. She doesn’t know what to do.

**Scenario B**
A 32-year-old woman with a severe intellectual disability becomes pregnant. She is unable to take care of herself independently. She has a history of numerous sexual encounters. Her genetic background indicates that she would probably have a child with an intellectual disability. It is clear that she would be unable to care for a child herself.

**Scenario C**
A 19-year-old college student is six weeks pregnant. She has been going with her boyfriend for seven months. For the past three months, they have been seeing only each other, but they do not consider themselves serious as yet. She had been using a diaphragm and contraceptive cream, but they failed to protect her. She doesn’t want a baby right now. However, she feels terribly guilty about getting pregnant.

**Scenario D**
A married 24-year-old woman is pregnant. She already has one child with a genetic defect. She and her husband have been through genetic evaluation and counseling at a local university. The conclusion is that because both parents have a history of significant genetic problems, the chances for a normal child are extremely small. The couple was deciding upon a sterilization procedure when she became pregnant.

**Scenario E**
A married 28-year-old medical technician has been unaware of being pregnant until now, the seventh week of gestation. Throughout her pregnancy, she has been exposed to dangerous X-rays. The possibility that her fetus has been damaged by the radiation is very high. She and her husband want children at some time, but they dread the thought of having a baby with a serious impairment.

**Scenario F**
Four months ago, a married man of 42 had a vasectomy. His 41-year-old wife just found out that she is five weeks pregnant. Some sperm had apparently still been present in his semen. The couple already have three children in their teens. They do not want more.

**Scenario G**
A 14-year-old girl is pregnant. It happened one night when she was out drinking. She had never really considered using contraception. She’s shocked that she’s pregnant and is having difficulty thinking about the future.

more scenarios for you to work out on your own. Remember, there are no easy or perfect answers.

**Scenario A**
A 16-year-old girl was raped by a middle-aged man as she walked home from school one night and became pregnant. Both she and her parents are horrified and plagued with worry. They come to you for help. The girl desperately wants an abortion.

**Application of Ethical Principles in Scenario A**
Consider Principle 1, the need to protect life. If you personally adopt an antiabortion stance and feel that abortion is murder, what do you do? A professional social worker’s personal values must be acknowledged yet put aside in professional situations.

The young woman and her parents want her to have the abortion.

We then look at Principle 2, which calls for the nurturing of equality and the combating of inequality. According to this principle, people should be treated equally. In this case, they should have equal access to services. A neighboring state, its border only 25 miles away, allows abortions for all women who want them within the first trimester. Is this fair? Is this ethical? Should you help the young woman and her parents seek an abortion in a state that has different rules? Or should you work actively in your own state to advocate for change so that abortion would be a legal alternative for clients such as this?

Now consider Principle 3, which stresses people’s right to autonomy, independence, and freedom. The
young woman has the right to make her own decision. Your state might legally allow abortions for all women seeking them, or it might restrict them to only those women who have been raped or sexually abused. Or your state might ban all abortions unless the life of the mother is critically endangered.

If an abortion is legal in your state for a teenager like this, you as a worker can help her get one. She has made her decision. It is her legal right. However, if your state does not allow her to have a legal abortion, you are confronted with another dilemma.

Principle 4 refers to choosing options that result in the least harm to those involved. Principle 5 reflects the importance of maintaining an optimum quality of life. If this young woman is prevented from having an abortion, will her future be harmed? In what ways might she lose control over her life? How will her short-term and long-term quality of life be affected?

This discussion simply raises questions and issues. Each case is unique. Circumstances and attitudes vary widely. It is a professional social worker's ethical responsibility to resolve dilemmas and help clients solve problems to the best of that worker's ability. Each client should be helped to identify alternatives, evaluate the pros and cons of each, and come to a final decision. There are no absolute answers or perfect solutions.

**LO 4 Explain Infertility**

Ralph and Carol, both age 28, had been married for five years. Ralph was a drill press operator at a large bathroom fixture plant. Carol was a waitress at a Mexican restaurant. They both liked their jobs well enough. They were earning enough to purchase a small three-bedroom house and to enjoy some pleasurable amenities such as going out to dinner occasionally, taking annual camping vacations, and having cable television.

However, they felt something was wrong. Although Carol had stopped taking birth control pills more than three years before, she had still not gotten pregnant. She had read in an article in *Cosmopolitan* that women over age 35 had a much greater chance of having a child with an intellectual disability or birth defects. Although she still had a few years, she was concerned. She and Ralph had always wanted to have as large a family as they could afford. This meant that they had better get going.

The couple really didn't talk much about the issue. Neither one wanted to imply that something might be wrong with the other one. The idea that one or both might be infertile was not appealing. It was almost easier to ignore the issue and hope that it would resolve itself in a pregnancy. After all, they still had a few years.

**Infertility** is the inability to conceive despite trying for 1 year, or 6 months for women age 35 or older (CDC, 2016). Women who are unable to sustain their pregnancies and experience miscarriage are also considered to have an infertility problem. Although many people assume that they will automatically initiate a pregnancy if they don't use contraception, this is not always the case.

It is estimated that infertility affects 6.7 million American women ages 15 to 44, or almost 12 percent of this group (CDC, 2016). However, this is an aggregate statistic that does not take into account the effects of age or a wide range of other conditions. Therefore, the 11 percent figure is probably not useful to individual couples seeking infertility counseling. Many other factors should be considered.

For example, consider the statement that older women tend to experience increased infertility. "With increasing age, the quality and quantity of a woman's eggs begin to decline. In the mid-30s, the rate of follicle loss accelerates, resulting in fewer and poorer quality eggs, making conception more challenging and increasing the risk of miscarriage" (Mayo Clinic, 2013b).

Several other factors also tend to increase infertility (Mayo Clinic, 2013b). Smoking increases the risk of miscarriage and *ectopic pregnancy* (a condition where a fertilized egg implants itself somewhere other than in the uterus, usually in a fallopian tube). Smoking may also age and diminish eggs prematurely, making it more difficult to become pregnant. Being overweight or extremely underweight, and heavy consumption of alcohol or caffeine (e.g., six cups of coffee or more each day) increases infertility. Contraction of STIs can damage the fallopian tubes, also making it harder to conceive.

**Causes of Infertility**

Of all infertility cases, males are responsible for approximately one-third and females for about one-third; the remaining third involves a mixture of male and female factors, or unknown causes (Mayo Clinic,
Aging Affects a Woman’s Fertility

As a woman ages, five conditions affect her fertility (American Society for Reproductive Medicine, 2012a; CDC, 2013c):

1. Her ovaries’ ability to release eggs ready for fertilization declines.
2. The number of eggs has decreased.
3. The health of the eggs themselves weakens.
4. A woman is more likely to experience other health problems that negatively affect fertility.
5. Her risk of miscarriage increases.

Female Infertility

A primary cause of infertility in women involves difficulties with ovulation (CDC, 2016; Mayo Clinic, 2013b). Highlight 2.6 summarizes how age affects a woman’s fertility.

Whether ovulation has occurred can be detected by daily monitoring of a woman’s morning temperature. Basal body temperature charts can be used for this purpose. A woman may experience a slight dip in body temperature on the day before ovulation. Immediately after ovulation, the body temperature rises slightly. There should be “a temperature shift of at least 4 degrees over a 48-hour period to indicate ovulation” (Fertilityplus, 2010).

Another cause of infertility in women involves blocked fallopian tubes (CDC, 2016). Pelvic inflammatory disease (PID) is an infection of the female reproductive tract (especially the fallopian tubes) that can cause inflammation and scar tissue that blocks tubes. It often results from STIs such as gonorrhea and chlamydia (both described in Chapter 6). Tumors or various congenital abnormalities can also cause blocked tubes.

Other conditions affecting a woman’s fertility include physical abnormalities in the uterine wall and benign fibroid tumors (ASRM, 2012). Endometriosis—the growth of tissue resembling that of the uterine lining outside the uterus, which often results in severe pain—can also cause infertility.

Male Infertility

Common causes of male infertility are low sperm count and decreased sperm motility (sperm’s ability to maneuver quickly and vigorously) (CDC, 2016). Another frequent cause of male infertility is a condition called varicocele (pronounced VAIR-ih-koh-seel) (Hyde & DeLamater, 2014; NWHIC, 2009). Here the veins on a man’s testicle(s) are enlarged, thereby producing too much heat and affecting sperm production. Numerous conditions can affect sperm count. Age, environmental toxins, declining health conditions, medical problems, smoking, use of drugs or alcohol, use of some medications, and radiation treatment and chemotherapy for cancer have all been blamed as contributors to infertility (NWHIC, 2009).

Couple-Related Causes of Infertility

Sometimes infertility results from a mixture of conditions and behaviors shared by a couple. It may involve timing and frequency of intercourse or specific coital techniques used. Occasionally, infertility is a consequence of antibodies produced by a woman that attack the man’s sperm (Hyde & DeLamater, 2017).

Psychological Reactions to Infertility

Some people experience serious reactions to infertility. They may show signs of depression, guilt, deprivation, frustration, or anger as they pursue infertility counseling. They may feel that their lives are out of their control. In many ways feelings resemble those of grieving, including denial, anger, bargaining, depression, and finally, acceptance (Greenberg et al., 2014; Kübler-Ross, 1969).

Especially for those who really desire to have children, infertility can be associated with failure. Van Den Akker (2001) studied 105 people who were infertile and found that three-quarters of them were
“devastated” by their infertility “diagnosis” (p. 152). Sixty-four percent of the female respondents and 47 percent of the males indicated happiness was an impossibility without having children. One respondent elaborated, “I was angry . . . there isn’t anything else in my life that I’ve worked that hard at really, that I didn’t get . . . I deserved to have succeeded. I didn’t have the energy to do anything else, I just couldn’t do it anymore. But I was really angry. It was like, this isn’t the way it was supposed to end” (p. 131).

An infertility problem is compounded by the fact that even the most intimate partners often don’t feel comfortable talking about their sexuality, let alone that something may be wrong with it. Some men associate their potency with their ability to father children. Traditionally, women have placed great importance on their roles as wife and mother. Hopefully, with the greater flexibility of women’s roles today, the technological advances aimed at improving fertility, and the new options available to infertile couples, the negative psychological reactions to infertility will be minimized.

Treatment of Infertility

A wide range of scenarios may reflect individual variations of infertility. One involves listening to the infamous ticking of the biological clock, an example of which Meadows (2004) describes:

Heather Pansera and her husband, Anthony, started trying to have a baby as soon as they got married . . . [A year later] they settled into a new house in Canton, Ohio, with plenty of room to raise a family. One year passed, and Heather, 32, didn’t think much about it. Another year passed and she panicked.

“We were a couple for five years by the time we got married, so we decided to let nature take its course,” she says. “It never crossed our minds that getting pregnant would be so difficult.”

“It seemed like everyone else was having babies,” says Anthony, 39. “I have three brothers and three sisters, and they all had kids. You’re happy for other people, but you want to experience it, too.”

The Panseras decided to pursue fertility treatments. After five unsuccessful attempts, Heather finally became pregnant.

Treatment for infertility depends, of course, on the specific problem involved and its seriousness. It is not necessarily an easy or effective process. It can also be very expensive.

After a year of trying to conceive, both partners should pursue a medical evaluation to help determine whether anything is physically wrong. When a woman is age 35 or older and has been trying unsuccessfully to get pregnant for six months, or when there is already some indication of a fertility problem, a couple may want to pursue treatment more aggressively before a year is up (see Highlight 2.6).

The first thing to be done in the case of suspected infertility is to bring the matter out into the open. People need to talk about their ideas and feelings. Only then can the various alternatives be identified and a plan of action determined. The couple’s sexual practices concerning pregnancy should also be discussed to make certain they have accurate and specific information.

Assessment of Infertility

The assessment of infertility usually begins with a general physical examination to evaluate the couple’s overall health; potential physical problems that might be inhibiting fertility are also investigated (ASRM, 2012). Additionally, the couple is asked about their sexual behavior to determine whether it is conducive to conception (ASRM, 2012).

Subsequently, infertility assessment typically involves a regimen of tests (Greenberg et al., 2014; NWHIC, 2009). Assessment of the male entails tests that evaluate the number, normality, and mobility of sperm. Sometimes hormonal tests are also conducted.

The first step in assessing female infertility usually involves evaluating whether the woman is ovulating each month. This can be done by monitoring her own body temperature fluctuations each day, by using home ovulation test kits that can be purchased over the counter at drug or grocery stores, or by a physician administering blood tests to establish hormone levels or taking ultrasounds of the ovaries. If it is determined that the woman is ovulating regularly, additional tests may include X-rays of the fallopian tubes and uterus after injecting dye (hysterosalpingography). The X-ray indicates whether the tubes are open and profiles the shape of the uterus. A laparoscopy may also be performed, in which a thin, tubular instrument is inserted into the body cavity to examine the female reproductive organs directly for any abnormalities.
Alternative Options for Starting a Family

Alternatives available to individuals and couples, both infertile and fertile, who want children include adoption, conventional treatment using surgery or drugs, in vitro fertilization, and various forms of assisted reproductive technology, all of which are explained in the following sections.

Adoption

Adoption is the legal act of taking in a child born to other parents and formally making that child a full member of the family. To provide a home and family for a child who has none is a viable and beneficial option for infertile couples.

Currently, there is an emphasis on encouraging parents to adopt children with special needs—that is, children who require additional support in the form of medical or financial help for adoptive placement; factors involved in special needs may include race, age, being part of a sibling group, or having a physical or mental disability (Barth, 2008). People pursuing the adoption alternative also often seek the adoption of foreign-born children (Barth, 2008; Crosson-Tower, 2013).

Surgery and Fertility Drugs

Conventional treatments including surgery or drugs are generally used first to treat infertility in 85 to 90 percent of all cases (Greenberg et al., 2014). Microsurgery has been used to correct blocked fallopian tubes, and remove pelvic adhesions and patches of tissue supporting endometriosis; examples of microsurgery for infertile men are vasectomy reversal and repairing varicose veins in the scrotum and testes (Hyde & DeLamater, 2017).

For women who have problems ovulating, drugs such as Clomid or Seraphine (taken orally), Repronex, or Gonal-F (both given by injection) may be prescribed to stimulate ovulation (Mayo Clinic, 2013b). Note, however, that such “fertility drugs” can result in multiple births, which may cause greater problems for both mothers and infants (American Society for Reproductive Medicine, 2012b). Infants may be born prematurely and experience health problems such as breathing difficulties, bleeding blood vessels in their brains, low birth weight, and other birth defects. Mothers may have difficulties during pregnancy including high blood pressure, diabetes, and low blood count (anemia). They may also encounter problems during the delivery of multiple infants.

Unfortunately, drug treatment for male infertility is much less advanced.

Intrauterine Insemination

Intrauterine insemination (IUI) (also referred to as artificial insemination (AI)) is the process of “injecting the woman with sperm from her partner or a donor” (Yarber & Sayad, 2016, p. 378). It tends to be used when the male’s infertility problems are mild or the cause of a couple’s infertility is unknown (CDC, 2013c). During IUI, sperm are deposited directly into the uterus instead of the vagina. This tends to enable pregnancy in cases where sperm have difficulty penetrating cervical mucus, as it allows it to bypass that barrier. Additionally, it gives sperm a head start.

Human sperm can be frozen for up to 10 years, thawed, and then used to impregnate (Carroll, 2013b). For a fee, a sperm bank collects and maintains sperm either for the donors themselves or for non-donors, depending on the arrangement made by the donor.

The sperm used in AI may be the husband’s or partner’s. This procedure might also be used for family planning purposes—for example, a man might deposit his sperm in the bank, then undergo a vasectomy, and later withdraw the sperm to have children. High-risk jobs or onset of a serious illness might prompt a man to make a deposit in case of impending sterility. It is possible to pool several ejaculations from a man with a low sperm count and to inject them simultaneously into the uterus or vaginal canal.

A second type of artificial insemination is by a donor other than the husband or partner. This practice has been used for several decades to circumvent male infertility and also when the partner is a carrier of a genetic disease (e.g., a condition such as hemophilia).11

In recent years, an increasing number of single women have requested the services of a sperm bank. A woman requests the general genetic characteristics she wants from the father, and the sperm bank then tries to match the request from the information known about its donors. Donors are paid for their sperm and remain anonymous.

11Hemophilia is any of several genetic disorders mostly affecting males in which blood fails to clot normally because of a defective clotting factor. Hemophiliacs must be wary of even slight injuries because these may cause excessive bleeding.
A third type of artificial insemination has received considerable publicity. Some married couples, in which the wife is infertile, may contract with another woman to be artificially inseminated with the husband’s sperm. Under the terms of the contract, this surrogate mother is paid and expected to give the infant to the married couple shortly after birth.

A number of ethical and legal questions have been raised about artificial insemination. Many religious leaders claim that God did not mean for people to reproduce this way. In the case of using another donor’s sperm, certain psychological stresses may be placed on partners and on marriages, as the procedure emphasizes the husband’s infertility and involves having a baby that he has not fathered. On a broader dimension, artificial insemination raises such questions as, What are the purposes of marriage and of sex? What will happen to male-female relationships if a couple does not even have to see each other to reproduce?

There are other possible legal implications. What happens if the sperm at a bank is not paid for? Would it become the property of the bank? Could it be auctioned off? If a woman was artificially inseminated by a donor and the child was later found to have genetic defects, could the parents bring suit against the physician, the donor, or the bank? What about frozen sperm used to inseminate a woman after the donor’s death? Could such children be considered the donor’s heirs?

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**Ethical Question 2.5**

Does a child resulting from artificial insemination by an unknown donor have the right to know who that donor was? What if this knowledge is necessary for some medical reason, such as diagnosing a hereditary disease? What if the donor does not want the child to know who he is?

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**Assisted Reproductive Technology**

Assisted reproductive technology (ART) involves procedures to promote pregnancy that involve handling both the sperm and the egg (CDC, 2016b). Artificial insemination is not considered ART because the egg is not manipulated. The results of ART procedures are often referred to as test-tube babies. However, this phrase is inaccurate because ART has nothing to do with a test tube. Earlier, we established that *in vitro* is Latin for “in glass” (Hyde & DeLamater, 2014). In vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and direct sperm injection are ART procedures discussed in this section.

**In Vitro Fertilization** In vitro fertilization (IVF) is a process in which eggs are removed from a woman’s body, fertilized with sperm in a laboratory dish, and then implanted in the woman’s uterus. Before egg removal, the woman is given fertility drugs to encourage multiple egg production. The process can be helpful for women whose fallopian tubes are damaged, blocked, or even absent, so that the normal process of fertilization is difficult or impossible.

The first successful IVF procedure took place in Oldham, England, in 1978. Baby Louise, weighing 5 pounds, 12 ounces, was born to her parents Lesley and John Brown. The world was stunned by such a feat. The physicians who developed the technique, Patrick Steptoe and Robert Edwards, had attempted the process more than 30 times before they achieved this first success.

As with artificial insemination, the ethical issues, legal complications, and other potential problems with IVF are numerous. For example, a Dutch woman underwent IVF after trying unsuccessfully to conceive for five years. The process was successful; twins were born—one black and one white. The University Hospital at Utrecht deemed “the mix-up ‘a deeply regrettable mistake,’ and took responsibility for accidentally fertilizing the woman’s eggs with sperm from a man from Aruba, as well as that of her husband” (American Association of Sex Educators, Counselors, and Therapists [AASECT], 1995).

ART’s effectiveness varies tremendously from couple to couple. As mentioned, variables include the viability of the eggs and sperm, the mother’s age, and the mother’s structural capacity to maintain a pregnancy. Mulrine (2004) describes the situation for some of the most difficult cases who seek help from the Sher Institutes for Reproductive Medicine in Las Vegas:

They have ... graduated to advanced treatments beyond their wildest calculations. Most of them have already undergone two or more in vitro fertilization
attempts with other doctors and some 75 percent of them have traveled from out of state to try again. It is an arduous process, not without its embarrassments. One couple speaks of feeling ridiculous racing through rush-hour traffic to deliver sperm gathered at home to the clinic; another describes an earlier treatment when the doctor, in a lame effort at humor, dressed in a bunny suit on egg retrieval day, in preparation for his “Easter hunt.” (p. 61)

In 2016, model Chrissy Teigen and her husband, singer John Legend, faced criticism when they announced to the world that they had picked the sex of their baby with the use of Preimplantation Genetic Diagnosis (PGD) during In Vitro Fertilization. The PGD process happens outside of the body. Once the sperm begins to fertilize the eggs (typically on the third day after fertilization starts), an embryologist removes cells from the embryo to determine whether the embryo is a male or a female. Following this procedure, only the embryos of the desired gender is transferred into the women’s uterus (Center for Human Reproduction, 2015). This can be an expensive procedure (approximately $18,000) and one that raises ethical questions (Yarber & Sayad, 2016; Hyde & DeLamater, 2017). A similar procedure, MicroSort, has already been banned in the United States by the Food and Drug Administration. Concerns have been raised about potential sex imbalances in the world and incidences in which the “non-chosen” sex is born. There is also no long-term research about the impact of these procedures.

**Gamete Intrafallopian Transfer (GIFT)** In gamete intrafallopian transfer (GIFT), collected eggs and sperm are placed directly into a fallopian tube. Resulting embryos can then drift into the uterus. GIFT differs from IVF only where fertilization takes place. In IVF, fertilization occurs in a petri dish; in GIFT, fertilization occurs in the fallopian tube. All other aspects of the two processes are alike. Both allow natural implantation to take place in the uterus. GIFT can be performed only in those cases in which the fallopian tubes are clear and healthy. It may be used successfully with women who have endometriosis or when no specific cause for infertility has been identified. GIFT is not useful for women with blocked fallopian tubes, a common cause of female infertility.

**Zygote Intrafallopian Transfer (ZIFT)** Zygote intrafallopian transfer (ZIFT) is similar to GIFT. In the ZIFT procedure, eggs and sperm are first combined in a laboratory dish to form a zygote. The zygote is then immediately transferred to the fallopian tube. An advantage of this technique is that fertilization is known to have taken place, whereas GIFT couples can only hope that it will take place. Natural implantation in the uterus can then occur.

**Direct Sperm injection (ICSD)** In intracytoplasmic sperm injection (ICSD), or direct sperm injection, a physician, using a microscopic pipette (a narrow tube into which fluid is drawn by suction), injects a single sperm into an egg. The resulting zygote is subsequently placed in the uterus. This technique can be used when the male has a low sperm count or the couple has failed to conceive using traditional in vitro insemination (Rathus et al., 2014). The first successful birth using ICSD occurred late in 1994 (Sparks & Syrop, 2005).

**Embryo Transplants** Embryo transplants may be used for women who do not have healthy ova (eggs) themselves, often due to age or ovarian failure (Carroll, 2013b; Rathus et al., 2014). Rathus and his colleagues (2014) explain:

> Embryonic transfer can be used with women who do not produce ova of their own. A woman volunteer is artificially inseminated by the male partner of the infertile woman, or by donor sperm. Five days later the embryo is removed from the volunteer and inserted within the uterus of the mother-to-be, where it is hoped that it will become implanted. (p. 299)

**Success Rates of ART** Note that the effectiveness of ART procedures varies from clinic to clinic. The Fertility Clinic Success Rate and Certification Act of 1992 requires all clinics practicing artificial reproduction technology to report their success rates annually to the Centers for Disease Control (CDC). The CDC, in turn, publishes an annual report, which details the success rate for each clinic (CDC, 2013g). (Note that success rates usually refer to pregnancy rates per cycle. A cycle involves a two-week period during which ART is undertaken, usually beginning with administration of a fertility drug [CDC, 2005]).

According to the 2013 CDC national summary on ART, the average percentage of ART cycles that led to a successful implantation in the uterus were as follows:

- 39.9 percent in women aged 34 or younger
- 30.8 percent in women aged 35–37
- 20 percent in women aged 38–40
- 10.7 percent in women aged 41–42
- 5.0 percent in women aged 43–44
- 2.3 percent in women aged 45 or older (CDC, 2016a).

**Surrogate Motherhood**

Thousands of individuals and couples who want children but who are unable to reproduce either because the woman is infertile or due to lack of a partner have turned to surrogate motherhood.

A surrogate can give birth to a baby conceived by artificial insemination using the sperm of the husband. Or a woman can function as a surrogate without using her own genetic material. For example, any egg fertilized using the GIFT or ZIFT process may be transferred to the surrogate mother’s fallopian tube.

On birth, the surrogate mother terminates her parental rights, and the child is legally adopted by the donor(s) of the egg and/or sperm. Agencies sponsoring surrogacy stress the need for clearly established contractual agreements. However, various ethical issues are involved in surrogacy, many of which are currently being debated in the courts. Ethical Questions 2.6 addresses some of them.

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**Ethical Question 2.6**

What if the surrogate mother changes her mind shortly before birth or right after birth and decides to keep the baby?

If the child is born with severe mental or physical disabilities, who will care for the child and pay for the expenses? Should it be the surrogate mother, the contracting adoptive couple, or society?

Should the best interests of the resulting children rather than their procreators be taken into account?

At some point in the children’s lives, should they be told that they have a surrogate mother somewhere?

How might this affect their own psychological well-being?

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**Acceptance of Childlessness**

For some infertile couples, accepting childlessness may be the most viable option. Each alternative has both positive and negative consequences that need to be evaluated. The positive aspects of childlessness need to be identified and appreciated. Increasing numbers of people are choosing to remain childless for various reasons. Not having children allows the time and energy that children would otherwise demand to be devoted to other activities and accomplishments. These include work, career, and recreational activities. A couple might also have more time to spend with each other and invest in their relationship as a couple. Children are expensive and time-consuming.

On the one hand, children can provide great joy and fulfillment. On the other hand, they also can cause problems, stress, and strain. Infertile couples (as well as fertile couples) may benefit from evaluating both sides of the issue.

Highlight 2.7 discusses the effects of macro systems on infertility.

**Social Work Roles, Infertility, and Empowerment**

Social workers may assume a number of roles to empower and help people address infertility: enabler, mediator, educator, broker, analyst/evaluator, and advocate. Social workers can enable people in making their decisions concerning the options available to infertile people. In cases in which the members of a couple disagree for some reason, a social worker can assume a mediator role to help them come to some compromise or mutually satisfactory decision. The social worker as educator can inform clients about options and procedures with specific and accurate data. The broker role is used to connect clients with the specific resources and infertility procedures they need.

The role of analyst/evaluator might be used to evaluate the relative effectiveness of different fertility clinics and the appropriateness of different assisted reproductive technologies to meet a couple’s or individual’s needs. As an advocate, a social worker might need to speak on behalf of clients if they are being denied services or if the process for receiving infertility treatment is overly cumbersome or expensive.

Spotlight 2.3 addresses client empowerment by using a feminist perspective on fertility counseling.
CONCEPT SUMMARY

Technological Procedures to Assist in Reproduction

**Assisted reproductive technology (ART):** Procedures to promote pregnancy that involve handling both the sperm and the egg.

**Direct sperm injection (intracytoplasmic sperm injection [ICSI]):** A process in which a physician, using a microscopic pipette, injects a single sperm into an egg, hopefully resulting in a zygote, which is subsequently placed in the uterus.

**Embryo transplant:** "A method of conception in which a woman volunteer is artificially inseminated by the male partner of the intended mother, after which the embryo is removed from the volunteer and inserted within the uterus of the intended mother" (Rathus et al., 2014, p. 299).

**Gamete intrafallopian transfer (GIFT):** A procedure in which collected eggs and sperm are placed directly into a fallopian tube where fertilization, hopefully, will take place.

**In vitro fertilization (IVF):** A process in which eggs are removed from a woman's body, fertilized with a sperm in a laboratory dish, and then implanted in the woman's uterus.

**Intrauterine insemination (IUI) [Artificial insemination (AI)]:** The "process of injecting the woman with sperm from her partner or a donor" (Yarber & Sayad, 2013, p. 381).

**Surrogate motherhood:** The procedure in which an egg fertilized using the GIFT or ZIFT process is transferred to the fallopian tube of a surrogate mother (a woman who will bear a child for another woman).

**Zygote intrafallopian transfer (ZIFT):** A procedure in which eggs and sperm are first combined in a laboratory dish to form a zygote, which is then transferred immediately to the fallopian tube.

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HIGHLIGHT 2.7

The Effects of Macro Systems on Infertility

Unlike abortion issues, which are fairly well crystallized and articulated, the issues, ethics, and values concerning infertility and reproductive technologies are only now being discovered and defined. Abortion has been available for a long time. However, modern technology has allowed sophisticated means of artificial fertilization to be undertaken for only a few decades. Additionally, new developments are rapidly advancing.

A major issue is that most fertility enhancement techniques are expensive. They may be available, but not to poor people and the uninsured. Organizations within the community will provide services only if they are paid. Is this fair or appropriate? Should infertile wealthy people be allowed to enjoy such advances when infertile poor people are not? Should these expensive advances be pursued at all in view of the world's exploding population? Vital philosophical and ethical issues are involved here. Once again, there are no easy answers.

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Chapter Summary

The following summarizes this chapter's content as it relates to the learning objectives presented at the beginning of the chapter. Chapter content will help prepare students to:

**LO 1** Describe the dynamics of human reproduction (including conception, diagnosis of pregnancy, fetal development, prenatal influences and assessment, problem pregnancies, and the birth process).

Human reproduction is a complex process involving ovulation, ejaculation, and conception.

Prenatal influences that affect the fetus include the mother's nutrition, drugs and medication, alcohol usage, smoking habits, age, maternal stress, and other factors such as specific illnesses (e.g., rubella or AIDS) during pregnancy.
A Feminist Perspective on Infertility Counseling and Empowerment

Feminist principles can be applied to counseling women who discover themselves to be infertile (Georgiades & Grieger, 2003; Solomon, 1988). The medical establishment tends to view infertility as a medical problem that needs to be solved, as dysfunctional equipment that needs to be fixed. Social attitudes tend to support this medical view in four basic ways (Georgiades & Grieger, 2003; Solomon, 1988). First, most people in society aren’t aware of the immense impact the crisis of infertility has on a woman. Second, people tend to look down on infertile women as if a woman can’t possibly live a well-rounded, worthwhile life without bearing children. Third, infertile women experience feelings such as denial, anger, and depression, as do people confronted with any serious loss (Carroll, 2013b). Fourth, infertility can pose a major life crisis for a woman (Yarber & Sayad, 2013). People in crisis are generally more vulnerable, more suggestible, and more easily manipulated than they are during more normal times.

A two-pronged approach to infertility treatment is proposed (Solomon, 1988). First, social workers and other helping professionals should address infertility as a very personal issue (Georgiades & Grieger, 2003). Women who are experiencing the crisis of infertility should be treated as people with other crises are treated. A woman needs to be encouraged to identify and express her feelings, even when they hurt, come to accept her situation, and eventually make decisions about how she wants to proceed. Too frequently, infertile women are told what to do by medical professionals and are led to follow extensive, expensive, complicated, time-consuming procedures that may have little chance of success. It should be acknowledged that the infertile woman is more vulnerable and more likely to respond to medical direction than when she is not experiencing a crisis. Instead, the infertile woman may need specific information about the options available to her, the risks, the amount of effort required to pursue treatment, and help in evaluating which alternative is to her individual best advantage. Each woman needs to evaluate whether she really wants to put forth the amount of effort needed. Infertile women need to be empowered to make their own choices.

The second level involved in a feminist approach concerns the more general social attitudes about women (Hyde, 2008), in this case infertile women and their treatment. Infertile women are stigmatized. They are viewed by society as having something wrong with them, as being incomplete. These attitudes need to be changed. The positive qualities of any life choice need to be emphasized. Women need to recognize their value as individual human beings, not as a failure or success because of their ability or lack of ability to bear children. People as citizens, advocates, and social workers can form pressure groups to encourage more extensive research into the causes and treatment of infertility and to alter the traditional manner in which fertility treatment is done. Women need to be and feel empowered, and to have their choices maximized.

Methods of prenatal assessment include ultrasound sonography, fetal MRI, amniocentesis, chorionic villus sampling, and maternal blood tests.

Conditions that cause problem pregnancies are ectopic pregnancies, toxemia, and Rh incompatibility. Spontaneous abortions also occur periodically.

Stages in the birth process include initial contractions and dilation of the cervix, the actual birth, and afterbirth.

Birth positions include the most common vertex position, breech presentations, and transverse presentations.

Newborn assessment approaches include the Apgar scale and the Brazelton (1973) Neonatal Behavioral Assessment Scale.

Birth defects include Down syndrome and spina bifida. Other factors affecting development include low birth weight, prematurity, and anoxia.

LO 2 Explain typical developmental milestones for infants and children.

Children pass many developmental milestones as they grow older. Typical motor, play, adaptive, social, and language profiles for children at various age levels provide guidelines for assessment, although individual variations must be appreciated.

LO 3 Examine the abortion controversy (in addition to the impacts of social and economic forces).

Macro-system policies and the battle between pro-choice and antiabortion forces affect service delivery.

Controversial issues include restricting access through legislation, limiting financial support, condition of the mother, fetal condition, violence against clinics, stem cell research, and intact dilation and extraction (often referred to by opponents as partial-birth abortion).
Significantly fewer abortions are performed today than in past decades.

Methods of abortion include medication abortion, vacuum aspiration, and dilation and evacuation. Illegal abortions pose significant health risks around the world. Major physical complications from legal abortion are rare.

Women who have had abortions generally experience no serious long-term psychological effects, although the decision to terminate a pregnancy is often a difficult and complex one. Men may also experience psychological distress following an abortion, a fact that is often ignored.

Proponents and opponents of abortion have developed arguments in support of their respective stances.

Many women face serious ethical dilemmas with respect to unwanted pregnancy. Professional social workers have an obligation to assist pregnant clients in evaluating the various alternatives open to them to empower them to make their own decisions.

**LO 4 Explain infertility (including the causes, the psychological reactions to infertility, the treatment of infertility, the assessment process, alternatives available to infertile couples, and social work roles concerning infertility).**

Almost 11 percent of all U.S. couples are infertile. Leading causes of women's infertility are difficulties with ovulation, blocked fallopian tubes, and physical abnormalities such as fibroid tumors and endometriosis. Most male infertility is caused by a low sperm count, decreased sperm motility, and varicoceles. Sometimes infertility results from a mixture of conditions shared by a couple.

People may suffer serious psychological reactions to infertility.

Treatment of infertility includes fertility drugs, microsurgery, intrauterine insemination (IUI) (also referred to as artificial insemination [AI]), and assisted reproductive technology (ART), which can involve in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI), and embryo transplants. Other alternatives include surrogate motherhood, adoption, and acceptance of childlessness.

An ethical issue is the cost of treatment, which limits access for those who are not wealthy. Social workers may assume many roles in helping people choose alternatives.

A feminist approach to treating infertile women emphasizes empowerment by dealing with the issue on a personal level and addressing general social attitudes about women and infertility.

**COMPETENCY NOTES**

The following identifies where Educational Policy (EP) competencies and behaviors are discussed in this chapter.

EP6a. Apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies;

EP7b. Apply knowledge of human behavior and the social environment, person-in-environment and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies;

EP8b. Apply knowledge of human behavior and the social environment, person-in-environment and other multidisciplinary theoretical frameworks in interventions with clients and constituencies (all of this chapter).

Material on concepts and theories about human behavior and the social environment affecting biological development in infancy and childhood are presented throughout this chapter.

EP1 Demonstrate Ethical and Professional Behavior (pp. 50, 71–72, 76, 78, 83–85, 89, 91) Ethical questions are posed.

**WEB RESOURCES**

See this text's companion website at www.cengagebrain.com for learning tools such as chapter quizzing, videos, and more.