SPRINGER PUBLISHING COMPANY

THIRD EDITION

THEORETICAL PERSPECTIVES FOR DIRECT SOCIAL WORK PRACTICE

A GENERALIST-ECLECTIC APPROACH

NICK COADY
PETER LEHMANN
EDITORS

Theoretical Perspectives for Direct Social Work Practice

Nick Coady, PhD, is professor and dean, Faculty of Social Work (FSW), Wilfrid Laurier University (WLU), Waterloo, Ontario, Canada. Dr. Coady has been with the FSW/WLU since 1994; prior to that, he was a faculty member in the FSW at the University of Calgary for 5 years. His practice background includes residential child welfare work, individual and family counseling with high-risk adolescents, and group work with abusive men. Dr. Coady's teaching, research, and publications have focused primarily on the importance of relationship and other common factors in various fields of direct practice, including adult psychotherapy, children and youth mental health, and child welfare. He will be retiring from his academic career in July, 2017.

Peter Lehmann, PhD, LCSW, is professor of social work with the School of Social Work, the University of Texas at Arlington. His research interests include the evaluation of youth and men adjudicated to domestic violence offender groups. Dr. Lehmann's clinical interests include the use of solution-focused brief therapy with all populations. He also works and consults with child welfare and is a certified Signs of Safety trainer.

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SPRINGER PUBLISHING COMPANY
NEW YORK

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Stephanie Drew
Composition: Exeter Premedia Services Private Ltd.

ISBN: 978-0-8261-1947-6
e-book ISBN: 978-0-8261-1948-3

Instructor's Materials: Qualified instructors may request supplements by emailing textbook@springerpub.com:
Instructor's Manual: 978-0-8261-1949-0
PowerPoints: 978-0-8261-3379-3

16 17 18 19 20 / 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Names: Coady, Nick, editor. | Lehmann, Peter, 1953- editor.
Title: Theoretical perspectives for direct social work practice : a generalist-eclectic approach / editors, Nick Coady, Peter Lehmann.
Description: Third edition. | New York, NY : Springer Pub. Company, [2016] | Includes index.
Identifiers: LCCN 2015049289 | ISBN 9780826119476
Subjects: LCSH: Social case work.
Classification: LCC HV43 .T42 2016 | DDC 361.3/2—dc23
LC record available at http://lccn.loc.gov/2015049289

Printed in the United States of America by Bradford & Bigelow.

Personally, to my best friends: my partner, Laurie, and my daughters, Devyn and Blaire (with honorable mention to the members of the Wednesday night poker club, including my late father, Matt; the amigos golf foursome; and members of Thursday night pool). Professionally, to the writing of Helen Harris Perlman, Carl Rogers, Jerome Frank, and Howard Goldstein.
—Nick Coady

To the Balzer family, Wapella, Saskatchewan . . . you gave me my first 5 years of life; to Duane Webster, MD, Burnaby, British Columbia . . . a lost brother found; to my forever-forward family . . . Delphine, Daley, Jen and Emma Victoria, and Rory.
—Peter Lehmann

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Contributors

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Nick Coady, PhD, is professor and dean, Faculty of Social Work (FSW), Wilfrid Laurier University (WLU), Waterloo, Ontario, Canada. Dr. Coady has been with the FSW/WLU since 1994; prior to that, he was a faculty member in the FSW at the University of Calgary for 5 years. His practice background includes residential child welfare work, individual and family counseling with high-risk adolescents, and group work with abusive men. Dr. Coady's teaching, research, and publications have focused primarily on the importance of relationship and other common factors in various fields of direct practice, including adult psychotherapy, children and youth mental health, and child welfare. He will be retiring from his academic career in July 2017.

Norman H. Cobb, PhD, LCSW, has taught in schools of social work for 33 years. He joined the School of Social Work at the University of Texas at Arlington in 1989 and is currently an associate professor. Although he has taught BSW, MSW, and PhD courses, he primarily teaches second-year master's mental health courses, such as the Seminar in Cognitive-Behavioral Interventions. Dr. Cobb graduated with his PhD in social work from the University of California, Berkeley, and his MSW from the University of Texas at Arlington. He maintains a small clinical practice with adolescents and adults. He has been recognized by students and peers for teaching and is a member of the Academy of Distinguished Teachers.

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Jacqueline Corcoran, PhD, LCSW, is a professor at the Virginia Commonwealth University School of Social Work, where she has been on the faculty since 2000. She also served on the faculty at the University of Texas at Arlington from 1996 to 2000. Dr. Corcoran has written over 50 journal articles and 14 textbooks that are used in schools of social work throughout the United States. Her website is www .jacquelinecorcoran.com.

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Adriana Gil-Wilkerson, MSc, is a marriage and family therapist and supervisor in Houston, Texas. She began her relationship with Houston Galveston Institute (HGI) as a master level learner/intern in 2004 and has held various roles since. Adriana received her Master of Science in Psychology with a focus on Marriage and Family Therapy from Our Lady of the Lake University in 2005. She is currently a faculty member at HGI and is the Walk-In Counseling program coordinator. Adriana's research and practice are focused on providing training in collaborative practices for therapists of all backgrounds and, as a bilingual therapist, she has a passion for research about the training needs of bilingual counselors. Adriana is also a doctoral candidate at Sam Houston State University and is currently working on her dissertation.

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Preface

The primary purpose of the third edition of our book continues to be to provide an overview of theories for direct social work practice and a framework for integrating the use of theory with central social work principles and values, as well as with the artistic elements of practice. It is intended primarily for graduate-level social work students and practitioners; however, we know that many undergraduate social work programs also use the book. This book has similarities to other books that provide surveys of clinical theories for social work practice; however, we think it has a number of distinctive and useful features. In brief, these features include: (a) grounding direct practice specialization firmly in the generalist perspective of social work practice; (b) documenting the trend toward, and rationale and empirical support for, eclecticism in the broad field of counseling/psychotherapy, and reviewing various approaches to eclecticism; (c) bringing order to, and demystifying theories by differentiating among levels of theory, organizing direct practice theories into like groupings, and providing an overview of the central characteristics of each grouping of theories; (d) providing a critical perspective on the dominant, scientific paradigm of direct practice that centers the use of theory and technique, and putting equal emphasis on the artistic elements of practice; and (e) proposing the problem-solving model as a useful structure for facilitating the integration of the artistic and scientific elements of practice.

The contents of all of the chapters in this third edition have been revised and updated to reflect developments in theory, practice, and research since the second edition was published. In Part II of the book there is a new chapter on strengths-based social work, as an additional metatheory for social work practice. In Part III, there are now separate sections on Humanistic and Critical Theories. A new chapter on emotion-focused therapy is part of the section on Humanistic Theories, and a new chapter on empowerment theory is paired with the chapter on feminist theory in the Critical Theories section. In the final section on Postmodern Theories in Part III, there are now separate chapters on narrative therapy and collaborative therapy (formerly these two therapies were covered in one chapter) that accompany the chapter on solution-focused therapy. In addition to the new chapters, there are new coauthors of the chapters on attachment theory and self-psychology, and there is a new author of the chapter on feminist theory. We have updated information on the movement toward eclecticism in counseling/psychotherapy, as well as on the critique of the movement toward empirically supported treatments.

The book is divided into four parts with a total of 21 chapters. The first three chapters constitute Part I of this book, which focuses on explicating our generalist-eclectic approach to direct social work practice. In Part II, high-level or metatheories for direct practice are presented. The three chapters in this part focus on critical ecological systems theory, individual and family development theory, and strengths-based social work practice. Part III is divided into five sections and focuses on theories, models, and therapies for direct practice that are at a mid-level of abstraction. The five sections contain a total of 14 chapters on psychodynamic, cognitive behavioral, humanistic, critical, and postmodern theories. Part IV consists of a summary chapter that considers the similarities and differences between the theories, models, and therapies that are reviewed in the book and the principles and values that are integral to our generalist-eclectic approach. The issue of integrating the use of theory with the artistic elements of practice via the problem-solving model is also revisited in this final chapter, and implications for research and practice are discussed. In addition to the book content, qualified instructors can request an ancillary package consisting of PowerPoints and an Instructor's Manual (send an e-mail request to textbook@springerpub.com).

We are very grateful to all of the contributing authors for taking time from their busy schedules and lives to write the original chapters contained herein. Their willingness to follow the structural guidelines for the chapters, the clarity of their writing, and their being amenable to editorial suggestions made our work that much easier. We feel privileged to have collaborated with a group of very gifted and personable professionals. Special thanks go to the late Dr. Al Roberts, former editor of the Springer Series on Social Work and contributor to this book, for his initial and continuing support for this book. We would also like to thank Stephanie Drew, acquisitions editor at Springer, for her support and patience. Finally, thanks go to Lauren Price, who provided very helpful editorial assistance.

ONE

An Overview of and Rationale for a Generalist-Eclectic Approach to Direct Social Work Practice

Nick Coady and Peter Lehmann

The focus of this book is on theories for direct (or clinical, micro) social work practice. More specifically, the book focuses on theories for practice with individuals, although the relevance of these theories for practice with families and groups is also considered. Beyond simply offering a survey of clinical theories in this book, we promote what we call a *generalist-eclectic approach* for the use of theory in direct practice.

Including the word *generalist* in the name of our approach might seem odd because one of the generally accepted hallmarks of generalist social work practice is that it spans direct and indirect (or macro) practice methods, whereas our approach focuses only on direct practice. By using the word *generalist* to describe our approach to direct practice, we want to emphasize our belief that specialization in direct practice must be firmly grounded in the generalist perspective of social work practice. Simply put, we believe that the values, principles, generic processes, and holistic perspective that are integral to generalist social work practice are a necessary foundation for direct practice specialization. Although this might be taken for granted by some, we think this sometimes gets lost in the rush for specialization.

One reason it is important to ensure that direct practice is grounded explicitly within the generalist perspective is because most theories that clinical social workers use have been developed outside of the profession, and aspects of such theories may not fit well with some social work principles. When this is the case, we think that modifications to these aspects of theories are necessary. For example, theories that place the worker in the role of expert should be used in a more egalitarian, collaborative manner, and theories that have a specific and narrow conception of human problems should be broadened to include consideration of a wide range of factors (e.g., environmental and sociocultural factors need to be considered along with biological, intrapsychic, and interpersonal factors).

A second reason for embedding direct practice within the generalist perspective is that the latter can function to broaden the mandate and role of direct practitioners beyond narrow clinical confines. For instance, we think it is important that the

focus of clinical social work should include helping clients to meet basic needs by providing them with or linking them to resources and services, and engaging in social advocacy for clients—and the generalist perspective reminds us of the importance of such helping strategies.

This chapter provides an overview of our generalist-eclectic approach to direct practice. First, we review the major elements of the generalist social work perspective that are central to our generalist-eclectic approach to direct practice. Then, we provide an overview of the distinctive aspects of our generalist-eclectic approach. Finally, we discuss in some detail the issue of eclecticism, primarily with regard to the trend toward eclecticism over the last 35 years in the broad field of counseling/psychotherapy. The latter discussion includes (a) an overview of eclecticism that documents historical resistance to eclecticism, the fact of and reasons for the trend toward the eclectic use of theory and technique, and continuing resistance to eclecticism (particularly in the form of the empirically supported treatment movement); (b) a review of the four major approaches to eclecticism in the literature and some of the specific eclectic models within each of the approaches; and (c) a delineation of our approach to eclecticism.

ELEMENTS OF THE GENERALIST PERSPECTIVE THAT ARE CENTRAL TO OUR GENERALIST-ECLECTIC APPROACH

There are many characteristics that are common to the various descriptions of the generalist perspective in the literature. The major elements of generalist social work practice that we have adopted for our generalist-eclectic approach to direct social work practice have been drawn from a range of literature (Derezotes, 2000; Hepworth, Rooney, Rooney, & Strom-Gottfried, 2013; Johnson & Yanca, 2007; Kirst-Ashman & Hull, 2009; Landon, 1995, 1999; Locke, Garrison, & Winship, 1998; Miley, O'Melia, & DuBois, 2013; Shatz, Jenkins, & Sheafor, 1990; Sheafor & Horejsi, 2006; Sheafor & Landon, 1987; Timberlake, Farber, Zajicek, & Sabatino, 2008; Tolson, Reid, & Garvin, 2003; Walsh, 2009). These elements are summarized in Table 1.1 and discussed subsequently.

A Person-in-Environment Perspective Informed by Ecological Systems Theory

"The central focus of social work traditionally seems to have been on people in their life situation complex—a simultaneous dual focus on individuals and environment" (Gordon, cited in Compton, Galaway, & Cournoyer, 2005, p. 6). A generalist approach embraces this traditional person-in-environment perspective of social

TABLE 1.1 Elements of the Generalist Perspective That Are Central to Our Generalist-Eclectic Approach

- A person-in-environment perspective that is informed by ecological systems theory
- An emphasis on the development of a good helping relationship that fosters empowerment
- The flexible use of a problem-solving process to provide structure and guidelines for work with clients
- A holistic, multilevel assessment that includes a focus on issues of diversity and oppression and on strengths
- The flexible and eclectic use of a wide range of theories and techniques that are selected on the basis of their relevance to each unique client situation.

work practice. This perspective emphasizes the need to view the interdependence and mutual influence of people and their social and physical environments. Also, it recognizes the link between private troubles (i.e., individual problems) and public issues (i.e., social problems; Mills, 1959). The person-in-environment perspective has been one of the primary factors that has distinguished direct social work practice from the practice of other helping/counseling professions (i.e., psychology, marriage and family therapy, psychiatry).

Ecological systems theory (see Chapter 4) is a conceptual framework for the person-in-environment perspective that "has been almost universally accepted in social work over the past three decades" (Mattaini & Lowery, 2007, p. 39). This theory "recognizes an interrelatedness of human problems, life situations, and social conditions" (Shatz et al., 1990, p. 223). As explained in Chapter 2, it is a high-level or meta-theory that is particularly useful for helping workers to see the big picture in terms of the reciprocal influence of people and the various systems (e.g., family, work, community) with which they interact. As such, it provides an "organizational tool for synthesizing the many perspectives that social workers apply in practice" (Miley et al., 2013, p. 27).

The Development of a Good Helping Relationship That Fosters Empowerment

Historically, social work has led the helping professions to advocate the importance of a collaborative, warm, empathic, supportive worker–client relationship. Social workers have described this type of relationship as the "soul" (Biestek, 1957), "heart" (Perlman, 1979), and "major determinant" (Hollis, 1970) of the helping endeavor. Although clinical social work has drifted away from such an emphasis over the last few decades in favor of attention to the theoretical/technical/scientific aspects of practice (Coady, 1993a; Perlman, 1979), the generalist perspective has reemphasized the importance of the helping relationship.

Along with a reaffirmation of the importance of a good helping relationship, the generalist perspective has promoted a focus on empowerment. A number of authors of generalist textbooks (e.g., Landon, 1999; Locke et al., 1998; Miley et al., 2013; Timberlake et al., 2008) have combined a consideration of empowerment and the strengths perspective (Saleebey, 2013). For example, Miley and colleagues (2013) argued that "an orientation toward strengths and empowerment compels social workers to redefine their relationships to embrace the notion of collaboration and partnership" (p. 85). Gutiérrez (cited in Miley et al., 2013) noted that this involves basing the helping relationship on "collaboration, trust, and shared power; accepting the client's definition of the problem; identifying and building upon the client's strengths; actively involving the client in the change process; [and] experiencing a sense of personal power within the helping relationship" (p. 133).

The Flexible Use of a Problem-Solving Model

Since Perlman's (1957) formulation of the problem-solving model for social casework, problem solving has been an integral part of social work practice. Most generalist approaches to social work practice include some version of the problem-solving model, and although there are various conceptualizations of the stages or phases of problem solving, all versions include guidelines for the entire helping process, from initial engagement to termination.

Some generalist approaches, in an effort to emphasize a strengths focus versus a problem focus, have renamed the problem-solving model. For example, Locke and colleagues (1998) called their version of the problem-solving model a "phase model," and Miley and colleagues (2013) called their version "phases and processes of empowering practice" (p. 103). We agree, however, with McMillen, Morris, and Sherraden (2004) who contended that the "grudge match" within social work that pits strengths-based against problem-focused approaches represents a false and destructive dichotomy. Thus, our use of the term *problem-solving model* does not denote a deficit or pathology orientation to practice. As is generally the case within social work, we construe problem solving as a collaborative process between workers and clients that has the ultimate goal of capacity building and empowering clients (see Chapter 3 for a more detailed discussion of problem solving).

A Holistic, Multilevel Assessment

The person-in-environment perspective and ecological systems theory suggest the necessity of a holistic, multilevel assessment. The term *holistic* refers to a "totality in perspective, with sensitivity to all the parts or levels that constitute the whole and to their interdependence and relatedness" (McMahon, 1996, p. 2). This represents a focus on the whole person (i.e., the physical, emotional, spiritual) in the context of his or her surroundings. Multi-level assessment goes hand-in-hand with a holistic focus because this means considering the entire range of factors, from micro to macro, that could be impacting a client. Thus, in conducting an assessment, the generalist-oriented direct practitioner should consider the potential influence of biophysical, intrapsychic, interpersonal/familial, environmental, and sociocultural factors. With regard to the latter class of factors, a generalist approach to direct practice assessment includes particular sensitivity to issues of diversity (e.g., gender, race, culture, class, sexual orientation, disability, age, religion) and oppression (Shatz et al., 1990). A generalist approach also demands that the assessment process includes a focus on clients' strengths, resources, and competencies.

The Flexible and Eclectic Use of a Wide Range of Theories and Techniques

The commitment to a holistic, multi-level assessment precludes a rigid adherence to narrow theories of human problems. A generalist approach should be "unencumbered by any particular practice approach into which the client(s) might be expected to fit" (Sheafor & Landon, 1987, p. 666). Theories can be useful in the assessment process if they are tentatively considered as potential explanations for clients' problems; however, theories represent preconceived ideas about human problems and can blind one to alternative explanations.

Just as the assessment process must avoid rigid adherence to narrow theoretical perspectives, the same is true for the intervention process: "the generalist perspective requires that the social worker be *eclectic* (i.e., draw ideas and techniques from many sources)" (Sheafor & Horejsi, 2006, p. 87). Generalists are open to using theories and techniques that seem most relevant to the understanding of the unique client situation: "Single model practitioners do a disservice to themselves and their clients by attempting to fit all clients and problems into

their chosen model" (Hepworth, Rooney, & Larsen, 2002, p. 17). Guidelines for selecting theories and techniques for particular types of clients and problems are reviewed later in this chapter in the discussion of approaches to eclecticism, as well as in Chapter 3.

DISTINCTIVE ASPECTS OF OUR GENERALIST-ECLECTIC APPROACH

A Differentiated Understanding and Demystification of Theory

One distinctive aspect to our approach of using theory in practice is differentiating between types and levels of theory, and classifying clinical theories in like groupings. Our approach to understanding theory differentiates between (a) high-level, metatheories (ecological systems and human development theories, the strengths perspective; see Part II, Chapters 4–6); (b) mid-level practice theories (see Part III, Chapters 7–20); and low-level models for specific populations and problems. Metatheories provide general guidance for holistic assessment and the generation of ideas for intervention, mid-level practice theories provide more specific ideas and directions for assessment and intervention for a range of presenting concerns, and low-level models provide more specific guidelines for work with specific populations and problems.

Furthermore, in an effort to demystify the vast array of practice theories that exist, we classify these theories in like groupings (psychodynamic [Chapters 7–9], cognitive behavioral [Chapters 10–12], humanistic [Chapters 13–15], critical [Chapters 16–17], and postmodern [Chapters 18–20]) and provide a brief overview of the distinguishing characteristics of each of these larger classifications of theory (see Chapter 2).

A Critical Perspective on the Use of Theory and Valuing the Artistic Elements in Practice

Perhaps the most distinctive feature of our generalist-eclectic approach is that it includes a critical perspective on the *scientific* view of practice, which contends that use of theory and technique reflects the essence and is the cornerstone of effective direct social work practice. We certainly do not deny the value of this scientific approach to practice (after all, this book focuses on the use of theory in practice), although we clearly favor an eclectic use of theory and technique over adherence to a single theory and its techniques. Still, a key element of our framework is the recognition and valuing of the *artistic* elements of practice (Coady, 1995; Goldstein, 1990; Kinsella, 2010; McCoyd & Kerson, 2013; Schön, 1983).

An artistic approach to practice, often referred to as reflective practice (Schön, 1983), includes the use of relationship-building skills, intuition, gut instincts, empathic listening, and inductive reasoning to collaboratively build with the client a theory that fits his or her unique situation and to problem solve creatively. We believe that practice is at least as much art as science, and is based at least as much on reflection-in-action (Schön, 1983), intuition, inductive reasoning, theory building, and general interpersonal/relationship skill as on the deductive application of theoretical knowledge and technical skill. Theory and research that pertain to this issue are reviewed both later in this chapter and in the second part of Chapter 2,

where the artistic, reflective, intuitive-inductive approach to practice is discussed. Our stance is that the best social work practice integrates scientific (i.e., theoretical/technical) and artistic (i.e., reflective, intuitive-inductive) elements.

Use of the Problem-Solving Model to Integrate the Art and Science of Practice

One of the main difficulties with both theoretically eclectic and artistic, reflective, intuitive-inductive approaches to practice is a lack of structure and guidelines for practice. For example, workers who are theoretically eclectic are sometimes overwhelmed by the sheer number of theories from which to choose. Also, practice can lack coherence and direction when one moves back and forth between theories, and sometimes workers can become preoccupied with or distracted by multiple theoretical considerations. When this happens, the worker's understanding of and relationship with the client can suffer.

On the other hand, workers who prefer a more artistic, humanistic approach to practice that is based on reflection, intuition, and inductive reasoning sometimes feel as if they are "flying by the seat of their pants." Their practice can similarly lack coherence and direction. This is a major reason why some practitioners prefer to adhere to a single theoretical orientation in their practice—a single theory approach provides clear structure and guidelines. The cost of adherence to a single theory is too large; however, there is no one theory that is comprehensive enough to fit for all clients, and clients should not be forced into theoretical boxes.

We believe that the problem-solving model offers a solution to the lack of structure and guidelines for practice that are commonly experienced by workers who prefer theoretically eclectic and/or reflective, intuitive-inductive approaches to practice. The general strategies for the various phases of helping (from engagement to termination) that constitute the problem-solving model provide useful and flexible structure and guidelines for both the scientific and artistic approaches to practice and enable workers to integrate these two approaches in their work. The generality and flexibility of the guidelines in each phase of the problem-solving process provide sufficient structure and direction for practice while also allowing workers to integrate theory and use reflection, intuition, and inductive reasoning. This issue is discussed briefly later in this chapter, and in more depth in Chapter 3.

AN OVERVIEW OF ECLECTICISM

As is evident from the earlier discussion, eclecticism is an inherent orientation in generalist practice and is endorsed by most authors of generalist (e.g., Locke et al., 1998; Sheafor & Horejsi, 2006; Tolson et al., 2003) and direct practice (Derezotes, 2000; Hepworth et al., 2002) social work textbooks. For example, Hepworth and colleagues (2002) argued that "because human beings present a broad array of problems of living, no single approach or practice model is sufficiently comprehensive to adequately address them all" (p. 17). Also, "surveys of practitioners repeatedly indicated that one half to two-thirds of providers prefer using a variety of techniques that have arisen from major theoretical schools" (Lambert, 2013a, p. 8). One survey (Jensen, Bergin, & Greaves, 1990) of a wide variety of mental health professionals revealed that the majority (68%) of social workers consider themselves eclectic, although this was the second lowest percentage among the four professional groups

surveyed (corresponding figures for marriage and family therapists, psychologists, and psychiatrists were 72%, 70%, and 59%, respectively). Despite clear and logical arguments for eclecticism and its prevalence in practice, it is still a contentious issue in the helping professions—and we think this is particularly so in clinical social work (see discussion in the Historical Resistance to Eclecticism section later in this chapter).

We would like to alert readers to the fact that our consideration of eclecticism in much of the rest of this chapter relies heavily on literature in clinical psychology because this is where most of the theory and research on eclecticism has been generated. Because of the reliance on literature from outside our profession, terms other than what we would normally use appear frequently (e.g., *therapist* instead of *worker*, *patient* instead of *client*, *therapy* instead of *direct practice* or *counseling*). We emphasize that we do not endorse the use of such terms and that our approach to eclecticism in direct practice is firmly rooted in social work values. Furthermore, we would like to point out that although most of the research on psychotherapy that we review has been conducted by psychologists and published in the psychology literature, this research has included direct social work practice. As Lambert (2013a) has pointed out, "in the United States, as much as 60% of the psychotherapy that is conducted is now provided by social workers" (p. 10).

Historical Resistance to Eclecticism

A historical perspective is necessary to understand the contentiousness of eclecticism. For most of this century, the helping professions have been marked by rigid adherence to narrow theories. Up until the 1960s, psychodynamic theory remained relatively unchallenged as the dominant theory in the helping professions (Lambert, Bergin, & Garfield, 2004). As humanistic and behavioral theories gained increasing prominence in the 1960s, they began to challenge the dominance of psychodynamic theory, and this initiated the era of the "competing schools of psychotherapy." For the most part, the next 25 years were marked by rigid adherence to one or another of an increasing number of theoretical camps, rancorous debate about which theory was right, and extensive research focused on proving which therapeutic approach was the most effective. Although there were some efforts to bridge the differences among the numerous competing schools of therapy, eclecticism was clearly a dirty word. As Norcross (1997) has commented:

> You have all heard the classic refrains: eclectics are undisciplined subjectivists, jacks of all trades and masters of none, products of educational incompetency, muddle-headed, indiscriminate nihilists, fadmeisters, and people straddling the fence with both feet planted firmly in the air. (p. 87)

Unfortunately, such negative views of eclecticism are still prevalent within the field of counseling, particularly within clinical social work. Despite the endorsement of eclecticism by the generalist perspective, many social workers do not seem aware of or at least have not embraced the movement toward eclecticism that has been sweeping the larger field of psychotherapy. Also, despite the prevalence of eclecticism in practice, many social workers seem loath to admit this publicly because they know that eclecticism is still a dirty word in some circles. We have encountered many clinical social workers (academics and practitioners) who have

disdain for eclecticism. One of the social work academics whom we approached to write a chapter for the first edition of this book, and who ascribed to a psychodynamic perspective, declined to contribute because of our endorsement of both a generalist perspective and eclecticism. Similarly, another academic who ascribed to a critical perspective declined to contribute a chapter to the current edition of this book for similar reasons. Unfortunately, such traditional negative views of eclecticism are difficult to change and they quickly filter down to students. We have had students tell us that their field instructors counsel them to never admit to an eclectic orientation in a job interview because it would count against them.

It is not surprising that adherence to one theoretical orientation is most prevalent for those who were trained in an older, more traditional theory. The Jensen et al. (1990) survey found that the most common exclusive theoretical orientation was psychodynamic. Furthermore, to bolster our contention about the traditional nature of clinical social work, this survey found that "of individuals endorsing an exclusively psychodynamic approach, 74% were either psychiatrists or social workers" (Jensen et al., 1990, p. 127; 25% of social workers and 36% of psychiatrists identified themselves as exclusively psychodynamic, whereas less than 10% of the other professional groups did so).

It should also be pointed out, however, that this phenomenon of adherence to one theoretical perspective also seems to be common for social workers who embrace more recent therapeutic approaches—for example, in the 1980s, family systems therapy (see Coady, 1993b); in the 1990s and forward, solution-focused therapy (see Stalker, Levene, & Coady, 1999); and from the late 1990s and forward, many critical approaches to social work practice. Thus, we felt that it was important to emphasize our endorsement of eclecticism in the title of the book and to review the fact of and rationale for the trend toward eclecticism.

Documenting the Trend Toward Eclecticism in Counseling/Psychotherapy

Three decades ago, with regard to the broad field of counseling/psychotherapy, Garfield and Bergin (1986) concluded that the era of the competing schools of psychotherapy was over:

> A decisive shift in opinion has quietly occurred; and it has created an irreversible change in professional attitudes about psychotherapy and behavior change. The new view is that the long-term dominance of the major theories is over and that an eclectic position has taken precedence. (p. 7)

The trend toward eclecticism is evidenced in a number of ways. First, the precedence of eclecticism has been demonstrated by surveys. The Jensen et al. (1990) survey found that the majority of practitioners in each of the four groups of helping professionals were eclectic (68% overall). Furthermore, similar surveys have repeatedly indicated that one half to two thirds of practitioners in North America prefer some type of eclecticism (Lambert, 2013a).

Second, an international professional organization, the Society for the Exploration of Psychotherapy Integration (SEPI), which has been in existence for over 30 years, has been influential in furthering the study of eclecticism in psychotherapy. SEPI has published the *Journal of Psychotherapy Integration* since 1991, holds annual conferences, and has a website (www.sepiweb.org). We should clarify

that the term *integration* is often used together with or instead of the term *eclecticism* in the literature. In brief, the difference between these approaches is that integration focuses on joining two or more theoretical approaches to arrive at a new, more comprehensive theory, while eclecticism simply draws on different theories and their techniques (Lambert, 2013a). The difference between eclectic and integrative models is revisited in our discussion of approaches to eclecticism; however, for the most part, we use the term *eclecticism* to encompass both approaches.

Third, there has been a proliferation of literature on eclecticism. The number of journal articles focused on eclecticism continues to increase annually. This is also true for books on this topic. *Psychoanalysis and Behavior Therapy* (Wachtel, 1977), *Systems of Psychotherapy: A Transtheoretical Analysis* (Prochaska, 1979), and *Psychotherapy: An Eclectic Approach* (Garfield, 1980) were three of the first books that presented arguments for eclecticism and/or integration. Some of the more recent editions of such books include Dryden (1992), Stricker and Gold (1993), Garfield (1995), Gold (1996), Beutler and Harwood (2000), Lebow (2002), Norcross and Goldfried (2005), Stricker and Gold (2006), and Prochaska & Norcross (2014).

Reasons for the Trend Toward Eclecticism: Key Conclusions From Cumulative Research

Although various writers have argued for eclecticism (e.g., Thorne, 1950), or have promoted the integration of various theories (e.g., Dollard & Miller, 1950), in the more distant past, it is only in the last 35 years that a definite trend toward eclecticism has emerged in the broad field of counseling/psychotherapy. The trend toward eclecticism has been fueled primarily by two interrelated sets of research findings, which are discussed here.

The Equal Outcomes/Dodo Bird Phenomenon

The era of the competing schools of psychotherapy spawned an immense volume of research which overall has failed to demonstrate the superiority of one type of psychotherapy over another. Two recent, comprehensive reviews of research (Lambert, 2013b; Wampold & Imel, 2015) examined both numerous meta-analyses (a quantitative method that aggregates the findings of numerous studies in order to test hypotheses; e.g., Smith & Glass, 1977; Wampold et al., 1997) and exemplary studies (large, well-designed studies; e.g., the National Institute of Mental Health Treatment of Depression Collaborative Research Program [NIMH TDCRP; Elkin, 1994]) of the comparative outcomes of different therapy models.

These comprehensive reviews of the research have both reinforced what is commonly referred to as the *equal outcomes* or *Dodo bird effect* conclusion. That is, overall, studies have indicated that the various types of therapy (psychodynamic, cognitive behavioral, humanistic, etc.) have roughly equal effectiveness and therefore, in the words of the Dodo bird from *Alice in Wonderland*, "everybody has won, and all must have prizes" (Carroll, cited in Wampold et al., 1997, p. 203).

Although the equal outcomes conclusion is widely accepted, there are those who continue to question its legitimacy. Some critics (e.g., Beutler, 1991) have surmised that in the future, more sophisticated research designs may yield superior outcomes for specific therapy–client problem combinations. Others criticize various aspects of meta-analytic studies that support the equal outcomes conclusions

(Wampold & Imel, 2015). Still, others point out that some studies have found differences in outcome between approaches to treatment. In particular, some researchers contend that cognitive behavioral approaches are more effective than other approaches with specific anxiety disorders (Wampold & Imel, 2015). We believe, however, that these contentions are not supported by empirical evidence to date. Lambert (2013b) has acknowledged tentative evidence that cognitive behavioral approaches may yield superior outcomes for a few specific, difficult problems (e.g., panic, phobias, and compulsions); however, he still accepts the general validity of the equal outcomes conclusion:

> differences in outcome between various forms of therapy are not as pronounced as might have been expected. . . . Behavioral therapy, cognitive therapy, and eclectic mixtures of these methods have shown marginally superior outcomes to traditional verbal therapies in several studies on specific disorders, but this is by no means the general case. (Lambert, 2013b, p. 205)

Wampold and Imel (2015) are even less accepting of the claims that cognitive behavioral approaches may be more effective with some specific problems. Their thorough, meticulous review of the research concluded that the equal outcomes result has held even in studies that have focused on specific treatments for depression and anxiety. These are two problems for which cognitive behavioral treatments were thought to be particularly appropriate and these are among the most common client problems for clinical social workers. Wampold and Imel (2015) concluded: "Claims that specific cognitive-behavioral therapies are more effective than bona fide comparisons are common but overblown and in need of additional testing" (p. 156).

Thus, we agree with Wampold and Imel's (2015) conclusion that "the Dodo bird conjecture has survived many tests and must be considered 'true' until such time as sufficient evidence for its rejection is produced" (p. 156). The acceptance of this conclusion does not lead directly to an argument for eclecticism; however, it does promote acceptance of the validity of alternative approaches. This, along with the recognition that "no single school can provide all theoretical and practical answers for our psychological woes . . . [makes it seem sensible] to cross boundaries, to venture beyond one's borders in search of nuggets that may be deposited among the hills and dales of other camps" (Lazarus, 1996, p. 59).

The Importance of Relationship and Other Common Factors

The cumulative results of psychotherapy research have stimulated interest in what has come to be known as "common factors." The findings of nonsignificant outcome differences among the variety of different therapies (the equal outcomes phenomenon) led many researchers to latch on to the ideas promoted earlier by Rosenzweig (1936) and Frank (1961) that factors specific to the various therapies (i.e., distinctive theory and techniques) had less impact on outcomes than factors that were common across therapies—particularly worker–client relationship factors. Early research on the client-centered core conditions of empathy, warmth, and genuineness, and later research on the related concept of the therapeutic alliance, have established that relationship factors are the most powerful predictors of client outcome and that a good helping relationship is necessary for good outcome regardless of the approach to

therapy (Horvath, Del Re, Fluckiger, & Symonds, 2011; Horvath & Symonds, 1991; Lambert & Barley, 2001; Wampold & Imel, 2015).

Cumulative research suggests that "common factors are probably much more powerful than the contribution of specific techniques. . . . Learning how to engage the client in a collaborative process is more central to positive outcomes than which process (theory of change) is provided" (Lambert, 2013b, p. 202). The two editions of Wampold's (2001; Wampold & Imel, 2015) book, *The Great Psychotherapy Debate*, focused on reviewing research related to the controversial question of whether therapy effectiveness is related more to common factors (e.g., therapeutic relationship) or specific factors (e.g., theory and technique). Wampold and Imel (2015) concluded that the research evidence provides overwhelming support for the importance of common versus specific factors. They found that the effects produced by common factors were much larger than the effects produced by specific factors and that "these effects make it evident that the 'common factors' are important considerations in the outcome of psychotherapy" (Wampold & Imel, 2015, p. 256). Furthermore, they concluded that despite concerted efforts by many researchers to establish the importance of specific factors, "there is no compelling evidence that the specific ingredients of any particular psychotherapy . . . are critical to producing the benefits of psychotherapy" (p. 253).

Although a variety of factors that are common across therapies have been conceptualized and there is empirical support for the importance of a number of such factors (e.g., reassurance, affective experiencing/catharsis, mitigation of isolation, encouragement of facing problems/fears, encouragement of experimenting with new behaviors; Lambert, 2013b), the therapeutic relationship or alliance "is the most frequently mentioned common factor in the psychotherapy literature" (Grencavage & Norcross, 1990) and it has been called the "quintessential integrative variable" (Wolfe & Goldfried, cited in Wampold, 2001, p. 150) in counseling. On the basis of their thorough review of psychotherapy research, Wampold and Imel (2015) conclude that the "relationship, broadly defined, is the bedrock of psychotherapy effectiveness" (p. 50). Again, although the research on common factors does not lead directly to an argument for eclecticism with regard to theory and technique, it does promote openness to crossing therapeutic boundaries. In fact, from within social work, Cameron (2014) has suggested that "eclecticism is equivalent to a common factors approach . . . in that common factors practitioners use strategies and skills that are found in many different practice approaches" (p. 152; see Approaches to Eclecticism section for further discussion of common factors).

Summary

Although there have been longstanding and persuasive arguments for eclecticism, the trend toward eclecticism has been fueled largely by research findings—both the equal outcomes phenomenon and the importance of relationship and other common factors relative to specific (i.e., theory and technique) factors. As Lambert (2013b) has noted, the trend toward eclecticism "appears to reflect a healthy response to empirical evidence" (p. 206). This has led practitioners to "increasingly acknowledge the inadequacies of any one school and the potential value of others" (Norcross, 1997, p. 86). From within social work, having reviewed much of the same psychotherapy research that has been reviewed in

this chapter, Cameron (2014) has concluded that "eclecticism, idiosyncratically shaped by the unique needs of clients as well as the person of the practitioner, is most effective" (p. 152).

Pockets of Resistance to Eclecticism

Acceptance of the research findings that have fuelled the trend toward eclecticism has not been easy for many mental health practitioners. Four decades ago, Frank (as cited in Lambert & Ogles, 2004) anticipated resistance to his hypotheses about equal outcomes across therapies and the importance of common factors when he noted that "little glory derives from showing that the particular method one has mastered with so much effort may be indistinguishable from other models in its effects" (p. 175). Similarly, as Glass suggested in the foreword to Wampold's (2001) book, giving up the idea that one's cherished theory and associated techniques are no more effective than another approach to therapy and that effectiveness is due largely to factors that are common across therapies "carries a threat of narcissistic injury" (p. x).

Even more dramatically, Parloff (cited in Wampold, 2001) contended that, in some practitioners' minds, if the conclusion about the primary importance of common factors is accepted, "then the credibility of psychotherapy as a profession is automatically impugned" (p. 29). With regard to this last point, we would argue that acceptance of these research findings does not impugn the credibility of psychotherapy, but it does change the general conceptualization of psychotherapy from a primarily scientific, theoretical/technique-oriented enterprise to one that is more humanistic, artistic, and reflective. Wampold and Imel (2015) have called for such a shift toward what they call a "contextual model" of therapy, in which common factors are emphasized, to replace the current "medical model." Still, there is "tremendous resistance" (Lambert, Garfield, & Bergin, 2004, p. 809) to accepting these research findings and this reconceptualization of psychotherapy/clinical practice.

The Challenge of the Empirically Supported Treatment (EST) Movement

The research findings on equal outcomes across different types of therapy, the importance of relationship and other common factors to outcomes, and the weak effect of specific techniques on outcomes stand in stark contrast to the rise of the EST movement in psychology that arose in the 1990s. As part of the broader movement toward evidence-based practice (EBP) in psychology (Barlow, 2000) and social work (Gambrill, 1999, 2006; Gibbs & Gambrill, 2002; Howard, McMillen, & Pollio, 2003; Magill, 2006; Rubin & Parrish, 2007; Shdaimah, 2009), the EST movement was spurred by the Division of Clinical Psychology of the American Psychological Association, which created criteria for the empirical support of therapies.

It is clear that the implicit assumption of the EST movement is that specific ingredients (i.e., therapeutic techniques and their underlying theory) are the important curative factors in psychotherapy (Messer, 2001). The EST movement has pushed for using specific treatments with specific disorders and using only treatments that have been "proven" effective in randomized clinical trial research that includes a formal diagnosis of the client's problem, a specific treatment that is delivered in accordance with a treatment manual, and outcome measures related to the diagnosis. The result has been to develop a list of ESTs, the vast majority of which are cognitive behavioral in orientation. ESTs have become widely advocated

by managed care, insurance companies, and government (Messer, 2001). In this regard, Wampold (2001) has lamented that "doctoral level psychologists and other psychotherapy practitioners (e.g., social workers, marriage and family therapists) are economically coerced to practice a form of therapy different from what they were trained and different from how they would prefer to practice" (p. 2).

Before moving to a critique of the EST movement, it is important to stress that it is much narrower than the EBP movement. As Gambrill (2006) has pointed out:

> Descriptions of EBP differ greatly in their breadth and attention to ethical, evidentiary, and application issues and their interrelationships ranging from the broad, systemic philosophy and related evolving process initiated by its originators . . . to narrow views (using empirically supported interventions that leave out the role of clinical expertise, attention to client values and preferences, and application problems). (p. 339)

We agree with Gambrill (2006) that the EST movement represents "a narrow view of EBP . . . that is antithetical to the process and philosophy of EBP as described by its originators" (p. 354). Thus, although we are concerned that the broader EBP movement has to some degree gotten aligned with the narrower views of the EST movement, our argument is with the latter movement and its narrow and rigid conceptualization of what constitutes evidence. We hope it is clear from our review of psychotherapy research that we believe practice should be informed by research—we just disagree with those within the EST movement about what the research to date tells us about practice and what research should focus upon going forward.

Critique of the EST Movement

Critics have pointed out that the predominance of cognitive behavioral treatments (CBTs) in the EST list is due to the fact that other more process-oriented therapies do not readily fit the research protocol requirements for manualized treatment and focus on specific symptoms with associated specific outcome measures, and that these requirements are biased toward CBTs (Messer, 2001; Wachtel, 2010; Wampold & Imel, 2015). Wachtel (2010) has argued that "there is an impressive body of evidence demonstrating the efficacy of a range of therapeutic approaches not on the 'EST' lists" (p. 268). Furthermore, in a provocative manner, he has contended that when EST advocates dismiss this body of evidence as irrelevant because the studies do not meet their very narrow research protocol requirements, "they engage in a kind of deceptive casuistry similar to that which characterized for years the tobacco companies' denial of the adverse health effects of cigarettes" (p. 269).

The use of treatment manuals is one of the research requirements of the EST movement that has received extensive criticism. Beyond the fact that many theoretical approaches are not structured enough to be manualized, Messer (2001) argued that overly close adherence to treatment manuals can stifle "artistry, flexibility, reflection, and imagination" (p. 8). This view is supported by Wampold and Imel's (2015) review of research, which found that "the evidence suggests that rigid adherence to a treatment protocol, particularly if it damages the relationship . . ., is detrimental" (p. 274).

More generally, noting the decades of research that have confirmed the equal outcomes phenomenon and the importance of the counseling relationship,

Wampold and Bhati (2004) argued that "there is compelling evidence that it makes more sense to think of elements of the relationship as being empirically supported rather than particular treatments" (p. 567). Similarly, Lambert (2013a) has pointed out, "the fact is that success of treatment appears to be largely dependent on the client and the therapist, not on the use of 'proven' empirically based treatments" (p. 8). Henry's (1998) argument against ESTs is still valid today:

> The largest chunk of outcome variance not attributable to pre-existing patient characteristics involves individual therapist differences and the emergent interpersonal relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of three decades of empirical psychotherapy research. (p. 128)

We agree with those who contend that the focus of EST research is misplaced and that the results are misleading. We also concur with Wampold's (2001) conclusion that "designated empirically supported treatments should not be used to mandate services, reimburse service providers, or restrict or guide the training of therapists" (p. 225). With regard to the latter issue, Wampold and Imel (2015) argued that "training programs need to teach a variety of treatments—and . . . the optimal training programs will combine training in treatments and relationship skills" (p. 276). From within social work, reflecting on the strong empirical support for the importance of the helping relationship, Furman (2009) has argued similarly:

> Increasingly, schools of social work and social work training centers that focus on methods or technique . . . may not sufficiently help future social workers develop the capacity for self-reflection, which is a key to developing functional or "good enough" helping relationships. (p. 84)

As noted earlier, it should be clear from the emphasis we have placed on reviewing research that we are not against the general concept of EBP; however, we think that psychologists and social workers who align themselves with the assumptions and principles of the EST movement are barking up the wrong tree in searching for empirically supported theories and techniques. Instead, we think that funders, researchers, and practitioners should shift to more productive research foci.

One example of a more productive research focus is that of the APA Task Forces (Norcross, 2001, 2002; Norcross & Lambert, 2011; Norcross & Wampold, 2011) that explored evidence-based therapy relationships. These task forces were established to counter, or at least balance, the EST movement. In fact, one of the conclusions of the second task force (Norcross & Wampold, 2011) was that "efforts to promulgate best practices or evidence-based practices (EBPs) without including the relationship are seriously incomplete and potentially misleading" (p. 98). Among the general elements of the therapy relationship that the second task force concluded as "demonstrably effective" were the overall quality of the therapeutic relationship/alliance, empathy, and collecting client feedback. Other elements found to be "probably effective" were positive regard, collaboration, and goal consensus. "Promising" elements of the relationship but with insufficient research included genuineness/congruence and repairing problems in the therapy relationship (Norcross & Wampold, 2011).

Policy recommendations from this task force included educating clinicians about the benefits of evidence-based therapy relationships and advocating for the "research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy" (Norcross & Wampold, 2011, p. 100). Reflecting on the research that supports the importance of the helping relationship, Lambert (2013b) said "It should come as no surprise that helping others . . . can be greatly facilitated in a therapeutic relationship that is characterized by trust, understanding, acceptance, kindness, warmth, and human consideration" (p. 206).

The second APA task force on evidence-based therapy relationships also found that adapting the relationship style to specific client characteristics enhances the effectiveness of counseling (Norcross & Wampold, 2011). Among the most important client characteristics to adapt one's relationship stance to were client preferences, resistance (highly resistant clients benefit more from a minimally directive worker, and vice-versa), culture, and religion/spirituality. As two of the first task force members concluded, research suggests that "improvement of psychotherapy may be best accomplished by learning to improve one's ability to relate to clients and tailoring that relationship to individual clients" (Lambert & Barley, 2001, p. 357).

Another example of a potentially productive focus for research is individual therapist differences. Although research has established equal outcomes across different types of therapy, it has also established that there are significant differences in effectiveness among therapists within each approach to therapy. Lambert (2013b) has noted that "some therapists appear to be unusually effective, while others may not even help the majority of patients who seek their services" (p. 206). From their review of research on this issue, Wampold and Imel (2015) concluded that the actions that differentiate more effective from less effective therapists include "warmth and acceptance, empathy, and focus on the other" (p. 211). On this issue, Lambert and Ogles (2004) have called for "research focused on the 'empirically validated psychotherapist' rather than on empirically supported treatment" (p. 169).

It is likely that differences in effectiveness among practitioners have much to do with the ability to establish good interpersonal relationships with clients, particularly difficult clients, and to use such relationships therapeutically (Asay & Lambert, 2001). Thus, promising foci for research on therapist differences include relationship and general interpersonal skills, interpersonal style, emotional well-being, and attitudes toward clients. Although we do not know how widespread it has become, Messer (2001) noted that it was encouraging that some "managed care companies are moving to a system of evaluating therapists and referring cases to the successful ones, rather than requiring the use of ESTs" (p. 9). On a related note, Lambert (2013b) has noted that "research suggests clients would be wise to pick a therapist as-a-person at least in parity with the selection of a kind of psychotherapy" (p. 206).

APPROACHES TO ECLECTICISM

Despite pockets of strong resistance such as the EST movement, the trend toward eclecticism and integration is clear in the broad field of counseling/psychotherapy and the profession of clinical psychology. As we have argued, however, despite the endorsement of eclecticism in the generalist perspective, this trend is less clear in

direct social work practice. We think it is important for social workers to become familiar with the literature on eclecticism and integration in psychotherapy. Many of the ideas and principles in this literature (e.g., the valuing of multiple perspectives for understanding and intervening, the centrality of the helping relationship) are consistent with and can inform social work practice.

Four broad approaches to eclecticism are commonly identified in the literature: technical eclecticism, theoretical integration, assimilative integration, and common factors (Castonguay, Reid, Halperin, & Goldfried, 2003; Lampropoulos, 2001; Norcross, 2005; Stricker, 2010; see Table 1.2). A survey (Norcross, Karpiak, & Santoro, cited in Norcross, 2005) of psychologists who self-identified as eclectics and integrationists found that a sizable proportion of therapists (19%–28%) are subscribed to each of these four approaches to eclecticism.

Each of the general approaches to eclecticism subsumes a number of more specific models of eclectic/integrative practice; however, not surprisingly, there are differences in the literature with regard to classifying some models. Although it is beyond the scope of this book to review specific eclectic/integrative models in detail, the following discussion of each of the four general approaches provides a brief discussion of some of the specific models that fall under their domain. Following this, we elaborate on the type of eclecticism we endorse for our generalist-eclectic approach.

TABLE 1.2 Approaches to Eclecticism/Integration

Broad Approaches	Examples of Therapies	General Characteristics of Approaches
Technical Eclecticism	Multimodal behavior therapy (MMT; Lazarus, 1981, 2005, 2006) Systematic treatment selection (STS; Beutler, 1983; Beutler & Clarkin, 1990; Beutler, Consoli, & Lane, 2005; Beutler, Harwood, Bertoni, & Thomann, 2006)	Using techniques from different theories based on their proven effectiveness with similar client problems/ characteristics, without necessarily subscribing to any of the theories
Theoretical Integration	Integrative relational therapy (Wachtel, 1977, 1997; Wachtel, Kruk, & McKinney, 2005) The transtheoretical model (TTM; Prochaska & DiClemente, 1984, 2005; Prochaska & Norcross, 1999, 2014)	Integrating/synthesizing the strengths of two or more theories to create a more comprehensive theory to explain human problems and guide intervention
Assimilative Integration	Assimilative psychodynamic psychotherapy (Gold & Stricker, 2001; Stricker, 2006; Stricker & Gold, 2005) Widening the scope of cognitive therapy (Safran, 1990a, 1990b, 1998; Safran et al., 2014)	Incorporating other theories and techniques into one's primary theoretical orientation
Common Factors	Common factors/contextual meta-model (Frank & Frank, 1991; Wampold, 2001; Wampold & Imel, 2015) Eclectic/integrative approach (Garfield, 1995, 2000) Client-directed, outcome-informed clinical work (Duncan, Sparks, & Miller, 2006; Miller, Duncan, & Hubble, 2005)	Focusing on factors that are shared by all types of therapy and that are central to therapeutic effectiveness (e.g., a good helping relationship)

Technical Eclecticism

Technical eclecticism, which is sometimes referred to as systematic eclecticism or prescriptive matching, "refers to the relatively atheoretical selection of clinical treatments on the basis of predicted efficacy rather than theoretical considerations" (Alford, 1995, p. 147). Thus, those who ascribe to technical eclecticism use clinical knowledge and research findings about what has worked best with clients with similar characteristics or problems to draw techniques from different therapy models, without necessarily subscribing to any of the theories (Norcross, 2005; Wampold & Imel, 2015). Lazarus (1996) differentiated this type of eclecticism from "the ragtag importation of techniques from anywhere or everywhere without a sound rationale" (p. 61). Technical eclecticism attempts to address the specificity question posed by Paul (cited in Lampropoulos, 2001): "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances" (p. 7). Of the four types of eclecticism, this type pays the least attention to the integration of theories (Gold & Stricker, 2006).

Multimodal Behavior Therapy (MMT)

Lazarus's (1981, 2005, 2006) MMT is one of the most prominent examples of technical eclecticism. MMT is based on assessment that specifies the client's problem and his or her primary aspects, or modalities, of functioning (i.e., behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological functioning [BASIC I.D.]). Lazarus contended that different techniques should be selected to address the client's various prominent modalities and that these should be addressed sequentially according to their "firing order" (e.g., if client affect leads to behavior and then cognition, these modalities should be treated in this order). He also argued that therapy should address as many modalities as possible. MMT uses techniques from a variety of theories, including humanistic, psychodynamic, and family systems theories, but there is an emphasis on cognitive behavioral techniques (Lazarus, 2005, 2006).

Systematic Treatment Selection (STS)

A second prominent example of technical eclecticism is Beutler's STS therapy (1983; Beutler & Clarkin, 1990; Beutler et al., 2005; Beutler & Harwood, 1995, 2000; Beutler et al., 2006). In this approach, techniques from a wide variety of theories are selected on the basis of "empirical evidence of usefulness rather than by a theory of personality or of change" (Beutler & Harwood, 1995, p. 89). STS focuses on matching treatment strategies and techniques to client characteristics (client–treatment matching) and is one of the most ambitious and thorough models of eclecticism. In this model, a thorough assessment of client variables (e.g., demographic qualities, coping style, level of distress, level of resistance, expectations of therapy, social supports, diagnosis) and a consideration of empirical evidence related to such variables leads to decisions about (a) treatment contexts (individual, group, marital, family therapy), (b) choice of therapist (e.g., based on interpersonal compatibility and demographic similarity), (c) goal of therapy (i.e., focus on symptoms or underlying themes), (d) primary level of experience to be addressed (affect, cognition, or behavior), (e) style of therapist (e.g., degree of directiveness, support, confrontation), and (f) therapeutic techniques (Beutler & Harwood, 1995).

The STS model has been researched extensively and the most promising results are related to matching treatment to client coping style and reactance/resistance level. With regard to coping style, it has been found that clients who externalize (e.g., blame others) do better in structured treatments such as CBT, whereas clients who internalize (e.g., blame themselves) do better in more process-oriented treatment (e.g., insight or relationship-oriented therapy). With regard to resistance, it has been found that clients who are highly resistant do better in less directive therapy (e.g., client centered), whereas clients low in resistance do better in more directive therapy (e.g., CBT; Schottenbauer, Glass, & Arnkoff, 2005).

Theoretical Integration

In this second category of approaches, "there is an emphasis on integrating the underlying *theories* of psychotherapy along with therapy techniques from each" (Prochaska & Norcross, 2014, p. 431). The goal is to produce a more comprehensive, overarching theoretical framework that synthesizes the strengths of individual theories. Norcross (2005) has referred to theoretical integration as "theory smushing" (p. 8). The ultimate form of theoretical integration would incorporate all of the various theories of therapy (i.e., those subsumed under psychodynamic, cognitive behavioral, humanistic/feminist, and postmodern classifications, as well as biological and family systems approaches) into a synthesized/unified whole. Leaving aside the question of whether such a lofty goal is viable or not, Stricker's (1994) conclusion that "psychotherapy integration has not succeeded in that grand attempt, . . . the leading current approaches usually incorporate two, or at most three, of these perspectives" (p. 6) still holds today. As Lampropoulos (2001) noted, theoretical integration is "the ideal, optimistic, but utopian view" (p. 6).

Integrative Relational Therapy

Wachtel's (1977, 1997; Wachtel et al., 2005) integration of psychodynamic and behavioral theories is the most commonly cited example of an integrative approach. Building on the earlier work of Dollard and Miller (1950), Wachtel integrated the strengths of the social-learning model of behavioral theory with his interpersonal type of psychodynamic theory to create Integrative Relational Therapy (Wachtel et al., 2005). This integrative theory posits that unconscious conflicts/anxieties and interpersonal interactions are mutually influencing and create vicious cycles (e.g., anxiety about dependency needs results in keeping people at arm's length, which heightens the anxiety). In this model, intervention involves integrating a psychodynamic focus on insight with a behavioral focus on action (e.g., skills training).

The Transtheoretical Model (TTM)

The TTM (Prochaska & DiClemente, 1984, 2005; Prochaska & Norcross, 1999, 2014) is another influential integrative model. In the TTM, the selection of interventions, or change processes as they are called, is based on the assessment of two factors. First, consideration is given to the "stages of change" through which people progress. Thus, the worker needs to assess which of the five stages of change a client is in:

1. Precontemplation (relatively unaware of problems with no intention to change)
2. Contemplation (aware of a problem and considering, but not committed to, change)
3. Preparation (intending and beginning to take initial steps toward change)
4. Action (investment of considerable time and energy to successfully alter a problem behavior)
5. Maintenance (working to consolidate gains and prevent relapse)

Second, the "level/depth of change" required needs to be assessed. Thus, the worker and client need to mutually determine which of five problem levels to focus on:

1. Symptom/situational problems
2. Maladaptive cognitions
3. Current interpersonal conflicts
4. Family/systems conflicts
5. Intrapersonal conflicts

After an assessment of the client's stage of change and the level of change required, the TTM suggests that available empirical evidence of effectiveness be considered, as much as possible, to determine which interventions from different theoretical perspectives to use. In general, with regard to stages of change, techniques from cognitive, psychodynamic, and humanistic therapies are thought to be most useful in the precontemplation and contemplation stages, whereas "change processes traditionally associated with the existential and behavioral traditions . . . are most useful during the action and maintenance stages" (Prochaska & Norcross, 2014, p. 467). More specifically, when the level of change required is considered in the action stage, behavioral techniques would usually be chosen for the symptom/situational level, cognitive techniques would be employed at the level of maladaptive cognitions, and psychodynamic interventions would be used at the intrapersonal conflict level. The general principle in this model is to focus intervention initially at the symptom/situational level and then to proceed to deeper levels only if necessary.

Assimilative Integration

This approach to eclectic/integrative practice was the last of the four categories of eclecticism to be developed (Stricker, 2010), and was proposed initially by Messer (1992). This approach maintains that it is important to keep a firm grounding in one theory of therapy while incorporating ideas and techniques from other theories. Lampropoulos (2001) explained how assimilative integration can be seen as a bridge between technical eclecticism and theoretical integration:

> When techniques from different theoretical approaches are incorporated into one's main theoretical orientation, their meaning interacts with the meaning of the "host" theory, and both the imported technique and the pre-existing theory are mutually transformed and shaped into the final product, namely the new assimilative, integrative model. (p. 9)

Assimilative Psychodynamic Psychotherapy

One example of assimilative integration is Assimilative Psychodynamic Psychotherapy (Gold & Stricker, 2001; Stricker, 2006; Stricker & Gold, 2005). As its name indicates, this is clearly a psychodynamic therapy, but one that allows for the incorporation of more active/directive interventions "borrowed from cognitive, behavioral, and humanistic approaches" (Stricker, 2006). Gold and Stricker (2001) acknowledged that psychodynamic therapy "is very good at answering the 'why' and 'how did this happen' questions . . . but it is not as effective at answering questions such as 'so now what do I do' or 'how do I change this'" (p. 55). In this approach, there is an effort to introduce techniques from other theories in such a way that they are "experienced as part and parcel of a consistent approach rather than an arbitrary intrusion on the ongoing work" (Stricker, 2006, p. 55).

Widening the Scope of Cognitive Therapy

Another example of this approach is Safran's (1990a, 1990b, 1998; Safran & Segal, 1990) attempt to widen the scope of cognitive therapy by incorporating aspects of psychodynamic (psychoanalytic and interpersonal) and humanistic theories. Beyond the cognitive and behavioral dimensions of human functioning, which are the sole foci of most CBTs, Safran's model also considers emotional, developmental, interpersonal, and conflictual dimensions. Techniques from other theoretical orientations are incorporated to address issues associated with these additional aspects of human experience. A more recent development by Safran and colleagues (Safran et al., 2014) has been to augment CBT with alliance-focused training (AFT), which is derived from the relational model of psychodynamic theory and focuses on resolving problems or ruptures in the therapeutic alliance.

Common Factors

In this last category of approaches to eclecticism, there is an attempt to identify and utilize the "effective aspects of treatment shared by the diverse forms of psychotherapy" (Weinberger, 1993, p. 43). This approach has been influenced largely by the extensive work of Jerome Frank, particularly his classic book entitled *Persuasion and Healing* (Frank, 1961, 1973, and co-authored with his daughter, J. D. Frank & J. B. Frank, 1991). Frank's writing on common factors amounted to a meta-model of psychotherapy, rather than a specific approach to therapy. Wampold (2001; Wampold & Imel, 2015) has adopted Frank's broad common factors conceptualization of psychotherapy, calling it a contextual model of psychotherapy, and contrasting it to the medical model, which purports that theory and technique (i.e., specific factors) are the keys to therapeutic effectiveness.

As we have noted earlier, Wampold's (2001) and Wampold and Imel's (2015) thorough analysis of psychotherapy research provides compelling empirical support for the common factors/contextual model of psychotherapy. Although Wampold (2001) clearly attributed the meta-model discussed in his book to Frank, because of Wampold and Imel's (2015) further conceptual development and empirical validation of the model, we see this model as a joint product of these authors' work. We will review the common factors/contextual model of Frank and Wampold and Imel in some depth before considering more specific common factors therapy models.

Common Factors/Contextual Model

Building on Rosenzweig's (1936) earlier ideas, Frank developed the demoralization hypothesis, which proposes that most of the distress suffered by clients stems from being demoralized and that "features shared by all therapies that combat demoralization account for much of their effectiveness" (Frank, 1982, p. 32). Frank (1982; Frank & Frank, 1991) suggested four factors that are shared by all forms of psychotherapy, as well as by religious and other secular types of healing, that represent means of directly or indirectly combating demoralization and that are primarily responsible for the effectiveness of any approach to healing.

First, and foremost, is an "emotionally supportive, confiding relationship with a helping person" (Frank, 1982, p. 19). If helpers can convince clients that they care and want to help, then this decreases clients' sense of alienation, increases expectations of improvement, and boosts morale.

Second is a "healing setting" that heightens the helper's prestige, thereby increasing the client's expectation of help, and provides safety. In psychotherapy, the healing setting is usually an office or clinic that carries the aura of science; in religious healing, it is usually a temple or sacred grove.

Third is a theoretical rationale or "myth" that provides a believable explanation for clients' difficulties. Frank uses the word *myth* to underscore the contention that the accuracy of the explanation is less important than its plausibility in the eyes of the client. Any explanation of their difficulties that clients can accept alleviates some distress and engenders hope for change.

Fourth is a set of therapeutic procedures or a "ritual" that involves the participation of helper and client in activities that both believe will help the client to overcome the presenting difficulties. With regard to the fourth common factor, on the basis of empirical studies of therapy, Frank and Frank (1991) contended that therapeutic procedures will be optimally effective if they

- Provide new learning experiences for clients (these enhance morale by helping clients to develop more positive views of themselves and their problems).
- Arouse clients' emotions (this helps clients to tolerate and accept their emotions and allows them to confront and cope more successfully with feared issues and situations—thus strengthening self-confidence, sense of mastery, and morale).
- Provide opportunities for clients to practice what they have learned both within therapy and in their everyday lives (thus reinforcing therapeutic gains, a sense of mastery, and morale).

Lambert (2013b) and Wampold (2001; Wampold & Imel, 2015) concurred with Frank that there is substantial empirical support for these therapeutic procedures that are common across therapies.

Although there is extensive empirical support for the first (therapeutic relationship) and fourth (common therapeutic procedures) of Frank's common factors, there is little research on the healing setting or on the theoretical rationale/myth. There is indirect support, however, for the latter factor. Frank's hypothesis about the importance of a theoretical rationale/myth that provides a believable explanation to clients of their problems is linked to "goal consensus and collaboration," which is one of the aspects of the therapeutic alliance for which there is strong

empirical support (Ackerman et al., 2001; Norcross & Wampold, 2011). Clearly, in order to establish goal consensus and collaboration, clients must believe in workers' explanation for their difficulties and strategies for ameliorating problems. Frank and Frank (1991) maintained that in order to maximize the sense and quality of an alliance with clients,

> therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient's personal characteristics and view of the problem. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. Creating a good therapeutic match may involve both educating the patient about the therapist's conceptual scheme and, if necessary, modifying the scheme to take into account the concepts the patient brings to therapy. (p. xv)

Following Frank and Frank's line of argument, and based on his review of research, Wampold (2001) has suggested that therapists should choose an approach to counseling that accords with the client's worldview: "the therapist needs to realize that the client's belief in the explanation for their [sic] disorder, problem, or complaint is paramount" (p. 218).

Wampold and Imel's (2015) most recent development of the common factors/contextual model posits three pathways that explain the benefits of psychotherapy. The first pathway is what they call the "real" relationship, which is the development of an authentic, genuine, trusting, open, and honest relationship in which the client experiences the worker's empathy. The second pathway involves the creation of positive expectations about therapy. This relates to Frank's ideas about clients being demoralized and therapists needing to instill hope and boost morale. It also relates to Frank's ideas about providing an explanation for the client's problem that is plausible to him or her and suggesting therapeutic actions that are in keeping with the explanation. The third pathway is what they call "specific ingredients." This does not refer to the importance of specific (theory and technique) factors, but rather to the fact that all therapies, in one way or another, involve encouraging clients to engage in activities (cognitive, behavioral, and/or emotional) that promote psychological well-being or symptom reduction.

Wampold and Imel (2015) emphasize that the common factors/contextual model is primarily a relationship-based model of psychotherapy: "The intervention we discuss in this book is still mostly a human conversation—perhaps the ultimate in low technology. Something in the core of human connection and interaction has the power to heal" (p. ix).

Eclectic/Integrative Approach

Another therapy that has been classified as a common factors model is Garfield's (1995, 2000) eclectic/integrative approach. Garfield contended that despite the many apparent differences among the various therapeutic approaches and the fact that these schools of therapy tend to emphasize the importance of their specific techniques, factors that are common across therapies account for much of their success. Garfield's (1995) model places a strong "emphasis on the therapeutic relationship and on the common factors in psychotherapy" (p. 167), while also supporting the eclectic use of interventions from different theoretical approaches.

Echoing Frank, Garfield (1995) contended that "being given some explanation for one's problems by an interested expert in the role of healer, may be the important common aspect of these divergent therapies" (p. 34). Garfield (1995) rationalized the theoretical openness of his approach:

> Although the absence of a unifying and guiding theory has its drawbacks, an awareness of one's limitations and of the gaps in our current knowledge is, in the long run, a positive thing—even though it may make for uncertainties. It is better to see the situation for what it really is than to have what may be an incorrect or biased orientation. (p. 216)

Garfield's (1995) model does, however, provide some structure for practitioners by presenting general guidelines for the various stages of therapy (beginning, middle, later, and termination). This is very similar to the use of the problem-solving model in the generalist-eclectic approach. Also, Garfield's approach has elements of technical eclecticism in that therapists are advised, where possible, to choose techniques "which on the basis of empirical evidence seem to be most effective for the specific problems presented by the client" (p. 218).

Client-Directed, Outcome-Informed Clinical Work

Another, more recent, common factors approach is the client-directed, outcome-informed clinical work model (Duncan et al., 2006; Hubble, Duncan, & Miller, 1999; Miller et al., 2005). This model focuses on the importance of the therapeutic relationship. It emphasizes three core ingredients of the alliance: (a) shared goals for counseling, (b) consensus on the approach to counseling (means, methods, tasks), and (c) the emotional bond between worker and client. It is proposed that one key to developing a strong alliance is to adopt the client's theory of change, that is, "the client's frame of reference regarding the presenting problem, its causes, and potential remedies" (Miller et al., 2005, p. 87).

A second important key is to solicit and respond to, on an ongoing basis, client feedback regarding the therapeutic alliance. This is the "outcome-informed" element of the model. If the client voices concern about any aspect of the alliance, then "every effort should be made to accommodate the client" (p. 94). This model places very little emphasis on theory:

> The love affair with theory relegates clients to insignificant roles in bringing about change. . . . When therapists' models, whether integrative or not, crowd our thinking, there is little room left for clients' models—their ideas about their predicaments and what it might take to fix them—to take shape. (Duncan et al., 2006, p. 236)

Summary

It needs to be emphasized that these four broad approaches to eclecticism are not mutually exclusive and "the distinctions may be largely semantic and conceptual, not particularly functional, in practice" (Norcross, 2005, p. 10). For example, it is unlikely that models within technical eclecticism and common factors approaches

totally ignore theory, and it is quite likely that all of the approaches to eclecticism incorporate an emphasis on common factors.

We should note that there is another trend within the overall trend toward eclecticism, which is the development of eclectic/integrative therapies for specific populations and problems. Prominent examples of these include Linehan's (1993; Heard & Linehan, 2005) dialectical behavior therapy (DBT) for borderline personality disorder, McCullough's (2000, 2006) cognitive behavioral analysis system of psychotherapy (CBASP) for chronic depression, and Wolfe's (2005) integrative psychotherapy for anxiety disorders.

We do not count these eclectic/integrative therapies for specific populations and problems as a fifth classification of approaches to eclecticism because each of these more specific therapies can be subsumed under one of the four broader approaches to eclecticism. For example, DBT and CBASP can be classified as assimilative integration models because, although they integrate a number of different theories, their primary theoretical base is cognitive behavioral. Wolfe's therapy for anxiety, however, can be classified as a theoretical integration model because it blends psychodynamic and cognitive behavioral views of and treatment strategies for anxiety.

Finally, we would like to note that research on eclectic/integrative models has increased substantially over the years, although it still lags behind research on single theory approaches. In a review of research on eclectic/integrative therapies, Schottenbauer et al. (2005) concluded that there is substantial empirical support (i.e., 4 or more randomized controlled studies) for 7 such therapies, some empirical support (i.e., 1–4 randomized controlled studies) for another 13, and preliminary empirical support (i.e., studies with nonrandomized control group or no control group) for another 7. In 1992, Lambert predicted:

> to the extent that eclectic therapies provide treatment that includes substantial overlap with traditional methods that have been developed and tested, they rest on a firm empirical base, and they should prove to be at least as effective as traditional school-based therapies. (Lambert, 1992, p. 121)

It would seem that Lambert was right. Still, we agree with those researchers who contend that it would be more productive to focus research on exploring common factors and therapist factors that impact on outcome than continuing to focus on validating individual models of therapy, whether these are single theory or eclectic models.

RELATIONSHIP-BASED THEORETICAL ECLECTICISM: OUR APPROACH

Given our commitment to the spirit of eclecticism, as well as the obvious overlap among the various approaches to eclecticism, we believe there is value in all four approaches discussed in this chapter. Although our approach to eclecticism incorporates some aspects of all of the approaches identified in the literature, it is closest to the common factors approaches. Similar to common factors models, our approach to eclecticism embraces the prime importance of the helping relationship.

We believe that a warm, genuine, trusting, empathic relationship is necessary, and sometimes sufficient, for good helping outcomes. Also, similar to the client-directed, outcome-informed clinical work common factors model, our approach to eclecticism is critical of an overreliance on theory and values the artistic, reflective, intuitive-inductive processes of collaboratively building theories that fit the circumstances of each unique client. We agree with Cameron and Keenan (2010), who contended that a common factors model is "consistent with social work values, ethics, and practice wisdom from social work's traditions (that is, start where the client is, respect for the dignity of each person, the importance of relationships, and so forth)" (p. 64; see Cameron [2014] and Cameron & Keenan [2009, 2010, 2013] for an example of the application of the general common factors model to social work practice).

We think, however, that our approach to eclecticism does not fit neatly into the common factors category of approaches because our use of theory differs in some important ways from these approaches (see discussion later in this chapter). We think that our approach to eclecticism is distinct enough from the four approaches currently identified in the literature, and that it has enough merits, to warrant a fifth classification of eclectic practice, which we call *relationship-based theoretical eclecticism*.

Our relationship-based theoretically eclectic approach values the potential relevance of all theories and promotes the use of multiple theories and their associated techniques with individual clients. The essence of theoretical eclecticism is to consider the relevance of multiple theoretical frameworks to each client's problem situation in order to develop, collaboratively with the client, a more complex, comprehensive understanding that fits for the client, and then to choose intervention strategies or techniques that fit with this in-depth understanding. As noted, however, our generalist-eclectic approach to practice does not rely solely on the use of theory to develop in-depth understanding and choose intervention strategies. The eclectic use of theory is complemented by artistic, reflective, intuitive-inductive processes, and both of these are guided by the problem-solving model.

Comparison of Relationship-Based Theoretical Eclecticism to the Four Major Approaches to Eclecticism

Our approach to eclecticism is different from technical eclecticism in that it emphasizes the use of multiple theoretical perspectives, rather than focusing primarily on the techniques that are derived from theories and matching these to client characteristics or problems. It is different from theoretical integration because it does not attempt to synthesize or "smush" theories. Relationship-based theoretical eclecticism is different from assimilative integration in that it does not promote primary reliance on one theory of practice. Similar to these three approaches to eclecticism, however, our approach supports the idea of drawing techniques from a wide variety of theories, depending on their fit for particular clients. In contrast to some models in these approaches, however, our approach to matching techniques to client variables (e.g., coping style, level of resistance, stage of change) relies at least as much on worker judgment as empirical evidence.

There are two reasons why we do not favor an exclusive reliance on empirical evidence for choosing techniques. First, we agree with Stiles, Shapiro, and

Barkham (1995) and Wampold and Imel (2015) who contended that there is not enough empirical evidence to warrant firm decisions about such matching of techniques to client variables. Second, we do not like the mechanistic flavor of some prescriptive matching models because individual clients are too unique to rely on formulaic decisions about a certain type of intervention for a certain type of client or problem.

For these reasons, we favor what has been called *responsive matching* (Stiles et al., 1995). "Responsive matching is often done intuitively, we suspect, as practitioners draw techniques from their repertoire to fit their momentary understanding of a client's needs" (Stiles et al., 1995, p. 265). This type of matching should draw on theory and empirical findings but is more tentative and open to modification based on sensitivity to the client's response: "it is grounded in both theory and observation of the individual case" (Stiles et al., 1995, p. 265). In the same vein, Garfield (1995) has argued that:

> In the absence of research data, the therapist has to rely on his own clinical experience and evaluations, or on his best clinical judgment . . . and make whatever modifications seem to be necessary in order to facilitate positive movement in therapy. (p. 218)

Such an approach fits well with our valuing of the artistic, reflective, intuitive-inductive aspects of practice.

As mentioned, our approach to eclecticism has the most similarities with common factors approaches, particularly with regard to the emphasis placed on the worker–client relationship. Similar to all common factors approaches, and supported by a vast body of research, we emphasize the importance of a trusting, collaborative, supportive, warm, empathic helping relationship that is focused on instilling hope, boosting morale, and empowering the client. Other common factors that have received strong empirical support, and that we endorse, include addressing and resolving problems in the worker–client relationship (Norcross & Wampold, 2011), achieving consensus on problem formulation and goals (Ackerman et al., 2001; Norcross & Wampold, 2011), soliciting and responding supportively to client feedback (Miller et al., 2005; Norcross & Wampold, 2011), supporting emotional expression/catharsis, providing the client with mastery experiences (Lambert, 2013b), and helping clients attribute change to their own efforts (Weinberger, 1993). Also, we agree with Wampold's (2001) recommendation that, at least in parity with the emphasis placed on learning theory and technique, clinical practitioners should be trained to "appreciate and be skilled in the common . . . core therapeutic skills, including empathic listening and responding, developing a working alliance, working through one's own issues, . . . and learning to be self-reflective about one's work" (pp. 229–230).

Relationship-based theoretical eclecticism differs, however, from most common factors approaches in how theory is used in practice. Although Garfield's (1995) model does support the eclectic use of theory, this is largely with regard to choosing techniques and procedures for intervention. Curiously, in Garfield's (1995) book, there is virtually no discussion of using various theoretical perspectives in the assessment process to develop understanding of the client's situation, which is a central feature of our approach.

Although the common factors/contextual model of Frank and Frank (1991) and Wampold and Imel (2015) espouses the value of multiple theoretical perspectives, there are important differences between their use of theory and ours. Wampold and Imel (2015) and Frank and Frank (1991) argued that practitioners should learn as many therapy models as possible so that they can better match or modify a model to fit clients' worldview or understanding of their problems. This follows from Frank's (1961; Frank & Frank, 1991) use of the word *myth* to underscore his contention that the accuracy of a theoretical rationale for the client's problem is less important than its plausibility in the eyes of the client. He argued that any explanation of their difficulties that clients can accept alleviates distress and engenders hope. Thus, Frank allowed for the therapist to "persuade" the client that his or her theoretical rationale makes sense or to modify his or her preferred theoretical understanding to fit better with the client's understanding.

What is missing from the common factors/contextual model is the emphasis our relationship-based theoretical eclecticism places on an open, holistic assessment that is conducted collaboratively with the client. In this process, the views of both worker and client are considered together with multiple theoretical perspectives in an effort to build a comprehensive and shared understanding of the client's situation. This process allows for the development of understanding by both worker and client that may be different from and/or more comprehensive than either of their initial understandings of the problem. A more comprehensive understanding of the problem situation can lead to formulation of strategies for intervention that have a higher likelihood for success. We agree that it is necessary to eventually arrive at an understanding of the problem that fits for the client, but we think that an open, collaborative exploration/assessment can not only expand awareness of the problem and potential solutions, but can also foster the development of a strong therapeutic alliance and a sense of empowerment for the client, all of which help to overcome demoralization and instill hope.

One of the most important distinguishing features of our approach to eclecticism, which stems from its grounding in social work's generalist perspective, is that it is broader in focus and scope of intervention than most of the approaches to eclecticism that are in the clinical psychology literature. The generalist perspective of social work demands a holistic, person-in-environment focus that is sensitive to issues of diversity, oppression, and empowerment. It necessitates that direct practice be viewed broadly. Thus, as mentioned earlier, we think that the mandate and role of clinical social work includes helping clients to meet basic needs by providing them with or linking them to resources and services, engaging in social advocacy, and supporting clients to engage in broader social change efforts.

It is heartening and worth noting that some of the leaders of the movement toward eclecticism in clinical psychology are also beginning to attend to a traditional social work holistic focus. In a consideration of the future of psychotherapy integration in the concluding chapter of Norcross and Goldfried's (2005) *Handbook of Psychotherapy Integration*, it is suggested that "in order to understand and effectively meet clients' needs, therapists should attend more to the broader social context of clients' lives, including social values . . ., economic realities . . ., and cultural differences" (Eubanks-Carter, Burckell, & Goldfried, 2005, pp. 506–507). Also, in the introductory chapter to this same volume, Norcross (2005) noted that recent thrusts in psychotherapy integration include focus on multicultural theory, spirituality, and

social advocacy. Furthermore, in elaborating upon the necessity for therapists to align their theoretical views with the client's worldview, Wampold (2001) noted:

> Clients from populations of historically oppressed persons will benefit particularly from therapists who understand this dynamic, who are credible to the client, who can build an alliance with a client who may mistrust therapists representing institutional authority, (and) who are multiculturally competent. (p. 226)

Although some might view these recent trends in eclecticism as an incursion by psychologists into the domain of social work, we welcome this broadened understanding of eclecticism in direct practice by an allied helping profession with the hope that all helping professionals can move together in such a direction.

One potential drawback to relationship-based theoretical eclecticism, which is also shared by the common factors and technical eclecticism approaches, is that without a primary theoretical base (as in assimilative integration), or a synthesis of two or three theoretical bases (as in theoretical integration), there can be a lack of structure and guidelines for practice. In our approach, however, this is remedied by the use of social work's general problem-solving model. As explained earlier, the problem-solving model provides structure and guidelines for practice across all the phases of helping (from engagement to termination), but these are general and flexible enough to allow for an eclectic use of theory and techniques. We think that the use of the problem-solving model to guide practice in our relationship-based theoretically eclectic approach is better than using a primary theoretical base, as in assimilative integration, or using a synthesis of theories, as in theoretical integration. The latter approaches are less theoretically open and have more theoretical biases than a theoretically eclectic approach that uses a problem-solving model. Our use of the problem-solving model has parallels to Garfield's (1995) common factors approach, which provides general guidelines for what he calls "the stages of the therapeutic process" (beginning, middle, later, and termination stages).

SUMMARY

This chapter has provided an overview of our generalist-eclectic approach to direct practice. It has included a description of the elements of a generalist social work perspective that are central to our approach, a delineation of the distinctive aspects of our generalist-eclectic approach, an overview of the rationale for and trend toward eclecticism in direct practice, a review of the major approaches to eclecticism in the literature, and a discussion of relationship-based theoretical eclecticism—our particular approach to eclecticism. It was beyond the scope of this chapter to discuss many of the topics in the depth that they deserve. Readers are directed to the literature cited in our discussions for a more detailed review of topics that are of interest to them. In the next chapter, the types, levels, and classifications of theories for direct practice are discussed in an effort to demystify theory and facilitate its use in practice. In addition, a critical examination of how and the extent to which theory is used in practice is presented, and a complementary, intuitive-inductive approach that represents the art of practice is considered.

REFERENCES

Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., . . . Rainer, J. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy*, *38*, 495–497.

Alford, B. A. (1995). Introduction to the special issue: Psychotherapy integration and cognitive psychotherapy. *Journal of Cognitive Psychotherapy*, *9*, 147–151.

Asay, T. P., & Lambert, M. J. (2001). Therapist relational variables. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 531–558). Washington, DC: American Psychological Press.

Barlow, D. H. (2000). Evidence-based practice: A world view. *Clinical Psychology: Science and Practice*, *7*, 241–242.

Beutler, L. E. (1983). *Eclectic psychotherapy: A systematic approach*. Elmsford, NY: Pergamon.

Beutler, L. E. (1991). Have all won and must all have prizes? Revisiting Luborsky et al.'s verdict. *Journal of Consulting and Clinical Psychology*, *59*, 226–232.

Beutler, L. E., & Clarkin, J. (1990). *Systematic treatment selection: Toward targeted therapeutic interventions*. New York, NY: Brunner Mazel.

Beutler, L. E., Consoli, A. J., & Lane, G. (2005). Systematic treatment selection and prescriptive psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 121–146). New York, NY: Oxford University Press.

Beutler, L. E., & Harwood, T. M. (1995). Prescriptive psychotherapies. *Applied and Preventive Psychology*, *4*, 89–100.

Beutler, L. E., & Harwood, T. M. (2000). *Prescriptive psychotherapy*. New York, NY: Oxford University Press.

Beutler, L. E., Harwood, M., Bertoni, M., & Thomann, J. (2006). Systematic treatment selection and prescriptive therapy. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 29–42). Washington, DC: American Psychological Association.

Biestek, F. (1957). *The casework relationship*. Chicago, IL: Loyola University Press.

Cameron, M. (2014). This is common factors. *Clinical Social Work Journal*, *42*, 151–160.

Cameron, M., & Keenan, E. K. (2009). A new perspective: The common factors model as a foundation for social work practice education. *Journal of Teaching in Social Work*, *29*, 346–358.

Cameron, M., & Keenan, E. K. (2010). The common factors model: Implications for transtheoretical clinical social work practice. *Social Work*, *55*, 63–73.

Cameron, M., & Keenan, E. K. (2013). *The common factors model for generalist practice*. New York, NY: Pearson.

Castonguay, L. G., Reid, J. J., Halperin, G. S., & Goldfried, M. R. (2003). Psychotherapy integration. In G. Stricker & T. A. Widiger (Eds.), *Handbook of psychology: Clinical psychology* (Vol. 8, pp. 327–345). New York, NY: Wiley.

Coady, N. F. (1993a). The worker-client relationship revisited. *Families in Society*, *74*, 291–298.

Coady, N. F. (1993b). An argument for generalist social work practice with families versus family systems therapy. *Canadian Social Work Review*, *10*, 27–42.

Coady, N. F. (1995). A reflective/inductive model of practice: Emphasizing theory building for unique cases versus applying theory to practice. In G. Rogers (Ed.), *Social work field education: Views and visions* (pp. 139–151). Dubuque, IA: Kendall/Hunt.

Compton, B. R., Galaway, B., & Cournoyer, B. R. (2005). *Social work processes*. Belmont, CA: Brooks/Cole.

Derezotes, D. S. (2000). *Advanced generalist social work practice*. Thousand Oaks, CA: Sage.

Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy: An analysis in terms of learning, thinking, and culture*. New York, NY: McGraw-Hill.

Dryden, W. (Ed.). (1992). *Integrative and eclectic therapy: A handbook*. Buckingham, England: Open University Press.

Duncan, B. L., Sparks, J. A., & Miller, S. D. (2006). Client, not theory, directed: Integrating approaches one client at a time. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 225–240). Washington, DC: American Psychological Association.

Elkin, I. (1994). The NIMH Treatment of Depression Collaborative Research Program: Where we began and where we are. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 114–139). New York, NY: Wiley.

Eubanks-Carter, C., Burckell, L. A., & Goldfried, M. R. (2005). Future directions in psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 503–520). New York, NY: Oxford University Press.

Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore, MD: John Hopkins University Press.

Frank, J. D. (1973). *Persuasion and healing: A comparative study of psychotherapy* (2nd ed.). Baltimore, MD: John Hopkins University Press.

Frank, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. H. Harvey & M. M. Parks (Eds.), *The master lecture series: Psychotherapy research and behavior change* (Vol. 1, pp. 9–37). Washington, DC: American Psychological Press.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: John Hopkins University Press.

Furman, R. (2009). Ethical considerations of evidence-based practice. *Social Work*, 54, 82–84.

Gambrill, E. (1999). Evidence-based practice: An alternative to authority-based practice. *Families in Society*, *80*, 341–350.

Gambrill, E. (2006). Evidence-based practice and policy: Choices ahead. *Research on Social Work Practice*, *16*, 338–357.

Garfield, S. L. (1980). *Psychotherapy: An eclectic approach*. New York, NY: Wiley.

Garfield, S. L. (1995). *Psychotherapy: An eclectic-integrative approach* (2nd ed.). New York, NY: Wiley.

Garfield, S. L. (2000). Eclecticism and integration: A personal retrospective view. *Journal of Psychotherapy Integration*, *10*, 341–356.

Garfield, S. L., & Bergin, A. E. (1986). Introduction and historical overview. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 3–22). New York, NY: Wiley.

Gibbs, L., & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice*, *12*, 452–476.

Gold, J. R. (1996). *Key concepts in psychotherapy integration*. New York, NY: Plenum Press.

Gold, J. R., & Stricker, G. (2001). A relational psychodynamic perspective on assimilative integration. *Journal of Psychotherapy Integration*, *11*, 43–58.

Gold, J., & Stricker, G. (2006). Introduction: An overview of psychotherapy integration. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 3–16). Washington, DC: American Psychological Association.

Goldstein, H. (1990). The knowledge base of social work practice: Theory, wisdom, analogue, or art? *Families in Society*, *71*, 32–43.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, *21*, 372–378.

Heard, H. H., & Linehan, M. M. (2005). In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 299–320). New York, NY: Oxford University Press.

Henry, W. P. (1998). Science, politics, and the politics of science: The use and misuse of empirically validated treatment research. *Psychotherapy Research*, *8*, 126–140.

Hepworth, D. H., Rooney, R. H., & Larsen, J. A. (2002). *Direct social work practice: Theory and skills* (6th ed.). Pacific Grove, CA: Brooks/Cole.

Hepworth, D. H., Rooney, R. H., Rooney, G. D., & Strom-Gottfried, K. (2013). *Direct social work practice: Theory and skills* (9th ed.). Belmont, CA: Brooks/Cole.

Hollis, F. (1970). Psychosocial approach to the practice of casework. In R. Roberts & R. Nee (Eds.), *Theories of social casework*. Chicago, IL: University of Chicago Press.

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, *48*, 9–16.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy. *Journal of Counseling Psychology*, *38*, 139–149.

Howard, M. O., McMillen, C. J., & Pollio, D. E. (2003). Teaching evidence-based practice: Toward a new paradigm for social work education. *Research on Social Work Practice*, *13*, 234–259.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart & soul of change: What works in therapy*. Washington, DC: American Psychological Association.

Jensen, J. P., Bergin, A. E., & Greaves, D. W. (1990). The meaning of eclecticism: New survey and analysis of components. *Professional Psychology: Research and Practice*, *21*, 124–130.

Johnson, L. C., & Yanca, S. J. (2007). *Social work practice: A generalist approach* (9th ed.). Boston, MA: Pearson Allyn & Bacon.

Kinsella, E. A. (2010). The art of reflective practice in health and social care: Reflections on the legacy of Donald Schön. *Reflective Practice*, *11*, 565–575.

Kirst-Ashman, K. K., & Hull, G. H. (2009). *Understanding generalist practice* (5th ed.). Belmont, CA: Brooks/Cole Cengage.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York, NY: Basic Books.

Lambert, M. J. (2013a). Introduction and historical overview. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 3–20). Hoboken, NJ: Wiley.

Lambert, M. J. (2013b). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 169–218). Hoboken, NJ: Wiley.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy*, *38*, 357–361.

Lambert, M. J., Bergin, A. E., & Garfield, S. L. (2004). Introduction and historical overview. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 3–15). New York, NY: Wiley.

Lambert, M. J., Garfield, S. L., & Bergin, A. E. (2004). Overview, trends, and future issues. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 805–822). New York, NY: Wiley.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York, NY: Wiley.

Lampropoulos, G. K. (2001) Bridging technical eclecticism and theoretical integration: Assimilative integration. *Journal of Psychotherapy Integration*, *11*, 5–19.

Landon, P. S. (1995). Generalist and advanced generalist practice. In R. L. Edwards (Ed.), *Encyclopedia of social work* (19th ed., Vol. 2, pp. 1101–1108). Washington, DC: NASW Press.

Landon, P. S. (1999). *Generalist social work practice*. Dubuque, IA: Eddie Bowers.

Lazarus, A. A. (1981). *The practice of multimodal therapy*. New York, NY: McGraw-Hill.

Lazarus, A. A. (1996). The utility and futility of combining treatments in psychotherapy. *Clinical Psychology: Science and Practice*, *3*, 59–68.

Lazarus, A. A. (2005). Multimodal therapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 105–120). New York, NY: Oxford University Press.

Lazarus, A. A. (2006). Multimodal therapy: A seven-point integration. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 17–28). Washington, DC: American Psychological Association.

Lebow, J. (2002). Integrative and eclectic therapies at the beginning of the Twenty-First Century. In J. Lebow (Ed.), *Comprehensive handbook of psychotherapy: Integrative/eclectic* (Vol. 4, pp. 1–10). New York, NY: Wiley.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford.

Locke, B., Garrison, R., & Winship, J. (1998). *Generalist social work practice: Context, story, and partnerships*. Pacific Grove, CA: Brooks/Cole.

Magill, M. (2006). The future of evidence in evidence-based practice: Who will answer the call for clinical relevance? *Journal of Social Work*, *6*, 101–115.

Mattaini, M. A., & Lowery, C. T. (Eds.). (2007). F*oundations of social work practice: A graduate text* (4th ed.). Washington, DC: NASW Press.

McCoyd, J. L. M., & Kerson, T. S. (2013). Teaching reflective social work practice in health care: Promoting best practices. *Journal of Social Work Education*, *49*, 674–688.

McCullough, J. P., Jr. (2000). *Treatment for chronic depression: Cognitive Behavioral Analysis System of Psychotherapy (CBASP)*. New York, NY: Guilford.

McCullough, J. P., Jr. (2006). Chronic depression and the cognitive behavioral analysis system of psychotherapy. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 137–152). Washington, DC: American Psychological Association.

McMahon, M. O. (1996). *The general method of social work practice: A problem-solving approach* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

McMillen, J. C., Morris, L., & Sherraden, M. (2004). Ending social work's grudge match: Problems versus strengths. *Families in Society*, *85*, 317–325.

Messer, S. B. (1992). A critical examination of belief structures in integrative and eclectic psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 130–165). New York, NY: Basic Books.

Messer, S. B. (2001). Empirically supported treatments: What's a nonbehaviorist to do? In B. D. Slife, R. N. Williams, & S. H. Barlow (Eds.), *Critical issues in psychotherapy: Translating new ideas into practice* (pp. 3–25). Thousand Oaks, CA: Sage.

Miley, K. K., O'Melia, M. W., & DuBois, B. L. (2013). *Generalist social work practice: An empowering approach* (7th ed.). Boston, MA: Pearson.

Mills, C. W. (1959). *The sociological imagination.* New York, NY: Oxford University Press.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (2005). Outcome-informed clinical work. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 84–104). New York, NY: Oxford University Press.

Norcross, J. C. (1997). Emerging breakthroughs in psychotherapy integration: Three predictions and one fantasy. *Psychotherapy*, *34*, 86–90.

Norcross, J. C. (2001). Purposes, process, and products of the Task Force on Empirically Supported Treatment Relationships. *Psychotherapy*, *38*, 345–356.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work*. New York, NY: Oxford University Press.

Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 3–23). New York, NY: Oxford University Press.

Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York, NY: Oxford University Press.

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, *48*, 4–8.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, *48*, 98–102.

Perlman, H. H. (1957). *Social casework: A problem-solving process*. Chicago, IL: University of Chicago Press.

Perlman, H. H. (1979). *Relationship: The heart of helping people.* Chicago, IL: University of Chicago Press.

Prochaska, J. O. (1979). *Systems of psychotherapy: A transtheoretical analysis.* Homewood, IL: Dorsey.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin.

Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 147–171). New York, NY: Oxford University Press.

Prochaska, J. O., & Norcross, J. C. (1999). *Systems of psychotherapy: A transtheoretical analysis* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Prochaska, J. O., & Norcross, J. C. (2014). *Systems of psychotherapy: A transtheoretical analysis* (8th ed.). Stamford, CT: Cengage Learning.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, *6*, 412–415.

Rubin, A., & Parrish, D. (2007). Views of evidence-based practice among faculty in master of social work programs: A national survey. *Research on Social Work Practice*, *17*, 110–122.

Safran, J. D. (1990a). Towards a refinement of cognitive therapy in light of interpersonal theory, I. Theory. *Clinical Psychology Review*, *10*, 87–105.

Safran, J. D. (1990b). Towards a refinement of cognitive therapy in light of interpersonal theory, II. Practice. *Clinical Psychology Review*, *10*, 107–121.

Safran, J. D. (1998). *Widening the scope of cognitive therapy*. Northvale, NJ: Aronson.

Safran, J., Muran, C., Demaria, A., Boutwell, C., Eubanks-Carter, C., & Winston, A. (2014). Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection. *Psychotherapy Research*, *24*, 269–285.

Safran, J. D., & Segal, Z. D. (1990). *Interpersonal processes in cognitive therapy.* New York, NY: Basic Books.

Saleebey, D. (Ed.). (2013). *The strengths perspective in social work practice* (6th ed.). Boston, MA: Pearson.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action.* New York, NY: Basic Books.

Schottenbauer, M. A., Glass, C. R., & Arnkoff, D. B. (2005). Outcome research on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 459–493). New York, NY: Oxford University Press.

Shatz, M. S., Jenkins, M. E., & Sheafor, B. W. (1990). Milford redefined: A model of initial and advanced generalist social work. *Journal of Social Work Education*, *26*, 217–231.

Shdaimah, C. S. (2009). What does social work have to offer evidence-based practice. *Ethics and Social Welfare*, *3*(1), 18–31

Sheafor, B. W., & Horejsi, C. R. (2006). *Techniques and guidelines for social work practice* (7th ed.). Boston, MA: Pearson.

Sheafor, B. W., & Landon, P. S. (1987). The generalist perspective. In A. Minahan (Ed.- in-Chief), *Encyclopedia of social work* (18th ed., Vol. 1, pp. 660–669). Silver Spring, MD: National Association of Social Workers.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*, 752–760.

Stalker, C. A., Levene, J. E., & Coady, N. F. (1999). Solution-focused brief therapy—One model fits all? *Families in Society*, *80*, 468–477.

Stiles, W. B., Shapiro, D. A., & Barkham, M. (1995). Technical eclecticism. In J. C. Norcross (Ed.), A roundtable on psychotherapy integration: Common factors, technical eclecticism, and psychotherapy research. *Grand Rounds*, *4*, 248–271.

Stricker, G. (1994). Reflections on psychotherapy integration. *Clinical Psychology: Science and Practice*, *1*, 3–12.

Stricker, G. (2006). Assimilative psychodynamic psychotherapy integration. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 55–64). Washington, DC: American Psychological Association.

Stricker, G. (2010). A second look at psychotherapy integration. *Journal of Psychotherapy Integration*, *20*(4), 397–405.

Stricker, G., & Gold, J. (Eds.). (1993). *Comprehensive handbook of psychotherapy integration.* New York, NY: Plenum Press.

Stricker, G., & Gold, J. (2005). Assimilative psychodynamic psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 221–240). New York, NY: Oxford University Press.

Stricker, G., & Gold, J. (Eds.). (2006). *A casebook of psychotherapy integration.* Washington, DC: American Psychological Association.

Thorne, F. C. (1950). *Principles of personality counseling: An eclectic view.* Brandon, VT: Journal of Clinical Psychology.

Timberlake, E. M., Farber, M. Z., Zajicek, M., & Sabatino, C. A. (2008). *The general method of social work practice: A strength-based problem-solving approach* (5th ed.). Boston, MA: Pearson/Allyn & Bacon.

Tolson, E. R., Reid, W. J., & Garvin, C. D. (2003). *Generalist practice: A task-centered approach* (2nd ed.). New York, NY: Columbia University Press.

Wachtel, P. L. (1977). *Psychoanalysis and behavior therapy: Toward an integration.* New York, NY: Basic Books.

Wachtel, P. L. (1997). *Psychoanalysis, behavior therapy, and the relational world.* Washington, DC: American Psychological Association.

Wachtel, P. L. (2010). Beyond "ESTs:" Problematic assumptions in the pursuit of evidence-based practice. *Psychoanalytic Psychology*, *27*, 251–272.

Wachtel, P. L., Kruk, J. C., & McKinney, M. K. (2005). Cyclical psychodynamics and integrative relational psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 172–195). New York, NY: Oxford University Press.

Walsh, J. F. (2009). *Generalist social work practice: Intervention methods.* Belmont, CA: Brooks/Cole Cengage.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum.

Wampold, B. E., & Bhati, K. S. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. *Professional Psychology: Research and Practice*, *35*, 563–570.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. New York, NY: Routledge.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, all must have prizes. *Psychological Bulletin*, *122*, 203–215.

Weinberger, J. (1993). Common factors in psychotherapy. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 43–56). New York, NY: Plenum Press.

Wolfe, B. E. (2005). Integrative psychotherapy of the anxiety disorders. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 263–280). New York, NY: Oxford University Press.

FOUR

Critical Ecological Systems Theory[1]

Michael Rothery

In this chapter, an exploration of ecological systems theory as a model for generalist social work practice begins with the historical development of core concepts and ends with considering how this evolving, robust perspective will continue to serve our profession in the future. The term *critical* has been added to the perspective's designation to highlight the need for consistent recognition of the social justice implications of an ecosystems viewpoint. A single case study, the Macdonnell family, is used to make abstract ideas concrete and to demonstrate their considerable practical importance.

ECOLOGICAL SYSTEMS THEORY AS A LONGSTANDING PERSPECTIVE FOR SOCIAL WORK

"The first social work course ever taught," wrote Wood and Geismar (1989), "was on 'The Treatment of Needy Families in Their Own Homes,' at the New York Charity Organization Society's Summer School of Applied Philanthropy (later the Columbia University Graduate School of Social Work)" (pp. 48–49). This was well over a hundred years ago, when psychiatry (the other prominent helping profession) was firmly focused on the person, on individual subjectivity and dynamics (Ellenberger, 1970). In contrast, even then social work's focus was on families as much as individuals, and it was seen as important to work with people in their social contexts rather than in the artificial world of the professional's office.

In 1949, Swithun Bowers published a review of everything he could find in the professional literature to that point exploring the definition and meaning of social casework (direct practice), concluding thus:

> Social casework is an art in which knowledge of the science of human relations and skill in relationship are used to mobilize capacities in the individual and resources in the community appropriate for better adjustment between the client and all or any part of his total environment. (Bowers, 1949, p. 417)

Further, Bowers fountno argument for giving priority to a focus on either individuals or their ecological context:

> This mobilization of inner and outer resources is in varying circumstances variously emphasized; in some instances it will be a primary mobilization of the individual's strengths; in others, mainly placing community resources on an active footing in regard to the client. (Bowers, 1949, pp. 416–417)

Decades after Bowers published his work, ecological systems (or ecosystems) theory has emerged as a contemporary effort to conceptualize social work practice in a way that gives equal weight to the individuality of our clients as people *and* to the social (even physical) environments that do so much to determine their well-being. However, as the earlier discussion indicates, it is not in any deep sense a departure from what we have always understood our job to be, and in this social work is special.

BASIC CONCERNS ABOUT ECOLOGICAL SYSTEMS THEORY

Although ecological systems thinking is seen as a framework capable of integrating (and extending) our traditional perspectives (e.g., Gilgun, 1996a, 1996b), the profession's growing interest in this perspective has not been unanimously applauded. Wakefield (1996a, 1996b) and others have worried that the ecosystems perspective is so abstract, or metaphorical, that it cannot reliably be operationalized. Social work is an applied profession, it is argued, and needs concepts that inform its efforts to ameliorate practical problems—domain-specific knowledge about such areas as addictions, child welfare, or mental health. The search for a general theory that can inform all practice risks a serious loss of credibility in respect to the delivery of concrete services. We are reduced to expounding general principles and philosophy, while other less lofty disciplines do the real work of helping people.

Another concern has to do with the perspective's open-endedness, which can be both good and bad news. As a strength, this openness encourages a broad understanding of the issues clients bring to us; instead of a narrow focus on the private lives and troubles of people seen as isolated individuals, we look also at the social context within which those troubles occur and to which they are inevitably bound. The potential bad news is that too broad a scope can be paralyzing: in principle, there is no end to the avenues that can be explored if the goal is a holistic understanding of someone's life. This elasticity of focus is illustrated when writers argue that a "deep" ecosystems perspective must expand to include concern for all of the natural environment or even an apparently spiritual appreciation of the unifying interrelatedness of all things (Ungar [2002] discusses examples). While accepting the real importance of such matters, this chapter's necessary boundaries restrict it to a focus on traditional social work concerns more narrowly understood by people in their sociocultural environments.

A further concern with the ecosystems perspective has to do with time. People and their social environments have a history and future, expressing the past and making choices about perceived possibilities. An ecosystems perspective need not be exclusively present-oriented, but tends, in practice, to have such an emphasis,

which can appear as a limitation to practitioners for whom the past roots and future solutions of problems are critical. This is a longstanding issue:

> Having sought to persuade the reader of the superiority of the process-person-context model over its contemporaries, I shall now, perversely, point to a major lacuna in this powerful design. The missing element is the same one that was omitted in Lewin's original formula—the dimension of *time*. This dimension has been given short shrift in most empirical work as well. (Bronfenbrenner, 2005b, p. 119)

A very important additional criticism is that the ecological perspective emphasizes adaptation; as such, it can easily become a model through which practitioners encourage clients to accommodate oppressive circumstances. It is for this reason that in the discussion that follows, an emphasis is placed on the fact that social realities, such as oppression and injustice, are part of the environment that must be considered in an ecological analysis. An ecological systems approach can be misused if it is employed in the absence of articulated social values; thus, social work's traditional concern for social justice is a necessary complement to the model. Fortunately, an integration of values like social justice with ecological thinking is altogether possible. They are not antagonistic ideas, which is why the word *critical* in the term *critical ecological systems theory* is being recommended.

The word critical is not intended to imply negative so much as a questioning, self-reflective use of theory within the context of a firm commitment to social justice. A thorough discussion of social justice theory is beyond the scope of this chapter (see Barry, 2005; McGrath Morris, 2002; McLaughlin, 2006; Miller, 1999; Nussbaum, 2000, 2001, 2011), and for our present purposes it is enough to say that just societies provide members with the essentials they need to flourish, such as food, comfort, safety, opportunities to grow, freedom, respect, and dignity. Some social justice theorists prefer to focus on the question of social recognition (Fraser, 1996; Young, 2000), emphasizing the need we all have for validation from the people around us. We are all happiest when we are welcome in our communities and are recognized as competent and credible—as having something of value to offer. The denial of such recognition through racism, sexism, or other forms of discrimination is what is usually implied by terms such as *disempowerment*, *marginalization,* or *oppression*.

As we explore the details of the critical ecosystems perspective, it should be apparent that it is a framework that easily accommodates social justice considerations. We discuss how the ecological niche that people inhabit comprises a balance of demands and resources; it is not difficult to bring the fair distribution of essential social justice "goods" into that equation. We note the ecological systems belief that everyone needs access to meaningful social roles, and this is in effect an argument for adequate social recognition that allows us to keep social work's anti-oppressive agenda high on our list of professional priorities.

Thus, useful concerns have been raised about the ecological systems perspective, but it seems the model is open and robust enough to accommodate them. Having made this case, the remainder of this chapter is an effort to present critical ecosystems thinking in a way that highlights its practical possibilities. Practicality is hopefully enhanced by proposing a framework that draws upon social support concepts

regarding resources (Cameron & Vanderwoerd, 1997; Rothery & Cameron, 1985), the "stress and coping" model's emphasis on demands and competence (Lazarus, 1993; Lazarus & Folkman, 1984), and elements of cognitive theory in our discussion of beliefs (cf. Brower & Nurius, 1993).

Still, the model remains a deliberately somewhat abstract "metaphor" that provides a basic orientation to clients and their problems, but does not prescribe interventions (Germain & Gitterman, 1996; Meyer, 1988). Offered as a conceptualization within which eclecticism with respect to models and methods can be organized, it provides a useful map and ideas about desirable destinations, but is silent on the question of how, concretely, we and our clients can travel from point A to point B.

CASE EXAMPLE

Fifteen-year-old Colin Macdonnell attracted attention at his school as his grades dropped precipitously. When this was commented on in the staff coffee room, his English teacher added another concern: he had submitted an essay that was severely depressed in tone (well beyond normal adolescent angst), and in which he devoted considerable space to the question of suicide.

Colin was interviewed by the school social worker, who subsequently invited his parents to come with him for a family meeting. Colin's mother, Dawn, accepted the invitation but his father, Eric, did not.

Both Colin and his mother were troubled, and knew they had serious issues to address. Each was therefore motivated to talk, and since they were also articulate, the initial interviews provided considerable information. Dawn's assessment was that Colin had begun "losing it" when his older brother, Sean, was charged with selling drugs to other students in their high school. Two days after the charges were laid, Sean came to class inebriated and was promptly suspended.

Sean was 2 years older than Colin and they were students in the same school. Sean's troubles were, of course, highly public. For weeks, it seemed to Colin that the various student grapevines talked of nothing else. He felt humiliated and helpless and withdrew from friends and his school activities, wishing he could somehow simply "disappear."

With very little prompting, Dawn also discussed deepening tensions in her marriage with Eric. In her view, Eric was alcoholic, though he rejected the label, preferring to see himself as a hard-living *bon vivant*, determined to live life to the full and contemptuous of sensible people and their lives of banal moderation. Dawn considered that his drinking had cost the family dearly financially, and that he had often neglected and occasionally embarrassed them.

Another important tension concerned religious commitments. Dawn was devoutly Roman Catholic. Eric professed to be committed spiritually to the values of the church, but was strongly anti-clerical, for which reason he refused to participate in services or other church activities. Once when he was very drunk, he accused his wife (in the presence of both sons) of having an affair with a young priest with whom she had been fund-raising for their parish.

Annoyed with his wife and son for talking about their family to a social worker, and wanting to correct any inaccuracies they might have put forth, Eric joined them for the third interview (and, sporadically, a number of sessions after that). He came

across as a loquacious man with modest accomplishments and a romanticized view of himself. He was not overtly hostile toward the worker, but did communicate a degree of amused superiority respecting the helping enterprise, with frequent references to "psychobabble" and "wet shoulders for hire."

Eric worked as a journalist. Well into middle age, he was earning an adequate income and enjoyed a certain local reputation based on his willingness to put forth conventional opinions in a flamboyant style. When he talked of his work, one could easily imagine him running with the likes of Hemingway and Mailer, battling the perniciousness of the powerful and struggling, against all odds, to expand the awareness of ordinary people. "Against human stupidity," he liked to recite, "the gods themselves contend in vain."

Eric was perplexed, he said, by his wife's unhappiness. He had no detailed analysis of what could explain it, but was attracted to the general idea that it implied a lack of understanding, or an unwillingness to be realistic on her part. Respecting his sons, he often declared that they were "wonderful" kids, dismissing Sean's difficulties as ordinary adolescent rebellion, perhaps even admirable in some ways. He thought Colin might be simply confronting some of his limitations, having done well in an educational system with low standards until he reached grade 10 and the sudden expectation that he should perform.

Eric acknowledged that his alcohol consumption was well above average. Harboring a certain fear of being "average," he was, at least at one level, proud of this. He could reference many accomplished people who had not bothered to contain similar appetites. Sir Winston Churchill was an example, as were many famous writers and heroic figures in the journalism trade. He stressed that he was not a "wino" but a person of discriminating taste—referencing his membership in the Opimian Society, a group that existed to celebrate the good life enhanced by fine wines and spirits. He also invoked the requirements of his profession, arguing that many important story ideas and leads were traded among his journalistic colleagues over drinks after work.

In an earlier time, a psychodynamically oriented social worker might focus very strongly on Eric's denial and narcissism, recognizing how frustrating such a father can be to his children. This alone helps explain the strength of Sean's acting out and the depth of Colin's helpless despair. An ecosystems analysis does not prohibit such considerations (Meyer, 1988), although it does require that we not stop with them. There is a broader view available to us, with a more complex understanding of the sources of this family's pain and options for ameliorating it.

For its more holistic view, critical ecosystems theory draws on three related schools of thought originating in the life sciences: general system theory, ecological theory and critical realism.

Basic Concepts From General System Theory

Introduced to social work in the 1950s (Hern, 1958), general system theory has been enormously important in highlighting how interconnected we are as people embedded in various social systems. Colin Macdonnell's problems are not simply a case of adolescent depression. Rather, his experience is better understood as the consequence of a much larger set of interacting factors: his family situation, his relationships to peers, the impact of the school, the school's treatment of his older

brother (and the vicarious effect of that on him), and so on. How such elements interact, reciprocally influencing each other, is the purview of systems theory.

Key ideas from general system theory that inform the ecosystems perspective are:

- All people or groups of people in a system share a reciprocal influence on one another.
- In systems, causes are considered to be *circular* rather than *linear.* Colin Macdonnell's depression and withdrawal are a consequence of a complex set of interactions among different people in the systems of which he is a part. When his brother comes to school drunk, he initiates events that lead to Colin withdrawing. If Colin's friends feel abandoned and become angry, they may in turn distance themselves from him. This distancing confirms Colin's belief that he is an outcast, and he withdraws further, becoming more acutely unhappy. When systems theorists talk about circular causality, they have such reciprocal transactions in mind, as opposed to simpler arguments—attributing Colin's depression to a neurotransmitter deficiency (and nothing else) would be an example of a nonsystemic, linear causal model.
- Systems possess structure, consisting of durable patterns of relationship behavior, especially boundaries. Boundaries are always somewhat arbitrary, but not entirely so. Given the impossibility of relating effectively to the whole of creation, we arbitrarily "draw" boundaries around a more manageable unit for analysis and intervention. We might decide, for example, to focus on the Macdonnell nuclear family, or more broadly on the family plus its proximal community, including the school, the church, and Sean's friends. This illustrates the idea of boundaries in the arbitrary sense. It is also the case that the school, the church, or the Macdonnell nuclear family possess boundaries in a nonarbitrary sense, which is that there is a flow of information *within* a given system that is different (quantitatively and qualitatively) from the information exchanged with people or groups outside itself. The Macdonnell family members know things about each other that others do not know, for example, and this represents a boundary. Dawn and Eric, as parents (or, more ponderously, a *parental subsystem*), share information with each other that their children (the *sibling subsystem*) know nothing of, and vice versa. Thus, there are boundaries within the family defining its parts, just as there are boundaries that separate it from other elements of its environment.
- Boundaries are qualitatively different in that the type and amount of information they restrict varies. Systems that exchange information relatively freely are considered *open*, whereas systems that rigidly restrict the flow of information are considered *closed.* Social systems like families are never completely impervious to influence from outside, so they are always, to some extent, open, and can only be *relatively* closed. Excessive openness leads to a loss of identity and other risks, while excessive closedness results in deprivation. A balance is what is desirable, with systems like families being open enough to access the resources they need to thrive, but closed enough that undesirable influences can be screened out and identity maintained. Some authors use the term *permeability* to describe ideal boundaries that are well-defined but sufficiently open (Nichols & Schwartz, 2004).
- Because everything affects everything else in a circular, reciprocal manner, it can be observed that different interventions can have similar impacts.

Colin might experience relief if his father and mother reduce the conflict in their relationship, or if Sean is provided effective treatment for his substance abuse, or if the teachers in his school find a way to rally to his support. A corollary is that very similar interventions can have rather different outcomes depending on how the system responds to them. A prescription of antidepressant medications could help Colin feel better, decrease his social withdrawal, and signal his father that the situation is serious and revisions to their relationship are in order. On the other hand, if such an intervention results in scapegoating—dismissal as an emotional weakling, for example—then Colin's symptoms may be made worse. This unpredictability is referred to by the terms *equifinality* (to indicate similar outcomes evolving from different beginnings) and *multifinality* (to indicate that similar beginnings can lead to multiple consequences).

Basic Concepts From Ecological Theory

Ecological theory was wedded to systems theory in the 1970s, enhancing it in important ways. "Ecology," according to Meyer (1995), "is the science that is concerned with the adaptive fit of organisms and their environments . . . ecological ideas denote the transactional processes that exist in nature and thus serve as a metaphor for human relatedness through mutual adaptation" (p. 19). When systems concepts are used to understand better how people like Colin achieve (or fail to achieve) a *goodness of fit* with the various aspects of their environment, ecosystems thinking is the result. We are not simply interested in Colin's symptoms or in how they might be explained as the actions of complex systems of which he is a part. We also attend to the vital question of how well Colin and those systems are adapting to *each other*, and the implications of that adaptation for his ability to get his needs met (Brower & Nurius, 1993; Germain & Gitterman, 1996; Gitterman, 1996; Meyer, 1988; Rothery, 2001).

As social work is slow to properly respect its own history, we should pause to appreciate this surprising accomplishment. The discovery of the *systemic* nature of families and other social units is often credited to people like Bateson (1972), von Bertalanffy (1968), Ackerman (1958, 1966), and Minuchin (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), the truth being that the basic insights on which they drew came from social workers in child and family guidance agencies (Wood & Geismar, 1989). Ackerman, for one, recognized this, and some of the early theoretical work came from social work scholars (Hern, 1958). As significant as their work is, psychologists like Kurt Lewin (1935, 1951) and Urie Bronfenbrenner (1979) did not on their own pioneer ecological thinking as an important perspective for understanding healthy human development; responsible as they were for foundational theory and research, their basic insights were also part of contemporaneous professional conversations in social work agencies.

The point is not meant to be territorial, as the work of the people just identified represents a richness we would not wish to be without. The intention is simply to support a pride in the accomplishments of our professional ancestors, and to establish that versions of the ecosystems perspective have been a hallmark of social work since it emerged as a discipline (Rothery, 2005).

What is relatively new about ecological systems theory is the conceptual frame with which it attempts to describe peoples' embeddedness in their environments. We

are thoroughly dependent on our social and physical world; without the resources it provides from moment to moment we would instantly perish. This is an obvious fact whose importance is easily lost, especially in a culture that overvalues ideals of individuality and autonomy.

Like the general system theory to which it is so closely tied, ecological systems theory is above all a relational perspective, pressing us always to take a surprisingly difficult conceptual step. The person and the environment are always reciprocally sustaining and shaping one another. When we try to understand ourselves, our clients, or our work by focusing on one at the expense of the other, we become reductionistic and prone to mistakes. Properly employed, an ecosystems focus is on the mutual contribution and response of each to an unending transactional process on which each is deeply dependent.

Basic Concepts From Critical Realism: Structure, Agency, and Reflectivity

Recent work in sociology—the body of theory called *critical realism*—suggests that humans flourish more or less well in an ecological niche that can be analyzed in terms of *structure* and *agency*, mediated by their *capacity to reflect* (Archer, 2007, 2012; Smith, 2010; see also Taylor,[2] 1985a, 1985b, 1989).

Social *structures* are given a somewhat expansive definition, compared with that which we used earlier, by Smith (2010). Smith highlights that social structures (a) are durable patterns of relationships; (b) make sense culturally, expressing the culture's values and morals; (c) make use of and influence available goods and services; and (d) are actively sanctioned by society through permissive and proscriptive rules.

People who live in social structures that, on balance, enable them to access what they need will flourish; people who live in social structures that, on balance, limit their access to what they need to flourish are, to some degree, oppressed.

The power of social structures is that they are contexts within which our lives are lived and experienced. Peoples' self-definitions and myriad choices regarding how to comport themselves are shaped and influenced by social structures, but not wholly determined by them. In fact, social structures are a product of decisions that people make—they both cause and are caused by people exercising *agency*. This proactivity is an essential part of being human; to deny it is to dehumanize ourselves and others (Archer, 2000; Smith, 2010).

A critical aspect of peoples' responses to the structures comprising their social environments is their ongoing inner and interpersonal conversations about what is experienced and what it means—a process of *reflection*. Archer's (2012) research suggests there are four reflexive modalities:

> Communicative Reflexivity . . . [in which] Internal Conversations need to be confirmed and completed by others before they lead to action, Autonomous Reflexivity . . . [in which] Internal Conversations are self-contained, leading directly to action, Meta-Reflexivity . . . [in which] Internal Conversations critically evaluate previous inner dialogues and are critical about effective action in society, [and] Fractured Reflexivity . . . [in which] Internal Conversations cannot lead to purposeful courses of action, but intensified personal distress and disorientation. (pp. 13, 318)

Charles Taylor's (1985a) discussion of "What is Human Agency?" gives considerable weight to reflections, which he describes as being the critical process of assigning value to experiences (evaluations):

> Shorn of these we would cease to be ourselves . . . we would lose the very possibility of being an agent who evaluates; that our existence as persons, and hence our ability to adhere as persons to certain evaluations, would be impossible outside the horizon of these essential evaluations, that we would break down as persons, be incapable of being persons in the full sense. (pp. 34–35)

The central significance of reflection is also stressed by Suddendorf (2013) as a necessary part of a process whereby we create scenarios, which in turn has a radical impact on agency: "As long as we can manage our more immediate urges, our mental simulations and reflections can gain control over actions. To a significant extent, we can become masters of our own destiny" (p. 218).[3] He goes on to describe how scenarios are collaboratively co-constructed and developed into shared stories, or narratives that "provide meaning and explanation . . . [and] create bonds between people," until ultimately "we have evolved a cultural world" (p. 222); a link between ecosystemic and narrative thinking (see Chapter 18) is established.

A final general point that we return to periodically is that an understanding of our client's circumstances that incorporates structure and agency invites observations pertinent to social justice and social action. Structures that limit reasonable opportunities to exercise agency in the service of flourishing are, as we have noted, oppressive; they are, therefore, a social justice issue. Under these circumstances reflection may take the politicized form of consciousness raising, and goals entailing social change may acquire weight and prominence.

CRITICAL ECOSYSTEMS THEORY WITH A MORE DETAILED REFERENCE TO THE CASE

The Person

To comprehend Colin's suicidal despair, we need to understand a singular person in a particular place and time. Colin's experience is the unique creative result of an interaction between himself (the person) and the circumstances life has handed him (his environment).

Needs

It is a given that most people who consult a social worker do so because they have *needs* that are being inadequately met. There is something they do not have that is necessary if they are to live well. Determining what our clients' needs are—what change could make their lives more successful and gratifying—is the basic purpose of the ecological perspective. It helps us help our clients to answer fundamental questions: "What do you need?" "What do you want?" "What will make the necessary difference in your life?" Current work attempting to identify needs basic to all people cannot be dealt with in detail here but is noted for its importance as an area of shared interest between critical ecosystems theory and social justice.

The philosopher, social justice scholar, and feminist Martha Nussbaum has proposed a set of 10 "capabilities" (Nussbaum, 2000, 2001, 2011), *capabilities* being synonymous with *needs* (Gough, 2014). Nussbaum (2011) considers that 2 of her 10 capabilities are foundational with respect to the rest: *affiliation* and *practical reason* (Nussbaum, 2011, p. 39). Affiliation is access to meaningful social roles and relationships; practical reason is the opportunity to be self-reflective respecting one's basic values and purposes. In a just society these needs are adequately met, while, conversely, their denial constitutes oppression.

Gough (2014) considers that *autonomy* and *health* are two universal human needs (*autonomy* subsumes Nussbaum's *practical reason*), and Taylor (1989) concurs respecting the basic importance of autonomy in a discussion that also addresses the broader concepts of *respect* and/or *dignity*.

This very brief excursion into an important developing area of current scholarship suggests a list of four basic universal human needs: *affiliation*, *autonomy*, *health*, and *dignity/respect*. Such a list obviously can be tweaked and expanded[4] and must be interpreted to accommodate cultural diversity—still, it may serve an heuristic purpose as a tool for thinking about basic needs.

Biology

Years ago, an earlier social work framework had an awkward name: the *biopsychosocial* model. Although this term is not currently in vogue, it did serve a purpose, emphasizing that people and their problems are understood holistically if we remember they have bodies (biology), minds (psychology), and a social context.

All peoples' physical bodies are obviously basic to who they are. Our gender, temperament, skin color, height, and a host of other things help define us, and are largely inherited. Other important physical attributes are acquired as we live, with nutritional practices, disease and accidents, and lifestyle choices making their mark.

Strengths-based approaches, like critical ecological systems thinking, are often presented as antithetical to medical or disease models, and these different perspectives are seen as alternatives between which one must choose. Concerns about biological approaches to human problems applied reductionistically are perfectly valid, of course. However, it can also be unhelpfully simplistic to dismiss biology (and biological interventions) as unpalatable irrelevancies. For this reason, a more inclusive *bioecological* perspective has recently been proposed for its theoretical (Bronfenbrenner, 2005a) and practical (Taylor, 2003, 2006) value. How the biological fact of illness interacts with ecosystemic events is also, understandably, an issue that has attracted scholars in the specialized field of family systems nursing (Wright, Watson, & Bell, 1996).

Creativity and Choice

A vitally important point to keep in mind is that while our environments are, obviously, very powerful in determining our health, happiness, and opportunities, we also have power; we are not passively becoming whatever our environment demands, but we are shaping it as it shapes us. Colin, like everyone else, is engaged in a two-way relationship with his environment, and we would be disrespectful if we failed to recognize how he changes that environment through his creative choices and behaviors, at the same time as *it* affects *him*. The fact that our

circumstances have a large effect on our health and happiness should not blind us to our capacities for creativity and choice—capacities that we use to decide what paths to follow and that enable us to have a positive impact on our world (Rothery & Enns, 2001; Runco, 2004).

Effective social workers know how improved circumstances can be essential to a client's healing, but also take care to recognize their client's ability to make creative choices. In working with Colin, who is feeling hopeless and alone, our skill at connecting with his creative self will do much to determine whether we are helpful to him or not.

Beliefs

We all have a habitual way of interpreting our lives, which affects how we feel about what happens to us. The result is beliefs that shape our feelings and behaviors, and this is something we listen for carefully when we talk to our clients.

Sustaining beliefs are seen when clients can be helped to feel hopeful and optimistic, and their motivation to change is enhanced. *Hope* is the belief that problems can be managed or solved and that something meaningful can come from painful, difficult times (Rothery & Enns, 2001). A client like Colin may not easily express hope, but if he can be helped to find and strengthen his capacity for optimism, he will benefit greatly from doing so (however cautious that optimism may initially be).

Another critical sustaining belief is *self-esteem*. Our relationship to ourselves is complicated, and very few people would say they like everything about who they are and how they have lived their lives. But those of us who generally believe we have value and our lives are meaningful are very fortunate compared with people who lack that sense of themselves.

We also all have different *beliefs about the world* we live in. A person like Colin who has become depressed will typically struggle with *constraining* beliefs of this sort, and it is easy to see how this will affect our efforts to help. How easy will it be for Colin to work with us to do something about his problems if he believes his world is empty of resources that mean anything to him? "My situation is hopeless" he seems to think, and this is an impediment—a very difficult base from which to attempt positive changes.

Another important category of beliefs has to do with *how we see other people* and our relationship to them. If there are people in your life whom you trust and admire, and with whom you feel you belong, that set of beliefs will be enormously supportive to you. If you are convinced that all or most other people are untrustworthy, selfish, or stupid—dangerous to be close to and not worth the effort in any event—you will likely be isolated and fearful. Given his recent history, Colin may well have difficulty believing that other people can be trusted, and he might consequently cut himself off from the emotional support he needs.

The importance of values to helping professionals is widely discussed. Our commitment to beliefs in peoples' rights to dignity, justice, and equitable access to resources is a large part of what defines us—these values tell us and the world what we are about. The same is true individually: values are basic and powerful beliefs that determine who we are and how we will respond to situations. Many social workers work long hours in very stressful circumstances, and they are able to do this because of a strong belief that their work is important—it has a personal and social value for them. Similarly, Colin's mother, Dawn, believes in the rightness and

importance of her commitment and obligation to her children, and she regularly puts their needs ahead of her own. This is part of the reason why, knowing Colin is at risk, Dawn is strongly motivated to find a way to make things better.

Dawn is also someone with strong spiritual commitments, and if she were asked what keeps her going in very difficult times she would invariably give her church and faith a full measure of credit. Her religion comprises a very powerful set of sustaining beliefs, and this is true for large numbers of people. *Spirituality*, for many clients (and helpers), is a critical source of meaning and values, which is why it can be such an essential dimension in people's lives (Folkman & Moskowitz, 2004). As social work and other professions have confronted the importance of cultural diversity, they have also come to accept the variety and often surprising power of the spiritual traditions in which our clients may be embedded. For this reason the literature on spiritual diversity in social work and other helping professions has grown enormously in recent years (e.g., see Walsh, 2009).

Strengths and Competencies

To relate to Colin effectively, his social worker will empathize respectfully with his painful experiences, but will carefully balance that conversation with recognition of his strengths and competencies, and his capacity for making effective, creative choices. Our clients' strengths and competencies are critical to their ability to change. If Colin seeks help for his depression and is told that his life is a disaster and it is high time he gets it back on track, he might agree with the assessment but he will not feel hopeful. If, in contrast, he is told that he has many strengths and successes to draw on as he figures out what to do about a situation that has had him stymied, he will approach the need to change with an entirely different frame of mind. First, he will feel more optimistic and therefore motivated; second, he will have ideas about what he has done in other situations that he could apply to the present problem.

Exploring clients' strengths is not always easy. Colin is feeling like a failure, regarding himself as worthless and incompetent, and he therefore might not find a discussion of what is right with his life very convincing. However, it is part of our professional skill and discipline to systematically and patiently look for the good news buried in the bad. One way to accomplish this is by thinking about roles.

Roles

Each of us occupies a number of social "spaces," which carry with them a set of expectations and prerogatives. Being a child in your family of origin is a role, a space you occupy in which your parents and siblings (and you yourself) expect certain things from you and in which you have certain rights and responsibilities. If Colin goes for help with his depression, he will occupy a client role with the agency that serves him. He is also a son, a student, and a friend to others in his social network. In discussion, it emerges that he is a very good writer (like his father) and that until recently he was editor of his school's student newspaper.

Take a moment to reflect: does the last item of information we have just presented change your mental image of Colin in any significant way? Until now, we have focused on his pain, and, as a result, it is likely you had developed a mental image of him based on that aspect of his life. Hearing about one of his successes suggests a somewhat different picture, perhaps a more hopeful one.

We do not always hear about our clients' successes unless we ask, and if we don't ask we miss an opportunity to learn about their strengths and competencies. We then are at risk of treating people reductionistically, as *nothing but* another depressed teenager, alcoholic, or parent lacking essential skills.

A necessary part of our assessment with clients, therefore, is not simply to discuss their problems, but to develop an understanding of the roles they occupy, and to explore with them the success and competencies they bring to each. This can be admittedly difficult—it is a discipline and skill that we can spend a lifetime perfecting.

We have now discussed the first element in our ecological model, which is drawn as a simple oval (see Figure 4.1). The circle will overlap with others to be added soon, and it is drawn using a dotted rather than a solid line. This is because we as people are not isolated entities, cut off from our environments; rather, we are always in communication with our surroundings and the people in them, influencing and being influenced on an ongoing basis.

The Immediate Environment: The Ecological Niche

Ecological theorists tend to differentiate aspects of our environment that have an immediate impact on our ability to cope from those that are less directly influential, aspects that are *micro* (relatively small) versus *macro* (larger and broader), or

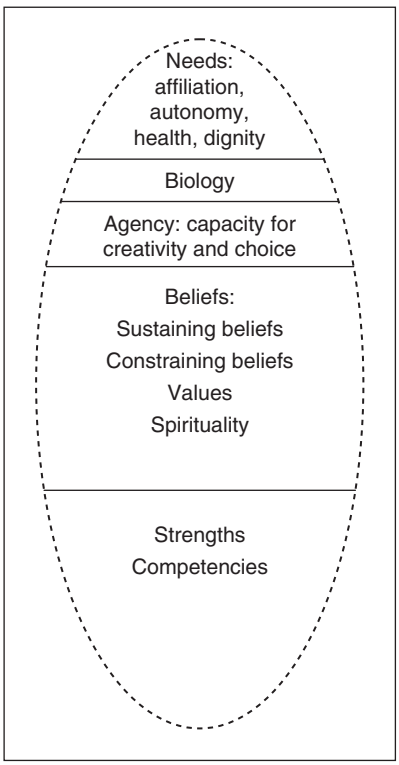

Figure 4.1 The person.

proximal (close) versus *distal* (further away). These terms are usefully suggestive but imprecise. Metaphors having to do with size and distance can mislead when applied to social phenomena, and might inappropriately suggest that some environmental aspects are more important than others when, in actuality, importance varies from circumstance to circumstance. There are environmental influences we can consider immediate, however, as they are commonly obvious contributors to clients' problems and targets for change. Other influences are no less important but tend to be less immediate, often less apparent, and less amenable to change in the short term. For purposes of discussion we address these types of influence separately, recognizing that the distinction can be fuzzy. Following a discussion of more immediate environmental influences, the less immediate aspects of the environment are considered.

If Colin was helped by a psychiatrist or a clinical psychologist wishing to alleviate his depression, these helpers would likely focus primarily on him as a person, addressing possible medical needs and one or two of the other variables listed in Figure 4.1 (problematic beliefs are a likely example). Working with him from social work's ecological perspective, there is more to take into account. Not only does our profession insist that the *whole* person is important—all the elements in Figure 4.1 deserve our attention—but we also know we cannot adequately understand Colin without considering his environment.

The pressures Colin faces and the help that is there for him combine to make an immediate environment that is or is not adequate. Given his unique capacities and needs, is Colin's immediate environment one in which he is likely to be successful? To answer this question, we need to explore the *goodness of fit* between him and his environment.

The social and physical space that Colin occupies is, to use the technical term, an *ecological niche* (Bronfenbrenner, 2005a; Brower & Nurius, 1993; Rothery, 2002). We all are given (and create) such a space for ourselves, and it has two aspects that are important for understanding how well we "fit" with our environments. The first of these aspects is *demands*, which means the things in our lives that require our attention for some reason: problems we have to attend to, fires to put out, people to care for, jobs to perform, a dog demanding a walk, and so on. The second aspect is *resources*, which means the sources of help and support that we rely on as we cope with life's demands. Let us have a close look at each of these aspects in turn.

Demands

Demands, as we just indicated, are events or situations in our lives that we have to respond to (Lazarus & Folkman, 1984). We have to adapt to these events or situations, which can be trivial (your nose itches and you adapt by scratching it) or vitally important (your car goes out of control on a slippery road and you have a second or two to determine what action to take). Most are easily managed and a minority present varying degrees of challenge.

Demands are with us from the cradle to the grave, as a constant part of living. For the most part, they are positive; by responding adaptively we learn and grow, and our sense of mastery and interest in life are sustained—we are all familiar with the pleasures of successfully solving problems or surmounting challenges. Under some circumstances, however, the demands in our lives have negative impacts.

A final general note has to do with time, an issue with ecological systems thinking that was identified earlier. The demands that affect us are not necessarily in the present. If you are a student who aced an exam a month ago, the memory of that triumph may still give you pleasure. If you anticipate that finding a job when you have finished your training is going to be difficult, you may well feel anxious *now* even though the event is still just an expectation.

Resources

In order to cope with the demands in his life, responding adaptively and creatively, Colin will rely on his own creative competence. However, he will depend on something else as well, and that is the resources in his environment. Of course, all of us do likewise—to take good enough care of ourselves we need tools, skills, and help from our friends and loved ones. The resources we all need to live well are described in different ways by different authors, but the four categories we suggest are consistent with what other scholars and researchers have concluded (Cameron, 1990; Cameron & Rothery, 1985). Here is what you have available to you when your world is as it should be:

1. *Emotional supports* are relationships that provide opportunities to discuss how you feel about the demands in your life, especially when you are feeling somehow vulnerable. Further, you can have those discussions expecting an empathic response (your confidante is understanding and is a safe person to talk to). Colin will go for help with his depression if he is supported in doing so by someone who understands his distress and responds to it compassionately.
2. *Information supports* are sources of the knowledge we need to effectively deal with particular demands. Dawn will be able to parent Colin more successfully if she has the best possible information about teenagers and depression, and about how other families have dealt with adolescent suicide risk.
3. *Concrete, instrumental supports* are help in the form of goods and services. This is a middle-class family, more economically privileged than many clients. Still they have needs for services that are effective and affordable, and the availability of such help in a timely manner matters enormously in determining the eventual outcomes of their troubles. Unfortunately, given Sean's criminal involvements, even legal services may well be an example of this type of support for this family.
4. *Affiliational supports* are the roles in which we feel competent and valued. If Colin feels like his family is failing him, his role as a son may not be providing him with a sense of importance and belonging. The same can be said of his role as a student and friend—roles from which he has withdrawn as they became, in his perception, more stressful than supportive.

Goodness of Fit: Demands and Resources in Balance

In any situation where we have to mobilize our resources to meet life's demands, we perform a balancing act, more or less like that diagrammed in Figure 4.2. The weight of the demand(s) and strength of the resources available to us are something we try

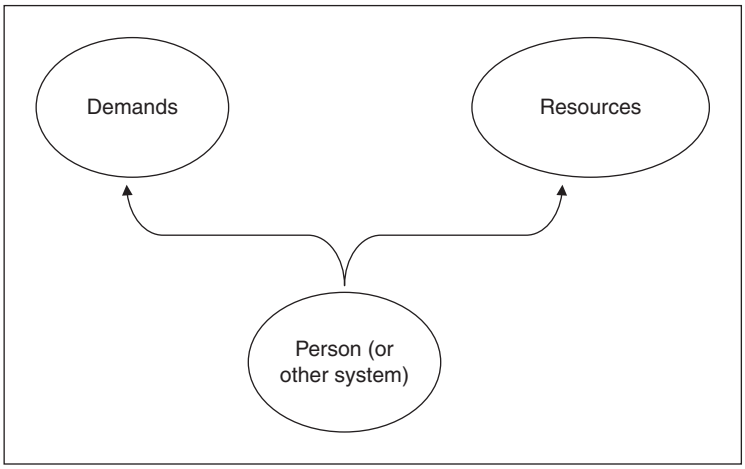

Figure 4.2 Goodness of fit.

to fit together: we draw on our strengths and competencies to access resources and use them effectively to deal with the demands we face.

If, *in our perception*, the demands are manageable, our resources are sufficient, and we are able to rise to the challenge, our experience will be positive. We will take care of the situation and enjoy a gratifying outcome. If, unlike Figure 4.2, we perceive that the weight of the demands we face is great and the resources at our disposal are inadequate, the consequence will be distress.

A Continuum of Responses to Demands

Dawn has a son who has thought about killing himself, and another who has been suspended from school for criminal activities. These are not the same as more common issues—such as having a child whose math grades are slipping—and such qualitatively different types of experience demand a different sort of response from a social worker.

Figure 4.3 suggests that we experience demands on a continuum, with our place on the continuum determined by our perception of what is at stake. On one side are those demands that we believe represent a threat to our survival, safety, stability, or basic comforts. On the other side are demands that have implications for our quality of life, our growth as people, or our ability to pursue a life that we find gratifying and meaningful (see also Rothery, 1990).

Dawn sees Colin's depression as a survival issue; given his suicidal ideation, we would not wish to argue with her. This, then, is a very different type of demand than Colin's slipping grades, which, although important, have to do with long-term success in life, but not survival. Similarly, we could make a serious mistake by attempting to get Dawn to learn to communicate more effectively with her husband if we don't *first* help her find ways to contain the threat of her son harming himself.

This understanding of demands is a very important piece of social work's ecological perspective. More than other professions, we have insisted on considering

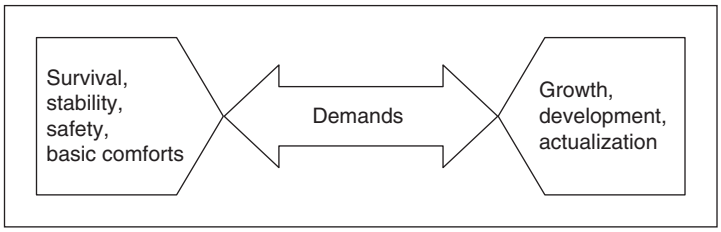

Figure 4.3 Continuum of types of demands.

how services should be appropriate to our clients' needs—to the demands they confront. We "start where the client is at." When we face demands we respond in different ways, and those differences can again be described as a continuum (see Figure 4.4).

The information summarized in Figure 4.4 has extremely important implications. It helps us respond appropriately and avoid serious mistakes with clients like Colin and his family. We cope adaptively and comfortably when we perceive that the resources available to us and our competencies exceed (or are at least equal to) the weight of the demands we face.

When demands are more than we feel we can bear, we tend to become rigid, or even disorganized or immobilized—the demands' weight has us feeling defeated. This can be partly due to the *number* of things we have to cope with: sometimes there is simply too much going on. However, it can also be a result of the *quality* of those demands. Demands that we perceive as relevant to our safety, survival, or basic comforts are heavier than other demands, and they lead us to feeling defeated and overwhelmed more easily because of their strong and immediate importance.

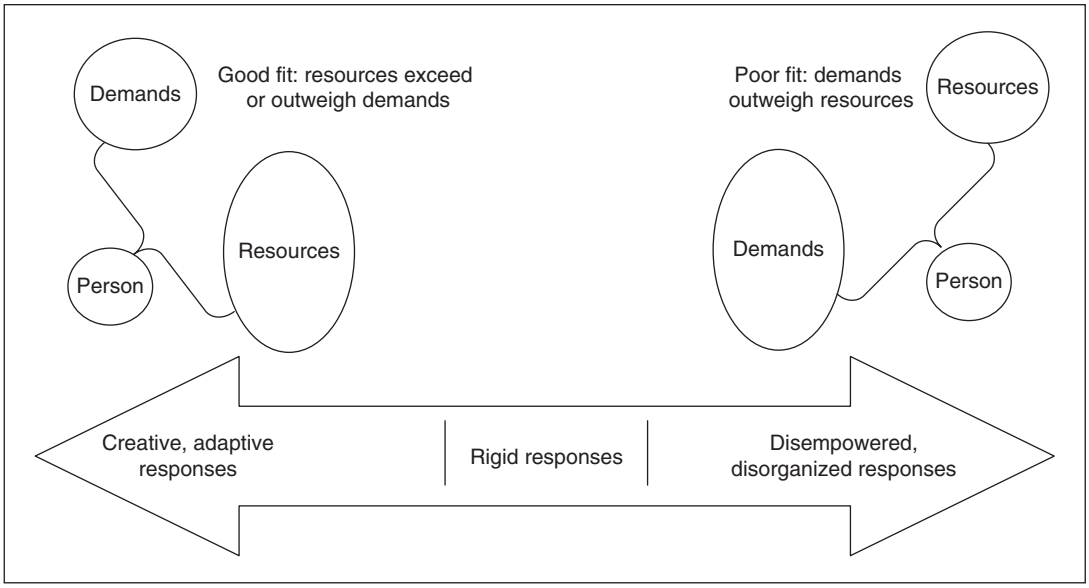

Figure 4.4 A continuum of responses to demands.

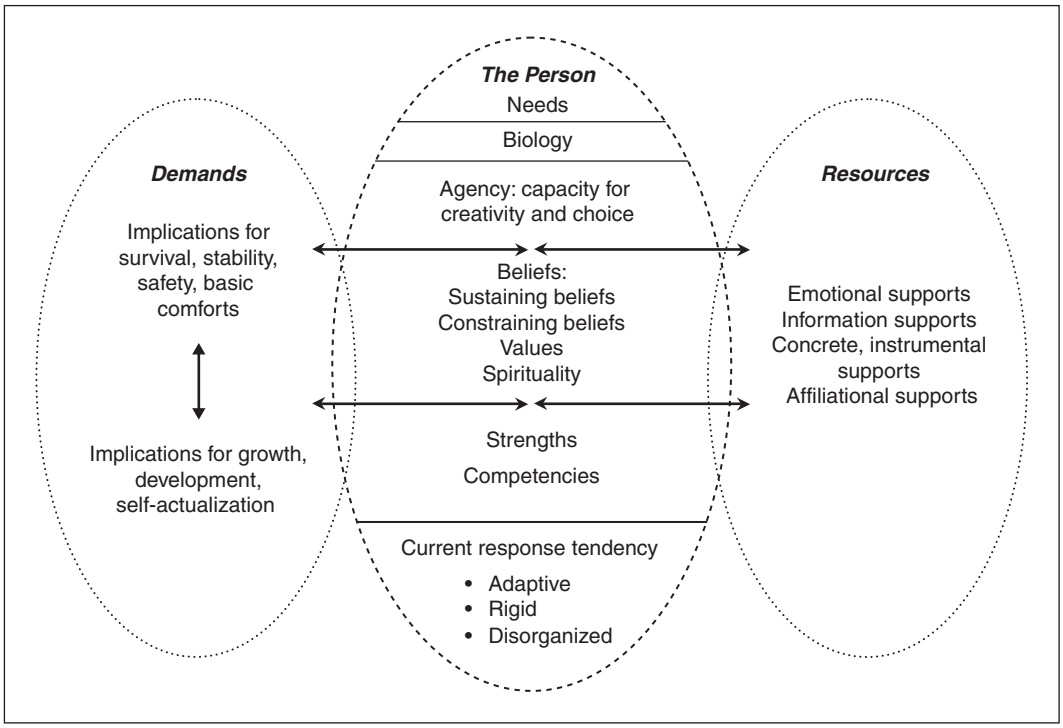

Figure 4.5 The person and the environment.

We set out to build our ecological perspective step by step. Figure 4.5 summarizes what we have considered so far: the person, dealing with life's demands on the one hand, utilizing the resources in his or her environment on the other.

Note that we continue to use dotted lines to symbolize the fact that ecological thinking emphasizes how our selves, demands, and resources overlap and constantly interact and influence each other. They are not as easily separable as we sometimes seem to suggest when we divide them up for purposes of analysis.

Also note that the oval for the person has new information added—the tendency to react in adaptive, rigid, or disorganized ways. This would not have made sense at the point where we introduced Figure 4.1, but its meaning and importance have been established in the material that has been covered since.

The Environment: Less Immediate Aspects

Demands and resources obviously constitute a significant part of Colin's environment, and do much to determine the quality of his life. However, understanding the context with which he, or any other client, must cope requires attention to other, broader issues. We cannot offer an exhaustive list, but can suggest a few that are universally important:

- As with all of us, Colin's culture provides him with language and ways of interpreting reality that work, minute by minute, to shape the way he relates to demands and resources, and provide him with preferred ways of interacting with his world and the people in it.

- Gender also matters enormously. Imagine if we had taken all the elements of this example, but written about a young woman instead of Colin. The story would be similar in some respects, but it would also have many important differences.
- Everything changes as we age. The fact that Colin is a teenager with depression means he is having feelings that are somewhat similar to an elderly person with the same condition—but his experience, its consequences for him, the help he will receive, and what he needs to do to cope are all different as well.

Culture, gender, and development work together to set a somewhat broader context than simply thinking about the environment in terms of demands and resources, and they are contextual variables that modern social work treats with considerable respect.

There is in Figure 4.6 one more circle of environmental elements to discuss in our effort to understand our clients' contexts—at which point we declare our model

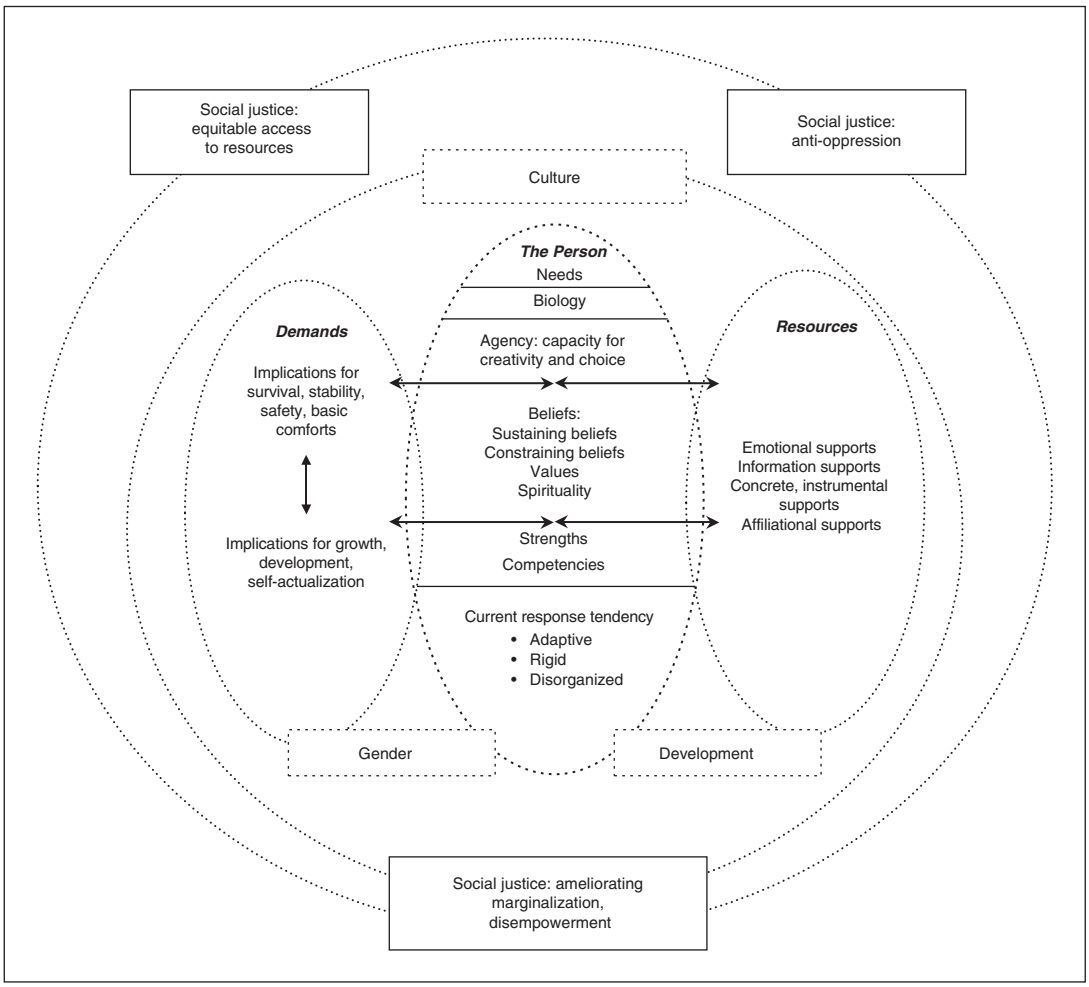

Figure 4.6 The "complete" ecological perspective.

complete for now (though it is an open model and therefore never complete). The elements that social work theory tends to highlight, which we have placed in our outer circle, are these:

- Our societies determine what our lives are like in a myriad of ways, as they are made up of arrangements and rules about who has power, status, and economic privilege.
- As an extension of the previous point, the idea of *oppression* refers to social arrangements that systematically disadvantage some groups of people, impeding their ability to lead safe, comfortable, and rewarding lives. Familiar examples of oppression are racism and sexism—social norms and practices whereby people with a particular skin color (or other visible attributes) or gender consistently face dangers and limitations that more privileged members of society do not.
- A related social reality that affects many of our clients is *marginalization*. This is a term (another is *disempowerment*) that recognizes how some groups are socially defined as powerless and unimportant.

THE ECOMAP: A TOOL FOR ANALYSIS

Not surprisingly, ecosystems theorists have experimented with various ways of diagramming the complex person-in-environment systems that they see as being the focus for social work practice. Genograms (see Chapter 5) are a popular tool for helping us understand nuclear and extended families, looking for the patterns that have affected the people with whom we work. From sociology and anthropology, approaches to diagramming social networks (in addition to kinship systems) have also been adapted.

The ecomap (Hartman, 1978, 1994) is a flexible tool that has been widely used, and is employed here to expand our understanding of Colin Macdonnell and his difficulties. It should be noted that there is not a standard approach to drawing ecomaps; rather, different authors suggest different formulae. Some approaches are very simple (Meyer, 1995) and some attempt to capture the full complexity of clients' contexts (Lachiusa, 1996).

The degree of complexity to be observed in constructing an ecomap is a practical matter. Such diagrams cannot be complete; indeed, they are useful *because* they are somewhat reductionistic. The more we include, the more complicated and difficult to understand the diagram becomes; on the other hand, we need to include enough information that we and our clients achieve a practical awareness of important contextual aspects of their problems and opportunities. A middle-of-the road approach, similar to Johnson and Yanca's (2003), is used here.

To begin with, a simple genogram of the Macdonnell nuclear family is drawn and enclosed in a circle, representing a boundary. Then, more circles are used to represent systems outside the family that are important (or potentially important) influences, impinging on the Macdonnells (see Figure 4.7).

One immediate advantage to this exercise in visualization is that it can direct our attention to systems that may have been neglected in the preliminary discussions. For example, where are Eric and Dawn's extended families in Figure 4.7?

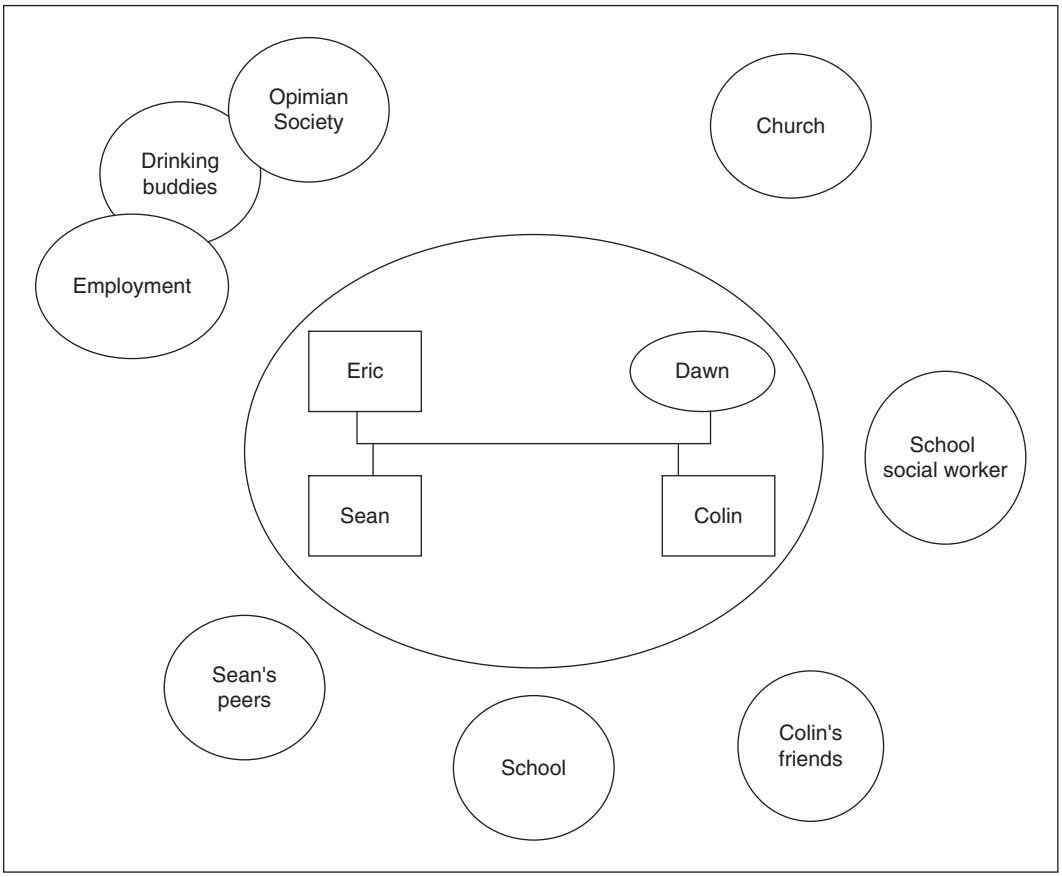

Figure 4.7 Step 1 ecomap.

When this is inquired into, further information is acquired. Dawn's father is dead, and her mother is a rather depressed person, distant geographically and emotionally. While they keep in touch, Dawn considers that her mother (and her siblings) have had a steadily waning influence on her since she left home as a young adult.

Eric's extended family is another matter. Dawn is ambivalent toward them, mixing admiration with misgivings. Eric likes to talk about them and, not surprisingly, describes his father and brothers (he had no sisters) as larger than life, and as models for his relentless pursuit of good times. All live at a distance, but there are annual stereotypically male reunions at his parents' mountain cabin, described by Eric as a convivial (if exhausting) few days of skiing, drinking, telling stories, and "smoking our brains out." Eric's mother is presented as a genteel person, who does not participate in such events, and who, as Eric describes her, does not possess the color or presence of the men in the family.

Once the major systems have been identified, a next step may be to diagram relationships between them. There are no standard formulae for doing this—the following example incorporates suggestions by Hartman (1978, 1994) and Johnson and Yanca (2003), somewhat modified. Different social workers and agencies evolve similar adaptations of the basic idea, in the service of their varying priorities and focuses.

The completed ecomap (Figure 4.8) is a rich stimulus for thinking about Colin and his family. Once the legend becomes familiar, the visual representation of their situation suggests numerous avenues for further exploration. In most cases, it is desirable to include the client(s) in such discussions, since a picture such as Figure 4.8 can be both illuminating and emotionally impactful for the people featured in it.

Ecomaps are snapshots, frozen in time. Thus, they represent a piece of a client's reality at one point—they are necessarily incomplete and only temporarily valid. In fact, they are often redrawn at selected intervals as an aid in identifying and emphasizing changes as they occur.

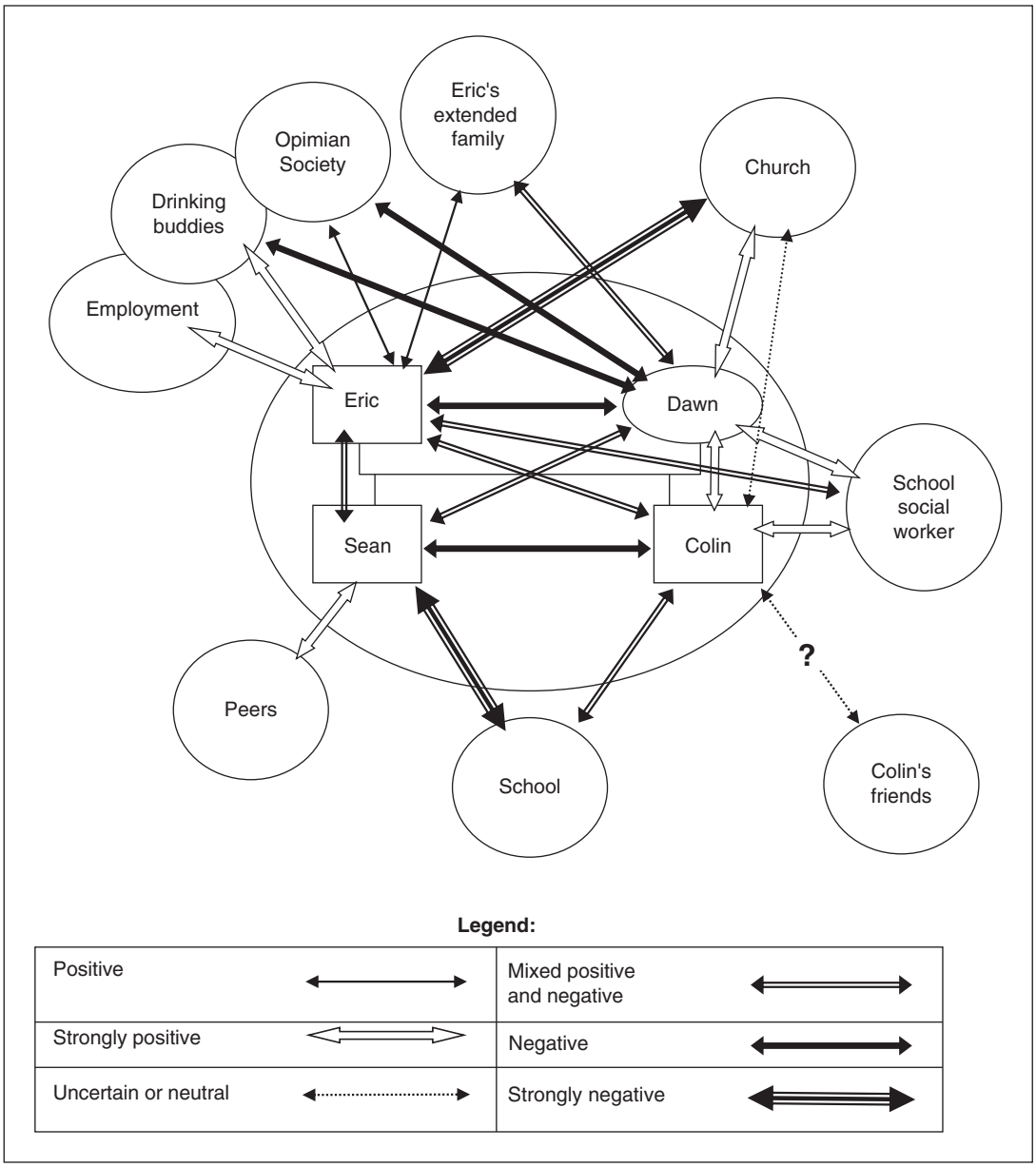

Figure 4.8 Developed ecomap.

At the time when the map in Figure 4.8 was drawn, Colin's isolation was made painfully clear: the only positive relationships he identified were with his mother and school social worker. Relations with his father and brother (and the school) were mixed at best, and although he attended church with his mother he was uncertain about its importance to him as a support. He had been actively avoiding his friends for weeks, and did not know what, if any, relationships still existed (or could be retrieved).

At the same time as the diagram highlights Colin's plight, it identifies opportunities for change—positive relationships that can be used and valued, tenuous relationships that could be strengthened, and resources (e.g., his friends) that have been unavailable to him but with which reconnections could be attempted.

Consider Colin's older brother, Sean. With his relations to his parents mixed, and connection to the school highly acrimonious, the only clearly positive relationship he has is with his friends. This makes these relationships very powerful in his life, and, as his friends are implicated in his substance abuse problems, that aspect of the ecomap is ominous.

Similarly, Eric's inducements to continue abusing alcohol are very powerful. His family is not as comfortable a place for him as one might wish, and his positive relationships to work and his drinking friends (which overlap), along with the Opimian Society and his extended family, all encourage his overuse of alcohol. Like his son Sean, if he were to give up abusing, he would also risk losing very important sources of social support.

The fact that Dawn's only positive extra-familial involvement (aside from the school social worker) is with the church makes it extremely important to her. Eric's very negative relationship to the clergy, therefore, also represents a distancing factor in their marriage for which there is no existing antidote. A striking, more general feature of the ecomap is the extent to which these marital partners are being pulled in different directions. As their own relationship has become hostile, the fact that they have no shared positive relations elsewhere suggests that the marriage will not likely last, unless corrective measures are undertaken.

Interestingly, it was through the drawing of the ecomap that Eric eventually began to contemplate the need for change, recognize how serious his marital difficulties were, and acknowledge (grudgingly) that his alcohol use was a contributing factor—and to see his sons' difficulties with more concern.

A final aspect to think about is the position of the social worker in this picture. The reader who empathically tries to imagine being in her place will immediately sense the difficulty one has maintaining balance when trying to engage helpfully with different people who are at odds with one another. The opportunities to become unhelpfully triangulated in this situation are many, and the worker will need to exercise considerable sensitivity and skill to sidestep such risks.

SUMMARY

In ancient Greek mythology, the goddess Harmonia represented concordance, or the value of things working well together—her name comes from the word *harmos*, which means *joint*, or the place where things are made to fit. Thus, the conviction that the healthy life is one of balance and *goodness of fit* is ancient, and it appears

to have an impressive shelf life. As a contemporary expression of that belief, critical ecological systems theory is rooted in the same basic insight: if people are to flourish, they require relationships that work, fitting them adequately well with the families and societies on which their lives depend.

Social workers are practical people, usually more given to action than philosophy, and it is hoped that the discussion that is about to end has shown how some admittedly abstract, grand ideas have very real practical value. Hopefully, we have also fully recognized that (like any ideas with power) it is possible for this theory to be misused if we are not careful to reflect continuously, asking challenging questions—a critical intelligence will always be an important asset in our profession.

Necessarily, a critical ecological systems perspective will always be a draft, a work in progress. The model's own basic premises require that it be kept open and can never be considered complete. In a world that is infinitely complex and restlessly changing, there can be no final word. For this reason, our work requires a certain humility and cautiousness, and in part that means accepting that whatever models we employ can never do justice to the rich complexity of our clients and their social lives.

There is a competitive narrative that characterizes the helping professions, in which models or schools of helping tend to define themselves *against* the practice wisdom that has gone before, and to market themselves as uniquely effective. One of the virtues of a critical ecosystems perspective is that it does not encourage this; it is, instead, essentially *integrative*. New approaches and techniques, and new professional challenges that come with social and cultural change, prompt us to respond creatively with innovative suggestions about how to help. Not all new approaches will prove equally good, but progress does benefit from our experimental spirit, and the theory featured in this chapter is a useful frame within which to evaluate next month's bright idea: How congruent is it with our core commitments to social justice? How good is it for assisting us in understanding what our clients need so they can flourish once more in areas of their lives that have been going wrong? What are its strengths and deficiencies *vis–à-vis* our commitment to developing arrangements that enhance our clients' competence and opportunities to live lives they find rich and meaningful?

When schools of helping are promoted competitively, clients often pay a price: if we believe one model (*our* model) is the one most worth knowing, we can easily expect that our clients should benefit from it and that there is something wrong with them if they do not—this is a distressingly frequent occurrence. One size does not fit all, and another value in the ecological systems approach is that it discourages us from ever imagining that it should. Indeed, the perspective suggests that many different interventions may well be helpful, and even that, as often as not, *service packages* will make much more sense than a singular intervention, however sophisticated (see Rothery, 1990).

The psychologist Kurt Lewin's famous dictum that there is nothing more practical than good theory is an apt conclusion. Social workers are, we said earlier, practical people, and they strive to respond usefully to a daunting array of complex challenges. The hope is that the critical ecological systems theory as developed for this chapter will help, not by prescribing particular interventions but by encouraging us to keep asking pertinent, useful questions.

NOTES

1. I am grateful to Dr. Anne-Marie McLaughlin, who read an earlier version of this chapter and made suggestions that have significantly improved the final product.
2. Taylor is not a critical realist but is acknowledged by Smith (2010) as someone whose philosophical insights have been fundamentally important to parts of his own thinking.
3. Perhaps a more accurate version would be: "To some extent we can sometimes somewhat influence our shared destinies."
4. See Smith (2010) for a set of 30 "Human Capacities."

REFERENCES

Ackerman, N. W. (1958). *The psychodynamics of family life*. New York, NY: Basic Books.

Ackerman, N. W. (1966). *Treating the troubled family*. New York, NY: Basic Books.

Archer, M. S. (2000). *Being human: The problem of agency.* Cambridge, UK: Cambridge University Press.

Archer, M. S. (2007). *Making our way through the world: Human reflexivity and social mobility*. Cambridge, UK: Cambridge University Press.

Archer, M. S. (2012). *The reflexive imperative in late modernity*. Cambridge, UK: Cambridge University Press.

Barry, B. (2005). *Why social justice matters*. Cambridge, UK: Polity.

Bateson, G. (1972). *Steps to an ecology of mind.* New York, NY: Ballantine.

Bowers, S. (1949). The nature and definition of social casework: Part III. *Social Casework, 30*(10), 412–417.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (2005a). The bioecological theory of human development. In U. Bronfenbrenner (Ed.), *Making human beings human: Bioecological perspectives on human development* (pp. 3–15). Thousand Oaks, CA: Sage.

Bronfenbrenner, U. (2005b). Ecological systems theory. In U. Bronfenbrenner (Ed.), *Making human beings human: Bioecological perspectives on human development* (pp. 106–173). Thousand Oaks, CA: Sage.

Brower, A., & Nurius, P. (1993). *Social cognition and individual change: Current theory and counseling guidelines.* Newbury Park, CA: Sage.

Cameron, G. (1990). The potential of informal social support strategies in child welfare. In M. Rothery & G. Cameron (Eds.), *Child maltreatment: Expanding our concept of helping* (pp. 145–167). Hillsdale, NJ: Lawrence Erlbaum.

Cameron, G., & Rothery, M. (1985). *An exploratory study of the nature and effectiveness of family support measures in child welfare.* Toronto, ON: Ontario Ministry of Community and Social Services.

Cameron, G., & Vanderwoerd, J. (1997). *Protecting children and supporting families: Promising programs and organizational realities.* New York, NY: Aldine de Gruyter.

Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York, NY: Basic Books.

Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology, 55*, 745–774.

Fraser, N. (1996). *Social justice in the age of identity politics: Redistribution, recognition, participation.* Retrieved from http://www.tannerlectures.utah.edu/_documents/a-to-z/f/Fraser98.pdf

Germain, C., & Gitterman, A. (1996). *The life model of social work practice: Advances in theory and practice* (2nd ed.). New York, NY: Columbia University Press.

Gilgun, J. F. (1996a). Human development and adversity in ecological perspective, Part 1: A conceptual framework. *Families in Society, 77*, 395–402.

Gilgun, J. F. (1996b). Human development and adversity in ecological perspective, Part 2: Three patterns. *Families in Society, 77*, 459–476.

Gitterman, A. (1996). Ecological perspective: Response to professor Jerry Wakefield. *Social Service Review, 70*, 472–476.

Gough, I. (2014). Lists and thresholds: Comparing the Doyal–Gough theory of human need with Nussbaum's capabilities approach. In F. Comim & M. Nussbaum (Eds.), *Capabilities, gender, equality: Towards fundamental entitlements* (Kindle ed., pp. 8527–9107). Cambridge, UK: Cambridge University Press.

Hartman, A. (1978). Diagrammatic assessment of family relationships. *Social Casework, 59*, 465–476.

Hartman, A. (1994). Diagrammatic assessment of family relationships. In B. Compton & B. Galaway (Eds.), *Social work processes* (5th ed., pp. 154–165). Pacific Grove, CA: Brooks/Cole.

Hern, G. (1958). *Theory building in social work*. Toronto, ON: University of Toronto Press.

Johnson, L. C., & Yanca, S. J. (2003). *Social work practice: A generalist approach* (8th ed.). Boston, MA: Allyn & Bacon.

Lachiusa, T. A. (1996). Development of the graphic social network measure. *Journal of Social Service Research, 21*(4), 1–35.

Lazarus, R. (1993). Coping theory and research: Past, present and future. *Psychosomatic Medicine, 55*, 234–247.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Lewin, K. (1935). *A dynamic theory of personality*. New York, NY: McGraw-Hill.

Lewin, K. (1951). *Field theory in social science*. New York, NY: Harper & Brothers.

McGrath Morris, P. (2002). The capabilities perspective: A framework for social justice. *Families in Society, 83*, 365–373.

McLaughlin, A. (2006). Liberal interpretations of social justice for social work. *Currents: New scholarship in the human services*. Retrieved from http://fsw.ucalgary.ca/currents.synergiesprairies.ca/currents/index.php/currents

Meyer, C. (1988). The eco-systems perspective. In R. Dorfman (Ed.), *Paradigms of clinical social work* (pp. 275–295). New York, NY: Brunner/Mazel.

Meyer, C. (1995). The eco-systems perspective: Implications for practice. In C. Meyer & M. Mattaini (Eds.), *The foundations of social work practice* (pp. 16–27). Washington, DC: NASW Press.

Miller, D. (1999). *Principles of social justice*. Cambridge, MA: Harvard University Press.

Minuchin, S., Montalvo, B., Guerney, B., Rosman, B., & Schumer, F. (1967). *Families of the slums*. New York, NY: Basic Books.

Nichols, M. P., & Schwartz, R. C. (2004). *Family therapy: Concepts and methods* (6th ed.). New York, NY: Pearson.

Nussbaum, M. (2000). *Women and human development: The capabilities approach*. Cambridge, UK: Cambridge University Press.

Nussbaum, M. (2001). *Upheavals of thought: The intelligence of emotions*. Cambridge, UK: Cambridge University Press.

Nussbaum, M. (2011). *Creating capabilities: The human development approach*. Cambridge, MA: Belknap Harvard University Press.

Rothery, M. (1990). Family therapy with multiproblem families. In M. Rothery & G. Cameron (Eds.), *Child maltreatment: Expanding our concept of helping* (pp. 1–9). Hillsdale, NJ: Lawrence Erlbaum.

Rothery, M. (2001). Ecological systems theory. In P. Lehmann & N. Coady (Eds.), *Theoretical perspectives for direct social work practice: A generalist eclectic approach* (pp. 65–82). New York, NY: Springer.

Rothery, M. (2002). The resources of intervention. In F. J. Turner (Ed.), *Social work practice: A Canadian perspective* (2nd ed., pp. 241–254). Toronto, ON: Prentice Hall.

Rothery, M. (2005). Ecological theory. In F. J. Turner (Ed.), *Encyclopedia of Canadian social work* (pp. 111–112). Waterloo, ON: Wilfrid Laurier University Press.

Rothery, M., & Cameron, G. (1985). *Understanding family support in child welfare: A summary report*. Toronto, ON: Ontario Ministry of Community and Social Services.

Rothery, M., & Enns, G. (2001). *Clinical practice with families: Supporting creativity and competence*. New York, NY: Haworth.

Runco, M. A. (2004). Creativity. *Annual Review of Psychology, 55*, 657–687.

Smith, C. (2010). *What is a person?* Chicago, IL: University of Chicago Press.

Suddendorf, T. (2013). *The gap: The science of what separates us from other animals*. New York, NY: Basic.

Taylor, C. (1985a). *Human agency and language: Philosophical papers 1*. Cambridge, UK: Cambridge University Press.

Taylor, C. (1985b). *Philosophy and the human sciences*. Cambridge, UK: Cambridge University Press.

Taylor, C. (1989). *Sources of the self: The making of the modern identity*. Cambridge, MA: Harvard University Press.

Taylor, E. H. (2003). Practice methods for working with children who have biologically based mental disorders: A bioecological model. *Families in Society, 84*, 39–50.

Taylor, E. H. (2006). The weaknesses of the strengths model: Mental illness as a case in point. *Best Practices in Mental Health, 2*(1), 1–30.

Ungar, M. (2002). A deeper, more social ecological social work practice. *Social Service Review, 76*, 480–499.

von Bertalanffy, L. (1968). *General system theory: Foundations, development, applications*. New York, NY: George Braziller.

Wakefield, J. C. (1996a). Does social work need the eco-systems perspective? Part 1. Is the perspective clinically useful? *Social Service Review, 70,* 2–32.

Wakefield, J. C. (1996b). Does social work need the eco-systems perspective? Part 2. Does the perspective save social work from incoherence? *Social Service Review, 70,* 184–213.

Walsh, F. (Ed.). (2009). *Spiritual resources in family therapy* (2nd ed.). New York, NY: Guilford.

Wood, K. M., & Geismar, L. L. (1989). *Families at risk: Treating the multiproblem family*. New York, NY: Human Sciences Press.

Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Beliefs: The heart of healing in families and illness*. New York, NY: Basic Books.

Young, I. M. (2000). *Inclusion and democracy*. Oxford, UK: Oxford University Press.

SEVEN

Attachment Theory

Debbie Wang and Carol A. Stalker

John Bowlby (1907–1990) is widely recognized as the originator of attachment theory. He was a British child psychiatrist and psychoanalyst who spent much of his career working with and observing troubled children. Unlike his psychoanalytic peers who privileged fantasy over reality, Bowlby paid attention to the real-life experiences of children, particularly the dire effects of separations from and losses of caregivers (Holmes, 1993b). He came to view attachment not only as a primary social need for human connections but also as essential evolutionary survival behavior. A strong influence on Bowlby was the work of social worker James Robertson, who made the 1952 documentary film *A Two-Year-Old Goes to Hospital*, demonstrating the painful effects of separation on children in hospitals. As a result of Bowlby's and Robertson's work, a virtual revolution was observed throughout the world in hospital visiting policies; hospital provision for children's play, educational, and social needs; and the use of residential nurseries. Over time, orphanages were abandoned in favor of foster care or family-style homes in most developed countries (Rutter, 2008). Six decades later, expanding from early attachment to human relationships across the life span, attachment theory has attracted much interest with very important implications for various disciplines, including social work (Bennett & Nelson, 2010; Sable, 2010; Schore & Schore, 2008).

AN OVERVIEW OF THE THEORY

Understanding of Human Problems

Attachment theory holds that many mental health problems derive from failures of caregiving relationships in the early years to optimally meet the child's need for emotional security, comfort, and protection. Interactions with inconsistent, unreliable, insensitive, or abusive attachment figures interfere with the development of a secure and positive internal representation of self and others, reduce resilience in coping with stressful life events, and predispose a person to break down psychologically in

times of crisis (Hartling, 2008). Attachment insecurity is therefore viewed as a general vulnerability to mental health challenges, with particular symptoms depending on genetic, developmental, cultural, and environmental factors.

One of the least recognized aspects of attachment theory is the importance of fear in the development of mental health problems (Slade, 2008). A core concept is that the attachment behavioral system is "hard-wired" in humans as a means of survival. Therefore,

> because a child is biologically programmed to seek care from those to whom he or she is attached, the child's recourse in the face of fear is to do whatever is necessary to maintain the relationship with an attachment figure, even if the attachment figure is the source of fear. (Slade, 2008, p. 775)

In contrast to Freud's psychoanalytic theory, which suggests that maladaptive behavior is rooted in frustration and anger, attachment theory implies that the therapeutic task is to help clients change the ways of thinking and feeling that were once essential to survival. Such an understanding is more likely to lead to a sympathetic and compassionate stance toward clients than one that suggests the need to confront clients about thoughts and feelings about which they feel shame and guilt.

Recent research in neuroscience suggests that many of the basic functions of the human brain may rely on social co-regulation of emotions and physiological states, especially in early childhood (Coan, 2008; Schore & Schore, 2008). These findings support attachment theory because they suggest that, rather than conceptualizing human beings as separate biological entities with brains that develop automatically and in isolation, we should consider social relatedness and its mental correlates as the normal and necessary condition. These empirical findings also help us to see why experiences of separation, isolation, rejection, abuse, and neglect are so psychologically painful, and why dysfunctional relationships are often the causes or amplifiers of mental health problems.

Conception of Therapeutic Intervention

Attachment theory supplies an overarching framework for understanding the need to intervene early in family relationships that seem to be failing to provide a secure base for children; it also provides a conceptualization of therapy with individuals and families as a way to support revision of maladaptive internal working models (view of self and others). Attachment theory has led to research demonstrating that individuals employ different strategies for regulating attachment distress. This knowledge can inform therapeutic interventions, allowing the therapist to identify when clients may be using strategies that contribute to problems in relationships and to mental health issues.

According to attachment theory, the therapist becomes an attachment figure and the therapeutic relationship becomes an opportunity to experience a significant relationship differently and thereby revise internal models of self and others. Therapy can also provide an opportunity to better understand how experiences in previous relationships may be affecting the client's current perceptions of self and others in a way that does not necessarily correspond with reality. The primary goal of attachment-informed therapy is to enhance the client's capacity to establish and

maintain increasingly secure attachment relationships. The research evidence leads to optimism about the utility of clinical interventions that increase clients' sense of attachment security.

HISTORICAL DEVELOPMENT

Although Bowlby was the creative force behind the original formulation of attachment theory, it was Mary Ainsworth who gave this theory its scientific rigor and academic reputation. Although initially rejected by classical psychoanalysis, developmental and social psychologists embraced Bowlby's theory, apparently because of its inclusion of concepts from biology, ethology, and cognitive psychology. Over several decades, numerous researchers have contributed to the empirical support for attachment theory and have extended it beyond a focus on early attachment to adult attachment relationships. At the same time, the rift between attachment theory and psychoanalytic thinking has been closing. This rapprochement has been helped by the evolution of psychoanalytic theories to their contemporary relational and interpersonal focus, the strengthening of empirical research in psychoanalysis, and the increasing recognition of the effects of abusive and other traumatic experiences on psychological development (Holmes, 2010). Modern conceptual frameworks of attachment continue to guide a wide range of research, theory, and clinical innovations.

CENTRAL THEORETICAL CONSTRUCTS

Attachment Relationship Through Affectional Bonds

Attachment develops and takes shape in the context of a relationship, interaction by interaction, over the course of the relationship. "Bond" is used to refer to an emotional or affectional bond. Ainsworth (1989) defined an affectional bond as a "relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other" (p. 711). Further, affectional bonds are characterized by "a need to maintain proximity, distress upon inexplicable separation, pleasure or joy upon reunion, and grief at loss" (p. 711). Attachment is essential not only for infants and children to survive and thrive but also for the caregiver to provide optimal caregiving. In childhood, primary caregivers typically serve as the main attachment figures. Because of the social norms at the time that attachment theory was initially developed, mothers were seen as the most likely primary attachment figure, but more recent research (e.g., Grossmann & Grossmann, 2009) shows that the attachment figure can also be the father, both parents, or nonbiological caregivers. From adolescence onward, we normally transfer our primary attachment from our parents to our peers, and typically, to a romantic partner (Zeifman & Hazan, 2008). Just as attachment remains significant from the cradle to the grave, so does caregiving—not just in parenting but also in providing emotional comfort and security to adults.

Ainsworth (1989) observed that many relationships have affectional bonds. Attachment relationships are distinguished from other affectionate relationships in that they provide comfort and a feeling of security in times of distress. Close

friendships, and other relationships that involve emotional confiding, meet attachment needs to some extent and could be considered as secondary attachment relationships—that is, secondary to primary attachments. In adulthood, attachment theorists refer to romantic relationships as "pair-bonds" or enduring love relationships (Hazan & Shaver, 1987; Zeifman & Hazan, 2008). These relationships involve romantic love as well as sociability and affiliation, that is, companionship and friendship.

Attachment as a Behavioral System

Bowlby proposed that the attachment behavioral system becomes activated in times of threat or danger (e.g., when one is frightened, injured, distressed, fatigued, or ill), prompting a person to seek an attachment figure for support, comfort, or protection through proximity-seeking behavior. Attachment behaviors in infants and young children include clinging to caregivers when frightened, protesting caregivers' departure, and following and greeting caregivers after an absence. Thus, any behaviors that increase the probability of caregivers' proximity and availability are deemed attachment behaviors. When children's attachment behaviors are adequately responded to, their attachment system becomes far less active as they move freely away from caregivers and explore the environment. The attachment behavior system operates in balance and interdependently with the exploratory behavioral system (Bowlby, 1988; Grossmann, Grossmann, Kindler, & Zimmermann, 2008).

In adulthood, the adaptive value of attachment goes far beyond physical protection to provide emotional well-being and developmental competence. This brings together all the core aspects of attachment: proximity (comfort that comes from the close physical or psychological presence of the attachment figure), a safe haven (to seek help and support when one is distressed), and a secure base (support in pursuing personal goals), in relation to the partner as a primary attachment figure (Ainsworth, 1989; Mikulincer & Shaver, 2009). When adult attachment behavior is adequately responded to, the individual's subjective experience is one of felt security: He or she experiences a sense of worth, a belief in the helpfulness of others, and is able to explore the environment with confidence.

Patterns of Attachment and Inner Working Models

Bowlby (1969/1982) emphasized that caregiver behavior and response determines the development of predictable patterns of attachment in the child. The earliest observable patterns are behavioral, and are the first manifestations of what will become representations or internal working models of attachment, which will guide the individual's feelings, thoughts, and expectations in later relationships (Bretherton & Munholland, 2008). Bowlby postulated that these inner working models include both cognitive and affective aspects and are largely unconscious.

Internal working models determine attachment orientations—patterns of expectations, needs, and emotions one exhibits in interpersonal relationships that extend beyond the early attachment figures. These working models have two sides, namely, models of self as worthy of care (or not) and models of others as being emotionally dependable (or not). Inner working models tend toward stability and go on to influence: (a) personality development, (b) social interaction tendencies,

(c) expectations of the world and of other people, and (d) strategies for regulating emotions (Mikulincer & Shaver, 2009; Sroufe, 2005).

Bretherton and Munholland (2008) make a crucial distinction between implicit and explicit models. We employ our implicit models habitually and nonconsciously, that is, without awareness that they are shaping our experience. These implicit models are based on memories that guide our behavior, and these memories become automatic procedures for interacting (like riding a bicycle or driving a car). What we may be most aware of, however, relates to emotion. We naturally resonate emotionally to each other without having to think about it (Jacobvitz, 2008).

By comparison, explicit working models are conscious and therefore can be thought about and talked about. Ideally, this process of explication begins early in life when "parents perform a positive role in helping a child construct and revise working models through emotionally open dialogue" (Bretherton & Munholland, 2008, p. 107). Such clarification through narratives is essential for updating out-of-date working models of self and others, as clients experience in therapeutic contexts such as psychotherapy.

Bowlby called these internalized memories of attachment "working models" because they are dynamic and capable of change. Therefore, although working models may remain stable, adult outcomes are not predetermined in childhood. With access to coherent, organized information about their own attachment, adults who have experienced rejection, neglect, or trauma are able to experience security in adulthood and facilitate secure attachment in their children.

Attachment Patterns in Childhood

Four decades of empirical research have yielded both measures and classification systems for these patterns of attachment. Mary Ainsworth developed the Strange Situation Procedure (SSP; Ainsworth, Blehar, Waters, & Wall, 1978), which was designed originally to assess the effect of maternal absence on 12-month-old infant exploration. The focus of attention later shifted to the infant's reunion behaviors following brief separations from the caregiver, as these behaviors seemed to best reflect the quality of the relationship. Employing a close study of videotapes of the child's behavior in the Strange Situation, Ainsworth and her colleagues identified three patterns of attachment: secure, insecure–avoidant, and insecure–ambivalent. In further research, Mary Main and her colleagues identified a fourth pattern and classification group called disorganized (Main & Solomon, 1990). See the left-hand column of Table 7.1 for behavioral descriptions of child attachment categories.

A longitudinal study showed that children classified as secure in the Strange Situation were found several years later to be more socially competent, more empathic, and happier than children rated in one of the insecure categories. Similarly, children having avoidant and ambivalent histories have been shown to exhibit more dependent behaviors (Sroufe 2005; Sroufe, Egeland, Carlson, & Collins, 2009). Similar findings with respect to the capacity for emotion regulation are discussed later. It is important to note that the "organized" patterns of avoidant and ambivalent insecure attachment are not viewed as problematic in themselves, but as a significant indicator of early development that is a risk factor for later problems. On the other hand, classifications of early attachment disorganization are considered a strong predictor of later disturbance.

TABLE 7.1 Corresponding Child and Adult Attachment Categories

Child Attachment Category	Adult Attachment Category
Secure: ■ Has caregiver who is consistently available, meets needs of infant, and has pleasurable interaction with infant/child ■ Child trusts caregiver, turns to caregiver for comfort and safety ■ Child perceives self as lovable and has positive expectations of others	**Secure/Autonomous:** ■ In AAI, describes coherent, believable narrative about childhood experiences ■ Values relationships, turns to intimate others for comfort and security ■ Is self-reflective and accepts that others have different perceptions ■ Adaptable, open, and self-regulated ■ Positive and realistic view of self
Avoidant: ■ Has caregiver who is unavailable or indifferent, perhaps hostile at times ■ Learns to deny needs/feelings and avoid close relationships ■ Appears independent ■ Believes that he/she has to take care of himself/herself ■ Often compliant and displays positive affect with caregiver	**Dismissing:** ■ In AAI, describes early history of rejection or neglect, but denies importance of this on his/her development ■ Needs to be independent and self-sufficient ■ Prefers not to depend on others ■ Avoids feelings of closeness and focuses on activities ■ Suppresses feelings ■ Distances himself/herself from others who may reject him/her ■ Views self as superior
Ambivalent: ■ Has caregiver who is inconsistently available ■ Does not trust caregiver to be consistently available to offer comfort and security ■ Longs for closeness ■ Clingy, or impulsively angry ■ May exaggerate need to elicit caregiver's attention ■ Difficulty separating from caregiver to develop autonomy	**Preoccupied:** ■ In AAI, describes confusing childhood experiences with caregivers who were unpredictably available and unavailable ■ Tends to depend heavily on others ■ Seeks approval from others and fears being devalued ■ Exhibits high levels of emotional intensity ■ Impulsive reactions ■ Views self as unworthy ■ Views others as superior
Disorganized: ■ Has caregiver who is abusive, severely neglecting, or experiencing unresolved loss or trauma ■ Hypervigilant ■ Conflicted by drive to flee to caregiver for safety and flee from caregiver as source of fear ■ Responds with fight, flight, or freeze ■ Does not have organized strategy for attachment	**Unresolved/Disorganized:** ■ In AAI, describes confused and incoherent family history ■ Has not resolved early trauma or loss ■ Perceives relationships as dangerous ■ Easily triggered in relationships ■ May dissociate ■ Views self as victim or becomes the aggressor to avoid this feeling

AAI, Adult Attachment Interview.

Attachment Patterns in Adults

Empirical studies exploring attachment between adults have been conducted by two groups of researchers. In one line of research, Mary Main and colleagues, who are developmental and clinical psychologists, created the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) to operationalize Ainsworth's patterns in terms of adult attachment categories—secure/autonomous, dismissing, preoccupied, and unresolved/disorganized. While the Strange Situation focuses on

attachment behaviors, the AAI focuses on how attachment processes are revealed through language and speech patterns. It is believed to tap into unconscious cognitive and emotional processes. The interviewer asks the adult to describe childhood relationships with his or her parents, and to provide specific biographical episodes that support more general descriptions. The individual is asked about experiences of rejection; being upset, ill, and hurt; and experiences of loss, abuse, and separation; and then, to reflect on the effects of early experiences on his or her development. The authors describe the interview protocol as "surprising the unconscious" as it quickly taps into sensitive issues. Attachment categories are determined through an assessment of how organized the speaker's state of mind is regarding past attachment relationships and how coherent the speaker's narrative is when discussing this attachment history. The AAI focuses on intergenerational and longitudinal patterns that translate into categories of attachment, and it requires specialized training to code reliably. The right-hand column of Table 7.1 gives a general description of the adult attachment categories assessed by the AAI.

In a second line of research, social psychologists emphasize the dimensional or continuous nature of adult attachments in terms of attachment styles. This second group of researchers observed that Ainsworth's original patterns of child attachment behavior fell along a two-dimensional continuum of attachment avoidance (high or low) and attachment anxiety (high or low; Mikulincer & Shaver, 2007). Hazan and Shaver (1987) used these two dimensions to create the first self-report measure of adult romantic attachment styles. Adults completing this measure were classified as having either an anxious attachment style or an avoidant attachment style when they scored highly on questions related to the corresponding two dimensions. When they scored neither in the high range nor in the low range on either dimension, they were classified as having a secure attachment style. Similar to the AAI, an anxious attachment style is characterized by an expectation of separation, abandonment, or insufficient love; a preoccupation with the availability and responsiveness of others; and hyperactivation of attachment behavior. An avoidant attachment style is characterized by devaluation of the importance of close relationships, avoidance of intimacy and dependence, self-reliance, and relative deactivation of attachment behavior. Later researchers added a fourth category that they labeled "fearful attachment," thereby creating a four-box grid with high and low avoidance representing one continuum and high and low anxiety representing the other (Bartholomew & Horowitz, 1991). Self-report measures of adult attachment focus on views that individuals consciously hold about themselves and others in close relationships. These measures are relatively easy to administer and score compared to the AAI.

Different methods of assessing adult attachment emphasize different attachment phenomena. Whether it is dimensional versus categorical ways of thinking about attachment or self-report versus narrative lines of research, Mikulincer and Shaver (2007) stated, "the two lines both derive from Bowlby's and Ainsworth's writings, and both deal with secure and insecure strategies of emotion regulation and behavior in close relationships" (p. 107).

Intergenerational Transmission of Attachment

Attachment theory has been supported by empirical research, showing that parents' attachment organizations tend to correspond to their children's attachment organizations and an infant's attachment organization tends to remain stable into

young adulthood. Remarkable research has shown that a parent's state of mind with respect to attachment as revealed in the AAI, even when administered prior to the birth of the infant, predicts the infant's pattern of attachment behavior at 12 months (Main, Hesse, & Kaplan, 2005). This finding holds for fathers (Steele, Steele, & Fonagy, 1996) as well as mothers. See Table 7.1 for a comparison of child attachment categories and AAI categories of the caregivers.

Research also suggests that adult romantic relationship styles are reflections of the attachment bond adults had with their caregivers in childhood. In longitudinal research, compared with 2-year-olds who were insecurely attached, 2-year-olds who showed secure attachment to their mothers were better able, at age 20 or 21 years, to resolve and rebound from romantic relationship conflicts. In addition, the partners of securely attached 20-year-olds rebounded faster from relationship conflict regardless of their own attachment history (Simpson, Collins, & Salvatore, 2011).

How do we get from parental state of mind with respect to attachment to infant attachment behavior? According to Allen (2013), for each attachment pattern,

> (1) parents' current states of mind with respect to their attachment history relate to (2) the way parents interact with their infants which, in turn, relate to (3) the patterns of security their infants display toward them and then to (4) adjustment in childhood, adolescence, and adulthood, which includes adult attachment patterns and caregiving behavior. (p. 109)

Understanding this intergenerational process points the way toward intervention; the possibility of interrupting this intergenerational transmission process is one of the most inspired endeavors in attachment research.

Mentalization: Reflective Functioning and Affect Regulation

Sensitive responsiveness—to an infant, a partner, or oneself—requires attunement to mental states in self and others. Fonagy and his colleagues, over the last two decades, have had an enormous impact on attachment theory and clinical practice with the introduction of the construct of mentalization (Allen, 2013; Fonagy, Gergely, Jurist, & Target, 2002). This term refers to the ability to reflect upon, and to understand one's own state of mind; to have insight into what one is feeling, and why. It also involves being able to imagine and consider another's state of mind when observing the other's behavior. Fonagy and colleagues use the phrase "holding mind in mind." Allen (2013) refers to mentalizing as a form of emotional knowing. In the emerging field of interpersonal neurobiology, Siegel (2010) has coined the term *mindsight* to help explain mentalization and link science with practical applications to cultivate mindsight skills and well-being.

Mentalization is considered a precondition of effective social skills, self-soothing, empathy, and other facets of emotional intelligence and social–emotional maturity. This skill of mentalization is thought to develop through a caregiver's empathic and insightful response to a child's distress and other emotions. This means mentalization is learned through a secure attachment to the caregiver. Insecure attachments limit the development of this important skill.

Reflective functioning is the term used in research to operationalize the capacity to mentalize. Metacognitive monitoring, with a meaning similar to reflective functioning, is considered central to coherent AAI narratives (Jacobvitz, 2008).

Parental reflective functioning (Slade, 2005) is distinctive from more general mentalizing processes. It is the caregivers' abilities to hold in their own minds a representation of their child's mind. When a caregiver is able to reflect on both her own and her child's mental states, whether positive or negative, and to appropriately reflect back the reality of the child's internal experience, the child develops a representation of his or her inner self, which is internalized over time. The child learns through this process of attunement or mirroring to be aware of what he or she is feeling and how to manage those affects. This is the beginning of self-organization and self-understanding as well as an understanding that others have internal experiences (Slade, 2005). Two conditions are essential to the reflecting or mirroring process. The mirroring must be "contingent." In other words, facial expressions, sounds, or behavior must be responded to within an optimally brief window of time so that the baby learns that the response came as a result of his or her effort. This enables the child to develop a sense of agency or of being able to influence others (Fonagy et al., 2002). Mirroring must also be contingent in terms of emotional tone. For example, if the caregiver's response to a baby's signal of distress is consistently one of depressed apathy, the child may develop a sense of helplessness and may come to depend only on the self for coping with emotional regulation (Tronick, 2009).

The capacity to mentalize is also necessary for affect regulation (Fonagy, Gergely, & Target, 2008). Through secure attachments, children learn to self-soothe and self-regulate their emotions because their caregiver has modeled these comforting responses to them in a manner that is neither too distant from, nor too close to, their experiences. In contrast, insecure attachment inhibits mentalization because the child must be concerned about the mind of the parent, who may be mirroring mental states that either are not in tune with what the child is experiencing or are frightening.

Attachment With the Brain in Mind

Allan Schore (2001) is one of the authors who has been exploring the convergence of attachment theory and neuroscience and the implications for psychotherapeutic treatment; he refers to this neuroscientific development as "the modern attachment/regulation theory." One of his most significant contributions has been the exploration of right brain-to-right brain communication between caregiver and child and between therapist and client, and its significance in attachment outcomes (Brown & Sorter, 2010). The right brain is responsible for the more intuitive, implicit, nonlinear forms of communication. According to Schore (2001), the caregiver's right brain is largely responsible for the "comforting functions" of the caregiver, while the infant's right brain is geared toward attachment. He emphasizes that the growth of the right brain continues throughout the life span but that its maturation is experience-dependent.

Although some writers (e.g., Rutter, 2008) argue that claims regarding the effects of experience on the brain are speculative, Schore's research suggests that attachment-based, emotion-focused therapies that have been shown to be most effective may be altering clients' brains at neurological levels as well as healing attachment traumas. For example, Diana Fosha's (2003) accelerated experiential dynamic psychotherapy (AEDP) for individuals, Sue Johnson's (2008) emotionally focused therapy (EFT) for couples, and Dan Hughes's (2009) dyadic developmental psychotherapy (DDP) for children and families focus on attuning to nonverbal

right brain signals of facial expressions, body language, tone of voice, and eye contact. They emphasize the relationships (therapist and client, client-client in couples and families) right here, right now, in this room, in this moment. These therapies explore engagement–disengagement, closeness–distance, intimacy, and individuation, and attempt to create a new experience of relationship, leading to new internal working models and a new experience of self in relationships.

Neurobiological research also suggests that early stress and trauma in attachment relationships have enduring effects on stress reactivity and affect regulation (Allen, 2013). Such traumas, including abuse and neglect, greatly compromise the capacity to regulate one's emotional state in times of stress; the neurochemical switch tends to shut down reflective thinking (mentalizing) in favor of reflexive action—fighting, fleeting, or freezing (Mayes, 2000).

Coan's (2008) review of research regarding the neural systems supporting emotion, motivation, emotion regulation, and social behavior demonstrates that collaboration between neuroscientists and attachment researchers is leading to an "attachment neuroscience" that has much potential for future knowledge. An example is a study by Coan, Schaefer, and Davidson (2006) that provided evidence that the attachment system functions to regulate emotion in the face of threat. In a clever experiment with married couples, these researchers fastened electrodes to the ankles of the women in the couples, and exposed them to electric shocks on selected trials; anticipating shock presumably activated their attachment needs. At different points, as patterns of brain activity were assessed, the women were permitted to hold their husband's hand, an anonymous experimenter's hand, or no one's hand. Holding hands decreased activation in brain areas associated with threat responding and emotion regulation. Moreover, holding the spouse's hand was especially powerful in this regard, as measured not only by brain activity but also subjective emotional distress. Furthermore, based on prior assessments of marital satisfaction, high-quality marriages were associated with lowered activation of threat-responsive brain areas. The authors interpreted their findings as showing that holding one's spouse's hand decreases the need for vigilance and self-regulation of emotion, although this beneficial effect may not be true of insecure relationships.

Both attachment and neuroscience research are offering us new lenses with which to view our clients and our interactions with them. Understanding the possible connections between attachment theory and brain research will deepen the biopsychosocial–cultural perspective of clinical social work (Schore & Schore, 2010) and equip us with more effective relational and therapeutic skills for child and family-centered practice.

PHASES OF HELPING

It is important to recognize that a single school of psychotherapy based on attachment theory has not been universally recognized. As Slade (2008) stated, "Attachment theory does not dictate a particular form of treatment; rather, understanding the nature and dynamics of attachment and mentalization informs rather than defines intervention and clinical thinking" (p. 763).

Holmes (2001) argues that attachment theory provides a theoretical base for "the story-telling, story-listening and story-understanding that form the heart of

psychotherapy sessions" (p. 16). Attachment theorists (e.g., Allen, 2013; Holmes, 2010) also point out that the empirical support for the association of secure attachment and reflective function is an endorsement of psychotherapy, because increasing reflective function or capacity to mentalize is one of the main functions of psychotherapy.

Engagement

The task for therapists in the engagement phase is to establish themselves as a secure base from which clients can explore painful aspects of their lives and find new ways of understanding themselves and others. If therapists are not able to provide clients with some sense of security, therapy cannot even begin (Bowlby, 1988). To depend on others is seen as part of the human condition—not an immature or dysfunctional response to be ameliorated (Bowlby, 1979). The focus in therapy is on the person rather than the problem; and the therapist is concerned with the process rather than the content (Holmes, 2010). The therapist responds to the client's pain and helps the client bear that pain. In cases of extreme trauma or lack of any kind of secure attachment, experiencing the therapist as an attachment figure gives the client a glimpse of another world where others are responsive and accessible, and where safe engagement with inner experience and with others is possible.

In therapy informed by attachment theory, how clients are seen is inherently nonpathologizing. Strategies or ways of dealing with emotions that land people in trouble are seen as having originated as defensive maneuvers to maintain connections with loved ones or ward off a sense of the self as unlovable and helpless. For example, the fearful clinging and hostile defensiveness of many clients labeled as having borderline personality disorder is easier to connect with if it is seen as fearful–avoidant disorganized attachment based on experiences in which key others have been both a source of safety and a source of violation. Such a client has experienced being left in an impossible, paradoxical position and is still caught in the mode of "Come here, I need you—but go away, I can't trust you."

Allen (2013) makes the important point that professional helping is limited in the degree to which it can meet attachment needs because of the professional boundaries that are essential to effective helping. These boundaries require that sessions are scheduled in the therapist's office and involve limited therapist self-disclosure. The provision of a safe haven in therapy must rely on psychological attunement and does not usually involve physical comforting.

Assessment and Intervention

In attachment-informed treatment, assessment and intervention are not easily separated. Initial sessions are normally used to gather information about the presenting problem and the client's history, but assessment is ongoing and continually informs the therapist's interventions. Assessment tools based on attachment research have been developed. Steele and Steele (2008) proposed 10 clinical uses of the AAI, suggesting how clinicians familiar with the interview questions and attachment categories may incorporate this information into their work with clients. Such knowledge can help clinicians become attuned to the client's relational style, history of traumatic experiences and losses, and ways of defending against emotional wounds. Clinicians not certified as AAI coders may still find that the questions enrich their

work, particularly in the initial stages of therapy. This information, in combination with knowledge of attachment patterns, will guide therapists' formulations of clients' experiences and their intervention strategies.

Clients who display avoidant/dismissing forms of attachment (see Table 7.1) are seen to have rigid, inflexible stories that function to restrict emotional expression because experience has taught them such expression leads to rejection. These stories lack coherence in that events that are expected to evoke pain are minimized, or relationships are described as "good" or "fine" when the evidence is not convincing. Attachment research suggests that for dismissing clients "the goal of treatment will be to tolerate and express emotional experiences that have been denied access to consciousness" (Slade, 2008, p. 774).

Clients with ambivalent/preoccupied attachment organization seem overwhelmed by intense feelings, their discourse tends to be rambling and unstructured, and they may have difficulty coming to the point. These clients "will require more 'containing' responses from the therapist and have a greater need for organization and structure" (Slade, 2008, p. 774) as they work to revise their ways of thinking about themselves and others.

Clients who are disorganized/unresolved with respect to loss or trauma can be particularly challenging. This classification is much more highly represented in clinical samples than in nonclinical samples. Holmes (2001) stresses the importance of timing and sequencing with these clients, and the importance of first establishing a secure base and strong alliance before any form of interpretation, challenge, or confrontation.

Understanding the early nonverbal processes that are involved in developing the capacity to mentalize is valuable for understanding the interactive patterns constructed in the therapy dyad. This understanding is especially useful with "difficult-to-serve" clients who may have deficits in mentalizing and verbalizing their feelings (Fewell, 2010). According to Schore and Schore (2008), when the early development of an individual's right brain was compromised because of caregiver misattunement, abuse, or neglect, significant change is still possible in psychotherapy as the therapist's right brain engages the client's right brain in a spontaneous, implicit, and explicit meeting of minds. Ultimately, effective psychotherapeutic treatment may be able to facilitate changes in the right brain, which future research may find to be associated with alterations of the internal working model and more effective coping strategies for affect regulation. While still a hypothesis, it may be that this form of communication contributes to treatment that transforms "insecure" into "earned secure" attachments (Schore & Schore, 2008, p. 69).

Monitoring of the self-of-the-therapist is considered critical because the client's painful narrative and behavior can evoke emotional responses in therapists similar to those experienced by clients. Therapists need to have astute reflective functioning skills because this capacity to reflect on one's own and others' mental states allows the therapist to more accurately appreciate the client's dilemma and communicate with the client more empathically. For clients, it is the need for empathy—the need to be seen, understood, and reflected—that drives the intersubjective work of psychotherapy. It is not defined by what the therapist says to the client, or does for the client; rather, the key mechanism is how to "be with" the client, especially during affective stressful moments (Schore & Schore, 2010).

Termination

It is well known clinically that separations from the therapist, even temporary ones, can be painful and lead to protest or despair. Rosenzweig, Farber, and Geller (1996) observed these responses independently of whether the clients were secure or anxious/ambivalent in their attachment patterns. It appears that clients with loss as a predominant theme may experience termination both as a crisis and, when given appropriate clinical attention, an opportunity for development. In other words, therapists can support these clients in more fully experiencing and processing their reactions to ending so that these clients have a corrective termination experience.

Holmes (2010) points out a number of clinical implications for termination from an attachment-informed perspective. For example, therapists must keep in mind the client's attachment style of coping. Deactivating clients may well appear to take an ending in their stride, apparently seeing it as inevitable and presenting themselves as eager to move onto the challenges of "real life" now that their symptoms have diminished. Regret, doubt, anger, and disappointment may be noticeable by their failure to be acknowledged. Expressions of gratitude can be superficial and conventional. The therapist should direct the client's attention to these possibilities as manifest in missed appointments, seeking other forms of treatment, or in overexcitement. Premature ending can be a frequent occurrence with such clients. It is always worth pushing for at least one final goodbye session, in which disappointments and resentments can be aired, rather than simply letting an avoidant client slip away.

A common phenomenon of clinical work holds that as the end of therapy approaches, the client's symptoms, even if diminished during the course of therapy, may reappear. This is particularly likely for hyperactivating clients who may overestimate the negative impact of ending. The therapist may be tempted by this response into premature offers of further therapy or suggestions of an alternative therapist or therapy modality (such as a group).

The client's social context should also be taken into consideration early in the process when deciding whether to offer or recommend time-limited therapy or longer-term treatment. Therapy informed by attachment theory can be used in a time-limited way; however, short-term intervention is much more likely to succeed when the client has a good social and emotional network to which he or she can "return" once therapy is over. For more disturbed clients who require longer-term therapy, if treatment has not strengthened the client's capacity to generate outside attachment relationships, post-therapy relapse is likely to occur.

The experiences of the therapist during the termination phase should also be processed. A study (Ledwith, 2011) explored the links between the attachment orientations of clinical social workers and their subjective approaches to termination. Findings suggested those with secure attachment were more likely to engage in the process of termination, whereas those with less secure attachment orientation were more likely to avoid the termination process. Attachment-informed therapy suggests that increased attention to termination and to client and therapist attachment in this phase of the work will strengthen the overall psychotherapy and minimize the unfavorable effects of termination on clients and on therapists.

APPLICATION TO FAMILY AND GROUP WORK

Family Work

Attachment theory is an important lens through which the relational context of family life can be examined. Research on attachment relationships in families emphasizes that the quality of affectional ties, whether secure or insecure, within the family is a more important mediator of developmental well-being than the particular structure of the family context (Shapiro, 2010). This is particularly relevant to social work practitioners who seek to bring a strengths perspective to work with nontraditional families or parents and children in a broad range of social contexts and situations.

When children have experienced traumatic early beginnings with primary attachment relationships, multiple areas of developmental vulnerability may exist. Practitioners can offer support to parents as they work to understand the impact of the child's attachment history and to create more stable bonds of attachment within the family context. The following are some clinical applications by attachment theorists and clinicians that are aimed at working with families with infants or children who have developed or are at risk of developing less desirable, insecure attachment styles or an attachment disorder: Infant/Child–Parent Psychotherapy (Lieberman & van Horn, 2008), Dyadic Developmental Psychotherapy (also called Attachment-Focused Family Therapy; Hughes, 2009), Watch, Wait, and Wonder (Cohen, Lojkasek, & Muir, 2006), and Modified Interaction Guidance (Benoit et al., 2001).

Attachment-based family therapy (ABFT; Diamond, Diamond, & Levy, 2013) is an empirically informed family therapy model based on the belief that strong relationships within families can buffer against the risk of adolescent depression or suicide and help in the recovery process. ABFT therapists are taught to rapidly focus on core family conflicts, relational failure, vulnerable emotions, and the instinctual desire for giving and receiving attachment security. ABFT has also been adapted for use with suicidal LGBTQ adolescents (Diamond et al., 2013).

EFT for couples, a short-term empirically validated intervention, views close relationships from the perspective of attachment theory and integrates systemic and experiential interventions (Johnson & Best, 2003). Research studies find that following EFT, 70% to 75% of couples move from distress to recovery and approximately 90% show significant improvements (Johnson, 2008). The major contraindication for EFT is ongoing violence in the relationship. EFT is being used with various types of couples in private practice and with different cultural groups throughout the world. These distressed couples include partners suffering from disorders such as depression, posttraumatic stress disorders, and chronic illness (Johnson & Wittenborn, 2012).

Group Work

Applications of attachment theory to group interventions have become a vibrant area for research and practice in recent years. Group interventions addressing important social relationships and contexts of human problems can provide a uniquely potent corrective experience because they involve the protective function of a community of peers functioning as a safe haven and secure base. Page (2010) conducted an extensive review of group interventions that are explicitly based on attachment theory. He divided his findings into the categories of group processes, psychiatric

symptom relief, intimate relationship in sexual pair-bonds, and parenting. Of these categories, the literature on parenting is the largest, reflecting the strong interest in improving attachment security in children through interventions aimed at strengthening parenting capacities.

The Circle of Security (COS) program (Powell, Cooper, Hoffman, & Marvin, 2013) is a 20- to 26-week manualized group intervention for parents based on attachment theory. Treatment plans are developed through videotaping of parent–child interactions and utilizing the Preschool Strange Situation Procedure for assessment. Excerpts from the videotaping, viewed in group sessions, constitute the basis of the intervention and it is the major evaluation outcome variable. Studies have shown that following the intervention, attachment classifications of children and caregivers tend to improve in the direction of security and organization.

Mentalization-based therapy (MBT; Fonagy, Bateman, & Luyten, 2012) is a specific type of psychodynamically oriented group therapy designed to help people with borderline personality disorder. MBT is offered to clients twice a week with sessions alternating between group therapy and individual treatment. During sessions, the therapist activates the attachment system through a range of techniques that include the elaboration of current and past attachment relationships, as well as encouragement and regulation of the client's attachment bond with the therapist, and attempts to create attachment bonds between members of the therapy group. The lasting efficacy of MBT was demonstrated in an 8-year follow-up of MBT versus treatment as usual (Fonagy, Bateman, & Luyten, 2012).

Flores (2004) argues that attachment theory provides a theoretical foundation for understanding why individuals with substance abuse disorders often respond well to group treatment. He conceptualizes addiction as a kind of attachment disorder and that individuals use substances as a substitute for satisfying relationships with others. The highs provided by the substance come to compensate for the pain associated with unmet attachment needs. Flores explains that an ongoing therapy group provided at the optimal time in the treatment of addiction can help the client create the capacity for reciprocal attachment and mutually satisfying relationships, which the individual must achieve in order to give up the substances that have become his or her "secure base." The group must become an "attachment object" so that participating in the group provides a new, more positive experience of relationships with others, thereby modifying internal working models and helping the client to develop healthier forms of affect regulation. He argues that group treatment is more effective than individual treatment because the group dilutes the intensity of the shame as well as the fear of becoming too dependent or being controlled that often floods the client with addiction issues in a one-to-one setting. Here again, the response of the group leader is critical to the development of a group that can serve the secure base function. Furthermore, a therapist who can reflect on his or her own affect and manage the client's "hostility or anger without retaliation or fear is likely to have greater treatment success" (Flores, 2004, p. 286).

COMPATIBILITY WITH THE GENERALIST-ECLECTIC APPROACH

The reader will recognize that attachment theory is very compatible with the generalist-eclectic framework for direct social work practice. It shares with the generalist-eclectic framework a strong emphasis on the development and

maintenance of the worker–client relationship. Bowlby (1988) explicitly stated that the therapeutic stance he advocated was "You know, you tell me" rather than "I know, I'll tell you" (p. 151). This defines his approach as collaborative rather than expert-oriented. Holmes (2001) stresses the need for the therapist to allow the client to lead, noting that responsiveness is essential to providing a secure base.

Attachment theory is also compatible with a systemic perspective and a holistic, multilevel assessment. It was Bowlby's criticism of previous theories' rigidity, and lack of attention to environmental factors, that spurred the development of the theory. Sable (1995, 2008) has been a strong advocate of the usefulness of attachment theory in social work practice and its compatibility with the *biopsychosocial* perspective of systems thinking. Similarly, Egeland (1998), whose longitudinal studies of high-risk families have supported the tenets of attachment theory, argued for the use of a comprehensive ecological model that recognizes that poverty and other social stressors have a significant impact on parents' ability to provide a secure base for their children. Following this line of thinking, Holmes (2004) has argued that borderline personality disorder (BPD) is best viewed as a social/psychological construct related to failures of society to care for its members:

> Social configurations such as endemic racism create fear in victimized minorities, and that fear transmits itself via attachment relationships to oppressed people's children. Similarly, the salience of absent or abusive fathers in the life-histories of people diagnosed as suffering from BPD cannot, and should not, be seen merely at the level of individual psychology. The social seedbed for these negative male roles—colonialism and consequent immigration, educational disadvantage, the move from manufacturing to a service economy—needs also to be acknowledged, and ultimately, worked with in increasing reflexive function of BPD sufferers not just in their own psychology, but consciousness of choices and dilemmas faced by their progenitors in previous generations. (p. 184)

With regard to eclecticism, many clinicians have recognized that attachment theory can be integrated with concepts from other models of therapy. McMillen (1992) noted that attachment theory "can easily be integrated into several approaches to clinical (social work) practice" (p. 211), and he identified these as psychosocial therapy, self-psychology, cognitive therapy, and family therapy. Many writers (Holmes, 1993a; McMillen, 1992; Rutter, 1995) have commented on the compatibility of attachment theory with cognitive-behavioral techniques in view of the similarities in the concepts of internal working models, basic assumptions, and cognitive schemata. Other authors have pointed out how cognitive behavioral interventions promote mentalizing (Bjorgvinsson & Hart, 2006) and how dialectical behavioral therapy can increase mentalizing (Lewis, 2006).

Attachment and narrative theories can also be productively integrated (Fish, 1996; Holmes, 1993b). Holmes (1993b) conceptualized psychotherapy as a process where the therapist and client work together on a "tentative and disjointed" story brought by the client until a more "coherent and satisfying narrative emerges" (p. 158). He explained, "Out of narrative comes meaning—the 'broken line' of

insecure attachment is replaced by a sense of continuity, an inner story which enables new experience to be explored, with the confidence that it can be coped with and assimilated" (Holmes, 1993b, p. 158).

CRITIQUE

Strengths

The greatest strength of attachment theory is the strong empirical support for its tenets (Cassidy & Shaver, 2008; Shilkret & Shilkret, 2011). The idea that the ability to be an adequate parent and the ability to relate to others in satisfying ways are transmitted from one generation to another through experiences beginning in early life is no longer just a hypothesis; it has reached the status of a well-supported proposition. Furthermore, we have clearer understandings of the mechanisms for this transmission, and therefore more specific ideas about how to intervene with high-risk families.

A second strength is that attachment theory has made clearer the relationship between certain kinds of early experiences with caregivers and attachment strategies commonly seen in adult clients. This knowledge can also help our ability to understand and respond empathically to difficult clients whose behaviors are often confusing, upsetting, and distancing.

A third strength is the accessibility of attachment theory. "Ideas are expressed simply and directly, in everyday language and without traditional jargon" (Sable, 1995, p. 34). Attachment theory retains many of the strengths of other relational theories (e.g., viewing relationship as the crucial factor and recognizing the power of the unconscious and internalized ideas) without the difficult terminology. Such accessibility in language reflects the "experience-near" quality of the concepts of attachment theory, which likely contributes to workers' comfort with the theory and their ability to be responsive to the client (Sable, 1992). Other strengths of this theory referred to earlier include a focus on strengths versus pathology, an acknowledgment of the influence of environmental factors, and recognition of the prime importance of the worker–client relationship.

Weaknesses

Attachment theory has been criticized for insufficiently acknowledging the role of temperament in human development, as well as the effects of racism, poverty, social class, and other environmental conditions; it has also been argued that the theory places too much importance on the relationship between mother and child and consequently supports "mother blaming" ideologies (Birns, 1999). Other authors have argued that attachment theory and research are excessively influenced by Western perspectives and they question the universality of its basic tenets (e.g., Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000).

A review of research findings with respect to the domains of attachment theory and temperament theories has led Vaughn, Bost, and Van Ijzendoorn (2008) to conclude that the relationship between measures of temperament and the development of attachment is very complex: "Aspects of both domains contribute meaningfully

to a broad range of interpersonal and intrapersonal outcomes, both as direct effects and as products of their interaction" (p. 210). They recommend that future studies of the "consequences" of either attachment or temperament should include measures from both domains.

With respect to criticisms about neglect of the effects of environmental conditions such as racism, social class, and poverty, Bowlby repeatedly recognized societal contributions to the quality of parenting and child well-being (Holmes, 1993b), and attachment researchers have certainly acknowledged the influence of systemic factors on parenting as previously noted.

Criticism with respect to "mother blaming" results from a narrow view of attachment theory, and fails to take into account the evolution of the theory since Bowlby first articulated it. Currently, considerable research has explored the contribution of fathers to attachment security in children. German researchers (Grossmann et al., 2008) have conducted many studies of the quality of child–father attachment, and they suggest that the Strange Situation may not be the best indicator of attachment between child and father—rather that "a father's play sensitivity . . . is the best and most valid measure of the quality of a child-father relationship" (p. 861). Their review of a "wider view of attachment and exploration" concludes "mothers and fathers both contribute to the lengthy, complex developmental process of achieving psychological security or insecurity" (p. 874).

In response to Rothbaum et al.'s (2000) claims that comparisons of attachment research conducted in the United States and Japan do not support the universality of key tenets of attachment theory, Van Ijzendoorn and Sagi-Schwartz (2008) conducted a thorough review of the empirical support for the core hypotheses of attachment theory. They concluded that the evidence for the cross-cultural validity of attachment theory is strong: The evidence is particularly robust for the hypothesis that attachment is a universal phenomenon and that even in cultures where children are cared for by a network of caregivers, the "caregiver who takes responsibility for the care of the child during part of the day or night becomes the favourite target of infant attachment behaviors" (p. 897).

Populations Most Suited to Attachment Theory

Attachment theory has something to contribute to the understanding of all clients. The most obvious populations to which attachment theory can be applied are those of all ages dealing with separation, loss, and grief, as well as trauma and abuse. Interventions heavily influenced by attachment theory and research include treatment of depressed parents or traumatized mothers (Iles, Slade, & Spiby, 2011; Toth, Rogosch, & Cicchetti, 2008), treating young children with disorganized attachment (Benoit, 2001), and working with maltreated children in child protection, foster care, or adoptive placements (Barth, Crea, John, Quinton, & Thoburn, 2005; Mennen & O'Keefe, 2005). Attachment theory has also been recognized as useful in interventions with adolescents and adults with borderline personality disorder (de Zulueta & Mark, 2000) and eating disorders (Tasca, Balfour, Ritchie, & Bissada, 2007), with adults coping with childhood abuse (Muller & Rosenkranz, 2009), with issues of domestic and intimate partner violence (Lawson, Barnes, Madkins, & Francios-Lamonte, 2006; Levendosky, Lannert, & Yalch, 2012), and with concerns involving intimacy with a romantic partner (Kilmann, Urbaniak, & Parnell, 2006).

CASE EXAMPLE

The following case example illustrates how an attachment-informed family therapy can help a blended family work through the issues that each member brings to the new family. It is also an example of how the therapist allows family members to use her or him as a secure base to explore their feelings, thoughts, and attitudes, and modify ways of thinking and perceiving that are interfering with positive feelings about self and others. When done effectively, attachment-informed family therapy helps children to express their fears and concerns and discover their place within the new family unit, and parents can learn how to maintain a healthy relationship with their children while building a new and loving bond with their spouse and stepchildren.

The Spencer family consists of Jeff, his second wife, Karen (both in their early 40s), and Jeff's two children from a previous marriage, Justin (age 14) and Linda (age 18, currently away from home attending university). The family was referred by Justin's school because of his inattentive and withdrawn behavior in school, which surfaced suddenly over the previous semester. Jeff and Karen have been married for 2 years and Jeff has been divorced from Justin's mother for 6 years. In the first session with the family, the social worker heard from the parents that the transition to a blended family seemed quite smooth at first. Recently, however, Justin's sister had graduated high school and moved out, and Jeff had been working more hours, leaving Justin and Karen at home alone in the evenings. Jeff said that he had always simply trusted Karen to build the connection with his son, because she raised two children on her own (her husband died several years ago) who were now grown and not living with them. Karen stated that her parenting style was somewhat different from Jeff's, and while Karen felt that she and Justin were getting along well with each other, it was the social worker's impression that her interaction style may not have been as energetic or warm as her husband's tended to be.

Karen described how hard she had been working to fit into Jeff's family and get close to Justin and his sister. She stated she had been very conscious of not wanting to be critical or authoritarian with them and had generally taken a "hands-off" approach; she stated it was not her role to discipline. It was very important to her that she not repeat what she had experienced with her own stepfather who had come into her life as a teenager and with whom she had a contentious and hostile relationship. She expressed how much she wanted to avoid being seen as the "wicked stepmother." Jeff acknowledged the efforts his wife had made coming into the family; he also stated that he had been preoccupied with work as he had been spending long hours at two jobs in an effort to overcome the financial debt incurred during the first marriage. He reported that Justin had seemed to adjust well and had made good progress both at school and at home until now.

Justin was very quiet and kept silent for much of the conversation; although he verbally stated he was happy, his face looked sad and he turned away and avoided eye contact with everyone in the room. The worker reflected in the session that Justin seemed sad; in response, Karen recounted that Justin was a quiet boy and she felt she had learned to understand his personality and that they had become closer when she had accepted his quietness and not pushed him to talk. Justin nodded silently when asked how this was for him. Jeff then explained how his son was a "good boy" who never was in any trouble and seemed content to spend time alone in his room or on his computer playing games. Jeff talked about how much he wanted his children

to be happy and how hard he was working to try and make that happen. As he described this, a flash of sadness crossed his face; however, when asked by the social worker, he stated he was not aware of feeling sad. When asked, he said that emotions were not talked about in his family of origin and that his way of dealing with problems was to try and solve them and fix anything that was amiss. Jeff's explanation was followed by an immediate assertion by Karen that Justin was really fine and that they as a family were really doing well. She did say, however, that the family was willing to engage in any sessions the social worker thought appropriate, but she was hopeful that this would not involve a lot of expense of time or money for the family.

In assessing the emotional connection between the family members, the social worker began to identify the patterns of interaction among the family members that might be interfering with openness and engagement. The overarching pattern seemed to be the avoidance of emotional contact as each member was reluctant to move the conversation beyond superficial descriptions and constructed a rather flat narrative that seemed to be motivated by a desire, particularly by Karen and Jeff, to be viewed positively by the social worker. Emotions of sadness or frustration that were observed and reflected by the worker were rationalized or minimized. Justin was quiet, shy, and avoided eye contact with both his parents and the social worker. Karen was the most verbal member of the family, and took the lead in the discussion, providing her version of Justin that seemed shaped primarily by her own experience. The social worker's goals in the initial sessions were to establish a strong therapeutic alliance with each family member and to explore each partner's emotional experience in the family. After the family session, the couple was seen separately from Justin in order to assess their relationship, specifically their ability to respond to Justin's attachment needs for safety, security, and comfort, and how the couple's interactional dynamic and their own attachment histories might be playing into the building of family cohesion.

The session with Karen and Jeff revealed the couple's openness and receptivity to therapy, fueled primarily by their strong connection with each other. The social worker hypothesized that the primary challenge to their understanding and responsiveness to Justin was their different relationships as father and stepmother. At the end of the initial couple session, the worker suggested that she meet with the couple for more couple sessions interspersed with the family sessions and sessions including only Jeff and Justin. She wanted to help the couple better understand how their earlier life experiences might be influencing their interactions in their roles as father and stepmother, and ultimately help them to more effectively support each other in these roles and be more accessible to Justin. She also wanted to better understand the nature of the relationship between Justin and his father.

The worker assessed that it was critical to help Jeff, the biological parent, focus on his son, Justin, and to separate out the marriage relationship from the parenting relationship due to the conflicting and competing nature of the attachment needs of the two subsystems. It appeared that for Justin to feel emotionally safer and secure he needed more of his dad's undivided attention and Jeff needed the opportunity to be entirely present for his son. During a session with only Jeff and Justin, the social worker actively directed the interaction between Jeff and Justin, by coaching Justin to openly express to his father his worries about whether he was truly wanted in the new family. She then helped Jeff to directly express his genuine wish to have his son continue to live with him and his deep concern and caring for his son.

During the following family session, Justin was able to tell his father that he missed the way they had been as a family before the divorce, but that he did not want to hurt his father's and Karen's feelings. He was able to say that the new family situation had felt unbearable for him, but he also did not want to go to live with his mother who now lived in another city in a new relationship. He had, therefore, been feeling quite hopeless. In this session, he was also able to acknowledge his own need for attention and consideration; Jeff was able to hear his son and respond with openness and reassurance.

Jeff took what he had learned from the session with his son back to the couple's session to help process the information together with Karen. Since Jeff's needs had been discussed previously, he was now more able to comfort and be present with Karen's feelings of inadequacy; he was now also able to ask for Karen's support around helping him to be there for Justin. Jeff's request for Karen's assistance worked to break the isolation she was feeling in the family. Over time, Karen's increased feelings of security helped her to relax her rigid, somewhat distant, stance around Justin, and Jeff was able to adopt a more active and effective role in parenting his son. A later joint family session, with Jeff and Karen demonstrating a more open and engaging manner toward Justin, allowed Justin to open up more; he creatively used lyrics from one of his favorite songs to express his grief over the loss of his own family and his feeling of not belonging within this new family structure. This is an example of how the increased sense of safety to express painful feelings that can be developed in a family session allows family members to take risks and have a "corrective emotional experience" when the response from the worker and other family members is one of support and understanding.

The Spencers had 13 sessions in total with the social worker. Five sessions were composed of the couple, four of the father and son, and four with all three family members. These were interspersed throughout the process to optimize the therapeutic outcome. The final session was held with the family unit to track and reflect how the family was functioning currently and help to solidify and consolidate the changes. In general, the family continued to have challenges associated with common issues in blended families, but the atmosphere in the family was one of greater ease and lightness with a more open flow of conversation between all the family members. This change reflected a recovery from the withdrawn, avoidant pattern that was characteristic of the family in the beginning of treatment.

SUMMARY

Attachment theory has provided the theoretical framework for enormous amounts of research into a wide range of human experiences. This research continues to both support and amplify the basic tenets of the theory, and to grow at a phenomenal rate. The theory provides a way of understanding human relationships that is very compatible with the best of social work practice. Attachment theory can be integrated with other perspectives, and can guide the use of techniques from a variety of therapeutic models. It is applicable to individual, family, and group interventions. It also has much to offer policies and interventions that aim to prevent mental health and social problems in future generations.

REFERENCES

Ainsworth, M. D. S. (1989). Attachments beyond infancy. *American Psychologist*, 44, 709–716.

Ainsworth, M. D. S., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: Assessed in the Strange Situation and at home*. Hillsdale, NJ: Lawrence Erlbaum.

Allen, J. (2013). *Mentalizing in the development and treatment of attachment trauma*. London, UK: Karnac Books.

Barth, R. P., Crea, T. M., John, K., Quinton, D., & Thoburn, J. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child & Family Social Work*, *10*, 257–268.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, *61*, 226–244.

Bennett, S., & Nelson, J. K. (2010). Contemporary theory and research on adult attachment: Where is the field today? In S. Bennett & J. K. Nelson (Eds.), *Adult attachment in clinical social work: Practice, research, and policy* (pp. 31–55). New York, NY: Springer Publishing.

Benoit, D. (2001). Modified interaction guidance. *IMPrint Newsletter of Infant Mental Health Promotion*, *32*, 1–6.

Birns, B. (1999). Attachment theory revisited: Challenging conceptual and methodological sacred cows. *Feminism & Psychology, 9*, 10–21.

Bjorgvinsson, T., & Hart, J. (2006). Cognitive behavioral therapy promotes mentalizing. In J. G. Allen & P. Fonagy (Eds.), *Handbook of mentalization-based treatment* (pp. 157–170). Hoboken, NY: John Wiley & Sons.

Bowlby, J. (1969/1982). *Attachment and loss, Volume 1: Attachment*. New York, NY: Basic Books.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London, UK: Tavistock.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.

Bretherton, I., & Munholland, K. A. (2008). Internal working models in attachment relationships: A construct revisited. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 102–127). New York, NY: Guilford.

Brown, K. M., & Sorter, D. (2010). Listening closely: The significance of the therapist's voice intensity, rhythm, and tone. In S. Bennett & J. K. Nelson (Eds.), *Adult attachment in clinical social work: Practice, research, and policy* (pp. 97–111). New York, NY: Springer Publishing.

Cassidy, J., & Shaver, P. R. (2008). Preface. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory research and clinical applications* (pp. xi–xvi). New York, NY: Guilford.

Coan, J. A. (2008). Toward a neuroscience of attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 241–265). New York, NY: Guilford.

Coan, J. A., Schaefer, H. S., & Davidson, R. J. (2006). Lending a hand: Social regulation of the neural response to threat. *Psychological Science*, *17*, 1032–1039.

Cohen, N. J., Lojkasek, M., & Muir, E. (2006). Watch, wait, and wonder: An infant-led approach to infant-parent psychotherapy. *The Signal: Newsletter of the World Association for Infant Mental Health*, *14*, 1–4.

De Zulueta, F., & Mark, P. (2000). Attachment and contained splitting: A combined approach of group and individual therapy to the treatment of patients suffering from borderline personality disorder. *Group Analysis*, *33*, 486–500.

Diamond, G. S., Diamond, G. M., & Levy, S. A. (2013). *Attachment-based family therapy for depressed adolescents*. Australia: Footprint Books.

Egeland, B. R. (1998, October). *The longitudinal study of attachment and psychopathology*. Paper presented at the Second International Conference on Attachment and Psychopathology, Toronto, Canada.

Fewell, C. H. (2010). Using a mentalization-based framework to assist hard-to-reach clients in individual treatment. In S. Bennett & J. K. Nelson (Eds.), *Adult attachment in clinical social work: Practice, research, and policy* (pp. 97–111). New York, NY: Springer Publishing.

Fish, B. (1996). Clinical implications of attachment narratives. *Clinical Social Work Journal, 24*, 239–253.

Flores, P. J. (2004). *Addiction as an attachment disorder*. New York, NY: Jason Aronson.

Fonagy, P., Bateman, A., & Luyten, P. (2012). Introduction and overview. In P. Fonagy & A. Bateman (Eds.), *Handbook of mentalizing in mental health practice* (pp. 3–42). Washington, DC: American Psychiatric Publishing.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Fonagy, P., Gergely, G., & Target, M. (2008). Psychoanalytic constructs and attachment theory and research. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory research and clinical applications* (pp. 783–810). New York, NY: Guilford.

Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disordered attachment. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain* (pp. 221–281). New York, NY: W. W. Norton.

George, C., Kaplan, N., & Main, M. (1996). *Adult Attachment Interview* (3rd ed.) [Unpublished manuscript]. Department of Psychology, University of California, Berkeley.

Grossmann, K., Grossmann, K. E., Kindler, H., & Zimmermann, P. (2008). A wider view of attachment and exploration: The influence of mothers and fathers on development of psychological security from infancy to young adulthood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory research and clinical applications* (pp. 857–879). New York, NY: Guilford.

Grossmann, K. E., & Grossmann, K. (2009). The impact of attachment to mother and father and sensitive support of exploration at an early age on children's psychosocial development through young adulthood. *Encyclopedia on Early Childhood Development*. Retrieved from http://www.child-encyclopedia.com/attachment/according-experts/impact-attachment-mother-and-father-and-sensitive-support-exploration

Hartling, L. M. (2008). Strengthening resilience in a risky world: It's all about relationships. *Women and Therapy*, *31*, 51–70.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *52*, 511–524.

Holmes, J. (1993a). Attachment theory: A biological basis for psychotherapy? *British Journal of Psychiatry, 163*, 430–438.

Holmes, J. (1993b). *John Bowlby and attachment theory*. London, UK: Routledge.

Holmes, J. (2001). *The search for the secure base*. Philadelphia, PA: Taylor Francis.

Holmes, J. (2004). Disorganized attachment and borderline personality disorder: A clinical perspective. *Attachment & Human Development*, *6*, 181–190.

Holmes, J. (2010). *Exploring in security: Towards an attachment-informed psychoanalytic psychotherapy.* London, UK: Routledge.

Hughes, D. (2009). *Attachment-focused parenting: Effective strategies to care for children*. New York, NY: W. W. Norton.

Iles, J., Slade, P., & Spiby, H. (2011). Posttraumatic stress symptoms and postpartum depression in couples after childbirth: The role of partner support and attachment. *Journal of Anxiety Disorders*, *25*, 520–530.

Jacobvitz, D. (2008). Afterword: Reflections on clinical applications of the Adult Attachment Interview. In H. Steele & M. Steele (Eds.), *Clinical applications of the Adult Attachment Interview* (pp. 471–486). New York, NY: Guilford.

Johnson, S. M. (2008). Couple and family therapy: An attachment perspective. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 811–829). New York, NY: Guilford.

Johnson, S. M., & Best, M. (2003). A systemic approach to restructuring adult attachment: The EFT model of couples therapy. In P. Erdman & T. Caffery (Eds.), *Attachment and family systems: Conceptual, empirical and therapeutic relatedness* (pp. 165–189). New York, NY: Brunner-Routledge.

Johnson, S. M., & Wittenborn, A. K. (2012). New research findings on emotionally focused therapy: Introduction to a special section. *Journal of Marital and Family Therapy*, *38*, 18–22.

Kilmann, P. R., Urbaniak, G. C., & Parnell, M. M. (2006). Effects of attachment-focused versus relationship skills-focused group preventive intervention on insecure women. *Group Dynamics: Theory, Research, and Practice*, *3*(2), 138–147.

Lawson, D. M., Barnes, A. D., Madkins, J. P., & Francios-LaMonte, B. M. (2006). Changes in male partner abuser attachment styles in group treatment. *Psychotherapy: Theory, Research, Practice, Training*, *43*(2), 232–237.

Ledwith, K. C. (2011). *Beginnings and endings: An inquiry into the attachment orientations and termination approaches among clinical social workers* [Doctorate in Social Work (DSW) Dissertation]. University of Pennsylvania, Philadelphia, PA. Retrieved from http://repository.upenn.edu/cgi/viewcontent.cgi?article=1013&context=edissertations_sp2

Levendosky, A. A., Lannert, B., & Yalch, M. (2012). The effects of intimate partner violence on women and child survivors: An attachment perspective. *Psychodynamic Psychiatry*, *40*(3), 397–434.

Lewis, L. (2006). Enhancing mentalization capacity through dialectical behavior therapy skills training and positive psychology. In J. G. Allen & P. Fonagy (Eds.), *Handbook of mentalization-based treatment* (pp. 171–182). Hoboken NY: John Wiley & Sons.

Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York, NY: Guilford.

Main, M., Hesse, E., & Kaplan, N. (2005). Predictability of attachment behavior and representational processes at 1, 6, and 19 years of age. In K. E. Grossmann, K. Grossmann, & E. Waters (Eds.), *Attachment from infancy to adulthood: The major longitudinal studies* (pp. 245–304). New York, NY: Guilford.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. T. Greenberg, D. C. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 121–160). Chicago, IL: University of Chicago Press.

Mayes, L. C. (2000). A developmental perspective on the regulation of arousal states. *Seminars in Perinatology*, *24*, 267–279.

McMillen, J. C. (1992). Attachment theory and clinical social work. *Clinical Social Work Journal*, *20*, 205–218.

Mennen, F. E., & O'Keefe, M. (2005). Informed decisions in child welfare: The use of attachment theory. *Child and Youth Services Review*, *27*(6), 577–593.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics and change*. New York, NY: Guilford.

Mikulincer, M., & Shaver, P. R. (2009). An attachment and behavioral systems perspective on social support (Special issue: Social support). *Journal of Social and Personal Relationships, 26*, 7–19.

Muller, R. T., & Rosenkranz, S. E. (2009). Attachment and treatment response among adults in impatient treatment for posttraumatic stress disorder. *Psychotherapy Theory, Research, Practice, Training*, *46*(1), 82–96.

Page, T. F. (2010). Applications of attachment theory to group interventions: A secure base in adulthood. In S. Bennett & J. K. Nelson (Eds.), *Adult attachment in clinical social work: Practice, research, and policy* (pp. 173–191). New York, NY: Springer.

Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2013). *The Circle of Security intervention: Enhancing attachment in early parent-child relationships*. New York, NY: Guilford.

Robertson, J. (1952). *A two-year-old goes to hospital: An abridged version of a scientific film*. Ipswich, Suffolk: Concord Video & Film Council.

Rosenzweig, D. R., Farber, B. A., & Geller, J. D. (1996). Clients' representations of their therapists over the course of psychotherapy. *Journal of Clinical Psychology*, *52*, 197–207.

Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist*, *55*(10), 1093–1104.

Rutter, M. (1995). Clinical implications of attachment concepts: Retrospect and prospect. *Journal of Child Psychology and Psychiatry*, *4*, 549–571.

Rutter, M. (2008). Implications of attachment theory and research for child care policies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 958–974). New York, NY: Guilford.

Sable, P. (1992). Attachment theory: Application to clinical practice with adults. *Clinical Social Work Journal*, *20*, 271–283.

Sable, P. (1995). Attachment theory and social work education. *Journal of Teaching in Social Work*, *12*, 19–38.

Sable, P. (2008). What is adult attachment? *Clinical Social Work Journal*, *36*, 21–30.

Sable, (2010). The origins of an attachment approach to social work practice with adults. In S. Bennett & J. K. Nelson (Eds.), *Adult attachment in clinical social work: Practice, research, and policy* (pp. 17–29). New York, NY: Springer Publishing.

Schore, A. N. (2001). The effects of a secure attachment relationship on right brain development affect regulation, and infant mental health. *Infant Mental Health Journal*, *22*, 7–66.

Schore, J., & Schore, A. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, 36(1), 9–21.

Schore, J., & Schore, A. (2010). Clinical social work and regulation theory: Implications of neurobiological models of attachment. In S. Bennett & J. K. Nelson (Eds.), *Adult attachment in clinical social work: Practice, research, and policy* (pp. 57–75). New York, NY: Springer Publishing.

Shapiro, J. (2010). Attachment in the family context: Insights from development and clinical work. In S. Bennett & J. K. Nelson (Eds.), *Adult attachment in clinical social work: Practice, research, and policy* (pp. 147–172). New York, NY: Springer Publishing.

Shilkret, R., & Shilkret, C. J. (2011). Attachment theory. In J. Berzoff, L. Melano Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (3rd ed., pp. 186–207). Lanham, MD: Rowman & Littlefield Publishers, Inc.

Siegel, D. J. (2010). *Mindsight: The new science of personal transformation*. New York, NY: Bantam Books.

Simpson, J. A., Collins, W. A., & Salvatore, J. E. (2011). Impact of early interpersonal experience on adult romantic relationship functioning: Recent findings from the Minnesota Longitudinal Study of Risk and Adaptation. *Current Directions in Psychological Science*, *20*, 355–359.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development*, *7*, 269–281.

Slade, A. (2008). The implications of attachment theory and research for adult psychotherapy research and clinical perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory research and clinical applications* (pp. 762–782). New York, NY: Guilford.

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment and Human Development*, 7, 349–367.

Sroufe, L. A., Egeland, B., Carlson, E. A., & Collins, W. A. (2009). *The Development of the Person: The Minnesota Study of Risk and Adaptation From Birth to Adulthood*. New York, NY: Guilford.

Steele, H., & Steele, M. (2008). Ten clinical uses of the Adult Attachment Interview. In H. Steele & M. Steele (Eds.), *Clinical applications of the Adult Attachment Interview* (pp. 3–30). New York, NY: Guilford.

Steele, H., Steele, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers, fathers, and their infants. *Child Development*, *67*, 1184–1199.

Tasca, G., Balfour, L., Ritchie, K., & Bissada, H. (2007). The relationship between attachment scales and group therapy alliance growth differs by treatment type for women with binge-eating disorder. *Group Dynamics: Theory, Research, and Practice*, *11*(1), 1–14.

Toth, S., Rogosch, F., & Cicchetti, D. (2008). Attachment-theory-informed intervention and reflective functioning in depressed mothers. In H. Steele & M. Steele (Eds.), *Clinical applications of the Adult Attachment Interview* (pp. 154–172). New York, NY: Guilford.

Tronick, E. (2009). *The neuro behavioral and social-emotional development of infants and children*. New York, NY: W. W. Norton.

Van Ijzendoorn, M. H., & Sagi-Schwartz, A. (2008). Cross-cultural patterns of attachment: Universal and contextual dimensions. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory research and clinical applications* (pp. 880–905). New York, NY: Guilford.

Vaughn, B. E., Bost, K. K., & Van Ijzendoorn, M. H. (2008). Attachment and temperament: Additive and interactive influences on behavior, affect and cognition during infancy and childhood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory research and clinical applications* (pp. 192–216). New York, NY: Guilford.

Zeifman, D., & Hazan, C. (2008). Pair bonds as attachments: Re-evaluating the evidence. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 436–455). New York, NY: Guilford.